

44°



22102152807

ROYAL COMMISSION ON LUNACY AND MENTAL DISORDER.

MINUTES OF EVIDENCE

TAKEN BEFORE THE

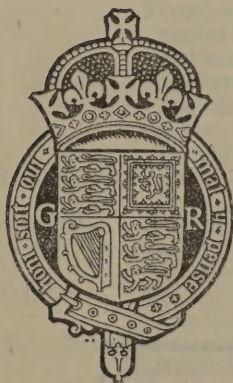
ROYAL COMMISSION ON LUNACY AND MENTAL
DISORDER.

PART I.

MINUTES OF EVIDENCE TAKEN ON DAYS 1—20

(7th OCTOBER, 1924—10th FEBRUARY, 1925).

Questions 1—11,834.



LONDON :

PRINTED & PUBLISHED BY HIS MAJESTY'S STATIONERY OFFICE.

To be purchased directly from H.M. STATIONERY OFFICE at the following addresses :

Adastral House, Kingsway, London, W.C.2; 28, Abingdon Street, London, S.W.1;

York Street, Manchester; 1, St. Andrew's Crescent, Cardiff;

or 120, George Street, Edinburgh;

or through any Bookseller.

1926

Price £1 1s. Net.

FA1

9427

BRITAIN Mental Diseases

20 cent.

M - D - : G - B - : 20 cent.

1772,935

MINUTES OF EVIDENCE

ROYAL COMMISSION ON LUNACY AND MENTAL DISORDER

ROYAL COMMISSION ON LUNACY AND MENTAL DISORDER

PART I

MINUTES OF EVIDENCE



336185



WELLCOME INSTITUTE LIBRARY	
Coll.	Wellcome
Call	GENERAL COLLECTIONS
No.	+
	M 7

TABLE OF CONTENTS.

MINUTES OF EVIDENCE.

Day.	Name.	Designation.	Questions.	Page.
First Day ... 7th Oct., 1924.	Sir FREDERICK WILLIS, K.B.E., C.B.	Chairman of the Board of Control.	1-480	1
	Mr. S. J. FRASER MACLEOD, K.C. ...	Legal Commissioner ...		
	Dr. C. H. BOND, C.B.E., D.Sc., M.D., F.R.C.P.	Medical Commissioner		
Second Day ... 8th Oct., 1924.	Sir FREDERICK WILLIS, K.B.E., C.B.	Chairman of the Board of Control.	481-944	24
	Mr. S. J. FRASER MACLEOD, K.C. ...	Legal Commissioner ...		
	Dr. C. H. BOND, C.B.E., D.Sc., M.D., F.R.C.P.	Medical Commissioner		
	Sir CLAUD SCHUSTER, K.C.B., C.V.O., K.C.	Permanent Secretary to the Lord Chancellor.	945-1061	44
Third Day ... 21st Oct., 1924.	Sir CLAUD SCHUSTER, K.C.B., C.V.O., K.C.	Permanent Secretary to the Lord Chancellor.	1062-1065	48
	Mr. L. G. BROCK, C.B. ...	Assistant Secretary, Ministry of Health.	1066-1222	49
	Mr. H. W. S. FRANCIS, O.B.E. ...	Assistant Secretary, Ministry of Health.	1223-1473	55
	Mr. E. J. LIDBETTER ...	President of the National Association of Relieving Officers.	1474-1775	62
Fourth Day ... 22nd Oct., 1924.	Brig.-Gen. Sir JOHN BARNESLEY, D.L., V.D., J.P.	Justice of the Peace for the City of Birmingham.	1776-2015	74
	Sir ROBERT WALDEN, C.B.E., J.P. ...	Justice of the Peace for the County of London.	2016-2180	81
	Mr. WILLIAM HENRY LORD, J.P. ...	Justice of the Peace for the City of Birmingham.	2181-2304	88
	Councillor C. F. SANDERS, J.P. ...	Justice of the Peace for the City of Cardiff.	2305-2448	92
Fifth Day ... 4th Nov., 1924.	Dr. A. L. Baly, M.R.C.S., L.R.C.P. ...	Medical Superintendent, Lambeth Poor Law Infirmary.	2449-3009	97
	Dr. J. DUDGEON GILES, O.B.E., M.D.	Medical Superintendent, Salford Poor Law Infirmary.	3010-3173	115
Sixth Day ... 5th Nov., 1924.	Mr. HAROLD SENIOR ...	President, National Association of Masters and Matrons of Poor Law Institutions.	3174-3539	121
	Mr. GEORGE USHER ...	Honorary Secretary of the Association.		
	Mr. L. WHITEMORE, J.P. ...	Justice of the Peace for the County of London.	3540-3598	135
	Col. P. BROOME-GILES, C.B., F.R.C.S., J.P.	Justice of the Peace for the County of Herefordshire.	3599-3711	138
Seventh Day ... 18th Nov., 1924.	Lt.-Col. J. FRANCIS DIXON, M.A., M.D.	Medical Superintendent, Leicester City Mental Hospital, Humberstone.	3712-4050	142
	Dr. O. G. CONNELL, M.C., L.R.C.P. ...	Medical Superintendent, Norfolk County Mental Hospital.	4051-4244	158
Eighth Day ... 19th Nov., 1924.	Dr. H. DEVINE, O.B.E., M.D., F.R.C.P.	Medical Superintendent, Portsmouth Mental Hospital.	4245-4560	166
	Dr. H. WOLSELEY LEWIS, M.D., F.R.C.S.	Medical Superintendent, Kent County Mental Hospital, Maidstone.	4561-4698	182
	Mr. HENRY FURSE KEENE, O.B.E. ...	Chief Officer, Mental Hospitals Department, London County Council.	4699-4746	187
Ninth Day ... 2nd Dec., 1924.	Mr. HENRY FURSE KEENE, O.B.E. ...	Chief Officer, Mental Hospitals Department, London County Council.	4747-5071	189
	Mr. WILLIAM GEORGE LOBJOIT, O.B.E., J.P.	Chairman, Visiting Committee, Middlesex Mental Hospitals.	5072-5205	201
	Mr. WILLIAM EDWARD LOVSEY, J.P.	Chairman, Asylums Committee, Birmingham City Council.	5206-5380	208
	Dr. T. C. GRAVES, B.Sc., F.R.C.S. ...	Medical Superintendent, Rubery Hill and Hollymoor Mental Hospitals, Birmingham.		

Day.	Name.	Designation.	Questions.	Page.
Tenth Day ... 3rd Dec., 1924.	Dr. HENRY YELLOWLEES, O.B.E., M.D. Mrs. CONSTANCE M. R. CROSLAND ...	Medical Superintendent, The Retreat, York. Member of Managing Com- mittee.	5381-5851	214
	Dr. J. G. PORTER PHILLIPS, M.D., F.R.C.P. Mr. LIONEL L. FAUDEL-PHILLIPS ...	Physician Superintendent, Bethlem Royal Hospital. Treasurer, Bethlem Royal Hospital.	5852-5981	235
Eleventh Day ... 16th Dec., 1924.	The Rev. P. S. G. PROPERT ... Mr. R. A. LEACH ... Mr. JAMES H. FORD ... Mr. J. W. FLINT, J.P. ... Dr. F. H. EDWARDS, M.D. ...	Representing the Association of Poor Law Unions.	5982-6309	240
		Medical Superintendent, Cam- berwell House.	6310-6479	257
Twelfth Day ... 17th Dec., 1924.	Sir CECIL CHUBB, Bt., LL.B. ... Dr. FRANK FAWSETT, M.B.... ...	Proprietor, The Old Manor, Salisbury. Medical Visitor to the Justices, East Sussex.	6480-6891 6892-7039	266 280
	Sir JAMES BARR, C.B.E., D.L., M.D., F.R.C.P.	Medical Visitor to the Justices, Liverpool.	7040-7165	285
Thirteenth Day.. 13th Jan., 1925.	Dr. G. F. BARHAM, M.D. ... Miss VICKERS ...	Medical Superintendent, Clay- bury Mental Hospital. Secretary, Mental After-Care Association.	7166-7694 7695-7795	291 309
Fourteenth Day. 14th Jan., 1925.	Dr. R. LANGDON-DOWN, M.B., M.R.C.P. Dr. J. W. BONE, M.B., C.M. ... Dr. F. H. EDWARDS, M.D. ... Dr. C. O. HAWTHORNE, M.D., F.R.C.P. Dr. E. G. W. MASTERMAN, M.D., F.R.C.S. Dr. CHRISTINE MURRELL, M.D. ... Sir JENNER VERRALL, LL.D., L.R.C.P., M.R.C.S. Dr. COURTENAY LORD, M.R.C.S., L.R.C.P.	Representing the British Medical Association.	7796-8215	313
Fifteenth Day ... 17th Jan., 1925.	Mr. H. ...	Former Patient ...	8216-9122	337
Sixteenth Day ... 26th Jan., 1925.	Sir MAURICE CRAIG, C.B.E., M.D. ... Mr. CHAS. RICHARD STEELE ... Dr. W. H. BUTTER STODDART ... Dr. REGINALD J. STILWELL, M.R.C.S., M.R.C.P.	Consultant ... Solicitor ... Consultant ... Licensee of Moorcroft House	9123-9543 9544-9616 9617-9704 9705-9940	375 395 398 401
Seventeenth Day 27th Jan., 1925.	Dr. R. PERCY SMITH, M.D., F.R.C.P. Dr. J. G. PORTER PHILLIPS, M.D., F.R.C.P. Mr. R. MONTGOMERY BIRCH PARKER	Consultant ... Physician Superintendent, Bethlem Royal Hospital. Chairman National Society for Lunacy Reform.	9941-10,132 10,133-10,345 10,346-10,641	407 414 420
Eighteenth Day. 28th Jan., 1925.	Mr. R. MONTGOMERY BIRCH PARKER	Chairman National Society for Lunacy Reform.	10,642-11,095	434
Nineteenth Day.. 9th Feb., 1925.	Mr. R. MONTGOMERY BIRCH PARKER	Chairman National Society for Lunacy Reform.	11,096-11,524	458
Twentieth Day ... 10th Feb., 1925.	Mr. R. MONTGOMERY BIRCH PARKER	Chairman National Society for Lunacy Reform.	11,525-11,834	484

Note.—The Appendices to the Evidence are printed separately in Part III.

ROYAL COMMISSION ON LUNACY AND MENTAL DISORDER.

FIRST DAY.

Tuesday, 7th October, 1924.

MEMBERS PRESENT :

THE RT. HON. H. P. MACMILLAN, K.C. (*in the Chair*).

THE EARL RUSSELL.

LORD EUSTACE PERCY, M.P.

SIR HUMPHRY ROLLESTON, BART., K.C.B., M.D.

SIR THOMAS HUTCHISON, BART.

SIR ERNEST HILEY, K.B.E.

SIR DAVID DRUMMOND, C.B.E., M.D.

MR. W. A. JOWITT, K.C., M.P.

MR. F. D. MacKINNON, K.C.

MRS. C. J. MATHEW.

MISS MADELEINE SYMONS.

MR. P. BARTER (*Secretary*).

MR. W. FAIRLEY (*Assistant Secretary*).

Sir FREDERICK WILLIS, K.B.E., C.B. (accompanied by Mr. S. J. Fraser Macleod, K.C., Legal Commissioner, and Dr. C. H. Bond, C.B.E., D.Sc., M.D., F.R.C.P., a Medical Commissioner of the Board of Control), called and examined.

Chairman: Before we begin our Inquiry this morning, I feel that it would be only fitting that we should record our regret at the death of Mr. Trevor, one of the Legal Commissioners of the Board of Control. Mr. Trevor's notable public services in this department of administration have won for him the respect and the appreciation of all. We had hoped that we should have the benefit of his assistance in our deliberations here, but unfortunately that is not to be so. Before we begin the work of this Inquiry, in which he would have been so much interested, I am sure you will all agree with me that we should take the opportunity of expressing our regret and paying a tribute to his memory.

The witness who is before us to-day is Sir Frederick Willis, K.B.E., C.B., Chairman of the Board of Control.

1. (*To the Witness*): Sir Frederick, you have been good enough to furnish us with a *précis* of your evidence, in which the whole position of the Board of Control in its relation to this branch of administration has been set out. I thought it would be most convenient if, with your *précis* before me and before the other members of the Commission, I were to address to you, and my fellow-Commissioners were to address to you, questions arising upon that *précis*. It might be well if, in the first place, we bring out the limitations of this Inquiry. I have no doubt that in addressing yourself to the task of preparing to give evidence here, you have had in view those limitations. We are instructed to concern ourselves with the person, and not with the property of persons of unsound mind. You will agree with me, I think, that that cuts out a very large chapter of lunacy administration, and simplifies our task to some extent?—Yes.

2. In the next place, within those limits, our Inquiry is directed to two points which one may summarise thus: The first relates to the certification, detention, and care of persons who are or are alleged to be of unsound mind; and the second relates to the question of the treatment without certification of persons suffering from mental disorder. On the first branch we desire your help as to the existing system of law and administration. On the second branch, I understand that we are concerned rather with the region of proposed legislation than of existing legislation. Am I right in that?—That is quite right.

3. So that the two chapters of our investigation relate, firstly to an existing system, and secondly to a possible system which might be instituted. Now with that preamble, first of all, you inform us that you are Chairman of the Board of Control?—Yes.

4. I think it might be convenient if you told us quite shortly the history of the institution of the Board of Control, its composition, and its general duties. As regards its history, will you explain to us the origin of the present Board of Control, as we know it?—Before we begin I would like to say that I and my colleagues are very grateful indeed to you for what you have said with regard to Mr. Trevor. His death is a very, very great loss to us, and we very much appreciate what you have said. The *part of the *précis* which I have furnished dealing with the legal safeguards was prepared by Mr. Trevor as Senior Legal Commissioner, in consultation with his colleagues, and Mr. Macleod, K.C., who is now Senior Legal Commissioner, is quite familiar with all the law on the subject, and he has come in place of Mr. Trevor.

* See Appendix I.

7 October, 1924.]

SIR FREDERICK WILLIS, K.B.E., C.B.

[Continued.]

Do you want me, Sir, to go over again what is more or less in my *précis*? For instance, in regard to the history of the Board of Control, it starts with the formation of the Lunacy Commission in 1845 really.

5. I thought it might be convenient if you dealt with the matter generally. I would not ask that you should go through the matter, vouching it by Sections of Acts of Parliament, and so on, but that you should give us a general description of the inception of your Board?—Quite. I think one might say that it really had its inception in 1845. Prior to that there were some temporary Commissioners, but then it was laid down that there should be a permanent Lunacy Commission. I think I am right in saying that it was then said it should consist of three legal members and three medical members. It was considered very important to get men of high standing, and also important that these positions should be positions of dignity, so that the Commissioners, in going round, should carry as much weight as public officials could; and they were given at that time what was then the highest salary of any member of the permanent Civil Service of this country, namely, £1,500 a year. That salary remains to-day. Of course, in relation to other salaries, it does not occupy the same position as it did in 1845. Whether our dignity, status, and usefulness has decreased in consequence, is hardly for me to say. That Lunacy Commission went on from 1845 until the Mental Deficiency Act of 1913, when the duties of the Lunacy Commissioners were very much enlarged. The Act was founded on the recommendations of a Royal Commission, and dealt largely with mental deficiency as distinguished from insanity. Under that Act a Board was formed which was to consist of not more than 15 members. I think it said that not more than 12 should be paid, and there were to be at least four paid legal members and at least four paid medical members; there were to be at least one paid woman on the Commission, and at least one unpaid woman. That very briefly is the history. It was considered in 1845 that it was very important to have men of high standing going about the country and seeing exactly what was going on; and, reviewing the history, I feel confident that the influence of the Lunacy Commission has been very very useful in producing great improvements. Notwithstanding what may be said against our public asylums to-day, I am confident that if you go round to them you will be struck by the hospital character of them and by the scientific spirit displayed throughout the service. There are, of course, differences in asylums; some of them are very old buildings; but it is wonderful to observe the manner in which these very old buildings have been adapted to modern requirements.

6. Do you attribute that state of efficiency in large measure to the existence of a central body such as the Board of Control?—I do in large measure, but I do not want to say at all that there has not been a general growth of a right spirit throughout the whole lunacy system, the medical men who are administering these asylums and the visiting committees who control them, and so on; but I am sure the Lunacy Commission has been of very great value in producing that present-day condition.

7. Now you have alluded to the Mental Deficiency Act of 1913, which, as you say, was the outcome of the previous Inquiry. It was under that Act that the Board of Control, as we now know it, was constituted?—That is so. I must say here that the Lunacy Commissioners then existing were added to the Board of Control; they were part of its membership.

8. I follow. The classes of persons with whom the Mental Deficiency Act deals are different from those with whom we are concerned in this Inquiry, are they not?—That is so. In theory the Mental Deficiency Act deals with persons who either at birth or early age exhibit some mental defect that arrests development.

9. Is there any over-lapping among the classes with which the two provinces are concerned?—That is to some extent a medical question. I should say there

is a little overlapping, and, of course, you may get lunacy imposed on mental defect. There are many cases of mental defectives who have a mental illness added.

10. An individual might be relegated to one or other of the categories on medical evidence, I suppose?—Yes, quite.

11. The Mental Deficiency Act of 1913, I understand, has created a separate code from the code of lunacy law and administration?—That is so.

12. A code with which this particular Inquiry is not really concerned?—No; it was expressly ruled out of the Reference, I think.

13. We are anxious at the outset to appreciate the principles upon which this branch of law has developed, Sir Frederick, and in a general survey of it, it occurs to me that it exhibits an attempt to accommodate two important legal principles, on the one hand the liberty of the individual, which the law regards as so sacred, and, on the other hand, the protection of the public against an individual who is abnormal in his actions, and the protection of the individual himself against unfortunate consequences of his abnormality. Now do you find that the history of the law exhibits an attempt to accommodate these two large principles?—I should say it does, certainly, and to-day, of course, we also look to the cure of the individual; that is a somewhat modern development; it is very much pressed now-a-days. We are always insisting on everything being done that can be done to effect a cure.

14. Of course the matter has both a legal and a medical aspect, and I was concerned for the moment to bring out what seemed to me to be the legal side of its history. It seems to exhibit an attempt to accommodate two principles, both of which are of great importance, but which must be accommodated in the public interest. On the medical side, I think the history has been one of a progressive effort to improve the conditions under which persons of unsound mind are detained, and to increase their opportunities of recovery at the same time?—That is quite true.

15. Then when one comes to consider how those principles are illustrated in the existing law, where should one look for what we may call the code of the lunacy law and administration at present?—In the earlier sections of the Lunacy Acts it is all set out.

16. I suppose also in the Rules and Orders which have been made in pursuance of those Acts?—Yes, quite.

17. May I take it that really the main source of the existing law is to be found in the Lunacy Acts of 1890 and 1891, with certain minor amending Statutes?—Yes.

18. And that the principles laid down in those Statutes have been developed in a series of Statutory Rules and Orders?—Yes. You do not want me at this stage to say briefly what the code is, I suppose?

19. I think we will take the code in its application to each of the topics we have got to deal with in a moment. It might be useful to get on the note that this is by no means the first Inquiry which has been ordered into these matters. There have been several important Inquiries in the past, have there not?—Several.

20. Would you, for the sake of getting them on the note, allude to the two or three which have been the most important?—There was in 1877 a Select Committee of the House of Commons which was called the Dillwyn Committee, which was appointed to enquire into the operation of the lunacy law so far as regards the security offered by it against violations of personal liberty. They reported on March 28th, 1878. They arrived at the conclusion that allegations of *mala fides* and of serious abuses were not substantiated.

21. And I think they suggested certain changes which would tend to improve still further the existing method of dealing with persons of abnormal mind?—That is so, yes.

7 October, 1924.]

SIR FREDERICK WILLIS, K.B.E., C.B.

[Continued.]

22. I think that Lord Shaftesbury and Mr. Phillips, a well-known Commissioner in Lunacy, and Dr. Blandford, all gave valuable evidence before that Committee?—That is so. I should say that Lord Shaftesbury objected very much indeed to bringing in the Justice to make an order. That was one of the recommendations of that Select Committee. He felt it was going to interfere very largely with the real interest of the insane person, and he resigned the Chairmanship of the Lunacy Commission rather than be a party to carrying out that new proposal.

23. Then there was also, in 1905, a Royal Commission, presided over by Lord Radnor, which issued its report in 1908?—Yes.

24. I think that report is useful as containing a full account of the constitution and procedure of the Lunacy Commission of England and Wales?—That is so, and a great deal of the evidence which they took would really be very valuable to-day, if any members were able to peruse it.

25. Do you suggest that the Members of the Commission might to some extent abbreviate the extent of our present Inquiry by referring to that evidence?—I think they might to some extent, certainly.

26. Especially in regard to non-controversial matters?—Yes. They will see a great many points were thoroughly considered.

27. Yes; it is useful for us to know that. Then another general question: The Lunacy Commissioners who preceded the Board of Control, and now the Board of Control itself, were formed, I take it, for the purpose of having a central body which should supervise and control the general administration of the Lunacy Law throughout the country?—That is so.

28. May one take it that the methods of supervision and control entrusted to the Board take the form of various safeguards in the matter of licensing premises in which insane persons may be detained, in visiting places where such persons are detained, in obtaining reports upon the condition of persons detained, tabulating and arranging statistics, collating information regarding insane persons, and ensuring the execution of the law in conformity with the Statutes and Rules?—Yes; that is a general statement. In addition to that, copies of all the documents on the admission of any patient to an institution for lunatics have to be furnished to the Board at the time, and they are very carefully scrutinised. If, for example, an admission document does not seem to show a sufficient ground for the detention of a patient, further inquiry is made.

29. One cannot read the Acts, I think, without noticing the importance attached to the Board of Control being apprised of what we may call every stage in the history of the insane person?—Yes; all the time we know everything that is going on about them. Dr. Bond mentions that on the occasions of visits by Commissioners to these institutions they make a great point of actually seeing the patients and talking to them; any of them that want a private interview can get a private interview.

30. Of course, a little later on we will discuss what is done. One wants to get at the start of this Inquiry a conspectus of the situation, so that we may understand the details when we come to consider them. I have stated in general terms the province of the Board of Control?—Quite.

31. It keeps in touch, if I may so put it, at every stage with the history of the persons affected?—Yes; and it was considered desirable to gather all of it together in one Department, a sort of separate Government Department, rather than to merge it into some other big Department like the Home Office, the Ministry of Health, or the Local Government Board.

32. Of course, we are the inheritors, are we not, of a somewhat complicated system in the past. What other bodies or persons are concerned with the insane persons in this country, besides the Board of Control?—Of course, to some extent, the Lord Chancellor is concerned with them.

33. He has a certain ancient jurisdiction, has he not?—Yes.

34. Does that relate to the person as well as to the property?—Yes, to some extent, to the person—those lunatics who are found so by inquisition, of which there are very few. He is concerned with the actual care of the person in those instances; he has his own visitors.

35. His jurisdiction is chiefly derived, is it not, from the common law rather than from Statute?—Yes. Of course, to some extent, he has powers under the Lunacy Act of 1890, but largely it is common law jurisdiction.

36. Then in addition to the Lord Chancellor's jurisdiction, is there any other body?—The Home Secretary, of course, has jurisdiction over criminal lunatics. The Minister of Health has no jurisdiction over the persons of lunatics, but plans for new asylums have to receive his approval, and loans for new asylums have to receive his approval. The method of doing that is for the Board of Control to investigate the matter thoroughly; it sometimes means months of investigation before you can settle on the plans of a big new institution which is going to cost anything from half a million to one million pounds; then they pass on, after they have been investigated, to the Minister of Health. The Lord Chancellor sanctions rules which we make for the government of asylums.

37. Do you think that any disadvantage has arisen from what I may call the distribution of functions among those different bodies?—Well, I think it is desirable that the Board of Control should be able to go to the Minister of Health for his side of it, just in the same way that the Ministry of Health, as a Department, goes to the Minister; but we do not do that nowadays. If, for instance, we have to go to the Minister at all, we go to him like any member of the public goes to him on many questions. I am not sure that there is not some duplication of work there.

38. It naturally occurs to one that if there are two bodies or authorities concerned with the matter who have specially to deal with the safeguards relating to lunatics there might be some overlapping?—Yes; on the safeguards I do not think there are two. The Minister of Health, like a number of other people, may have letters sent to him. There is a section saying that letters sent to him, and to Judges, and so on, shall be sent unopened. The usual plan is for the Judges or the Lord Chancellor or the Minister to send them on to us, and ask us what we know about the case; but as to the safeguards of the person, I should say they are in the Board of Control, they are not spread about.

39. But take the Lord Chancellor's jurisdiction. Do you ever find that the Board of Control and the Lord Chancellor are both engaged in investigating the state of any particular lunatic?—Well, in some few cases he visits the same cases that we visit, and if his medical man and our medical man did not quite agree as to the course to be taken about the patient, we should communicate one with the other; we have never any difficulty in that way. His powers in that matter, as I said just now, relate to some very small number, a few hundreds, whilst we deal with over 100,000.

40. But he has certain medical visitors whose functions are not exclusively confined to lunatics found so by inquisition?—No, not exclusively. If an order is made about their property he sends one of his visitors to see the case.

41. So that in the matter of investigating particular cases there are two authorities at the moment?—For this small number.

42. But you have not experienced any inconvenience from that duplication, have you?—No. I have often felt myself that the visitation of all these people should be done by the Board of Control. As to the inquisition cases, we do not visit those at all. I could give you the actual number, but it is a very small number; the procedure is almost obsolete.

43. Arising out of that, have you any views, Sir Frederick, as to the desirability of continuing this distinction between lunatics so found by inquisition

7 October, 1924.]

SIR FREDERICK WILLIS, K.B.E., C.B.

[Continued.]

and lunatics not so found by inquisition?—I think whatever work is necessary to be done by any Government Department could quite well be done by the Board of Control; but whether the Lord Chancellor would wish to give up his jurisdiction is another matter.

44. We are concerned for the moment in inquiring as to the efficiency of the system. What I want to ask is this. Take the case of lunatics so found by inquisition: Do you think the process of finding a person insane by formal inquisition affords more or better protection to the person concerned than the methods adopted where the person is not so found by inquisition?—I do not think I am entitled to express any very definite opinion about that; I am not familiar enough with the actual cases that have been found by inquisition.

45. Then I put this question to you: You tell me that the number of persons who are formally found to be insane by inquisition has shown a tendency to decrease?—Yes.

46. And is still diminishing?—Yes.

47. You think it would be a reasonable inference to draw from that that the form of procedure in finding a person insane by inquisition is regarded as less necessary now than it formerly was for the protection of the person concerned?—I should say it is much less necessary; it affords him no better protection; it also gives a certain amount of publicity, which a lot of the friends do not like.

48. So far as the public are concerned, there has been very much less resort to that method in recent years?—Yes; it is really dying out, I should say.

49. It is still available, but less used?—Yes.

50. May one legitimately infer from that, do you think, that the other method of dealing with the case, the method which you are concerned with, meets adequately the public interest?—I think it meets it quite adequately.

51. In the case of a person found to be insane by inquisition, what is the warrant or certificate for his detention?—It is something like an Order of a Court.

52. Yes, but in their case you do not have the judicial authority or the justice certifying?—No.

53. The verdict, I suppose, in the inquisition, is the warrant?—The inquisition is either by the Master in Lunacy, or by the Master in Lunacy with a jury, and following the inquiry so held there is an order made that the person shall be detained.

54. That is really an Order of the High Court, is it not?—Yes.

55. And that is the warrant or sanction for the detention of the person so found by inquisition?—Yes. Section 108 of the Lunacy Act 1890, says: "The Judge in Lunacy may make orders for the custody of lunatics so found by inquisition, and the management of their estates." Section 12 prescribes the procedure for placing the patient under care.

56. Therefore, in their case the certification really is in the form of an Order of the Court?—It is.

57. The first main classification, from the legal point of view, of lunatics is into those so found by inquisition and those not so found by inquisition?—Yes.

58. Then it might be useful, I think, if you told us what are the various categories of patients at present with which you have to deal?—The two main ones are what are called "Private" and "Rate-aided," or "Private" and—"Pauper" is the word in the Act. We do not like the word "pauper," and perhaps at some time I might be allowed to say something about that. We feel it is a great hardship that a man who has been working all his life quite properly and so on, and suddenly gets a mental illness and has to go to a hospital, has to go as a pauper. But that is the main division—the private case and the publicly supported case.

59. And does the Statute deal separately with the two cases?—Yes; the provisions are somewhat different.

60. Some of the provisions, I take it, are identical, while others are varied?—That is quite true. I would like to say with regard to our public asylums that approximately 80 per cent. of all the cases are in county and borough mental hospitals; the others are in registered hospitals, licensed houses, naval and military hospitals, State criminal asylums, Poor Law institutions, in single care, or getting out-door relief; but 80 per cent. are in county and borough mental hospitals.

61. We shall have, then, to consider the topic of our remit in its relation to those two main classes—the private patient and the pauper patient?—Yes.

62. And the system applicable to each differs, although there are some features in common?—Yes; the main difference is that the pauper case goes in on one medical certificate and an order of the justice, while the other one has two medical certificates and an order of the justice.

63. That is a leading distinction?—Yes, but of course, in the rate-aided case it is always considered that there is a very strong tendency to get rid of the liability. As Mr. Macleod says, in the case of the pauper the justice is bound to see the case; in the case of the private patient he need not see the case.

64. We will develop the distinctions, but I am at the moment still on the general lay-out of the case, in order that we may have the general scheme in our minds. Now you have told us of the legal classification of the patients. Would you be good enough to tell us next of the places in which such patients are dealt with. There are various classes of places where we shall find those patients?—First of all, the county and borough mental hospitals; those are the main places. Then there are registered hospitals; that is to say, places not run for profit at all; they are in a sense like our general hospitals—St. Thomas's, or any of those in London. There is a committee and a foundation, and so on. In registered hospitals they do charge fees, but they may not make a profit. If they charge one individual a larger fee than it costs to treat that individual, the excess has to go to supporting some individual who pays less than he costs. The actual definition of registered hospital is contained in Section 341 of the Lunacy Act, 1890. Then there are the licensed houses; there are what are called metropolitan licensed houses and provincial licensed houses; they are private asylums run for profit. Then there are the naval and military hospitals. On the 1st January there were only 171 cases in those hospitals.

65. I shall have to ask you to give some figures at the end?—Quite. Then there is the criminal lunatic asylum at Broadmoor; Poor Law institutions; private single care; and out-door relief.

66. And shall we find all the persons who are subject to lunacy laws in one or other of the institutions or places which you have enumerated?—Yes. There are also the boarded-out cases; they are not in institutions, and they are not in what is called single care. Under the provisions of Section 57, "Where application is made to the visiting committee of an asylum by any relative or friend of a pauper lunatic confined therein that he may be delivered over to the custody of such relative or friend, the committee may, upon being satisfied that the application has been approved by the guardians of the union to which the lunatic is chargeable or the local authority liable for his maintenance"—they may authorise the patient to be delivered over to the friends.

67. Now having given us the different places, could you give us figures showing the distribution of patients among those different classes of institutions or places?—Yes. On the 1st January, 1924, in county and borough mental hospitals there were 103,892; the males were 45,897, and the females 57,995—a rather larger percentage of females. In registered hospitals there were 2,139, and there the females were half as many again as the males. In the metropolitan licensed houses there were 1,187. In

7 October, 1924.]

SIR FREDERICK WILLIS, K.B.E., C.B.

[Continued.]

the provincial licensed houses there were 1,610. In the naval and military hospitals, 171; and in the criminal lunatic asylum at Broadmoor, 785. Then in Poor Law institutions, in the ordinary Poor Law institutions, there were 11,323; in the metropolitan district mental hospitals—that is, hospitals provided by the Metropolitan Asylums Board, which acts for the whole metropolis from the Poor Law point of view—there were 5,266. Then in private single care there were 417, and the number of insane people receiving out-door relief was 3,544.

68. Making a total for England and Wales?—Of 130,334.

69. Of which 57,170 were men, and 73,164 women?—Yes.

70. Now I do not find in these statistics any mention of boarded-out cases?—No.

71. They are excluded, are they?—Their names are on the books of the asylum.

72. So they will be included under the first class in these statistics—under the county and borough mental hospitals?—Yes.

73. Can you tell us, incidentally, how many boarded-out cases you have?—I am sorry to say there are very few. I say I am sorry to say that because I think it is a system that ought to be developed more. In Scotland you have a far greater percentage than we have.

74. It is very largely taken advantage of in Scotland, in the rural areas?—Yes; it has not caught on in England so much.

75. You regard the encouragement of that form of treatment as desirable?—I think it very desirable.

76. We will examine it later?—Yes, and when we come to examine it, there are one or two minor alterations of the law that ought to be made in order to facilitate it.

77. It has been impeded by the existing code?—It has to some extent. When they are boarded-out they are still on the books of the asylum, and they have to be visited by the asylum doctor. It is very inconvenient for him to have to go round to make what are called the continuation reports. At the end of a certain period a person is discharged unless a continuation medical report is made at a certain date.

78. And do you think the inconvenience attaching to the boarded-out method has discouraged its use?—Yes. We tried it in Suffolk some years ago, and it broke down on that sort of point. Of course, that was rather before motor cars were so plentiful as they are now.

79. Now I think we may, for our present purpose, rule out entirely the naval and military hospitals, and the criminal lunatic asylum?—Yes; we only go there by invitation.

80. You have been good enough to tell us of the various classes of patients and the places where we may find them. I think it would next be useful in pursuing our outline to consider how those persons reach those places, and that brings one pretty close to the subject-matter of our inquiry?—Quite. Just before we go on to that, I would like to mention the case of the voluntary boarder. A licensed house and a registered hospital receive voluntary boarders.

81. He is a person whom we should consider particularly in relation to the second part of our remit?—Yes.

82. Perhaps you would also add this, in order to complete it, that the licensed house has to some extent been discouraged, has it not? There are to be no more?—No more.

83. When was that enacted?—In the Lunacy Act of 1890.

84. So that the number of such places is now stereotyped?—Yes. As Mr. Macleod says, there is no limitation on registered hospitals; you could found a new registered hospital to-morrow.

85. But that is an institution not run for profit?—Quite.

86. But as regards institutions run for profit, Parliament has enacted that the number of those institutions shall not exceed the number in existence in 1890?—That is so.

87. If any such institution ceases, does the number diminish, or may another one be created?—No; if they have lost a licence they cannot get it back again.

88. Then are these institutions diminishing in number?—Very slightly, I think. Now and then a licence drops out.

89. Could you give us, at the same time, the number of county and borough asylums in England and Wales?—There are 99, including the Maudsley Hospital, and the Ewell Colony.

90. How many of the registered hospitals are there?—13, excluding St. Luke's, which is a registered hospital, the committee of which has gone on existing, but has very little work lately; they were recently considering plans for building a new place.

91. Then I think we may approach the question of how the different types or classes of patients reach the particular institutions; and may one take it that an essential pre-requisite of any person being detained in any institution is certification in some form or other?—Certainly, yes, followed by a reception order. It is the order that authorises the case to be taken.

92. But upon the threshold, so to speak, of our inquiry, we find this, that no person can be detained by any one of the methods or in any one of the institutions or places you have enumerated, unless a certificate of some kind has been obtained?—Quite.

93. Now shall we consider, Sir Frederick, first of all, the case of the private patient, and how the private patient reaches an institution or place of care and detention? First of all, will you tell us—and I am putting it quite colloquially for the moment—suppose any person unhappily becomes afflicted mentally, what happens to him? May I put an example quite dramatically? Suppose any person in this room suddenly lost his reason, what happens to him—what are the methods?—I think I will ask Mr. Macleod to deal with that, if you will allow him. (*Mr. Macleod*): I suppose the first thing that would happen would be that a medical man would be called in, and if that medical man advised that that person was of unsound mind, then a petition would have to be presented, and the petition has to be presented under Section 5 of the Lunacy Act. We are now speaking of private patients.

94. Suppose any one of us here suddenly required treatment. What happens to us?—(*Mr. Macleod*): If the man is dangerous, either to himself or to the public, then an urgency order could be obtained under Section 11, quite apart from the petition. That would be the first thing.

95. You would send for a doctor?—You would send for a doctor, and the doctor would come in and ask him some questions. Perhaps the man might be violent, and if the doctor thought he was in a dangerous state, he would then advise that an urgency order should be obtained. The urgency order would be obtained, and could be signed by the husband or wife of the alleged lunatic, and if it is not signed by the husband or wife, the order has to contain a statement of the reasons why the same is not so signed. The doctor would sign a certificate saying that the person was of unsound mind, that he was dangerous to himself or to the public, and upon that the patient could be sent to an institution with which arrangements have been made before, and there he could be detained for seven days.

96. That is the emergency procedure applicable to the private person?—Yes. Supposing it is not an emergency case, but a case of an ordinary petition, then the medical man would be called in, and if he advised that the person was of unsound mind, he might say, "Well, I should think you ought to send this person to some institution."

7 October, 1924.]

SIR FREDERICK WILLIS, K.B.E., C.B.

[Continued.]

97. If you take it as an unhappy incident of family life, a member of a household may be observed to be suffering mentally; a medical practitioner is called in, and he may observe that the case shows mental features?—Yes, and if he advises that the patient is a proper person to be sent for care to some institution, the relatives would look round, and find out a suitable place—what the cost of it was; and where they should send him—and if they make arrangements a petition must be presented accompanied by a statement of particulars and by two medical certificates. If the petition is not signed by a relative, then you have to state why it is not so signed. Sometimes, of course, a person becomes insane when he is not in close touch with his own relations, and then somebody else has to present the petition.

98. I am again putting it quite colloquially. In the case of an ordinary illness occurring in a household or anywhere else, the patient is generally able to take some part in considering what is the place he would like to be sent to, and so on.—May or may not.

99. It depends upon the nature of the illness, of course. But the feature of mental illness is that by its attack upon the citadel of reason it precludes the patient generally from dealing rationally with his own case?—Quite so.

100. And therefore to some extent, indeed to a large extent, he must be dealt with by others?—Yes, by his friends or relatives.

101. In the ordinary case of illness the patient is able to take a considerable part, generally, in his own disposal?—Quite.

102. But is the unhappy feature of mental illness that the patient is disabled by the very character of his illness from participating rationally in his own disposal?—Quite.

103. That is a feature one must always bear in mind?—No doubt.

104. You have told us of the two methods by which the private patient may reach an institution?—Yes.

105. The urgency order is applicable to the emergency case, but expires in seven days?—Yes, or it can go on if a petition is presented, until an order is made upon the petition.

106. Until the petition is disposed of?—Yes.

107. Does it in the meantime ensure that the person is protected from himself, and that the public are protected from that person?—It does.

108. If no petition is presented within a period of seven days, the person must be released, I suppose?—He is discharged.

109. The urgency order requires one medical certificate?—Yes, one medical certificate.

110. Then, on the other hand, the more formal procedure by petition requires, does it not, the support of two medical certificates?—Yes.

111. To whom is that petition presented?—It is presented to the person who is called the judicial authority. The judicial authority is a member of the justices selected at certain Quarter Sessions in each county every year for the purpose of performing these duties, or a judge of county courts or magistrate.

112. "Judicial Authority" is a general term. Of course, it embraces any judicial authority having power under the Statute?—Yes, but there is a difference, Sir. There is a judicial authority who deals with petitions and the ordinary justice who has ordinary jurisdiction as to lunacy, but the judicial authority is a person specially appointed.

113. And really is the certifying authority?—He is the one who makes the order on the certificates of the medical men.

114. Is that jurisdiction of making orders confined to the justices specially appointed?—Oh, no. The judicial authority only can make the order in certain cases. The judicial authority has general jurisdiction everywhere. The ordinary justice for the purpose of pauper patients under Sections

14 and 16, only has jurisdiction over the place where the alleged lunatic resides.

115. The petition or application which has to be made to a judicial authority with a view to an order being pronounced, may be made to any judicial authority?—Yes. That judicial authority is described under Section 9 of the Act. He is a person to whom a petition must be presented. "The powers of the judicial authority under this Act shall be exercised by a justice of the peace specially appointed as hereinafter provided, or a judge of county courts, or magistrate."

116. So that any justice of the peace specially appointed in the manner provided, or any county court judge, or any stipendiary magistrate, can act as the judicial authority?—Yes, in the matter of private patients on petition.

117. Are the county court judges resorted to at all for this purpose?—I think in very few cases.

118. Are the magistrates?—It is nearly always an order made by the judicial authority; sometimes in London the metropolitan magistrates, and in the country stipendiary magistrates; but as a rule it is a justice of the peace specially appointed. You see under Section 10 how they are appointed.

119. What is the distinction between a magistrate and a justice of the peace?—After all, the justice of the peace is a magistrate?—Yes, but you see the Act says that petitions must be presented to a judicial authority in regard to private patients. An ordinary magistrate can make no order in respect of private patients on petition. (*Sir Frederick Willis*): "Magistrate" there means a stipendiary magistrate. It is defined under Section 341. (*Mr. Macleod*): I am afraid I did not follow what your point was. They call the others justices really.

120. But the great majority of the orders are pronounced by the judicial authority, that is, the justice of the peace specially appointed?—That is so, (*Sir Frederick Willis*): And there is a special part of this Section 9, which says, "A judge of county courts and magistrate shall not be required to exercise any powers under this Act so as to interfere with or delay the exercise of his ordinary jurisdiction."

121. So it is contemplated that resort to the county court judge or magistrate is unusual?—Quite. (*Mr. Macleod*): It is nearly always a judicial authority.

122. Now the application or petition, having reached the judicial authority as you have described, what does he do upon that?—He proceeds then as laid down in Section 6. He considers the allegations in the petition and statement of particulars and the evidence of lunacy appearing with the medical certificates, and whether it is necessary for him to see the patient personally or not. In the case of private patients it is not necessary that the judicial authority should see the patients. In the case of pauper patients, under Sections 14 and 16 he must see the patient.

123. So that in the case of the private patient, the judicial authority examines the papers before him, and is entitled, if he likes, to say that he wishes to see the patient before making an order?—Yes, and then he can visit the patient if he likes, under Section 6, Sub-section 2.

124. He may dispose of the petition without any visit?—He can make the order without seeing the patient at all if he likes; but I should point out that that is subject to the provisions of Section 8 of the Act; a safeguard comes in there.

125. Let us take it in order. If the papers before him appear to be satisfactory and conclusive, then without actually seeing the patient he may pronounce the order?—He may pronounce the order.

126. If, on the other hand, there is any circumstance disclosed by the papers which invites enquiry, he may visit the patient before making any order?—Yes.

127. Then the proceedings on the consideration of the petition are taken in private, are they not?—Yes, they are taken in private; it is specially provided in the Section.

7 October, 1924.]

SIR FREDERICK WILLIS, K.B.E., C.B.

[Continued.]

128. Then again, is there a certain safeguard introduced in that a person nominated by the alleged lunatic as his friend can be admitted to the proceedings?—Yes; that is Section 6, Sub-section 3: "The petition shall be considered in private, and no one except the petitioner, the alleged lunatic (unless the judicial authority shall in his discretion otherwise order), any one person appointed by the alleged lunatic for that purpose, and the persons signing the medical certificates accompanying the petition shall, without the leave of the judicial authority, be present at the consideration thereof."

129. So that apart from the persons applying for the order, the person in respect of whom the application is made is entitled to have some independent person of his own selection present during the proceedings?—He is.

130. If the judicial authority is not quite satisfied that a case is made out, either on the papers by themselves or after a visit, he then dismisses the petition, I suppose?—He can either dismiss it or adjourn it for further consideration.

131. And then, if the petition is dismissed, the applicant or petitioner is entitled to have a statement of the reasons for its dismissal supplied to him?—Yes. Section 7 says: "If the petition be dismissed, the judicial authority shall deliver to the petitioner a statement in writing under his hand of his reasons for dismissing the same." At the same time he sends a copy of such statement to the Commissioners, and if the lunatic is detained under an urgency order he has to send notice by post or otherwise to the person in whose charge the alleged lunatic is, so that he will no longer be detained under the urgency order.

132. Then if the judicial authority either makes or refuses a reception order on such an application, is the Board of Control entitled to require any information it desires?—Under Sub-section 2 of Section 7.

133. Is the Board of Control notified of what the judicial authority has done by the machinery of the Acts?—Yes.

134. Then on being apprised of how a particular application has been disposed of, the Board of Control may proceed to its own independent investigations?—Yes, we can. Perhaps I should say here that if a second petition is presented under Sub-section 4, these facts have to be stated on the second petition, so that there is that further protection.

135. So that the history of the case must be disclosed?—The whole history must be disclosed.

136. In the event of the patient not having been seen by the judicial authority, does the Statute provide a special safeguard?—Section 8 provides the special safeguard.

137. What is it?—Perhaps I had better be exact and read it: "When a lunatic has been received as a private patient under an order of a judicial authority without a statement in the order that the patient has been personally seen by such judicial authority, the patient shall have the right to be taken before or visited by a judicial authority, other than the judicial authority who made the order, unless the medical officer of the institution, or, in the case of a single patient, his medical attendant, within twenty-four hours after reception, in a certificate signed and sent to the Commissioners, states that the exercise of such right would be prejudicial to the patient."

138. Now, does that provide for really a second judicial consideration in the event of the patient not having been seen by the judicial authority who made the order?—Certainly, because it must be by a judicial authority other than the one who made the order.

139. Now, as regards the material presented to the judicial authority in considering an application, what must he have before him in addition to the actual application? I want to get the material that the judicial authority has before him in pronouncing the order. There must be an application containing a statement of particulars?—Yes.

140. Signed by husband or wife or relative or some other person, whose intervention is explained by that other person?—Yes.

141. Then, is the other vital matter the medical certificates?—Yes, the two medical certificates.

142. Will you now tell us who makes those certificates?—A qualified medical man, and he makes them under the terms of the Section which provides how those certificates have to be made.

143. They are very important. I am to take it that those two medical certificates really represent the evidence upon which the order is pronounced, where the judicial authority does not see the patient?—That is so. The Section is Section 28: (1) "Every medical certificate under this Act shall be made and signed by a medical practitioner. (2) Every medical certificate upon which a reception order is founded shall state the facts upon which the certifying medical practitioner has formed his opinion that the alleged lunatic is a lunatic, distinguishing facts observed by himself from facts communicated by others; and a reception order shall not be made upon a certificate founded only upon facts communicated by others. (3) The medical certificate accompanying an urgency order shall contain a statement that it is expedient for the welfare of the alleged lunatic or for the public safety that he should be forthwith placed under care and treatment, with the reasons for such statement." Then Section 29 is a further protection, namely, that "A reception order shall not be made unless the medical practitioner who signs the medical certificate, or where two certificates are required, each medical practitioner who signs a certificate has personally examined the alleged lunatic in the case of an order upon petition not more than seven clear days before the date of the presentation of the petition, and in all other cases not more than seven clear days before the date of the order. (2) Where two medical certificates are required, a reception order shall not be made unless each medical practitioner signing a certificate has examined the alleged lunatic separately from the other."

144. Now, the medical practitioners who furnish those certificates first of all must be independent, I understand, of the applicants?—Yes. If you would look at Section 32, that prescribes it.

145. Section 30 also deals with it?—Yes; that deals with it too.

146. We are anxious to bring out the qualifications of the medical practitioners to act. They must not be related to the applicant?—That is what it comes to practically; they must be independent people.

147. Secondly, must they make their examination of the patient independently of each other?—Separately.

148. And must they so state?—Yes.

149. Then must their examination have been a recent examination?—Yes "not more than seven clear days before the date of the presentation of the petition and in all other cases not more than seven clear days before the date of the order."

150. So that the certificate must be given by an independent person; it must be a recent certificate, and it must be the result of an examination conducted independently by the observer?—Yes.

151. And must it further state the grounds upon which the conclusions have been reached?—Yes; both facts observed by himself as distinct from facts communicated by others, and no order can be made simply upon facts communicated by others.

152. Are these statutory provisions designed to secure that the medical certificate which is the evidence on which the judicial authority proceeds, shall be as independent and as complete as possible?—That is the policy of the Act.

153. And must the certificates, in order that an application may be granted, show that the facts upon which the medical practitioner proceeds, include facts which have come under his own personal observation, warranting the conclusion he has reached?—They must. I do not know whether this

7 October, 1924.]

SIR FREDERICK WILLIS, K.B.E., C.B.

[Continued.]

would be a favourable opportunity to introduce this to show what is actually done. A copy of those documents is sent to us at the office. All those documents are carefully inspected by experienced clerks, and then they are further inspected afterwards by the Commissioner on duty for the day and by the Secretary.

154. Now just pause there for a moment. We are looking at it from the approach of the judicial authority to the matter. We now have before us how the case has been presented to him, the application presented by the appropriate person; the statement of particulars, and the two medical certificates, the features of which you have described. Upon that material the judicial authority can proceed?—He can proceed.

155. But if that material discloses to him any circumstances which he wishes to examine further, he can adjourn the proceedings and get additional information?—He can adjourn for 14 days.

156. Or, if he thinks it proper, he can require the attendance of the patient himself?—He can visit the patient.

157. And you have told us the safeguard which exists in the case where the patient has not been visited?—That is so.

158. If everything is in order to the satisfaction of the judicial authority, then an order for the detention of the patient will be made, I take it?—An order for the reception of the patient will be made.

159. In a particular institution?—Yes, arranged by the relatives.

160. And designated in the order?—Yes.

161. Now will you deal with the point you were making. These papers, which are what one may call the vouchers of the proceedings, reach the Board of Control within what time?—Perhaps I had better point out the Rule; it is under the Commissioners' Rules, 1895, Rule 8, Sub-section 3. There is one slight omission I made which shows a further protection. In the case of a private patient one of the certifying doctors has to be the usual medical attendant, and that has to be stated. Sometimes the medical man is away on a holiday, or perhaps the patient has never had a medical attendant.

162. We will reserve the latter point if you please, for a moment. That material which the judicial authority has proceeded upon in pronouncing the order, is required to be transmitted to the Board of Control within the specified short period?—That is so.

163. When that material reaches the Board of Control is it subjected to a careful scrutiny?—It is.

164. With what object?—With the object of seeing that all the papers are in order.

165. And, as you have just told us, responsible officials scrutinise the papers?—Very carefully.

166. Do you find as the result of the scrutiny that the papers are sometimes defective?—At times they are.

167. Does that frequently occur?—No, I should say not.

168. What are the defects which have been observed on such a scrutiny?—Sometimes the medical certificates are not as we think they ought to be; there is not a sufficient statement of facts observed by the certifying medical man himself. A certificate has been made on what appears to us to be really facts which he has had communicated to him by others; and if we are not satisfied with that the papers are sent back, and if they cannot be amended, then of course the order will go.

169. Is your criticism both as to form and as to substance?—Yes, both.

170. In such cases as call for your observations, is the defect which you have encountered generally a defect in the nature of the information upon which the doctor has proceeded?—I think so, and sometimes we think that the facts which he alleges, which have led him to come to the conclusion that the person is

a person of unsound mind, and a person to be kept under care and treatment, do not justify that conclusion.

171. Now does that occur in any substantial number of cases?—I should say not; there are some, but they are few.

172. They are few and far between?—They are few.

173. When such a case occurs and your examiner is not satisfied, does he report to one of the members of the Board of Control?—Shall I tell you exactly what the practice of the office is?

174. If you please.—These documents first of all go before some experienced clerk; he goes through them all, and if he thinks there is something wrong he marks them opposite the part of the order or the certificate which he thinks is not correct. Those marked admission documents go before the Secretary. All the others that he has not marked go before the Commissioner on duty for the day. If the Secretary, in considering those marked admissions wants the advice of the Commissioner, he comes in and sees the Commissioner in the adjoining room and talks the matter over with him; they are dealt with by the Secretary and the Commissioner on duty for the day. It may be that we think some amendment is necessary, or that the facts alleged by the medical man as enabling him to come to the conclusion that the patient is a lunatic, do not justify that conclusion. They are sent back, and if those are not amended so as to satisfy us, then of course we say the order is bad. Now those that are unmarked, and to which no special attention has been drawn by the experienced clerk who has to go through them, go before the Commissioner on duty for the day, and he examines every one of them after the clerk has done it, so that they are doubly examined. If the Commissioner thinks they are not quite as they should be, then he takes steps to see that they are put in order, or, if they cannot be put in order, that the order should lapse.

175. It seems to me that the scrutiny is of very great importance. Of course we have a large number of judicial authorities throughout the country considering those applications, I suppose?—Yes, no doubt.

176. And those judicial authorities will be of varying competence, I suppose?—Quite.

177. Could you give us any idea of the extent of this routine business—I mean how many such sets of papers would have to be considered in a day or a week, at the office?—They are brought in to us in baskets; the baskets are piled *that high* (*describing*). Some days there are more than others, but there are numbers—I could get you the exact number.

178. I merely wanted to get an idea of the office routine.—There are large numbers daily. (*Sir Frederick Willis*): There are approximately 30,000 new admission documents every year, besides a large number of other documents. (*Mr. Macleod*): All the documents are examined in the same way; there is no distinction made as to the examination of the documents as between private patients and pauper patients.

179. If there are 30,000 a year there must be, allowing for Sundays, about 100 a day to consider?—I dare say there are more than that sometimes.

180. Out of those that come in, could you give us any idea of the number that are specially referred by your scrutineer to the Secretary?—I should think perhaps between a dozen and 20 a day.

181. It is a comparatively large proportion.—But some of those are mere technical things—*e.g.*, that the judicial authority has not been described rightly; but I should say the number of cases in which the certificates are not in order is very small.

182. That seems to me a vital matter. You must keep the procedure on the rails properly and draw attention to such informalities.—I should think that if I put it at one to three a day which really want any substantial amendment, that is about the average.

7 October, 1924.]

SIR FREDERICK WILLIS, K.B.E., C.B.

[Continued.]

183. Possibly from one to three in a day call for substantive criticism as distinguished from criticism of form?—I should think that is about right.

184. Perhaps you would have that looked into, would you?—Certainly. (*Sir Frederick Willis*): I have often gone through these papers and not found one in a day. I have had a lot marked because they had spelt a name wrongly, or put a date wrongly.

185. It is the point of substance we are concerned with.—(*Mr. Macleod*): We will get the actual numbers as far as we can.—(*Sir Frederick Willis*): I very much doubt if we can give you the number of documents which are sent back because there is something substantially wrong with them. We could keep watch for a fortnight or a month and see how many we got.

186. I would rather like a typical week to be taken by you, and during that week you might see in how many cases the papers which have been before the judicial authority and are now scrutinised in your office show some defect of substance, as distinguished from a mere technicality which does not affect the order.—(*Mr. Macleod*): I think you will find they are very small. (*Sir Frederick Willis*): *We will do it for a month.

187. In making that investigation I do not think it will be necessary to distinguish between private and pauper patients for this purpose.—(*Mr. Macleod*): If you please.

188. Now suppose we have such a case as you have figured, first of all the scrutineer, then the Secretary and then the Commissioner being of opinion that the material before the judicial authority was in some respect defective: what is the practical step you take upon that state of matters?—The papers are sent back.

189. To whom?—To the superintendent of the institution where the patient is.

190. The patient is now in the institution, of course?—Yes.

191. What happens to them?—Section 34 gives us the powers we have: "If an order or certificate for the reception of a lunatic is, after such reception, found to be in any respect incorrect or defective, such order or certificate may, within fourteen days next after such reception, be amended by the person who signed the same."

192. What I wanted to know was how it reached the person who had signed the same. It has been found defective in your office. Then you tell us it is sent back to the superintendent of the institution where the patient is.—Yes; "No amendment shall be allowed unless the same receives the sanction of the Commissioners, or of some one of them, and (in the case of a private patient) the consent of the judicial authority by whom the order for the reception of the lunatic may have been signed."

193. The class of amendment that is contemplated there would be, I suppose, really further and better particulars in the medical certificate?—Something of that sort, yes.

194. In practice would the doctor's defective certificate be sent to him again in order that he might amplify it?—That would be the practice.

195. And would he have an opportunity if he desired, of seeing the patient again?—He could see the patient, certainly. You see Sub-section 2 says: "If the Commissioners deem any such certificate to be incorrect or defective, they may, by a direction in writing, addressed to the manager of the institution for lunatics, or to the person having the charge of a single patient, require the same to be amended by the person who signed the same, and if the same be not duly amended to their satisfaction within 14 days next after the reception of the patient, the Commissioners, or any two of them, may, if they think fit, make an order for the patient's discharge."

196. Yes, but that seems to contemplate the amendment by the person who signed the same, that is the doctor?—Yes, that is the medical man.

197. Now suppose that what is wanting in his certificate is a sufficiency of facts personally observed by him, would he be entitled to see the patient again for the purpose of amplifying that information?—Yes.

198. I mean it is not merely an amplification of the statement of what he had previously observed but further observation?—I should think probably it would be an amplification of what he had observed previously.

199. The two things are different?—Quite.

200. Is it an amplification of his account of what he formerly saw, or must he obtain new facts?—He could go and see the patient again if he liked, but he could not state any facts observed after the appropriate date.

201. Then what you really get on amendment is an amplification of the account of what the medical practitioner observed?—That is really what it comes to. (*Sir Frederick Willis*): Doctor Bond would like to say something upon that. (*Dr. Bond*): Very often some medical men find the giving of certificates for mental disorder, especially those who do not have to do it frequently, a matter of great difficulty, and when we come to peruse their certificates, often it is quite doubtful in our minds whether the symptoms were observed at all at the time the examination is required by Statute. I mean, often in the few cases that my colleague cited. I am not using the word "often" higher than he has used it. They are so worded that a person like one of us cannot make out from the certificate whether he observed the symptoms at the time. That is quite a common reason why we return the certificate. Another reason is because, although it is clear that what he has written down is the result of what he did observe at the time, yet really to us, away from the patient in that detached position, the words do not indicate necessarily unsoundness of mind. Of course, at the head of the certificate is the governing and important point that he has already stated in the plainest English that "I hereby certify that" so and so "is of unsound mind and a proper person to be taken charge of for care and treatment." That governs the whole thing; but when we come to scrutinise his evidence, it happens that we do not see that the words he has used do indicate necessarily unsoundness of mind. We send it back, and it is marked down on the side with a rubber stamp to ask him, "Was this observed really at the time of examination? Cannot this be amplified?"

202. Dr. Bond, are there forms prescribed for the medical certificate?—Eight and nine. Eight is the real one.

203. Is the form so framed as to elicit from an ordinary and intelligent practitioner the material that you desire?—Yes, that one can say unhesitatingly. There is a governing certificate which I have given you from memory. After that, opportunity is given for expressing the grounds on which he formed the medical opinion, and those grounds are divided into two classes. One of those is the facts indicating insanity observed by himself at the time of examination, and there is a special section in the Act which states that no certificate shall be acted upon for the purposes of an order except founded at least in part upon facts observed at the time of the examination; so that if that portion of the certificate is weak in our minds, or inconclusive, that is the more important consideration in our mind. The other class of facts are facts communicated by others. Then there is a third class which, if I am not out of order in alluding to it, has a printed paragraph to itself in certificates under the Mental Deficiency Act, but which is only provided in the margin of the Lunacy Acts forms, where it says that if the same or other facts were observed previous to the time of the examination, the certifier is at liberty to subjoin them in a separate paragraph; but unless he has filled in this first paragraph: "facts indicating insanity observed by myself at the time of examination," to our satisfaction, this will not in the long run hold good.

* See Appendix II.

7 October, 1924.]

SIR FREDERICK WILLIS, K.B.E., C.B.

[Continued.]

204. Now is the special scrutiny in the Board's office directed to those facts stated to have been observed by the certifier at the time of the examination?—Our scrutiny is directed truly to the whole certificate, but I think you are quite right that accent in our mind is placed on that paragraph.

205. And whether the facts there set out warrant the general conclusion to which the certifier has arrived?—Yes; but so long as there are facts indicating insanity at the time of examination, although they may not be as strong as we are accustomed to find in that paragraph, there are certain types of cases (I could give some illustrations) the difficulties of which we know, where we certainly look to the next paragraph: "facts communicated by others"; and are guided as reasonable beings in our action.

206. Now in the criticism of those filled-in forms which reach you after an order has been pronounced, are they subjected always to examination by a Medical Commissioner?—Oh, no. My colleagues will correct me if I am wrong, but I think I am quite safe in saying that if any very purely medical point arises out of this, if it is one of the Legal Commissioners, he gets hold as quickly as possible of his most available medical colleague, and vice versa. We may be looking at something which does not seem to be altogether clear to us, and we medical members of the Board go to the Chairman, who is always there, or to the legal members of the Board; we work together.

207. Have you a rota of attendance? Mr. Macleod spoke of the Commissioner of the day. Is there a particular Commissioner on duty?—I do not know whether "Rota" is the word to use, but it is arranged for the year. At the beginning of the year we depute as a rule two of ourselves to avoid wastage of time of the whole Board, to put a programme before the Board for the whole year, to cover the whole of the work required by the Statutes, and divide it up among ourselves.

208. As the duties imposed upon you require, I take it, visitation of premises away from London, the result is that you have to make a programme?—We do make a programme.

209. But then may the Commissioner in attendance for the day be either one of legal qualifications or one of medical qualifications?—Yes. (Mr. Macleod): There is a card which will show you how it is worked out. (*Handing in the same.*) (Dr. Bond): The Commissioner on duty for the day might be more accurately described as two Commissioners. They are both on duty every day, but for practical purposes we do not find it absolutely necessary. We can keep in touch. For instance, Mr. Macleod may be on duty and I may be profitably doing an inspection in London or elsewhere, and he knows where I am. (Sir Frederick Willis): The short point is this: I am there practically every day and one of the other Commissioners. If I or a Legal Commissioner have a medical question turning up, we should ask a Medical Commissioner to come and see about it.

210. Would every case of insufficiency of the medical certificate come before you?—Not before me necessarily. As a routine matter it would go to the Commissioner on duty.

211. Would a difficult case come before you—suppose there were a border-line case?—A case involving some question of policy or of principle they would bring to me, and we should discuss it together.

212. Have you any suggestion to make, Dr. Bond, as to whether Form 8 is a successful form in eliciting the material you require?—(Dr. Bond): I think that the form can be said definitely to be successful. I have some suggestions in my mind, but with your permission I would very much rather be allowed a later opportunity of stating them; I would like them to germinate a little longer.

213. Quite. I think that is a matter we shall have to consider later. The British public has been well educated in filling up forms of all sorts?—I think I can say it is definitely successful, yes. If there is a difficulty about it, and I say this with

every possible respect to my medical confreres in the profession, it is, that medical men in their medical education have not always grasped some of the essentials of the certificate, and when they are new to it evidently some of them find a difficulty in setting out the case properly; although a case undoubtedly needs care and treatment and detention, they have difficulty in framing the words; but that has nothing to do with the form.

214. One is not surprised at that, because it is often very difficult to get a clear and satisfactory proof out of a witness?—I am sure that the matter I have mentioned, and I have mentioned it with diffidence, is improving. Education in this matter is going ahead, especially since some of the medical bodies have established diplomas in psychological medicine; the subject is receiving much better attention, and you see that reflected in the certificates.

215. I think this is rather an important point, and therefore I have explored it a little fully. We have now got the reception order which has been pronounced upon consideration of the material in question. A scrutiny of the material has been made by the Board of Control, and everything is found to be in order. What is the next stage at which you intervene in the history of that case; when do you next hear of it?—(Sir Frederick Willis): We have got to get a medical statement; that is made by the head of the institution.

216. That is the next stage at which you come into contact with the case?—Yes.

217. Is that the statement which is made by the person who has received the patient?—(Mr. Macleod): Yes, by the medical superintendent of the institution or the medical attendant of the single patient.

218. Just tell us about that step. When is that sent to you?—Within a week. It is described in Rule 8, Subsection 3: "After the second and before the end of the seventh day after the patient's admission, send to the Commissioners a notice of admission, and also copies of the reception order and of the medical certificate or certificates upon which the same was made, and in the case of reception orders upon petition, copies of the petition and statement of particulars; and shall, in every case after the second and before the end of the seventh clear day after the patient's admission, send to the Commissioners a medical statement to be made and signed by the medical officer of the institution."

219. What are the contents of that medical statement which are sent in to you after the reception of the patient?—(Dr. Bond): The statement is a description of the mental and bodily condition of the patient.

220. This is the statement which you have sent to you practically at once?—Yes; it is a statement of the mental and bodily condition of the patient. The medical man who makes it does not give a certificate in the statement of insanity; he describes the mental and bodily condition of the patient.

221. Is there a form on which that is done?—Yes, there is a form. He may or may not make a diagnosis; we do not ask for it.

222. Or a prognosis?—No. Sometimes he does, but of course a prognosis at the end of a week is an extremely rash thing to make, and you may say it never is made except he happens to give a diagnosis, which itself carries with it a prognosis; but apart from that there is no prognosis.

223. It is a description of the case; he has had it under observation from its admission?—Yes. There is a small practical point that apart from being a description of the case, the bodily condition should state any marks whatever of injury to the patient, and you will readily understand that in an excited case in removal from a home to the institution, or in what has been going on at home, perhaps before full care was obtained, or in the removal from one institution to another, sometimes injuries do occur; they are something usually of a trivial nature, but if they do

7 October, 1924.]

SIR FREDERICK WILLIS, K.B.E., C.B.

[Continued.]

occur those evidences of injury should be stated in the bodily condition. However trivial a point may be, our scrutineer always draws our attention to it, in case it should escape the Commissioners' observation, and we exercise our discretion as to what further enquiry we make as to those injuries.

224. Does that statement proceed upon an examination by the medical superintendent or the medical attendant of the case on admission?—(*Sir Frederick Willis*): I think I may read the form. It says, "I have this day seen and examined" So-and-so, "admitted into this asylum on the" so-and-so, "and hereby certify that with respect to mental state he"—then describing it—"and with respect to bodily condition he" is so-and-so.

225. As I say, it is a description of the case?—That is all it is.

226. Now when that document is received by your Board, what is done with it?—It is seen and examined by a Commissioner and if, perchance, the medical officer said, "I do not think this case shows real signs of insanity," we should make further enquiry into that. That very very rarely happens, but anyhow it is examined by a Commissioner.

227. Reverting for a moment to a topic we were dealing with before, in the event of the medical certificates not being amended to the satisfaction of the Board, and the Board being of opinion that the certificates are inadequate, do you then direct the discharge of the patient?—We should tell the medical superintendent that the case should be discharged. We have got power to make an order discharging the case. We ordinarily do that by telling the superintendent that the documents are invalid, there is a fatal defect in them; we cannot accept them, and that the case should be discharged, and it is discharged.

228. On the ground that there is not sufficient material before you to justify the continued detention of the patient?—Yes; but I would like to say that that very very rarely happens.

229. Again you might help us upon that point by telling us how often you have had that experience, that after affording an opportunity for amendment, you have nevertheless found the justification for detention is inadequate, and you have had either directly to order the discharge, or have had to direct the superintendent or medical attendant to see to the discharge of the patient. How often do you think that occurs?—I should think it does not occur once a year, but we will carefully watch during the next month or two months and see exactly what points are arising, how many of each I mean, and so on.

230. It is rather instructive to know when, so to speak, the cases are found out under it and how often it happens?—Yes, quite. They are very very carefully scrutinised. I think myself there is too much time spent on them rather than too little.

231. Now you have just said with regard to this information received in Form 10 of the Commissioners' Rules, after the reception, that the case is again considered?—Yes.

232. And still more rarely, I gather from you, upon such consideration the case has been considered to be an unsuitable one for detention?—I am personally not aware of any case.

233. But at any rate, at that stage there is further consideration of the case?—There is, yes.

234. And will this form then be filed away with a record of the case?—Yes, upon the patient's file.

235. Now up to this point the procedure that you have outlined is the procedure applicable to private patients. I take it?—(*Mr. Macleod*): That is so.

236. What divergencies from that procedure are there in the case of the rate-aided patient?—In the case of the rate-aided patient there is no petition.

237. What initiates the proceedings?—I should draw your attention to the Sections just to tell you which they are. They are Sections 14, 15 and 16, which refer to what are called summary reception orders, which are reception orders made in the case

of rate-aided patients. Section 13 is not "pauper"; I was going to deal with that afterwards.

238. Just give it us in your own order, but I wanted to get a clear conception of how the rate-aided patient reaches an institution for treatment?—The rate-aided patients are dealt with in Sections 14, 15 and 16.

239. Where is the rate-aided patient to be found—where does he come from?—Supposing a working man or a mechanic in a village or in a town suddenly shows signs of mental disorder, probably a doctor is called in; it would now be a panel doctor; in the days of the Act of 1890 probably it would be the medical officer of the Union. If the medical officer of the Union has knowledge that he is a pauper resident within the district, who is alleged to be a lunatic, or if the relieving officer or overseer have that knowledge, then it is his duty to give notice to the justice within a specified time of that state of facts.

240. Then the existence of this case may reach the authorities either through the friends and relatives of the unfortunate person informing their medical attendant or panel doctor, or through a local official obtaining knowledge that such a case exists in his district?—Yes; it is the local official, either a medical officer or relieving officer or overseer, whose duty it is to give notice to a justice of the alleged lunatic within a certain time. That is the initiation, and when the justice has this notice given to him, then he has to order the lunatic to be brought before him.

241. Is that justice not necessarily the judicial authority?—No; any justice having jurisdiction in the place where the lunatic is resident.

241A. He is apprised of this state of affairs. What happens next?—Under Sub-section 3 of Section 14, just to take it generally, "A justice, upon receiving such notice, shall by order require the relieving officer or overseer giving the notice, to bring the alleged lunatic before him or some other justice having jurisdiction in the place where the pauper resides at such time and place within three days from the time of the notice to the justice as shall be appointed by the order."

242. Now one is struck at once with this: In this procedure the patient is brought face to face with a magistrate at once?—Yes; that is the distinction I drew before, that in the case of a private patient it is not necessary; in the case of a rate-aided patient the magistrate must see the patient.

243. What happens next?—Then the justice before whom a pauper alleged to be a lunatic, or an alleged lunatic wandering at large, is brought shall call in a medical practitioner whom he may select—he can call in anybody—"and shall examine the alleged lunatic and make such inquiries as he thinks advisable, and if upon such examination or other proof the justice is satisfied in the first mentioned case that the alleged lunatic is a lunatic and a proper person to be detained, and, in the secondly mentioned case, that the alleged lunatic is a lunatic and was wandering at large, and is a proper person to be detained, and if in each of the foregoing cases the medical practitioner who has been called in signs a medical certificate with regard to the lunatic, the justice may by order direct the lunatic to be received and detained in the institution for lunatics named in the order." So that when the justice sees the lunatic he calls in a medical man, the medical man, if he can, signs a certificate, and the justice after examining the lunatic and seeing the medical certificate, and making such other inquiries, can, if he is satisfied, make an order sending him to one of the public institutions.

244. Now it strikes one that the difference in procedure in the two cases resides chiefly in the imperative confrontation of the lunatic with the magistrate and the single certificate in the pauper case as contrasted with the optional visitation and the two certificates in the private case. Are those the cardinal distinctions?—They are.

7 October, 1924.]

SIR FREDERICK WILLIS, K.B.E., C.B.

[Continued.]

245. And there is the further feature that the justice dealing with the private patient's application is a selected justice, and in this case it may be any justice having jurisdiction in the place?—Yes.

246. The initiation is not taken in this case by a relative?—No; it is taken by an official.

247. *Mr. Mackinnon*: In practice it is very often taken by a relative?—The relative may inform the overseer.

248. *Chairman*: The person before the justice as the applicant is an official in this case?—Yes.

249. How do you think the adequacy of the safeguards at this stage compares in the two instances, practically?—I think the experience of the Board is that we are satisfied that the safeguards are sufficient. The two things are different. A private patient, I suppose, is apparently protected more than the ordinary rate-aided patient, by having the petition, the judicial authority, and the two certificates, because it might be said that there were friends who were interested in sending a patient away, shutting him up and taking his liberty from him, and that in most of those cases the patient was being sent to an institution which was run for profit. In the case of the rate-aided patient there is no person at all who is interested really in sending him away and depriving him of his liberty, because if the wife sends him, she loses her wage earner, and if he is sent to a public institution and detained there, he is sent there at the cost of the ratepayers; so that it is really to everybody's interest that a person in that position should not be detained longer than is necessary.

250. Any person who is so detained becomes a charge upon public money?—Yes.

A Member of the Public: I should like to be informed whether any person who objects to this summary procedure has any locus standi in the matter.

251. *Chairman*: I think at this stage the Commissioners must conduct the examination themselves. We are endeavouring to ascertain a statement of the law as it exists. Opportunities of criticism will be afforded later. (*To the Witness*): Then having got in each of those cases the preliminary material which issues in an order; in the case of the rate-aided patient who, in consequence of the order you have described, is now in the institution, do you receive also the material upon which the justice has proceeded in pronouncing his order?—Everything; all the documents are scrutinised in an exactly similar manner.

252. Do you obtain in his case also a report within a short period?—Within the same period, as to his mental and physical condition.

253. So that after reception in the institution the procedure seems to be on parallel lines?—Up to that point, yes.

254. Having brought ourselves abreast of the two cases, let us take up the private patients again. When do you next come into contact with them?—Perhaps before you go back to private patients, there is another aspect under Section 13, which is, as it were, rather between the two. That is the case of a person who is not a pauper and not wandering at large. Section 14 deals with an ordinary alleged lunatic. Section 15 deals with a lunatic wandering at large, and there are rate-aided patients with regard to whom a justice makes an order under Section 16. Then, apart from that, there is Section 13: "Every constable, relieving officer, and overseer of a parish, who has knowledge that any person within the district or parish of the constable, relieving officer, or overseer, who is not a pauper and not wandering at large, is deemed to be a lunatic and is not under proper care and control, or is cruelly treated or neglected by any relative or other person having the care or charge of him, shall within three days after obtaining such knowledge give information thereof upon oath to a justice being a judicial authority under this Act." So that if the person, as to whom information has been received

that he is an alleged lunatic, is not a pauper and is not wandering at large, then one of these public officials has to lay information upon oath and lay it before a judicial authority with regard to that person, and then the justice takes the steps set out in Section 13, Subsection 2.

255. I am not sure that I have got quite clear in my mind the distinction between this person and the other cases. He is a person who is not a pauper and is not wandering at large?—Yes.

256. And nobody has taken any steps to protect him?—No, nobody; and you see from the Section he is "deemed to be a lunatic and is not under proper care and control, or is cruelly treated."

257. How would a relieving officer come to have knowledge of such a case?—Information is given to him by somebody; one does not quite know how he gets it. (*Sir Frederick Willis*): It may be given by a relative. (*Mr. Macleod*): Just in the same way as in the other cases.

258. And the condition of this Section operating is that the person who is not a pauper and is not wandering at large, is deemed to be a lunatic?—Yes.

259. And is not under proper care and control, or is cruelly treated and neglected. In that case the initiative is taken by one of those officials?—Yes, by information on oath.

260. Is this class of case of frequent occurrence?—Yes, there are a good many of those cases. Then the information has to be laid before the judicial authority and the judicial authority then calls in the medical practitioner; and there are two medical certificates in that case. (*Sir Frederick Willis*): Dr. Bond has made some rather careful inquiries as to the working of this particular Section in Cardiff and in other places.

261. I would like to understand this particular class of case as contrasted with the other two. One would like to have a clear idea about it. Perhaps, Dr. Bond, can help us?—(*Dr. Bond*): Cardiff happens to come into my mind at the moment, and in that particular case the great majority of patients find their way into the public institution of that city under Section 13. I do know a little of the working of the individual cases in the city, having inquired into them. There, so far as I know the facts, when a person not in affluent circumstances is mentally ill, the relative or the doctor of that patient communicates the fact to the relieving officer, and the proceedings are taken under this section. Two certificates are made out in connection with the patient: one by the doctor, if there be one, a panel doctor or family doctor of the patient, and one usually, I think, but I will not be certain, by the medical officer of the Poor Law institution in the city.

262. One must not infer that those are cases necessarily of cruel treatment, but cases not under proper care.—That is so. In the great majority of instances where mental illness occurs to a person, it is only in very exceptional circumstances, and when there is plenty of money to get in the requisite trained nurses that one can say that the home, however nice, affords proper care, and therefore it is no aspersion on the home or on anybody to notify the case as not under proper care and control. When that has been notified, if there be the family doctor, he gives one certificate, and so does the medical officer of the Poor Law institution. The reason for that second certificate is because (I am speaking personally now, desiring only to express my own personal opinion), I believe, unfortunately, by a routine process the great majority of these cases are first taken to the Poor Law institution, so that the second medical certificate is naturally, and not improperly, that of the Poor Law medical officer. The case having been got (as I venture to think often unnecessarily so) to the Poor Law institution, and these two medical certificates obtained, he is seen at the Poor Law institution by a judicial authority, and I think my colleague, Mr. Macleod, has already pointed out

7 October, 1924.]

SIR FREDERICK WILLIS, K.B.E., C.B.

[Continued.]

to you that the justice who makes this order under Section 13 must be a judicial authority. Again, to the best of my belief, the practice that obtains in the city is that the judicial authority calls at the institution about twice a week, so that he easily sees the cases within the specified time, but the Section, as you will see, does not require him to see the patient. He can make the order on the two medical certificates without having seen the patient.

263. But the procedure is similar to that of the procedure on petition?—No; there are words in it which invite the judicial authority to proceed as far as practicable as if the case were on petition, but there is this most important difference, whether accidental or intentional, I do not know: The form of the order under Section 13 does not state whether the judicial authority saw the patient or not, so that the medical superintendent, on receipt of a patient under Section 13, has no official means of knowing whether the person who made the order saw the patient or not, and he has no duty to bring that fact to the patient's notice or to make any enquiry whatever from that point of view. There is that difference.

264. I follow; but this intermediate procedure seems to be found at Cardiff, and no doubt elsewhere, to be a convenient equivalent in certain cases for the more formal petition?—The cases would not go under petition because that would involve the machinery of admitting the patient as a private patient, with an arrangement to pay the whole cost of maintenance, which they cannot afford.

265. But this is a comparable procedure adapted to the case of those who are not able to avail themselves of the private patient procedure?—I think that it is not unfair to put it in that way, but I am not too sure of it myself.

266. It has certain features in common with the procedure on petition, has it not? It has the feature of two medical certificates being required; it has the feature of the judicial authority being the special justice who has jurisdiction, and, as far as I can see, the chief distinction is just that one you have alluded to: that the justice making the order is not required to state whether he has seen or has not seen the patient?—If I may venture to express a personal opinion, it always appears to me that this most valuable Section was framed as a prompt way of dealing with cases dangerous to themselves or to the public, and for whom nobody may be available, perhaps no relative available, to take any steps at all. For instance, there may be a case known in a house. It is not merely a constable or overseer or relieving officer: any member of the public may on oath state that he believes this person is of unsound mind and not under proper care and control, or is cruelly treated or neglected; and once that is done on oath, the judicial authority has to get the opinion of two doctors.

267. Just help me with regard to this: When Mr. Macleod was speaking a few minutes ago, he spoke of the case of the working man, the wage-earner in the home, who has unfortunately developed a mental malady, and suggested that his case would be treated under the procedure for a pauper?—In the great majority of instances in the kingdom it is.

268. Would the procedure under Section 13 not be available in his case because he is not a pauper?—I venture to say so.

269. Why should the stigma of calling him a pauper patient be attached to him when he is an excellent member of society?—Mr. Macleod will draw your attention to the definition section. (*Mr. Macleod*): A pauper is defined under Section 341 as a person "wholly or partly chargeable to a union, county or borough." Then if you look at Section 18, it is: "A justice shall not sign an order for the reception of a person as a pauper lunatic into an asylum for lunatics, or workhouse, unless he is satisfied that the alleged pauper is either in receipt of relief, or in such circumstances as to require relief for his proper care. If it appears by the order that the justice is

so satisfied, the lunatic shall be deemed to be a pauper chargeable to the union, county, or borough properly liable for his relief. A person who is visited by a medical officer of the union, at the expense of the union, is, for the purposes of this section, to be deemed to be in receipt of relief."

270. I can well conceive that the expense of treatment may be beyond the means of the wage-earner, but at the time when he becomes afflicted he is not a pauper in any sense of the term; he is a self-respecting and self-sustaining citizen?—Quite.

271. Is it because the treatment necessary for his case is beyond his means that he is relegated to the category of the pauper?—I suppose the justice says he is not in fact a pauper, but he is in such circumstances as to require relief for his proper care. That is stated on the justice's order.

272. One quite understands that a person may not have the means of lying by for a period of treatment, and may have to get it provided from public funds, but that class of person seems to me quite a different class of person from the pauper, who is a person who has not supported himself and is not able to do so?—You must also look at Section 3 of the Act of 1891, which says: "A lunatic sent to an institution for lunatics under Section thirteen or sixteen of the principal Act shall be classified as a pauper, until it is ascertained that he is entitled to be classified as a private patient." So that if he is dealt with under Section 13 he is still first of all classified as a pauper, and is not removed from that class until it is shown that he can pay for his own maintenance and is entitled to be a private patient. (*Sir Frederick Willis*): It is very objectionable in these cases that they should be paupers.

273. I do not know whether it is before us here, but it does occur to me that the attaching of the label of pauper to a person who is not a pauper at all is very unfortunate?—In our new Mental Treatment Bill we propose to eliminate that altogether as regards early treatment.

274. He is not a pauper by his own act; he is a pauper by the misfortune of his illness?—(*Mr. Macleod*): That is so.

275. However, it rather seems that Section 13 provides a method whereby without the initial stigma of describing the person as a pauper, he can reach a proper institution for treatment. And yet he has to be classified as a pauper once he gets there?—(*Dr. Bond*): Section 13, I think, is of very great value, and personally I wish it were much more often used. It has this disadvantage, that if it be considered that the seeing of the patient by a judicial authority or other justice is a wise and proper thing and is a safeguard, then this section has the disadvantage that it does not compel such a person to see the patient, and the official at the institution has no means of knowing whether one did, and if he did know, there is no section under which he can call in a judicial authority to see the patient. That may or may not be a disadvantage; it depends which way that point is looked at.

276. It is at least a difference, at any rate?—It is a difference. I think I should be right in saying on this point that north of the border, in Scotland, the judicial authority is the wrong term, but the corresponding person sees the papers but rarely sees the patients, and is not expected to, as far as I know; but I should not like to speak authoritatively.

277. I am still a little confused as to the line of demarcation between the case dealt with under Section 13 and the pauper case properly so called. It seems that a case might be dealt with under one section or the other?—(*Mr. Macleod*): Both are open, but if the justice finds that the person is a pauper, or is in such circumstances as to require relief, he can describe him as a pauper patient. Supposing a man is brought before a justice under Section 14, and the justice says: "This is not a case for pauper treatment at all; this is a case of a person who is not a pauper and not wandering at large; I will

7 October, 1924.]

SIR FREDERICK WILLIS, K.B.E., C.B.

[Continued.]

not make an order under Section 14"; then you must take proceedings under Section 13; you must give your information on oath; two medical men must be called in, and it must go before a judicial authority; then he could make the order. But there is the distinction. You have the private patient on petition; the ordinary pauper patient; and the patient wandering at large. Under Section 15: "Every constable and relieving officer and every overseer of a parish who has knowledge that any person (whether a pauper or not) wandering at large within the district or parish of the constable, relieving officer, or overseer, is deemed to be a lunatic, shall immediately apprehend and take the alleged lunatic, or cause him to be apprehended and taken, before a justice." Then you have got Section 13, where the man is not a pauper and not wandering at large.

278. But where the procedure applicable to private patients is not appropriate?—That is the position; there are those three classes, and yet, as I said before, once the order is made he is classified as a pauper until he shows that he is entitled to be classified as a private patient.

279. What is the reason for that what I may call interim classification of a person as a pauper? Is it in order that he may get the benefit of the assistance in the institution without charge?—Yes, I suppose so.

280. *Lord Eustace Percy*: Might I ask, bearing on this point of the substantial difference between paupers and private patients, what is the difference as regards chargeability? Under Section 271 of the Act, a patient may become a private patient upon his relatives agreeing to make such payments as the visiting committee think fit?—Yes.

281. There is nothing about full cost. On the other hand, how far can the Poor Law authority recover the cost of treatment of a pauper patient from his relatives? As far as I can see, you may have this situation: Generally speaking, the guardians have power to recover the cost of maintenance; so that you may have a pauper patient in respect of whom the guardians are recovering the whole cost, and you may have a private patient in respect of whom the visitors have agreed he shall be a private patient if he pays half the cost.

Chairman: I can see an anomaly there.

282. *Lord Eustace Percy*: I wanted to ask how far that was a real point or merely one of theory?—I believe there are some London asylums where, if the relations pay the full cost of maintenance, they are classified as private patients. (*Dr. Bond*): That

was so after a certain case; that was the practice adopted in the London mental hospitals and in certain others, that whenever a so-called pauper patient's relative or the patient could pay the whole cost of maintenance, he was immediately put on the private list, but I think that that is rarely done now; because to that is now added a sum equal to the interest on the capital expenditure of the institution. About 5s. or 6s., or something like that, is added to the actual cost of maintenance. If the relatives can pay that, then certainly in London and certain other local authorities' mental hospitals, all those patients are classified as private patients; but the visiting committee of a county or a borough mental hospital is not compelled to take in any private patient as such, and so some will not adopt this method. There are not many who will not, but I do know of one or two that will not have a private patient in their institution; they are not bound to by the Act; but the overwhelming majority do, and some few actually provide separate accommodation for private patients, paying very considerable sums above the cost of maintenance.

283. *Chairman*: I think we have now reached a convenient stage for adjournment?—(*Sir Frederick Willis*): Before you leave the summary reception orders, might I just draw attention to Section 22?

284. If you please?—That Section says this: "In the case of a lunatic as to whom a summary reception order may be made, nothing in this Act shall prevent a relation or friend from retaining or taking the lunatic under his own care if a justice having jurisdiction to make the order, or the Visitors of the asylum in which the lunatic is or is intended to be placed, shall be satisfied that proper care will be taken of the lunatic."

285. That would cover the case of a person who could be properly looked after at home?—Yes. (*Mr. Macleod*): We have dealt now with cases on petition presumably sent direct to an institution; we have dealt with pauper patients under Sections 14, 15 and 16 and cases under Section 13. Then there is an intermediate stage where they do not go direct to the institution, i.e., under Section 20.

Chairman: We will deal with that case after the adjournment.

286. *Sir Ernest Hiley*: In the case of Cardiff, mentioned by Dr. Bond, who actually does pay for the patients who are sent to an institution under Section 13?—(*Dr. Bond*): The Guardians of the city.

287. They are then treated as rate-aided patients?—Yes.

(After an adjournment.)

Mr. Macleod: You will understand, Sir, that urgency orders do not apply to any but private patients.

Chairman: Yes.

287A. *Sir Frederick Willis*: I have the figures about the number of inquisition cases—there were 225 up to the 1st of January out of approximately 130,000.

288. Then it is fairly a negligible number?—It is practically negligible.

289. Then I suppose there is no reason why that form of procedure should be preserved, as it has not been sought after much?—Well, I should like you to ask the Lord Chancellor about that.

290. We have discussed the various proceedings which have taken place in the case of both private and rate-aided patients up to the stage when they find themselves under care, and when the first report of the medical examination on reception has been made—can you now tell us when the Board of Control next comes in contact with the case?—(*Mr. Macleod*): Yes, under Section 39 we get what we call a month-end report on the patient's mental and bodily condition, the same sort of report as when the case comes in.

291. Is there a prescribed form for that month-end report—I do not think there is one scheduled to the

Act?—(*Sir Frederick Willis*): No, I do not think there is—there is a form for the first report, but not the second one. Yes, there is one scheduled to the Rules, but not in the Act—Form 13.

292. That is absolute, of course, with regard to every private patient?—(*Mr. Macleod*): Except this, that under the Act of 1891, it does not apply to transfer cases, if a patient should be transferred from one institution to another.

293. Yes, I follow that. I suppose the purpose of the month-end report is formally to apprise the Board of Control of the condition of the patient after he has been under observation for a reasonable time?—(*Sir Frederick Willis*): Yes, I think that is the object.

294. I think it is Section 39 which deals with all these reports?—Yes, under Section 39, when the visitors of licensed houses get these month-end reports arrangements are made for a visit by the medical visitor of the justices, who is, of course, an independent officer, and he has to make a special report on the case, and if he reports that he is doubtful as to the propriety of the detention of the patient, we get a copy of the report, and are thereupon required by the Act to make such inquiries as will satisfy us whether the person is properly detained as a lunatic

7 October, 1924.]

SIR FREDERICK WILLIS, K.B.E., C.B.

[Continued.]

or whether he ought to be discharged, and whether the case ought to be reported to the Lord Chancellor with a view to an inquisition. We quite recently had a case where the medical visitor expressed a doubt whether a person was or was not properly detained, and we sent a Medical Commissioner to make a special report on the case, and after considering the report we informed the superintendent that in our view the case ought to be discharged and it was discharged. We could ourselves have made an order for the discharge in that case if we had liked, but that was the more formal way of proceeding. As to the last words in the Section, we are required to say whether the case ought to be reported to the Lord Chancellor with a view to an inquisition. We considered whether that course should be adopted in that case, and I discussed it with Sir Claud Schuster. Also the Section says we may report, yet the machinery does not exist, and practically those words were of little or no use.

294A. Then important action may follow on the month-end report, I take it?—Yes, very.

295. The Section prescribes what is to be done on its being received, and is a visit essential immediately after the reception of the month-end report?—Yes. (*Mr. Macleod*): The first thing to be done is that the medical superintendent of the institution has to send a report to the Commissioners in all cases.

296. What I really want to know is, what follows upon that report?—May I refer to Sub-section 2 to clear it up. There the medical officer shall in cases of houses licensed by justices send a report, and then comes Sub-section (3), which provides: "The Commissioners after receiving a report upon any person in a licensed house within their immediate jurisdiction" (of which there are 19) "shall make arrangements for a visit being paid as soon as conveniently may be to the patient by one or more of the Commissioners; and the Commissioner or Commissioners so visiting shall report to the Commissioners whether the detention of the patient is or is not proper."

297. That is with regard to licensed houses?—That is with regard to houses licensed by us—what are called metropolitan licensed houses, and of those there are 19 as distinct from those licensed by justices, which are called provincial houses, of which there are 36.

298. Sub-section (3) ensures consideration and visitation by the Board of Control?—Yes.

299. What happens in the case of the others?—That is dealt with by Sub-section (4), which provides that "the visitors after receiving the report shall in every case of a private person in a licensed house in the county or borough for which the visitors are appointed, make arrangements for a visit being paid by the medical visitor." The medical visitor is one of the visitors appointed by the justices, and he has to pay a special visit to see the new patient as to whom the month end report has been given; and then the sub-section goes on to tell you what he shall do: "And if on such visit there appears to be doubt as to the propriety of the detention of the patient, such visitor or visitors shall forthwith report the same in writing to the Commissioners, who shall thereupon make all such further inquiries as may be necessary," and so on. So that there, you see, you get an independent report of a medical visitor who has been appointed by the justices of the county or the borough. (*Sir Frederick Willis*): It really occurs at the end of the month in the report of a medical examination which has to come to us, and we have power to discharge the case if necessary.

300. And you obtain it through the visitor?—Yes.

301. By your own visitor, in the case of a metropolitan licensed house?—(*Mr. Macleod*): From the Commissioner. Under the Act the metropolitan licensed houses have to be visited six times a year by the Commissioners, but the Lord Chancellor has a power of dispensation, and every year authorises a reduction of the statutory visits to two—that is visits

by a Medical Commissioner and a Legal Commissioner, and we undertake that the number of actual visits shall be no less than are required under the Act. In fact, eight visits are paid to each house during the year, though at two of the visits only new cases are seen.

302. Then after a month has elapsed you have the report of a visit which is an *ad hoc* visit, a special visit following the report as soon as conveniently may be?—Yes, we really have eight visits a year to these places, seeing the new patients when we go; but the visitors of the justices to provincial licensed houses are compelled to pay four visits in the year by two or more visitors, and twice a year by one or more. In addition, the medical visitors have to pay *ad hoc* visits to see all new patients. See Section 39 (4).

303. We will consider a little later the regulations as to visits, because that is an important part of the inquiry, but now one is anxious to see and inquire into a patient's history; and as I understand it, a month has elapsed, a report has been made, a visit has taken place, and no cause has been seen by the Board of Control to discharge the patient; then I think one should next ask how long does the order last?—Under Section 38 as amended by Section 7 of the Act of 1891, the order lasts for a year in the first instance, and then it lasts for another year, then for two years, then for three years, and then for five years, if continuation orders are made in pursuance of Section 38 of the Act of 1890, and Section 7 of the Act of 1891. You must look at Section 7 of the Act of 1891, which provides that "A reception order shall remain in force for a year after the date by this Act or by an order of the Commissioners appointed for it to expire, and thereafter for two years, and thereafter for three years, and after the end of such periods of one, two, and three years for successive periods of five years, if not more than one month nor less than seven days before the expiration of the period at the end of which, as fixed by this Act or by an order of the Commissioners under Sub-section 2, the order would expire, and of each subsequent period of one, two, three and five years respectively, a special report of the medical officer of the institution or of the medical attendant of the single patient as to the mental and bodily condition of the patient with a certificate under his hand certifying that the patient is still of unsound mind and a proper person to be detained under care and treatment is sent to the Commissioners." So that for all these respective periods the medical superintendent at the institution or the medical attendant of a single patient has to send a report on the mental condition of the patients, and give a certificate, if he can, that a person is of unsound mind.

304. So that, apart from the question of visitation, which brings you into contact with the patient, the stages are, a report at the expiry of one year, then at the expiry of a second year, then for two years, and then at three years and five years?—Yes.

305. *Mr. Jowitt*: Is this procedure limited to a private patient?—No, it applies to all patients.

306. *Chairman*: This periodical report is applicable to all patients?—It is applicable to all patients; they cannot be detained unless these detention orders are made. Then as a further precaution, if you look at Sub-section (6) of Section 38 of the Act of 1890, it provides: "If in the opinion of the Commissioners the special report does not justify the accompanying certificate, then (a) in the case of a patient in a hospital or licensed house or under care as a single patient, the Commissioners shall make further inquiry, and if dissatisfied with the result they or any two of them may by order direct his discharge." That applies to single patients and patients in licensed houses or in a registered hospital. In the case of a patient in the asylum, that is to say, a county or borough asylum—then

7 October, 1924.]

SIR FREDERICK WILLIS, K.B.E., C.B.

[Continued.]

"(b) in the case of a patient in an asylum, the Commissioners shall send a copy of the report, with any other information in their possession relating to the case, to the clerk to the visiting committee of the asylum, and the committee, or any three of them, shall thereupon investigate the case and may discharge the patient or give such directions respecting him as they may think proper."

307. The important matter is that the case is brought up for reconsideration in that form at these intervals?—Yes, that is so.

308. What happens to the report when it is received in your department?—When the report is received in our department, and I suppose there are about 800 a week, they are all examined by an experienced clerk first of all, and then they are examined by the Commissioner on duty, and they are initialled by the Commissioner on duty to show that he has seen them.

309. Those reports are the justification for the continued detention of the person?—That is so.

310. Do you find in point of practice occasions on which the special report does not justify the certificate of continued detention?—I should say there are occasions on which we think sometimes the facts are rather meagrely put, but I do not know myself of any case in my experience since 1908 where the patient has been discharged after it has been sent back so far as our part is concerned. (*Sir Frederick Willis*): I would like to explain in regard to that, that in Section 83 it is provided that "The manager of every hospital and licensed house, and a person having charge of a single patient, shall forthwith upon the recovery of a patient," do various things, including discharge; so that all the time it is the scheme of the Lunacy Act that the medical man responsible for the case under review has to say whether a lunatic has recovered, and can discharge him; they do not consider the point only at this period, and therefore practically all the discharges take place at different times.

311. You do not await the formal review?—We do not.

312. The importance of Section 83 is that it keeps each case continuously under review?—Yes, a practice recommended by the Commission.

313. Is there provision made also for the compilation and preservation of records, both in the asylums and institutions and so on, and also in your department, of all the cases under the Act?—(*Mr. Macleod*): They are all kept, every one, and if anyone comes into the office and inquires about any patient A B in such and such an asylum, within ten minutes he can get the information.

314. So that you have a clue to every case throughout the country?—Yes, except those in workhouses (*Sir Frederick Willis*): I do not want you to assume that we disclose that information to anybody who may turn up.

315. You do not hand them the papers, of course?—(*Mr. Macleod*): No.

316. But you have before you, as it were, a patient's dossier?—Yes, we have his dossier, but we verify the cases; we say to the people making enquiry, "Who are you?" and if the reply is not satisfactory we do not disclose anything; if the reply is satisfactory, we give them the information.

317. Is the system of records satisfactory, do you think?—Yes, I think so. (*Sir Frederick Willis*): We suffer rather from a lack of clerical assistance. I do not think we have a big enough staff to do all the work we have to do.

318. Do you work on a card index system?—Yes.

Chairman: I think we might next turn to the provision for the visitation of patients.

319. *Lord Eustace Percy*: May I ask the reason for the omission of the month end report in the case of rate-aided patients?—I do not know; it is not in the Act.

320. *Chairman*: Can you suggest any substantive reason?—I suppose it is the same reason as I have mentioned before—there is no inducement for keeping a rate-aided patient in the institution at all.

321. But if you are so anxious to get rid of the rate-aided patients, why protect them against improper detention at all?—(*Sir Frederick Willis*): I think all that can be said is that it is not there; why the legislature omitted it I do not know.

322. Does it not come to this, that it is a feature of this legislation, that you do not require so much formal protection in the case of rate-aided patients as you do in the case of private patients?—That is so.

323. And there might be an illegitimate motive for detention in the one case which would not be present in the other?—I think that must be the reason why there is the difference. (*Dr. Bond*): But also historically one of the changes was almost entirely directed to the private patient.

324. *Earl Russell*: You are referring to the Radnor Committee?—No; I was referring to the 1877 Committee. (*Sir Frederick Willis*): I think the reason may be that the rate-supported cases do not come under the same protection as a private patient.

325. *Chairman*: Not because there was less money in the matter, but rather because the motive might be different?—Yes. There is keen competition among men connected with asylums to get a good recovery rate.

326. *Mr. Jowitt*: I think you said you found this month-end report of considerable value as to private patients?—I mentioned one case where I found it recently to be of value; I do not think I said generally it was of value, the great safeguard is having responsible, upright men, as there are in these institutions—that is the real safeguard.

327. *Chairman*: But you surely do attach importance to being brought into contact with these cases?—It does compel a formal revision of the case, and I would not like to give it up.

328. *Mr. Jowitt*: Would the institution of a month-end report generally involve a great deal more work?—Yes, it would mean a great many more documents coming to the office.

329. And with your existing staff you say it would be impossible to deal with it?—Quite impossible. (*Dr. Bond*): I should like to say this—I have not heard mention made of what we in the office know as further reports which very frequently take the place with regard to pauper patients of month-end reports. In certain of those cases which we are not satisfied with, we send for what we call a further report. We ask the person who is making the further report to add to his statement a certificate, if he can, that the person being dealt with is of unsound mind and a proper case for care and detention. Those words do not come in either in the week-end or the monthly report, and it is only when we have reason to be anxious that we send for a further report. There is the same provision in rate-aided cases as in private cases, and we make no difference at all between them, and certainly send in all cases for it where we think it necessary.

330. But you do attach importance to having your attention jogged from time to time by the receipt of reports relating to the patients, and having them brought to your knowledge in that formal shape?—Yes, certainly, in every case where we have a scintilla of doubt, we ourselves take additional steps and have our memories jogged by making a mark for a further report. When these cases come before us, the Commissioner on duty will ask for a further report in a fortnight, which goes to the Secretary and the clerk, and so we get the further information.

331. On the other hand, it is undesirable that a form should be repeated for form's sake, and there is no value in accumulating useless paper?—(*Sir Frederick Willis*): Quite.

332. *Chairman*: I think you might help us now with regard to the visitation system if you will tell

7 October, 1924.]

SIR FREDERICK WILLIS, K.B.E., C.B.

[Continued]

us who the visitors are, the different classes of visitors, their duties, and generally what they do. I want to know what visits are paid to persons in institutions, and to persons under single care?—(*Mr. Macleod*): I have told you what visits we pay to metropolitan licensed houses.

333. Those are visitations by the Commissioners themselves?—Those are visitations by the Commissioners themselves.

334. But there are many other places and other classes of visits I want to know about—will you tell us what are the kinds of visits paid?—First of all there are the visits of the Commissioners and the visitors of licensed houses in the country, who are specially appointed by the justices at Quarter Sessions; they appoint a certain number of visitors, one of whom must be a medical visitor.

335. But these licensed houses are also visited by yourself?—Yes; first, there are the Commissioners, then, secondly, there are the visitors of licensed houses who are specially appointed by the justices with a medical man. Then, with regard to public asylums and county and borough asylums, there is the visiting committee, which is appointed to visit once every two months all the patients, and at those visits they have to see the patients and the admission papers of the newly-admitted cases.

336. Are not there some general visits?—General visits are only made under special circumstances under a special section of the Act, under which orders have been made as to property, and the Master can ask visitors to visit.

337. With regard to the different classes of institutions first, as to the county and borough asylums in which the great bulk of the patients are maintained, what visitation are they open to?—They are visited once a year by two Commissioners, and they are visited by members of their own visiting committee once in every two months.

338. So that they are visited by two different authorities; they are visited by the headquarters' representatives, and also by the local people?—Yes. (*Sir Frederick Willis*): Those are members of the county and county borough councils. (*Mr. Macleod*): They are the statutory committee appointed under the Act. (*Sir Frederick Willis*): And also I might mention the guardians have a right to visit cases coming from their Unions.

339. They may go and see how their patients are getting on?—Yes.

340. But they are not bound to do so?—(*Mr. Macleod*): No, they are not bound to do so, and that is why I did not mention it.

341. Then with regard to the licensed houses, by whom are they visited?—They are visited twice a year by the Commissioners. The provincial licensed houses are visited, first of all, by the Commissioners twice a year, and by the visitors who are appointed by the justices four times a year.

342. *Miss Symons*: In order to clear up one point under Section 205 of the Act of 1890, do I understand you to say that the Lord Chancellor or a Secretary of State could only visit in the small number of cases you have mentioned?—No, the Lord Chancellor can visit other cases. Perhaps I had better quote the section.

343. *Chairman*: The Lord Chancellor's visitor may go to any particular case he wishes, I understand?—Certainly, but he can only send to cases in which there has been an inquisition, or cases where the patients have property dealt with by the Master.

344. *Miss Symons*: Under Section 205 it is provided that the Lord Chancellor "in the case of a lunatic so found by inquisition, and the Lord Chancellor or a Secretary of State, in any other case, may at any time, by an order in writing directed to the Commissioners or any of them, require the persons or person to whom the order is directed to visit."—(*Mr. Macleod*): That is another provision altogether. The Lord Chancellor may order or direct a person to visit and examine a lunatic and to report, and that occurs in this way—

345. *Earl Russell*: It is an order directed to the Commissioners or to any other person so that he might send his visitors?—He might. The position is this—sometimes information is laid before a Commissioner that a person is of unsound mind but is in illegal custody—that is to say, without being certified he has been received by someone to look after him for payment, and that is a breach of Section 315 of the Lunacy Act. Now, when we have that information before us, and we think it a proper case, we would report to the Lord Chancellor, who appoints someone nominated by the Commissioners to visit and see the case, but he never sends one of his own visitors.

346. But he might send one of his own visitors?—He might, but he sends an independent person, who goes down and reports to the Commissioners on the patient's mental condition, and whether the patient is a lunatic and a proper person to be certified insane.

347. *Chairman*: I think *Miss Symons* is accurate in pointing out that the Lord Chancellor's visitors are not necessarily restricted to visiting lunatics so found by inquisition or those with property; but that the Lord Chancellor could, if he so desired, utilise their services for any special visitation?—That is quite a different thing.

348. But in practice you say that such visits do not occur?—Certainly. (*Sir Frederick Willis*): In addition, I think the Lord Chancellor is concerned with persons who have property: he does not confine himself to lunatics so found by inquisition; he also visits cases of persons in whose property he has concern. (*Mr. Macleod*): May I give you the section to make it all clear—it is Section 183, which provides: "The Chancellor's visitor shall visit lunatics so found by inquisition at such times and in such rotation and manner, and make such inquiries and investigations as to their care and treatment and mental and bodily health, and the arrangements for their maintenance and comfort, and otherwise respecting them, as the Rules in Lunacy, or as any special order of the Judge in Lunacy in any particular case, shall from time to time direct." When an order has been made under Section 116 for the appointment of a receiver, very often the Master sends one of the visitors to inspect patients in respect to whom that order has been made.

349. Suppose a case of a person found by inquisition to be insane and confined in a licensed house, and subject to visitation by the Chancery Master, he would be subject to visitation then also by the Commissioners, would he not?—Yes, he might be—we should see him, but we should have no power over him.

350. Would he be subject to visitation by any of the local visitors?—Well, they would see him in going round, but they would have no power to deal with him in any way.

351. *Earl Russell*: In fact they would not see him at all officially?—Quite. Sometimes our Commissioners will go to a large county asylum where there are patients subject to the Lord Chancellor's visiting orders, or where there is a person who is subject to a Master's order, and they see them there; very often the Lord Chancellor's visitors are there while we are visiting other patients.

352. *Chairman*: But that is quite accidental?—That is quite accidental.

353. What I want to know is the extent to which each different class of person is seen by responsible visitors and has an opportunity of complaining and bringing his or her case before the attention of the visitors?—In the case of metropolitan licensed houses, provincial licensed houses, registered hospitals and patients in single care, patients so found by inquisition, and other persons as to whom the Master has made an order are visited by the Lord Chancellor's visitors also. Visitors of licensed houses do not visit registered hospitals, which are visited by their own managing committees. Then the county and borough asylums are visited by the Commissioners

7 October, 1924.]

SIR FREDERICK WILLIS, K.B.E., C.B.

[Continued.]

once a year and by members of their own visiting committee every two months, and there is a guardians' visit if they like. (*Sir Frederick Willis*): Then, of course, on the question of visiting every petitioner in the case of a private patient has to undertake to visit not less than once in six months. (*Mr. Macleod*): The visits to single patients are made by Commissioners as often as are ordered, but they are all visited once and some twice a year, and if for any special reason it is thought desirable that one should go oftener, a special visit is made. They are visited by a person who is called the medical attendant, who has to visit the patient, unless an order is made to the contrary, once a fortnight. We make a dispensation order very promptly in the case of, say, a chronic patient, and a record is kept in what is called the medical journal.

354. What is the purpose of the visit?—In the case of the single patient the reason of the visit is, first of all, to inquire into the condition of the patient, and whether the patient, in the opinion of the Commissioners, is properly detained, and, secondly, to see that the conditions and the circumstances under which the patient is residing are proper—whether the patient is being properly cared for, in other words.

355. The Statute prescribes, does it not, the matters to which the visitor is to attend?—(*Sir Frederick Willis*): Yes, the point with regard to a single patient is that they have to inquire into the treatment and the mental and bodily state of health of the patient.

356. And, of course, they have to record the result of inspection?—(*Mr. Macleod*): Yes. We have a little book in the case of every single patient, and when a Commissioner goes down to visit that patient he takes the book with him, and having seen the patient and made his notes in the book, he writes a report on what he has found, and states whether, in his opinion, the patient is properly looked after—that report goes before the Commissioners at their meeting every week.

357. Will you tell us what is done by the visitors with regard to other institutions?—Taking the county and borough asylums, the statutory visit must be by a Medical and Legal Commissioner, and we go there without giving previous notice. What we do generally is this—we drive out to the asylum and ask for the superintendent, or, if he is out, we ask for the deputy-superintendent, who sees us, and we tell him that we have come to pay our annual visit. We then give him a list of things as to which he has to give us certain answers—the number of patients resident, the number of patients who have been discharged, the number who have died, the causes of death, whether seclusion has been used, the number of the staff and so on. When we go into the asylum the superintendent, and, as a rule, the doctor who has charge of the branch we are about to visit are in attendance. We may be asked which side we want to visit first, the male side, or the female side, and we say we will go to whichever side is most convenient to us. Then, in the case of people who are at work out of doors, we say to the attendants, "Leave the people as they are, we do not want you to bring them into the wards, we will see them as they are, we want to see how the asylum is carried on day by day." Then we go into the ward, whichever it may happen to be, male or female, and ask for the charge nurse. We ask him the number of the ward, the number of patients in it, the number of the staff, how many epileptics there are, how many there are on special card—that is, how many patients there may be who are suicidal and for whom there are special nurses to be provided—how many there are in bed, have there been any accidents, and, if so, we get a list of them, and then we go round the ward, and perhaps one of us will look at the beds, one of us will inspect the lavatory, another will see whether the medicine chests are kept in order, whether the poisons are kept separate from the ordin-

ary medicines; then we ask to see the ward records and things of that sort. We then see the patients in the ward, and if any patient wants to engage us in conversation, he can speak *ad libitum*, and talk quite freely, and if they do not feel inclined to talk, and are rather shy, we try to draw them into conversation. We often find that there are people who will not at first talk at all, but when they have been encouraged, they will do so. When we come to the sick people the Medical Commissioner sees them especially—he sees every sick person and has a long conversation with the medical officer in charge of them. Then we go into the chapel, into the bakehouse, into the kitchen, into the laundry, where we see them at work, and at the end of our visit, which may last during one or two days, we have all the books brought before us; we have to sign all the books. Then the two Commissioners discuss the condition of the place, and if there is anything special that anyone wants to mention, he mentions it, and the Legal Commissioner writes the report and we sign it.

358. The account you have given us shows that there is, then, a very thorough investigation into the conduct of these institutions you are visiting, but I should like to know a little more in detail what are the opportunities the patients have of seeing the Commissioners individually, or, possibly privately?—Any private patient has a right under the Statute to demand a private interview, an ordinary rate-aided patient has no such right, but if any patient says he wants to have an interview with one or both of the Commissioners, that interview is granted at once, and we see him in one of the rooms, nobody else being present, so that the patient has a chance of making any statement he desires either with regard to his detention or anything else.

359. *Earl Russell*: Has the patient any opportunity of requesting a private interview without anybody knowing it?—Yes, a patient has every opportunity of asking us for a private interview, and frequently we have letters sent to the Secretary asking when the Commissioner comes round if the patient can see him as he would like to see him, and the answer is sent that on the next occasion of a visit the Commissioner will give that patient a private interview, and when we go down we tell the Superintendent that we have such and such an application and we want to see the patient.

360. *Chairman*: I should have thought there were many cases where a patient would not be in a position to take advantage of an interview?—Yes, of course if a superintendent says that a patient is a dangerous character we have to use our own discretion, and there are some cases in which we cannot possibly see the patient, because we are told that he is homicidal.

361. *Sir David Drummond*: Do you think that with the time you devote to visiting such an institution as you are speaking of you are able really to interview 1,500 or 2,000 patients and find out all about them?—(*Dr. Bond*): Certainly not—of course we have not sufficient time to satisfy all our aspirations, but I do think that we have time to make an effective inquiry into any case from the point of view of the Lunacy Act. And more and more I think the Commissioners are being appealed to and looked up to for guidance and advice—personal advice by those conducting mental hospitals, and those who have the care of persons mentally afflicted. More time is taken up with the discussion of important matters with members of the medical staff, and sometimes we meet members of the visiting committee whom we meet accidentally, which all takes up a great deal of time. If there were more time certainly I think it could be used to advantage.

362. Because it seems to me that the utility of a visit is summed up in a consultation with the medical officer?—No, not quite.

363. *Chairman*: I think I might ask Dr. Bond this question—of course the visitors are not the people who are responsible for the certification of the patient or

7 October, 1924.]

SIR FREDERICK WILLIS, K.B.E., C.B.

[Continued.]

for his detention?—No, neither the visiting committee nor the Commissioners.

364. But they are responsible for his general supervision, and to see that the Statute is being observed?—Yes, that is so.

365. And any person desirous of bringing up his case, you admit, should have an opportunity of doing so?—Yes, certainly.

366. There is no examination made of a patient in the sense of making a medical examination?—No, none at all. It has been often put to me by those who do not know and probably have never seen the inside of a mental hospital: "How can you see in two or perhaps three days the working of a large mental hospital?" Well of course those who ask that question have never seen one and know nothing about it; but, as a matter of fact, those of us who do know, appreciate that a large proportion of the patients are suffering from secondary or other forms of dementia; and, although, as Mr. Macleod has said, when we are there as we go amongst them we do our best to draw them out (I think I might say we speak to practically every patient), still in cases of secondary and terminal dementia and other cases of acute excitement, it is quite impossible; and to insist upon it would be interfering with the doctors and nurses in their treatment of the patients. In the case of a great many patients you can do all that can possibly be done by visitors like ourselves in a very short time, and, as a matter of fact, we have time to talk over quite a large number of cases.

367. *Chairman*: In short, you would not have an application from a person who was in an advanced state of dementia?—No, certainly not. We should probably say to that person, "Good morning, how are you?" and our training tells us whether it is worth while to stay more than a moment with him; sometimes we can see that a patient is not suffering from dementia, but from something like shyness, and we then encourage that patient to talk a little further, and there are some cases in which you can see it is no good pursuing the matter at all. We do our best, but the nature of the case in many instances prevents us doing much.

368. *Miss Symons*: With regard to interviews with private patients, could you say whether a large proportion of those interviews are granted on the application of the patients?—A substantial proportion. In the case of every private patient the patient has a right to demand an interview, and it is always granted. Nor is it ever refused in pauper cases—we make no distinction.

369. I was wondering whether you thought that the fact that that right existed in private cases restricted the number of interviews with regard to pauper cases?—No, I think not.

370. *Mr. Jowitt*: Is any record kept of these interviews?—I think so, with regard to the private patients. The proceedings are entered in the visitors' book, containing a report of our visit. We never make any mention of the patients' names, but there is another book kept, known as the patients' book, and in that book we do enter names. For instance, if we have private interviews with seven patients we do say in the patients' book that the patients with whom we had had seven private interviews were So-and-so, and against each of the names put some remark.

371. The question is, do you or do you not keep a record of the purport of the interview?—(*Sir Frederick Willis*): No. (*Dr. Bond*): In my own private note book I nearly always do, and I think we all express our view in the case of patients who complain of detention as to their fitness for discharge. If one patient was improving we would say that one was improving.

372. *Chairman*: A rate-aided patient might want an interview, to complain with regard to food or clothing or it might be to complain of being there at all?—Certainly, that is what the usual complaint is.

373. Can you see any reason why the rate-aided patient should not equally with the private patient be entitled to complain to the visitors?—I should say they are equally entitled to.

374. They are not entitled to demand a private interview?—No.

375. I mean that they should be on an equal footing with the private patient in that respect?—I think they are now. (*Sir Frederick Willis*): It would not secure to them any more private interviews than they already get, and we should not object. On the point as to whether a record is kept of some of these private interviews, I should like to say that in certain cases it would be quite absurd to keep a real record, because the most mad people ask for interviews and talk about all sorts of silly things, like electricity coming down the wall, and that kind of thing, and to make a record of such an interview would be a waste of time; but if there was anything worth recording, of course, by all means let a record be kept.

376. *Earl Russell*: You have interviews with people on the question of their sanity or otherwise?—Oh, yes.

377. And many of them make all sorts of complaints, some of them being quite absurd?—Yes.

378. But if you made a note in all cases, would you not get some information as to what is the kind of thing which a patient is complaining of?—Well, we have that.

379. But I think if you made short notes of all the interviews, you might get some information which might enable you to deal more effectively with the patient. A patient might, of course, complain of anything. (*Dr. Bond*): In regard to Earl Russell's point, there is a differentiation to some extent between the private patient and the rate-aided patient. We take round with us books with the name of every patient, which we keep up to date, with regard to the private patients, but the reason is not that one patient is a private patient and the other is a rate-aided patient, but because we have the power to discharge the private case; and with regard to the private case we make a note against every patient.

380. Are the books you speak of books belonging to the Board of Control, or belonging to the asylum?—They are our own books.

381. *Chairman*: There are also books kept at the institution, are there not, in which entries are made?—Yes. (*Mr. Macleod*): There are the medical journals and casebooks, and also the visitors' book, in which we enter the report of our visit. (*Dr. Bond*): In case there might be some misunderstanding about it, complaints are matters to which we attach the utmost importance, but in the great majority of cases they refer to questions of liberty, and if that is all that one has to listen to from each patient who makes a complaint about detention, and we are satisfied that none of the patients are fit to be discharged, it can all be summed up at once in a very few words. If we receive no complaints, except on the score of detention, one word or one phrase would be sufficient for a number of patients—"My opinion of them was they were not fit for discharge"—that comprehends a good deal. But if we find that these complaints are growing, and are more than we are accustomed to, we not infrequently say we are surprised to find the complaints are more numerous than we are accustomed to, and contrariwise we might say, "We received no complaints." Now complaints may not be confined to detention, but they may relate to ill-usage, and those are investigated at once on the spot in a judicial fashion, because we have the benefit of a lawyer who is with us. The result of our investigation in such a case is set out in full in our report. We do not mention the patient's name, but in the patients' book we say the patient who made such-and-such a complaint was heard, and that is recorded. The complaint may not be one of ill-usage—it may be a complaint with regard to something else, and if we are

7 October, 1924.]

SIR FREDERICK WILLIS, K.B.E., C.B.

[Continued.]

satisfied that it is of a trivial nature, we may say nothing whatever about it; but if many patients complained about some dereliction of duty, as sometimes happens, we say so in our report—we say that we have received an unusual number of complaints about the dinners, it may be, and that it is a matter which wants looking into. Therefore, I should not like it to be thought that there is no record made of complaints—I think there is, and sometimes it takes a long time to deal with them.

382. I am concerned for the moment with the question of safeguarding a patient against illegal detention, and on that matter at present the first safeguard is the periodical revision of the case, or the ordinary consideration of the case in the institution, and discharging the patient if recovered?—Yes.

383. While he is at the institution there is the formal investigation and report at recurrent intervals?—Yes.

384. Then I was considering the importance of visits in regard to these matters. If a patient is under the impression that he or she is being illegally detained, do they have an opportunity of putting forward their case?—(Sir Frederick Willis): Yes, and a great many of them, in talking to us, say, “I am illegally detained,” and one or two minutes conversation shows you that they are very mad indeed. But if, on the other hand, a patient makes a complaint which appears reasonable, you make a note of it and discuss it with the doctor. (Mr. Macleod): And we would ask for his papers, and get out the medical journal and the case book, in which a record is kept from period to period of what the mental condition of the patient is, and that would be discussed with the superintendent.

385. It must be apparent that owing to the character of the ailment a person might imagine all sorts of things, and the position is more complicated than in the case of an ordinary person suffering a certain amount of injustice which he might be able to explain. But does the visit give to a patient an opportunity to put his case to a visitor?—(Sir Frederick Willis): I should say it did, and I should say any sane person would have a very full opportunity of explaining the whole circumstances. (Mr. Macleod): Might I say still further, supposing after discussing the case of a patient we said to the superintendent, “Have you ever given this patient a trial?” and the superintendent said, “No,” we would suggest that he should consider it; and, if he thought fit, the patient might have a trial to see how he got on; if he did not get on he would have to come back. Very often patients are given an opportunity in that way, on our suggestion. We have no power to discharge rate-aided patients, but we do often make that suggestion.

386. By trial you mean an experimental period of liberty?—Yes, and also, you see, there is the case of sending a patient out under Section 79. Section 55 of the Act provides that absence on trial or for health may be granted, and Section 79 provides: “When application is made to the visiting committee of an asylum by a relative or friend of a pauper lunatic confined therein, requiring that he may be delivered over to the custody and care of such relative or friend, any two of the visitors may, if they think fit, discharge the lunatic upon the undertaking of the relative or friend, to their satisfaction, that the lunatic shall be no longer chargeable to any union, county or borough, and shall be properly taken care of and prevented from doing injury to himself or others.” So that we do suggest trial with a view to discharge—and to see whether a patient is fit to be sent to the care of his friends.

387. Mrs. Mathew: I should like to know if it is a common thing to have patients interviewed?—(Sir Frederick Willis): Yes, we often do so.

388. A large proportion, or a small proportion?—Well, not a large proportion, but a large number in the end.

389. In particular asylums?—I cannot say in any one asylum more than in another. (Dr. Bond): I should say that the highest proportion are in the metropolitan licensed houses, where they know us and we know them.

390. Chairman: Do you find them often wanting interviews over and over again?—Yes, we find the same patients every time we go asking for interviews. (Sir Frederick Willis): They like talking to the Commissioners really, strange as it may seem.

391. I can quite understand that, and that a certain type of patient may have a predisposition to air his views to the Commissioners when they really have nothing new to say?—(Dr. Bond): Yes, nothing new whatever.

392. Mrs. Mathew: Are any particulars of the interviews taken down in a book?—That is a matter for each of us to determine. Interviews are always recorded.

393. Chairman: But not the purport of the interview, officially?—No, although by the words we use I think we would generally know what the purport was.

394. I suppose we may take it that a large proportion of the interviews are necessarily futile?—(Sir Frederick Willis): Yes. (Dr. Bond): I would not like to say that. I believe that the really free talk of the men, and their being let loose to talk, does them good; it does them good to talk about what they wish to talk about, and it helps to content a patient. I would not say, therefore, it was really futile, though from the point of view of discharge it may be so.

395. I can imagine it might well be a certain solace to them?—Yes.

396. But I was thinking of it from the point of view of its operative effect.—(Sir Frederick Willis): Really a great majority of them are futile from the point of view of discharge, certainly. (Dr. Bond): I would not say it does not happen that an order putting on trial very often follows after the interview.

397. Lord Eustace Percy: Do I understand that the Commissioners have no statutory power to discharge or procure the discharge of a patient from a public institution?—(Mr. Macleod): We have no power to discharge rate-aided patients except under Section 34 (2); we have power to make representation to the visiting committee if we think a patient ought to be discharged, and there is no doubt he would be then discharged. In the case of the pauper, the rate-aided patient, the power of discharge vests in the visiting committee. (Dr. Bond): We have an indirect power, I think. Have we not been given a power of intervention by Section 49? It is a circuitous method, but it is there. (Sir Frederick Willis): It is certainly the fact that if we came across a proper case which we thought ought to be discharged we should be able to get the discharge, although we have no legal power.

398. Chairman: Then we find in the Statute directions as to what the visitors are to attend to?—Yes, it is all set out. (Dr. Bond): We do a very great deal more than is set out in the Statute.

399. You have to do the things prescribed in the Statute, but you do more. Then a record has to be kept of what you have done, and I understand everyone in charge of the institution has to give you every facility?—(Sir Frederick Willis): Yes.

400. Later on, no doubt, we shall have evidence from members of visiting committees, but in regard to the evidence you have given to-day, you have been speaking of the Commissioners and your own practice?—(Mr. Macleod): Yes.

401. Are you satisfied with regard to the value of these visits?—Oh, indeed, yes.

402. Do you regard them as affording an important safeguard against the detention of any person who ought not to be detained?—It is a safeguard, undoubtedly; but there is no inducement for institutions to keep a patient, quite apart from our visits, but it is a strong safeguard, undoubtedly.

7 October, 1924.]

SIR FREDERICK WILLIS, K.B.E., C.B.

[Continued.]

403. It seems to me to be a very important one, because it gives you an opportunity of being brought into contact with cases as to which there is any doubt?—(*Sir Frederick Willis*): Yes. I should say in the matter of private cases it is a strong safeguard. (*Mr. Macleod*): Yes, I should think it is a great safeguard. (*Dr. Bond*): I think the most important part of our work is the personal contact with the patients, if I may say so.

404. Then I think the petitioner, in the case of a private patient, has to visit him?—He undertakes to visit once in six months, and if we find out he has not done so, a letter goes from the office pointing out what his statutory duty is.

405. Is provision made for visits of friends and relatives to patients?—Do you mean in county and borough asylums?

406. Yes.—Yes, there are regular visiting days when patients can be visited, and if any patient is seriously ill notice is sent to the relatives that he is so, and if the relatives cannot visit him on visiting days they can attend at another time. Dr. Bond will tell you that they are always encouraged to do so.

407. Suppose you have a person under treatment in a county or borough asylum, not a very acute case, who is anxious to see a relative, you say the relative would be admitted to see that patient at any time?—(*Dr. Bond*): Practically so, yes, but there are exceptions.

408. I put it as being a certifiable but not an acute case, supposing a patient was visitable, would a relative have access to him?—(*Mr. Macleod*): Certainly. (*Dr. Bond*): Except where it was thought that a visit might be harmful to the patient.

409. I was putting a rather ordinary case. In the case of a patient who might be unreasonable or unwilling to dilate on his own grievances to a Commissioner, would he have an opportunity of speaking on the subject to his or her relatives—would the relative have an opportunity of putting the points before you?—(*Mr. Macleod*): Yes; any relative would either write or come and see us. They constantly do that.

410. The importance of the point is, Is there any vehicle by which complaints may reach you, apart from the purely official machinery?—Yes, a relative seeing the patient might lay the case before us.

411. Then the relative would be the vehicle in conveying any complaint?—(*Sir Frederick Willis*): Yes, and it frequently happens. (*Mr. Macleod*): And they come to the office.

412. What would be the ground for not allowing a relative to visit a patient?—(*Dr. Bond*): That a visit had already been proved to have had a detrimental effect upon the patient, or, as has happened from time to time, that a relative disobeys an important rule framed for the safety of the patients generally, and after a warning still disobeys. Then they are told regretfully that their visits will be barred. There is one other point—with regard to fresh arrivals, the most competent physicians of a hospital urge relatives not to be in a hurry to visit, but to let a month go by without a visit at all, and some of them prescribe that in their visiting regulations—that no visit should be permitted for the first month, but even where that is so, that could be abrogated in a moment if there were any necessity.

413. *Lord Eustace Percy*: Taking the case of a girl who is quite properly placed in an asylum, whose mother is very anxious to get her out, and says that she will look after her, and the girl is very anxious to get out as well, precisely in proportion as the mother is anxious to get the child back, I suppose that any visits on the part of the mother would be very undesirable, and have a detrimental effect upon the girl from the medical point of view?—Yes, and that undoubtedly happens.

414. Is there not that danger, that interviews with relatives should be refused in precisely those cases where there is liable to be what one might call agitation displayed on the part of the relative, to

the detriment of the patient?—I see the trend of your question, but I do not know of an identical case, and there is not a single instance which I can call to mind, except that there are some cases in which a relative has willingly, after being interviewed, probably at length, by the medical staff, acknowledged the undesirable way in which they were acting with regard to patients, and the harm it was doing. I daresay there are occasional cases, but they are very rare, and I cannot call to mind one case where a responsible near relative has been told that his visits must cease. Of course, one comes across cases of division in the family, where one side is working against the other, and then one cannot tell.

415. Not an uncommon form of delusion is that a patient may conceive a hatred against a person of whom, under sane conditions, he is most fond?—Yes, that is most common.

416. And, as I understand, in such a case it might be dangerous to excite a patient?—It might be so, but visits are much encouraged throughout the country, I am sure, both in institutions for private patients and in public institutions, and I think the cases that are forbidden are extremely few and far between, and we have power to override that forbidding. (*Mr. Macleod*): That is Section 47.

417. *Chairman*: So that the relation of relative and patient is very well safeguarded in the Statute?—Yes.

418. *Miss Symons*: Taking the hypothetical case of a mother who is very anxious for her daughter to come home, would she, in a case of that kind, be allowed to bring her own doctor in to see the daughter, or not?—(*Dr. Bond*): Ordinarily the physician of a mental hospital is only too willing to allow any medical man to come in and see his patients.

419. *Chairman*: I rather thought there was something about that in the Act?—(*Mr. Macleod*): Yes, there is, in Section 47: "Any one of the Commissioners, as to patients confined in an institution for lunatics or other place (not being a gaol) authorised to be visited by the Commissioners, and any one of the visitors of a licensed house, as to patients confined in such house, may at any time give an order in writing under his hand for the admission to any patient of any relation or friend or of any medical or other person whom any relation or friend desires to be admitted to him."

420. That is permissive?—That is permissive. Then Section 49 gives a further power. (*Sir Frederick Willis*): But the point Miss Symons was making was whether there is any disinclination on the part of a medical superintendent of an asylum to allowing, apart from any Statute, a medical man to go and see a patient. But in the last resort we have power to authorise it, and I would like to make it quite clear that there is no disinclination on the part of medical superintendents to admit outside doctors.

421. *Miss Symons*: I wonder whether in practice it is ever done?—Permission would not be often refused, quite apart from statute, if a mother said, "I should like my own doctor to see my girl, who is in your asylum"; I am sure he would be allowed to go.

422. *Chairman*: Is that permission often asked?—No, it is not often asked.

423. Is it ever refused?—I have never heard of it.

424. *Earl Russell*: You have never had to make an order under this section?—(*Mr. Macleod*): I have never heard of such an order. (*Sir Frederick Willis*): Of course, you may get busybodies wanting to make visits to asylums for no reason whatever, but no *bonâ fide* application would be refused.

425. *Sir David Drummond*: The fact is that you must have confidence in the superintendents?—Quite.

426. *Chairman*: I do not think it has ever been the subject of complaint that such visits have been prevented, or that opportunities of access by private medical attendants have been refused.—(*Sir Frederick Willis*): I think that is so.

7 October, 1924.]

SIR FREDERICK WILLIS, K.B.E., C.B.

[Continued.]

427. Then there are various other provisions in the Act for the protection of persons in asylums—the Lord Chancellor may direct visits, and there are various other directions. In a very serious case I understand the Commissioners can hold an inquiry on oath?—(Mr. Macleod): They can.

428. Under Section 332?—Yes.

429. And call witnesses?—Yes. We do hold those inquiries.

430. Have you held any such inquiry?—Yes, I have—I held two last year, I think it was.

431. What subject-matter was under consideration?—The last long one I held was with Dr. Bond in the north of England—it was a case of an allegation by the husband of a deceased patient that she had been improperly treated in the asylum; the inquiry lasted two or three days.

432. And what was the other case?—The other case was a case of some broken ribs, I think, or some injury, but I cannot remember the facts now.

433. Then correspondence is a very valuable means of communication. Are there ample facilities afforded for that?—(Sir Frederick Willis): Yes, they are allowed to write letters, and they have to be sent unopened to the Board of Control or to the Lord Chancellor or to a Master or Judge in Lunacy.

434. Earl Russell: Or to any Judge.—Or to any Judge; and we get hundreds a week.

435. Chairman: Then it is very largely taken advantage of?—Yes.

436. And the great bulk of the correspondence is quite futile?—The bulk of it is futile. If any allegation of cruelty is made on the part of any official, of course, there is at once an investigation, no matter how mad the letter may seem to be.

437. Mrs. Mathew: Where are the letters put when they are written?—(Mr. Macleod): Do you mean where they are put after they are written? In most of the asylums there are letter boxes in each of the wards, where the patients put their letters, and in other cases they hand them to the person in charge of the ward, who hands them to the superintendent for posting. (Sir Frederick Willis): Were you wondering, Mrs. Mathew, whether they always got out?

438. Yes.—I do not think there is anything of that kind, judging by the great number we get. (Dr. Bond): I think the head of the place has by law a wide discretionary power with regard to many of the letters sent, but he cannot by law refuse to post letters addressed to persons named in Section 41 of the Lunacy Act, and if they are sealed down they must go without being opened. With regard to all other letters he has a discretionary power, but our experience is, and we have often been into the matter regarding individual complaints, that the discretion is used most generously, kindly and sympathetically, and in the public asylums the almost universal practice is that where letters are not sealed they are put before the chairman or visiting committee at the next meeting.

439. I think the requirement that letters should be forwarded unopened, is an important matter, and there is a penalty attached, is there not?—Yes.

440. In fact a good many of the matters with which we have been dealing have penalties attached to them. Is it required that all patients should be notified that they have these privileges?—(Mr. Macleod): Section 42 deals with that. It provides: "Whenever the Commissioners so direct, there shall, unless there is no private patient therein, be posted up in every institution for lunatics, printed notices setting forth (a) the right of every private patient to have any letter written by him forwarded in pursuance of the last preceding section: (b) the right of every private patient to request a personal and private interview with a visiting Commissioner or visitor at any visit which may be made to the institution; (2) The notices shall be posted in the institution, so that every private patient may be able to see the same; (3) The

visiting Commissioners or visitors may give directions as to the place in which such notices are to be posted; (4) If the manager of any institution for lunatics makes default in posting such notices, or does not within 10 days carry out any directions as to such notices given by the visiting Commissioners or visitors, he shall, for each offence, be liable to a penalty not exceeding twenty pounds."

441. Earl Russell: You ought to direct your mind to the words "unless there is no private patient therein"?—Yes.

442. Chairman: The first point that attracts my attention is that it is permissive—notice may or may not be put up.—Yes, but we insist on it in all cases, especially in the case of private patients.

443. Why should there be a notice where there are private patients, and no notices where there are not? If you look at the last line and a half of Section 41 you will see that it says, "and may also, at his discretion, forward to its address any other letter if written by a private patient." Nothing is said there about rate-aided patients, you see, so that it is left to the absolute discretion of the superintendent, but as Dr. Bond has explained, they are dealt with in a very kindly and thoughtful way. (Dr. Bond): The great majority of the letters are from rate-aided patients, but I do not think there is a notice with respect to the section and the rights under it in every ward in every mental hospital in the Kingdom, but I do not think you would find that many patients have not the knowledge.

444. Miss Symons: Do I understand that there are not many wards in public institutions without these letter boxes?—It is a growing practice to have them, but there are wards without them; I hardly think there is a hospital in the Kingdom which has not a letter box on each side of the building, in a convenient place, in which patients can post letters; they are the glass-fronted letter boxes, locked, the key of which is carried by an officer. I should not like to say that every ward has a letter box, but it is a growing practice.

445. I suppose the important consideration is not so much by whom the letters are written, but by whom they may be read?—Yes. Speaking generally, patients and nurses are on the very best of terms, but there are some patients who have delusions, and who are no doubt inclined to resent a nurse being able to read a letter, and the letter boxes such as we devised would prevent that. The patients feel themselves secure because they see the box unlocked and their letters taken out when it is cleared.

446. Chairman: I see that notification has also to be given in the case of a private patient of the right to request a private interview.—(Dr. Bond): Yes, that is posted up, too.

447. I find difficulty, personally, in seeing why, in regard to matters of correspondence and notices, there should be any difference made between a pauper patient in an institution and a private patient.—(Sir Frederick Willis): No, I do not see any reason whatever, but it is historical.

448. Being historical does not make it necessarily right.—(Mr. Macleod): No, but as far as we are concerned we make no distinction.

449. But it seems to me in practice you have made this a matter of law?—Yes.

450. But you see no objection to all inmates being put on the same footing in regard to the matter of writing, in regard to the matter of interviews, and in regard to the matter of the notification of privileges?—(Sir Frederick Willis): No objection whatever. (Dr. Bond): With regard to the notification of privileges, it would have this disadvantage that the more you put up notices of this kind the more you are going away from what you would expect in an ordinary hospital. If you go to an ordinary hospital you do not put up notices of this, that and the other, and the more you go in for this line of safeguarding the more you mark the mental hospital as different from an ordinary hospital.

7 October, 1924.]

SIR FREDERICK WILLIS, K.B.E., C.B.

[Continued.]

451. Yes, but there are ways in which the notice can be dealt with—I mean if it is worded: “If anyone who wishes to send a letter will be good enough to place it in this box,” and so on, it would be innocuous; but, of course, if you say: “Under section so and so, you may post here” it is quite a different thing?—(*Sir Frederick Willis*): We have been pressed to put up Section 79, which gives a right to a relative or friend to get a particular patient out; but we think it would be a mistake to do that, because a patient might say to a relative: “Why do not you take me out under that power?” and it would cause a lot of illfeeling. But we do insist on a new admission that people should be told there is that right. (*Mr. Macleod*): I told you, Sir, what we are bound to do with regard to statutory visits by a Legal and a Medical Commissioner, but I should point out that during and since the war these strictly statutory visits have not been made by two Commissioners, but in many cases by one only because we have not the staff.

452. The next thing we come to is the trial or experimental leave of absence—do you find that the provisions of the Act on that subject are very useful?—Most useful.

453. Do they enable you to try whether a patient is in point of fact sufficiently recovered to be completely discharged?—It is the mode of testing.

454. Is it largely resorted to?—Very largely.

455. Will you tell us what you do in cases of temporary release?—Any two visitors of the asylum can let a patient out on trial. They are the people who can do it, and they do it on the advice of the medical superintendent. Now what would happen would be this—the medical superintendent and his staff would have a patient under complete observation, and they would come to the conclusion: “We are not sure that this patient can go out on his or her own, we will give him or her a trial.” That patient is brought up on visiting day, and the probability is that he or she is recommended for trial—“I think the patient might go out on 28 days’ trial,” and if at the end of 28 days the patient has gone on well then another extension of time may be granted. It is done for the purpose of testing. Then there is another power by which the committee may give an allowance to a necessitous patient during the trial to help him.

456. Is it the visiting committee in every case, or can the Commissioners do it?—In the case of county and borough asylums by the visiting committee.

457. And in licensed houses?—In our own licensed houses it may be granted with the consent of the Commissioners.

458. But when it is done by the Visiting Committee, is it reported to the Board?—No.

459. So that you do not know how many people are out on trial?—(*Dr. Bond*): No, we do not, but very frequently with regard to the special reports and certificates and the month-end reports we ask that a patient should be further reported upon, and we are constantly getting replies saying that the patient may be allowed out on trial from such and such a day to report on such and such a day. Apart from that, we have no knowledge of individual patients going out on trial, but when we go to an institution one of the things we invariably ask is: How many patients have been transferred to other care, how many have been discharged, of those how many have recovered, how many were sent out on trial by way of test first, and of those we always ask how many had an allowance.

460. And it is largely taken advantage of, is it?—Yes.

461. Can you give us any number?—(*Sir Frederick Willis*): We have not any collected statistics of how many people were let out on trial last year.

462. But it will be on record somewhere?—At each institution they would have a record there.

463. *Earl Russell*: I suppose you could inquire from half a dozen representative asylums?—Yes.

464. *Chairman*: One would very much like to know to what extent this very useful provision is taken advantage of?—Quite, we will make inquiries and give you the figures.*

465. I think you might make inquiries at two or three institutions?—Very well.

466. *Miss Symons*: Under what power is the allowance made?—(*Mr. Macleod*): Under Sub-section 2, Section 55: “The visitors may make an allowance to a pauper lunatic absent from the asylum on trial, not exceeding the charge in the asylum, and that allowance, and no more, shall be paid for him as if he were in the asylum.”

467. *Earl Russell*: What is the meaning of these words in your proof?—The meaning is that the visiting committee of a county or borough asylum have power to allow a pauper patient out on trial, but in the case of other patients the power is not only given under this section to go out on trial, but to allow a patient to go away for the benefit of his or her health. For instance a patient might go to the seaside for a month in the summer, or a patient might be allowed to travel with friends, but there is no power with regard to a rate-aided patient.

468. Do you mean that a pauper patient should not be given this privilege?—They use the trial for everything you see there, so that it makes no real practical difference.

469. *Chairman*: The objective is different—the purpose of the trial is to see whether freedom can be given to the patient, while leave is given in order to benefit his bodily health?—Yes.

470. *Sir David Drummond*: Do you think a medical superintendent is influenced by the fear that his reputation might suffer in the event of a patient out on trial going wrong?—(*Dr. Bond*): I have heard of that, but I think if there was such a feeling it is dead now. (*Sir Frederick Willis*): There was a case in one of the Courts last week of a girl who was out on trial breaking a window, and the magistrate made some remarks about the danger of letting people out on trial. (*Dr. Bond*): With regard to that, 25 years ago one certainly heard expression given to the view, and advice sometimes given that it was better to wait till patients were well and then discharge them in case something might happen during the period of trial for which the superintendent might be held more or less responsible, but I hope and think that that feeling is dead. We have encouraged the system of trial to our uttermost, and have gone so far as to say that should any untoward event occur and some inquiry is made with regard to the occurrence we ourselves will give evidence that we do advise it. (*Sir Frederick Willis*): It is certainly a very valuable provision.

471. What happens if the period of trial turns out to be useless, or, rather, is not productive of any beneficial result—what is done then—does the patient come back?—(*Mr. Macleod*): If the patient is not a fit and proper person to be out he would go back.

472. I want to see what happens during his absence from the institution?—On trial?

473. Suppose the patient unhappily turns out to be not capable of being released, who has charge of the matter then?—Technically, I believe, it has been said that if a patient is on trial he is a free agent during the period that he or she is on trial, but in point of fact when the patient is allowed out on trial there is a condition attaching to that under which it becomes necessary, if the mental condition of the patient requires it, for him or her return to the institution before the time has expired. That is what happens. (*Sir Frederick Willis*): Those interested would at once communicate with the institution and say that he or she had broken down.

474. But the reception order is still in operation?—Yes, that goes on all the time.

475. Supposing a person, on the other hand, shows that the trial is effective, is the patient released

* See Appendix III.

7 October, 1924.]

SIR FREDERICK WILLIS, K.B.E., C.B.

[Continued.]

at the end of the trial?—(Mr. Macleod): Certainly, the patient is discharged then. (Dr. Bond): The practice differs a good deal in different hospitals; in some hospitals, for instance, in London, it is the invariable practice to get the patient back to the hospital in order that the medical staff might see him or her and assess the recovery, and see if they were satisfied that the recovery was good, and, as a matter of fact, whether the patient had fallen backward rather than progressed. But if they were satisfied then, as Mr. Macleod says, a discharge is ordered on such and such a date by the visiting committee.

476. What is the alternative?—The alternative of that, as provided in the section, is for a doctor who is cognisant with the place where a patient is residing on trial to send his certificate.

477. And is that sufficient?—If the visiting committee, on the advice of the superintendent, like to act on that, they could do so.

478. So that the release of a patient may be much less formal than the proceedings at the beginning?—(Sir Frederick Willis): I think if they are satisfied that the person out on trial is no longer necessary to be detained, they have no power, to recall the case. (Dr. Bond): No, but we usually arrange with the patient to come back on a certain day. (Mr. Macleod): Sub-section 8 of Section 55, I think, deals with the point. It says, "If a person allowed to be absent on trial for any period does not return at the expiration thereof, and a medical certificate certifying his detention as a lunatic is no longer necessary is not sent to the visitors of the asylum or the manager of the hospital or house, he may at any time within 14 days after the expiration of the period of trial be retaken as in the case of an escape." So that if he does not return at the end

of his trial, and there is no certificate of recovery, he can be taken within 14 days, but if there is such a certificate, he cannot.

479. It does seem to be the case, then, that a patient can really be relieved from detention with less solemnity than occurs on his detention?—(Sir Frederick Willis): Yes.

480. It may be quite right, but it may be that a patient who has been admitted on an application with two certificates and with all the formalities, may cease to be detainable, on being let out on trial and simply getting a doctor to say that he is of right mind?—Quite, but I should like to say the general practice is that patients are now seen by the doctor at the institution.

Mr. Walter Stewart (representing the National Society for Lunacy Reform): May I ask, Sir, if you are in a position to indicate whether any facilities will be given to any person representing any organisation which is interested in this matter of being heard by Counsel, or being allowed to put questions after the evidence-in-chief has been led?

Chairman: We do not propose that witnesses attending here should be examined or cross-examined by other than members of the Commission, but, on the other hand, if any persons are interested on behalf of any responsible body, and think that any subject has not been explored sufficiently, the most convenient course would be to submit that matter or any questions to myself, and, if it is appropriate matter, or if the questions are appropriate, we will see that they are put. I do not think it is desirable that questions should be addressed to witnesses by everybody in the hall.

Mr. Stewart: But it would be permissible to put, through you, any questions?

Chairman: Quite, and no doubt that would be a useful course to follow.

(The Witnesses withdrew.)

(Adjourned to to-morrow at 10.30.)

5, OLD PALACE YARD,
WESTMINSTER, S.W.1.

SECOND DAY.

Wednesday, 8th October, 1924.

MEMBERS PRESENT :

THE RT. HON. H. P. MACMILLAN, K.C. (*in the Chair*).

THE EARL RUSSELL.

LORD EUSTACE PERCY, M.P.

SIR HUMPHRY ROLLESTON, BART., K.C.B., M.D.

SIR THOMAS HUTCHISON, BART.

SIR ERNEST HILEY, K.B.E.

SIR DAVID DRUMMOND, C.B.E., M.D.

MR. F. D. MACKINNON, K.C.

MRS. C. J. MATHEW.

MISS MADELEINE SYMONS.

MR. P. BARTER (*Secretary*),

MR. W. FAIRLEY (*Assistant Secretary*).

SIR FREDERICK WILLIS, K.B.E., C.B. (accompanied by Mr. S. J. FRASER MACLEOD, K.C., Legal Commissioner, and Doctor C. H. BOND, C.B.E., D.Sc., M.D., F.R.C.P., a Medical Commissioner of the Board of Control), re-called and further examined.

481. Chairman: Sir Frederick, I think this morning we might proceed to consider the question of discharge, dealing with the private patient and the

pauper patient separately. Perhaps you would be good enough to inform us of the methods by which a discharge is obtained, first of a private patient

8 October, 1924.]

SIR FREDERICK WILLIS, K.B.E., C.B.

[Continued.]

and second of the rate-aided patient.—(*Sir Frederick Willis*): There are a number of different provisions contained in the Lunacy Act in regard to the discharge of private patients. First of all there is the point which was mentioned yesterday, that if the reception documents are not amended to our satisfaction we have a right to say that the case must be discharged.

482. That is the early stage, I take it?—The earliest stage. On that point I would like to say that the number of discharges that take place because the medical certificates do not disclose sufficient ground for the detention of the case, and, when amended, still do not disclose sufficient ground, is very small indeed. I do not know what the actual figures are, but I should doubt if there are more than one or two a year. We are going to get the information for you; we will take a year's figures. Then another point that I think we mentioned yesterday is that under Section 38 a medical report has to be made at stated intervals, and if we are not satisfied that sufficient grounds are shown for keeping the case, again we have got power to order the discharge; that applies to cases in a registered hospital or a licensed house or in single cases. Then under Sections 75 and 76 the Commissioners have power to discharge from a hospital or licensed house, or a single patient if after visit they consider it is necessary and desirable to do so. Then there is a provision in Section 49 of the Act which gives us power, on the application of either a relative, or friend, or other person, to make an order authorising two medical practitioners to visit the case; they have to make two visits. The section is a little ambiguous as to how those visits should be paid, but our view is that the two doctors have got to go together twice; there are two visits, on each occasion by two doctors, seven days elapsing between these two visits, and if they report to us that the patient may without risk to himself or injury to the public be discharged, we may order the patient to be discharged. I do not know whether, in going through this, you would like me to say anything about the policy on which we act; but with regard to Section 49, of course, it may easily be that a patient might be discharged without risk to himself or injury to the public, though he is still quite insane; and there may be reasons for thinking that in the interests of the patient himself it is not desirable that he should be discharged. Then Section 72 (3) primarily gives the petitioner the right to discharge a patient.

483. That is the person upon whose application the patient has entered the institution?—Yes. That is subject to a right on the part of the doctor to give what is called a "barring" certificate—Section 74. If he says that the patient is dangerous and unfit to be at large then the petitioner cannot discharge the case; there would be an appeal to us, or the Visiting Committee, as the case may be.

484. Against that "barring" certificate?—Against that "barring" certificate. Perhaps I might read the words: "A person shall not be discharged under"—the section I have referred to—"if the medical officer of the institution, or, in the case of a single patient, his medical attendant, certifies in writing that the patient is dangerous and unfit to be at large, together with the grounds on which the certificate is founded, unless two of the visitors of the asylum, or the Commissioners visiting the hospital or house, or the visitors of the house, or in the case of a single patient, one of the Commissioners, after the certificate has been produced, consent in writing to the patient's discharge." Then, in addition to the petitioner having that right to discharge the case, if he is dead or cannot be found various relatives mentioned in Section 72 (2) have that right. Section 72 (3) says: "If there is no person qualified to direct the discharge of a patient under this section, or no person able or willing to act, the Commissioners may

order his discharge." We come in there really in lieu of the original petitioner.

485. On consideration of what you have told us, does it come to this, that a patient must always be discharged if the person upon whose application the patient is being detained desires that discharge, provided only that a patient is not in a state which would be dangerous to himself or to the public, or provided that he is not unfit to be at large, in the opinion of the medical officer in charge of him, subject to appeal to your Board or the Visiting Committee?—That is the position, yes.

486. Now, of course, the person on whose application the patient has been detained might conceivably be a person who had an interest in the continued detention of the patient?—Quite.

487. Suppose some person equally interested in the patient is of opinion that the detention is improper, or has been improperly obtained by the applicant, what redress would such a party have?—He could come to the Board of Control, and under Section 75 "Two of the Commissioners, one of whom shall be a medical and the other a legal Commissioner, may visit a patient detained in any hospital or licensed house, or as a single patient, and may, within seven days after their visit, if the patient appears to them to be detained without sufficient cause, make an order for his discharge."

488. What I am concerned with for the moment is the independence of the inquiry into the state of the patient, because one can see the desirability of providing independent means of inquiry?—Quite.

489. That is achieved, is it, by the person who wishes the inquiry addressing the Board of Control, who will then proceed at their own hand to investigate the case?—Yes, it seems to be the most independent form of medical examination you can secure. It is a Government Department.

490. That independent inquiry is the right, is it not, of any person who approaches you?—Yes, they have got a right. They would have to disclose some reason. If we got such an application as that, the first thing we should do would be to get a medical report from the medical superintendent of the hospital or licensed house in which the patient was.

491. Has such a person interested in the patient, but not the petitioner, a right of access to you?—Oh yes, certainly.

492. And is it your duty, on such an approach, to take the steps you have indicated?—It would be our duty to take the case up quite seriously.

493. And do you have such cases?—Yes, we have had such cases; I cannot give you the numbers, but Dr. Bond says they are fairly frequent.

494. And are they always inquired into in that independent fashion?—They would be always inquired into unless you did get an application from somebody whom you knew to be an absolutely unreliable person, or if it were in regard to a patient we had ourselves visited very recently, and knew all about; but there is no doubt whatever that the thing would be considered quite seriously, and there would be no disinclination on our part to investigate, visit, and discharge.

495. Now you are speaking of the policy of your Board rather than of any matter of obligation upon your Board?—There is no statutory obligation. It says, "Two of the Commissioners may visit," but in the case of a Government Department in dealing with a matter of this kind it is exactly the same as if it were worded "shall." In my view it is rather better, because if it said "shall" you would have to send two experienced men in some instances to visit a case where you knew it was perfect waste of time to do so; it is only to that extent that I prefer "may" to "shall."

496. Then you read the power as a power coupled with a duty?—I should, certainly.

Sir David Drummond: Suppose there is no such independent person to move the machinery?

8 October, 1924.]

SIR FREDERICK WILLIS, K.B.E., C.B.

[Continued.]

497. *Chairman*: Suppose there is no interested party, interested in the welfare of the patient, and the petitioner is not moving, who really is entrusted with the consideration of the case?—Well, you see, in the case of single patients we have got to pay visits to the cases and consider this sort of question for ourselves. In the case of a registered hospital and licensed house we have to visit those frequently.

498. May I take it that it is the machinery you described yesterday which would bring to your knowledge that sort of thing? It would be your domestic machinery which would bring to your notice anything deserving attention?—Yes, and from my experience of the medical heads of our registered hospitals and licensed houses there is no sort of inclination on their part to detain a case that ought not to be detained. I wish to say that most definitely. It is a very adequate safeguard. If to-day officers were willing to work in collusion with people who wanted to lock up patients unnecessarily, the position would, of course, be dreadful.

499. Of course, one knows that the institutions concerned pride themselves on their percentage of recoveries?—Undoubtedly. On that point, I should like to mention Section 83, which says: “(1) The manager of every hospital and licensed house, and a person having charge of a single patient, shall forthwith, upon the recovery of a patient, send notice thereof in the case of a patient not a pauper to the person on whose petition the reception order was made, or by whom the last payment on account of the patient was made, and in the case of a pauper to the guardians of his union, or if a local authority is liable for his maintenance to the clerk of the local authority. (2) The notice shall state that unless the patient is removed within seven days from the date of the notice he will be discharged. (3) In case the patient is not removed within seven days from the date of the notice he shall be forthwith discharged.”

500. But the initiation there starts with the person in charge of the case?—Yes, he has an absolute obligation in law to discharge a case on recovery.

501. *Earl Russell*: His notice is not sent to you, I observe, under that section.—After discharge a copy of every discharge comes to us.

502. But I mean the notice the section refers to—the notice of recovery?—No.

503. *Chairman*: What we are concerned with is to examine into all the safeguards, and to satisfy ourselves with the adequacy of those safeguards?—Certainly.

504. It is not from the point of view of reflecting upon the administration of the Act; it is rather from the point of view of seeing whether the Act gives you sufficient powers, and one is, therefore, scrutinising those sections a little closely from that point of view?—Of course, we welcome any scrutiny of that sort.

505. Now you have been dealing with discharge from the point of view of the Commissioners' intervention. Of course, there are other persons who may intervene and bring about a discharge?—Yes.

506. The Committee of a registered hospital; they may discharge, may they not?—As regards registered hospitals, there is Section 38 (7), but that is not quite the section I wanted; that is after considering the month-end report; that is at a specific time.

507. *Mr. Mackinnon*: That is the wrong reference, I think?—(*Mr. Macleod*): It is Section 39. (*Sir Frederick Willis*): As regards the registered hospitals, the Justices who are specially appointed do not visit; there, the managing committee are constantly visiting, but the duty primarily rests on the superintendent to discharge a case when he thinks it ought to be discharged. See Section 83.

508. *Chairman*: There is a safeguard there, is there not, in visitation by your Board?—Yes, that is so in the case of the registered hospital, the licensed house, or the single patient; we have the absolute right.

509. Then take the case of the public mental hospital. In the case of the public mental hospital the visiting committee has the power to discharge under Section 77 (1): “Any three visitors of an asylum may order the discharge of any person detained therein, whether he is recovered or not. (2) Any two such visitors, with the advice in writing of the medical officer, may order the discharge of any person detained in the asylum.”

510. With the advice of the medical officer two of the visiting committee may do so?—Yes, and of course it is the practice of visiting committees to be constantly seeing cases that want their discharge; I mean they personally interview them; they come up at their meetings, they meet very frequently, and it is quite a regular part of their business to see applicants for discharge.

511. Then I think the visiting committees have also power to discharge if they are dissatisfied with the continuation report?—Yes. What so very often happens with these poor people who have no friends to look after them is that they could be discharged if the friends were able really to look after them; I mean they would not be a danger to the public or to themselves, but they do need a very great deal of care and supervision, and it frequently happens that there is no home suitable for them to go to, where they could get the necessary supervision. There is always an inclination on the part of a visiting committee to discharge as many cases as they safely can discharge.

512. But if there is no home where the patient can be received and properly treated it may be very much to the detriment of the patient that the discharge should be granted?—Very much, and cases are kept in the mental hospitals for that reason, not because they want to detain them; there is no sort of object for them to detain them. (*Mr. Macleod*): In Section 79 there is power to discharge to the care of friends.

513. That is the pauper case, rather. For the moment we were taking the private patient. We will deal with the pauper patient later?—If you please.

514. In the case you mention, Sir Frederick, of a patient who might be discharged without danger to himself or to the public, you are figuring the case of a patient who is still insane?—(*Sir Frederick Willis*): Yes.

515. Of course, if the patient is not insane he must automatically be discharged under the general duty of discharging recovered patients?—Yes.

516. But you are figuring the case of a patient not recovered, but who might, if adequate provision were made for him, be discharged with safety to himself and to the public?—Yes.

517. The discharge being in that instance not because of the recovery, but because provision could be made outside the institution, with safety?—You would say in that case that he no longer needs detention or care.

Sir David Drummond: Supposing the patient is still insane, but in the opinion of the visitors the conditions are not favourable, what steps are taken?

Chairman: The question put is rather from the medical point of view with regard to the patient.

Sir David Drummond: It is rather that there is overcrowding in a particular place, or that the conditions are not favourable in a particular private asylum.

518. *Chairman*: What would happen in that case? Is the balance of consideration whether the provision that could be made for him outside would be more beneficial than the provision being made for him inside?—Of course, it very often happens that the visitors to licensed houses, or ourselves, come across cases where we think removal to another institution is desirable. We, or the visitors, then communicate with the petitioner, and suggest removal.

519. Let us follow it out. Take the harmless case figured: Do you consider in such a case whether it may not be more detrimental to the case that it

8 October, 1924.]

SIR FREDERICK WILLIS, K.B.E., C.B.

[Continued.]

should be retained in an asylum or registered hospital or whether it might not be better for him to be handed over to his friends?—Yes, we should consider that, or to single care. One often gets a case where it seems desirable on every ground that the case should no longer be in an institution, but should go to single care. A case a little bit better than that would be one where we thought it should be sent out on trial. I would like just to give you these figures. I was asked yesterday how many cases went out on trial. We got out the figures last night for the year 1922-23, and the number of cases that went out on trial was 5,525.

520. Is that all patients, both private and pauper?—Yes, from county and borough mental hospitals; it does not include the much smaller number in registered hospitals or licensed houses; we have not had time to get those figures out; but those are the figures from our public county and borough mental hospitals, and they are for the whole country, England and Wales. I should like to say on that that it is the policy of our Board to press that cases shall be allowed out on trial freely.

521. It would be interesting if you could complete that by telling us, after the 5,000 odd cases were sent out on trial, how many it was found necessary to bring back?—I think we could get that for you; unfortunately, many do come back.

522. It would be interesting to know in how many cases the trial proved successful and the patient did not require to return?—Yes.

523. *Miss Symons*: Might I know what is the maintenance grant for such cases on trial, or is there a maintenance grant?—Not for private cases, but for the public rate-aided cases the visitors can make an allowance which is equivalent to the cost of keeping the case in the asylum.

524. And what is that cost?—It varies; it is anything from 18s. or 20s. up to 36s. or £2 a week, that is the sort of figure it is; and although that is a very substantial number, 5,525, yet we should like more cases to go out on trial. We find on going round that some visiting committees send hardly any cases out on trial, and we invariably draw attention to that in our reports, and we correspond with the visiting committees, urging them to attend to this point, and to use their powers.

525. *Chairman*: I suppose, like other public administrative bodies, you issue circulars from time to time, indicating the powers that are possessed and how they should be exercised?—Yes, constantly. In some instances you get a medical superintendent who is frightened of taking any responsibility. He says, "Well, the patient is being very well looked after here; there is a little risk in letting him go out." We are always urging them to take their courage in their hands and risk certain things, because we think in the general interest it is a wise thing to do.

526. *Earl Russell*: Every now and then they do?—Yes, and the public says, "This is a monstrous thing."

527. *Sir Humphry Rolleston*: Might I ask whether there is any difference between that category and the "on trial" category, and if there is any difference with regard to the question of certificates?—Do they remain under certificates?—The case on trial remains under certificate; the case discharged to friends under Section 79 ceases to be under certificate. As *Dr. Bond* says, very often discharge to friends and discharge from certificate come after the case has been kept for three or six months on trial.

528. *Chairman*: But the essence of the trial is that the legal nexus is still there. As the result of the trial it may be thought desirable to discharge, whereupon the legal nexus disappears altogether; but the case where it is thought expedient that the patient shall be removed from the place of detention, and entrusted to friends is a case of discharge?—(*Dr. Bond*): It may be after trial.

529. It may or may not be after trial?—(*Sir Frederick Willis*): And of course there is very great convenience in maintaining that nexus in a large number of cases; it saves the friends a great deal of trouble. If the case breaks down they write and say, "Can you have him back?"

530. You have not to begin *de novo*?—No.

531. Now in addition to the cases where the patient is discharged through the intervention of the Commissioners of the Board, and the cases where the visiting committees and managing committees discharge, there is discharge also by operation of law, is there not?—Yes.

532. May we just take these very shortly? If there is recovery, you have already referred to the section dealing with that, and the patient must be discharged under penalty?—That is so.

533. Then if a patient has escaped from detention and is not recaptured within fourteen days, again automatically the certification lapses, does it not?—Quite. Why that should be so I do not know; I have tried to find the origin of that provision, but I do not know what it is.

Chairman: It seems curiously arbitrary.

534. *Earl Russell*: It can only be that they thought if a man could maintain himself for fourteen days he could look after himself?—Yes. Under the Mental Deficiency Act a case like that does not become discharged within fourteen days.

535. *Chairman*: It is difficult to find the reason for it?—I do not know what it is.

536. Is it an inheritance from older days?—Yes, it is an inheritance, from 1845, I think.—(*Dr. Bond*): Of course, there is a great difference between mental defectives and lunatics. One is suffering from a permanent condition, whereas presumably all the cases we are dealing with are going to recover, or have a chance of recovering.

537. Supposing an admittedly dangerous lunatic gets away and manages to secrete himself for fifteen days somewhere?—There is recourse to Section 14. (*Sir Frederick Willis*): Then he has to be taken in charge by a constable or relieving officer and brought back again; he is a wandering lunatic.

538. *Earl Russell*: And the re-certification costs about £5?—It would cost at least that—perhaps more.

539. *Chairman*: It is not based on principle; it is purely an arbitrary provision?—I think so.

540. Then if a patient is out on trial and fails to return after the expiration of fourteen days he is treated again as an escaped patient?—Yes, unless a medical practitioner sends a certificate.

541. Then discharge also follows where an urgency order or a reception order lapses?—Yes.

542. And I think we need scarcely refer to the Habeas Corpus powers, which are always in the background?—Yes.

543. Now would you pass to the case of the pauper patient?—In the case of the pauper patient there is no petitioner, of course, and the primary way of discharging those patients is through the visitors—that is, members of the county or borough council who have the duty of looking after the various institutions. It is the same for all inmates of public institutions.

544. Then if a special report is received on the subject by the Commissioners, are the visiting committee directed to consider the case and to investigate it?—Yes, invariably. If we consider that a continuation certificate did not *prima facie* disclose grounds for detaining the case we should at once inquire into it, and when a Commissioner was next going there, if they did not act on our view or did not take much notice of us, we should pay very special attention to that case.

545. Does one find the explanation of the difference between the cases of the private patient and the pauper patient in the matter of discharge in this circumstance, that there is no pecuniary inducement in the case of the rate-aided patient to detain the patient?—It is an essential difference, really.

8 October, 1924.]

SIR FREDERICK WILLIS, K.B.E., C.B.

[Continued.]

546. There may be, although there ought not to be, a motive in the case of the private patient?—Quite. There can be none in the case of the rate-aided patient.

547. But notwithstanding that there may be no motive to detain, there is this machinery which you are describing for obtaining discharge?—Yes.

548. I mean, there is in their case also supervision and an investigation by the Commissioners?—Yes.

549. What power have you as Board of Control in the case of a rate-aided patient, to direct discharge?—The only direct power, I think, is, in Section 49; that applies to private or rate-aided patients; that is on the application of anybody. We can make an order allowing two doctors to go and visit the case, and on the report of those two doctors we could discharge it. Then there is Section 34; that is if the original documents are not amended.

550. Have you had in recent years any instance of the necessity for your intervening in a case?—Do you mean a rate-aided case?

551. Yes. We have had some applications under Section 49 to send two doctors, and in some cases we have discharged the case on the report of those doctors. I have seen, I think, all those cases within the last two or three years, and in the cases that have been discharged, though one does not like to say they will certainly not recover, my impression is that they were not normal; but the doctors said that they could be discharged without risk of injury to themselves or to the public, and there seemed to be some sort of ground for thinking there were friends going to look after them, and we have ordered the discharge of the case. Our leaning is always to discharge a case if we can possibly think it might be discharged.

552. Just one point on that: Take the case of the rate-aided patient; with whom does the initiative in obtaining the discharge lie?—Under that section it may be a relative or friend, or anybody.

553. I put that question because I gather that some members of the public are interested in it—the question of the right of a person interested in a rate-aided patient to have the case considered?—Quite.

554. And to procure, if expedient, the discharge of such patient?—Yes.

555. What is the right of such a person?—They have an absolute right to make an application to us in respect of any patient.

556. What is your duty in that matter?—Our duty is to consider the application—not necessarily to make the order authorising the two doctors to visit. We get a number of foolish applications under that section; there are certain busybodies about; there are one or two societies who form themselves with a view to using this section; I suppose it is a little advertisement for them; but some of the applications we have had under the section are very foolish applications.

557. Some, on the other hand, I suppose, would be serious—I mean disclosing grounds for inquiry?—Yes, proper for inquiry, but, of course, in the case of these rate-aided patients the medical superintendent or his medical staff and the visiting Committee are all anxious to get rid of the cases all the time; the patients are constantly under review from that point of view.

558. Still, one is anxious to see that there are means by which their condition might be judged from outside?—Quite. There is an absolute right for anybody to make an application to us under Section 49, and we have a duty to consider that application.

559. I suppose one of the difficulties in the matter of imposing an absolute duty or obligation upon the Board of Control is that many of the communications you receive on the face of them appear to be baseless?—Yes, but I think even on those very absurd applications, or at any rate applications which at

that stage seem absurd, we should take some action; we should get some report on the case.

560. *Mrs. Mathew*: Who pays for the examination by the two doctors?—Whoever makes the application. Then with regard to Section 49, I would just like to say that of the applications we get under that section more are complied with than are refused; that has been the experience up to now, but there have not been a very large number; during the last year perhaps there have been 30 at the outside, under Section 49.

561. *Chairman*: Now, with regard to the documents upon which a patient is detained: I think the statute puts an obligation of secrecy upon you, does it not?—Yes.

562. You are not entitled to disclose the documents relating to a particular patient except under certain circumstances?—That used to be statutory, but although those sections are repealed we do still regard these things as secret, and we do not disclose them. But there is a section, Section 82, which says this: "The secretary to the Commissioners shall, upon the discharge of a person who considers himself to have been unjustly confined as a lunatic, furnish to him upon his request, free of expense, a copy of the reception order and certificate or certificates upon which he was confined, and if the order was made upon petition, also of the petition and statement of particulars upon which the reception order was made." Those particulars have also to be furnished.

563. But suppose a person *bona fide* interested in the welfare of a patient desires to know upon what statement of particulars or on what certificates that patient is being detained, is there any provision for such an applicant seeing the documents?—There is no provision, and we should want to be very, very fully satisfied that they were entitled to any information of that kind. That person coming and asking for documents of that kind could himself go and visit the case if he liked.

564. Or have this medical examination?—Or have this medical examination, or they could see the medical superintendent. The doctors at our public institutions are quite willing to see any friends and would discuss a case with them, and advise them about the case.

565. Of course we are dealing with the position where the sufferer himself and his relatives may not desire to disclose to the public the unhappy state of the individual?—Quite.

566. Is that the justification for the secrecy?—I think so. Sometimes it may happen that a wife has furnished a lot of particulars about her husband when he was ill, and if he recovers it is rather undesirable he should know his wife had stated this or that about him; it may really lead to his becoming ill again.

567. *Lord Eustace Percy*: On the other hand, the wife of a pauper patient would not be able to obtain information from you as to the grounds upon which her husband was detained?—Yes, I think we should give information in a case like that, and I think she would have no sort of difficulty in getting the information locally. I do not think there is any disposition on the part of the medical superintendent or anybody in a responsible position not to give her that information.

568. *Chairman*: So far as the proceedings before the judicial authority are concerned, there is a statutory obligation of complete secrecy. I think we find that in Section 6, subsection (5)?—That is so.

569. I was considering for the moment the *bona fide* case of a person interested in the welfare of a patient, who says, "I should like myself to see the documents on which that patient is being detained." Is the public consideration to the contrary the undesirability of making public private statements which you have received and which might cause pain, or really be disadvantageous?—Yes.

570. On the other hand, do you not think that if you are satisfied that the inquirer is a responsible

8 October, 1924.]

SIR FREDERICK WILLIS, K.B.E., C.B.

[Continued.]

person interested in the welfare of that patient, there is something to be said for that party having a right to see the documents?—If I were dealing with a case like that and I was quite satisfied that the man ought to know something about the case, I should tell him sufficient for his guidance without actually showing him the documents. I think it is rather important to maintain the view that he shall not have actual access to the documents, but I should tell him quite enough for him to know all about the case, and for him to take any action if he wanted to. It would, I think, be exceedingly undesirable to give anybody a sort of absolute right to come and demand to see all the private papers about people.

571. I suppose they frequently contain the most intimate details of the life of the patient?—Frequently.

572. Which are given on a confidential basis?—Yes. I am sure it would be productive of much more harm than good.

573. *Lord Eustace Percy*: In the case of a private patient there is a person who may be appointed by the lunatic himself who is present at the judicial proceedings?—Yes.

574. There is also the relative who signs the petition. Those two may be the same people, and they may not; but in the case of a pauper patient those very people who would be closely interested and have full knowledge in the case of a private patient would not be entitled to any information at all, and if you gave them any information you would give it them verbally rather than show them the documents?—I should give anybody who came to our office verbal information, rather than show them the documents, whether private or pauper, but there is no similar procedure in the case of the pauper that the relation has in the case of the private patient. In the case of the rate-aided patient it usually is the case that the wife or the husband moves the relieving officer to take action.

575. *Chairman*: And gives the information necessary?—And gives the information.

576. But there is no provision for the patient having a friend at hand who is conversant with the facts, in the same way as a private patient is entitled to have?—No; but this sort of thing very often happens: You have a pauper case, a man, and this man is visited by the wife, and she writes to us and says, "I visited my husband yesterday; he is very much better, and I should like him to be discharged." We should send that on to the medical superintendent and get a medical report on the case. If on medical grounds it was considered wise that his period of treatment should continue, we should write to the wife and tell her we have had the case specially investigated, and the medical advice is so-and-so, and in the interests of her husband we advise her that it is the best thing to allow him to remain for a further period; and of course they can approach the visiting committee in the same way as they can approach us.

577. But there is always access by any relative or friend to a rate-aided patient in the institution?—Yes, they can go and visit.

578. They can go and visit, and they can further, if they think that the patient ought to be discharged, apply either to the Board of Control or to the visiting committee as the case may be?—Yes.

579. And are they entitled to have the patient visited by a medical attendant of their own selection?—Yes, they could do that. Under Section 47 they have got a right, but as we were saying yesterday, a medical superintendent usually would welcome a visit from another doctor if a friend felt very uneasy about a case he had under his charge; I do not think any medical superintendent would object, but if he objected we have a right to give an order saying, "You shall admit this doctor to see that case."

580. *Miss Symons*: In a case of that kind, where you admitted the patient's own doctor, if he happened to disagree with the view that the doctor in the hospital took, what would be the procedure then?—Are you taking a pauper case now?

581. Yes.—If it were a pauper case we could not discharge the case. If Doctor A, acting for the friend outside, says, "I think patient B ought to be discharged; he is certainly not insane," and the head of the institution, knowing very much more about that case than the doctor who comes in for half an hour, says, "These are the facts about this case: It is quite true that on the day Doctor A saw him he was comparatively quiet and harmless"—that is the way with these unfortunate people; they have their periods of sanity and insanity—nothing statutory would happen upon that.

582. *Chairman*: The new outside doctor's certificate would be an authoritative element for consideration by the Board of Control in their investigation?—Absolutely.

583. But it has no sanction attached to it?—That is so.

584. It really comes to be a competition of medical views?—Yes. You realise the difficulty there is in seeing a case for half an hour; it is sometimes exceedingly difficult for a doctor on a visit of that kind to form any judgment.

585. *Earl Russell*: Would he be allowed to see the case-book, or be told what was in it?—I think the medical superintendent would usually tell him all about the case. Doctor Bond, who was a medical superintendent, says that in a case like that he would show the outside doctor all his notes.

586. Have you had a case in your experience of a friend wishing an independent medical examination of a patient under your care?—(*Dr. Bond*): Yes.

587. Did the medical attendant come in and make the examination?—Yes.

588. Did you accord to him the sort of welcome Sir Frederick indicates is accorded?—Freely.

589. Did you give him facilities?—Full.

590. Did you give him, in fact, access to the case-book of the patient?—Yes.

591. So that that outside doctor had not, of course, been with the patient, but had the history of the case and had the opportunity of examining the case?

—Yes. I may mention, upon the very point you have raised, in which there has been a disagreement between the superintendent and his visiting committee on the one hand, and the family doctor on the other, that there is a case in my mind now where not so very long ago, at the request of the Board, I went down and saw a patient at once.

592. Has that arisen frequently in your experience?—No.

593. It is a rare occurrence, is it?—It is a rare occurrence for that chain of events to occur.

594. But is it a rare occurrence for a difference of opinion to arise between the outside doctor visiting a patient, and the staff doctor?—I should think it is a very rare occurrence. It is not a frequent occurrence in the case of rate-aided patients for doctors to visit; but there is a growing and happy practice—it is not universal, but there are a few places where it exists, and certainly I could name one place in which it is universal—by which, on the admission of a patient, the superintendent, in getting out the history of the case, finds out the name and address of the family doctor, if there is one. On finding out that, he writes him—it is a nice but stereotyped letter, to save time—to say that so-and-so, whom he believes is a patient of his, has been admitted; he tells him very brief facts about the case, and says he would be so much obliged if he would tell him such facts as are known about the patient, and perhaps the family, at his discretion, and if he is near the hospital and can find the time, he would be so glad to welcome him and to discuss the case further with him. I think it is a splendid practice; it is universal in the hospital I am thinking of; and it is one which is going to grow and should create very nice relationships.

595. *Earl Russell*: The section to which you refer, Sir Frederick, seems to me to be only permissive, not to give a right to pauper patients' friends?—(*Sir Frederick Willis*): It is permissive as far as we are concerned.

8 October, 1924.]

SIR FREDERICK WILLIS, K.B.E., C.B.

[Continued.]

596. That is to say, they cannot be visited by two medical men unless you assent?—That is so.

597. It is not an absolute right?—It is not an absolute right.

598. I understood you to refer us to it as an absolute right?—Perhaps I did; I may have been wrong. It is not absolute in this sense: there might be cases where it would be very unwise to allow a particular doctor to visit a particular patient.

599. *Chairman*: I suppose, as I have said, the difficulty in all these matters is that, dealing as you are with abnormal people, a certain measure of discretion must be reposed in responsible bodies?—I think it must: it will lead to very, very great difficulty if you do not.

600. Then the question really for consideration is whether the exercise of these responsible discretionary duties is sufficiently safeguarded. It was said once by Bishop Blomfield that, "When you leave a thing to a man's discretion you equally leave it to his indiscretion."—I hope we have not much indiscretion.

601. What one has to consider is whether there are safeguards which fence about the discretion?—On that the Lunacy Commission was formed to be a very independent Government Department. We have only the patients to look after.

602. That is the feature in considering this legislation, that the element of discretion must be present at some point?—It must. It seems that the best way is to have a Government Department doing this kind of thing and to select men of character and ability to fill the posts. I do not see anything better that can be done. If you were to allow an appeal to the Secretary of State, it seems that you would be going from an expert body to an inexperienced body.

603. And even so it would still be his discretion?—Absolutely.

604. Now, to exhaust the question of the rate-aided patient, you have given us the sections, but there is also discharge to Poor Law institutions, is there not?—Yes, Section 80: "When the visitors of an asylum order a pauper lunatic confined therein to be discharged, except on the application of a relative or friend, they may when they think fit, send a notice in writing, signed by the clerk of the asylum, by post or otherwise, of their intention to discharge the lunatic to a relieving officer of the union in which the lunatic is chargeable, or to the clerk of the local authority liable for his maintenance. Upon receipt of such notice, the relieving officer or clerk shall cause the lunatic upon his discharge to be forthwith removed to the workhouse of the union to which the lunatic is chargeable."

605. The matter is dealt with also, is it not, in Section 25?—Yes; but it is a case "not recovered" which they consider is suitable to be treated in a workhouse as distinguished from an asylum.

606. Then there is discharge by operation of law in the case of the rate-aided patient, analogous to that of the private patient?—Quite analogous, the continuation order and all else apphes.

607. And in the case of the rate-aided patient have the friends of the patient as well as the patient himself very wide facilities for approaching the Commissioners directly?—Very wide.

608. Do you receive a great many letters daily in the case of rate-aided patients?—Yes, far more than in the case of private patients.

609. And do you receive visits from their relatives at your office?—Constantly.

610. Are these persons received?—Yes, and seen by responsible officials; their cases are discussed, and they are helped as far as we can help them.

611. Now before we come to the workhouses, which is our last topic, I just want to pick up one or two small points on the way. In the case of private patients they may have some property which can be administered for their benefit?—That is so.

612. The Act, I think, provides for the management of their property during the period they are under care; I am speaking of Section 116?—Yes.

613. And is provision made for their money being utilised for their benefit?—Yes, that would be the usual thing. (*Mr. Macleod*): We can report under Section 100. You are speaking of Section 116?

614. Yes. There is another section as well. (*Sir Frederick Willis*): Section 100 is: "Where the Commissioners report to the Lord Chancellor that they are of opinion that the property of any person detained or taken charge of as a lunatic, but not so found by inquisition, is not duly protected, or that the income thereof is not duly applied for his benefit, or to the same effect, the report shall be filed with the Masters, and shall be deemed to be an application for inquisition supported by evidence, and the alleged lunatic shall have notice of the report from such person as the Judge in Lunacy directs." We have got a right to require information as to the property of any person detained as a lunatic.

615. I was only concerned that we should see there is provision for the means of a patient being applied for the benefit of that patient—There is that provision.

616. Then as regards the institutions in which patients are kept, you have powers, have you not, in connection with the licensing of houses for the reception of patients?—Yes; what are called the metropolitan houses we license. Outside the metropolitan area the justices license them.

617. We will consider in the evidence of the Ministry of Health the procedure as to the passing of plans and so on; but there is machinery which is concerned with seeing that the premises are comfortable and satisfactory from the public health point of view.—Yes. With regard to plans, of course, primarily we start by looking into any plans, alterations proposed, or anything of that nature; we thoroughly investigate them. After that has happened they are passed on to the Minister, who sometimes, I think, again thoroughly investigates them.

618. That is only incidental to our reference in so far as it relates to the care of patients. One wants to know that some authority is concerned with seeing that the premises are, as I put it, comfortable and satisfactory from the public health point of view?—Quite.

619. Then there is machinery in the Act dealing with licensing and an appeal from you to the Secretary of State?—Under Section 221, the Lord Chancellor, on the recommendation of the Board, has power to revoke a license.

620. As regards the places in which one will find the patients, I think we might just get this on the note: Pauper patients are to be found only in either public asylums or workhouses?—Yes. They can, in law, be in licensed houses, and in registered hospitals.

621. Yes, but they are not as a fact?—No.

622. So that at the moment all the pauper patients in this country will be found detained either in public asylums or in Poor Law institutions?—Yes.

623. On the other hand, the private patients will be found, all of them, either in registered hospitals, in licensed houses, in single care, and to some extent in public asylums?—That is quite true.

624. Then we will also find some cases, but you have told us comparatively few, where the boarding-out provision has been taken advantage of?—Yes.

625. Is that pauper patients only?—That is only pauper patients.

626. We find, therefore, some pauper patients boarded out?—Yes. Then those receiving outdoor relief are not certified cases; they are regarded as lunatics, but are not certified; they are given outdoor relief and are living with their friends.

627. *Sir David Drummond*: I should like some information about the licensed houses and private asylums (we know that new licences are no longer granted), as to whether, in your opinion, there are sufficient, and sufficient accommodation throughout the country; what are the grounds for limiting the number of private asylums?—That is a matter of big

8 October, 1924.]

SIR FREDERICK WILLIS, K.B.E., C.B.

[Continued.]

general policy. I gather, in 1890, Parliament decided that there should be no more licensed houses, and however full they may be, and some of them are full, the law says there shall not be any more.

628. *Earl Russell*: The existing ones may be enlarged, I suppose?—Not to take more cases.

Chairman: I think probably there was a feeling at the time that any person who was in charge of a patient for gain might have an interest in the continued detention of the patient; that was the history of the thing.

629. *Sir David Drummond*: In the district I am familiar with there is only one private home within a radius of 100 miles, and the difficulties in the way of disposing of a private patient are enormous?—I have considerable sympathy with that. As far as I know our private asylums are exceedingly well administered.

630. *Chairman*: Take the case of a private patient where there is no accommodation for that private patient in any neighbouring licensed house: He is quite well-to-do, but it is desirable that he should be sent to an institution: There is no licensed institution, they are all full. Registered hospitals are also full, or there are none in the neighbourhood, and it is desired to have the patient kept in the neighbourhood of his family. How would such a patient be disposed of?—He would have to go a distance in the case you put.

631. Or to a public asylum.

632. *Sir David Drummond*: Or to the workhouse?—No, he would not go to the workhouse.

633. *Chairman*: Has he any right to demand as a private patient to be received into a public asylum?—Yes. However wealthy the person was, if he had got an acute breakdown and required to be removed somewhere at once, no matter why it is, you could give notice to the relieving officer and the relieving officer could take the case to the workhouse.

Sir David Drummond: That is what happens.

634. *Lord Eustace Percy*: It can only be done through the Poor Law machinery?—Yes, an emergency case like that.

635. I think you told us that certain asylums refused to take private patients?—Yes, some of them.

636. Therefore that person would have to go into an asylum as a rate-aided patient?—Yes. (*Dr. Bond*): And the cost would be recovered by the guardians from the person's estate. (*Sir Frederick Willis*): It would not be a charge upon public funds, because although technically he is a pauper, they would recover from him.

637. *Chairman*: Must not the treatment all be exactly the same in the public asylum?—They get the treatment which the medical man says they ought to get.

638. I mean he would get no advantage of his means. (*Dr. Bond*): The county mental hospitals that will not have a patient upon a private list are very few indeed, but I know of cases such as Sir David Drummond is referring to, and you cannot call those rare, although I do not think that many are in a position of being rate-aided for long.

639. It is suggested that the matter might be dealt with by treating the case as a single care case, if you could get somebody to undertake it?—(*Sir Frederick Willis*): Yes. Of course some cases are not fit for single care; you must occasionally have a padded room to put a case in.

640. *Earl Russell*: Does single care count as a licensed house?—No sanction is required at all for one case. The person taking the one case has got immediately to inform us that he has got that case, and the case must be under certificate; we must have a copy of the admission documents, and we have to visit the case almost immediately.

641. *Chairman*: It will not always be possible to provide by single care for a case such as is figured?—(*Dr. Bond*): Not possible and not desirable. Many of the private cases, although in a well-to-do position, cannot possibly afford the nursing required in single care, because if it is really an acute case it means two nurses by day and one by night—that is three.

642. Of course this is raising a very large question as to the adequacy of accommodation in this country for the various classes of patients?—(*Sir Frederick Willis*): Yes. Speaking generally, the accommodation is inadequate, and the position will, I think, be very serious in a comparatively short time.

643. *Earl Russell*: If I might follow out this single care question for a moment, you have to give no antecedent sanction at all. Do I understand that you may say a house is not a fit one for the patient to be kept in?—We could say it. (*Mr. Macleod*): A person cannot take more than one single patient without our consent.

644. I am dealing with the one case. Have you power to say that the patient shall not be kept there if you disapprove of the accommodation?—(*Sir Frederick Willis*): I think we have, but I will look it up.

645. *Lord Eustace Percy*: Arising out of that point, might I ask this question: You have told us that the reason for the special safeguards in regard to private patients is to prevent the relatives of the private patient getting him put away for financial reasons, but it appears that in practice not only can the relatives of a man of means get him put away as a rate-aided patient with none of those safeguards, but, indeed, they are forced to do so very often by reason of the inadequacy of the private accommodation?—I would not say they are often forced to do so, and, of course, if a wealthy sane man did get to an asylum he would not remain there more than a day or two.

646. Why not?—Because the medical superintendent would see that he did not.

647. But why?—I said a wealthy sane man.

648. I beg your pardon. My submission really was that in view of the inadequacy of the accommodation, in view of the policy generally pursued by public asylums, in view of the fact that you can recover the cost of a pauper patient from the relatives, the substantive reason for any distinction between the private patient and the pauper patient is really gone by the board altogether. There is nothing whatever to prevent any man of means being detained in an asylum through pauper machinery and not through private machinery, and that at the request of the relatives?—Of course, if a wealthy man goes in via the Poor Law, he goes in under the ordinary Poor Law machinery; there is one certificate instead of two, and in so far as those safeguards are concerned, in the case of a private patient, they do not apply to the wealthy man going in via the public machinery; but I should suggest that they are not required in that case, because you are dealing with public officials, and I do not think they would be willing to work with persons who wanted to do wrong things.

649. That is an argument for abolishing the private patient procedure altogether?—Well, yes.

650. *Chairman*: There is the public point of view that if beds in public asylums are occupied by these persons, the accommodation is taken up, and there may be more charges on public money to extend public asylums?—Quite.

651. *Mr. Mackinnon*: They only get the cost of maintenance out of them.—You mean if it grew very much.

652. *Chairman*: Yes.—At present very little of that sort of thing goes on.

653. It is only what we may call surplus accommodation in asylums that is used for this purpose?—Yes. Some institutions provide special accommodation for private patients.

654. In the case of those private patients they pay?—They pay.

655. *Mr. Mackinnon*: Can they pay more than their cost?—Yes.

656. I was looking at Section 315, and I was wondering whether you could, for profit?—(*Mr. Macleod*): Section 315 provides that "Every

8 October, 1924.]

SIR FREDERICK WILLIS, K.B.E., C.B.

[Continued.]

person who, except under the provisions of this Act, receives or detains a lunatic, or alleged lunatic, in an institution for lunatics, or for payment takes charge of, receives to board or lodge, or detains a lunatic or alleged lunatic in an unlicensed house, shall be guilty of a misdemeanour." If a person has a patient in an unlicensed house who is a lunatic and should properly be certified and is not certified, that is a contravention of that section, and that person is liable to prosecution.

657. *Chairman*: Section 271 disposes categorically of the matter?—Quite. Clearly that is the section. Some of these asylums have villas and private places exclusively for these private patients; others have them mixed with pauper patients, and others have separate wards for them.

658. But we must take it from Sir Frederick that his evidence is this, that at the moment, no doubt due to national exigencies, the accommodation for different classes of patients throughout the country is reaching its limit?—(*Sir Frederick Willis*) Is reaching its limit.

659. And there may be embarrassment in dealing with the appropriate accommodation of the different classes very soon?—Quite. The accommodation of to-day will be quite used up in a year or so by mere growth of population; I do not mean by increase in insanity.

660. Then it may be necessary therefore to reconsider the policy which has arrested the licensed houses which cater for a particular class of patient at the present stereotyped figure of 55?—Yes. In my opinion the private licensed houses perform a very useful purpose in the whole system.

661. It might be put in a sum of proportion, that if 55 was a reasonable number in 1890, it may be necessary to have a larger number in 1924 after a lapse of 34 years?—Quite. Might I say with regard to cases in single care, the point raised by Earl Russell is met under Section 59 (3).

662. *Earl Russell*: So that if you disapprove of it you can close the house?—We can remove the patient.

663. *Chairman*: Then with regard to the care of the lunatic, your Board, I understand, has power to investigate the question of the comfort of the patient in the matter of diet and bedding, and all the other ordinary incidents of domestic life, and to see that these are properly attended to?—Yes.

664. You may have complaints about these matters. Would those be investigated?—They would.

665. Have you any duty with regard to rules and regulations for institutions?—(*Mr. Macleod*): Section 275 is the section.

666. Section 275 deals with the general framing of rules and regulations, and these have to be prepared by the Visiting Committee and submitted to the Secretary of State. I take it that is now the Minister of Health?—(*Sir Frederick Willis*): Yes, but via the Board of Control.

667. So you have opportunities of considering and dealing with the comfort of the patients, apart from their medical treatment?—Yes. I would like to say generally about that that after the Commissioners have visited an institution they invariably make a report which is entered in the books of the asylum; a copy of that report comes to the Board of Control; it is read by an experienced clerk and a Commissioner. I read all these reports on asylums, and if any of us think that correspondence ought to be started on some particular point, it is started, and we follow it up.

668. That is on the domestic side of the life of the asylum; but in regard to the treatment of the case what is your jurisdiction?—That would be dealt with in the same reports. If the Commissioners considered that the medical arrangements were insufficient, we should correspond about it.

669. One is aware, of course, that on the initiative of the Ministry of Health, in conjunction with the Board of Control, various meetings and conferences have taken place, and Committees are at present

considering matters relative to the internal administration of institutions?—Yes. The Board of Control themselves called a conference when a number of these points were discussed. As the outcome of that conference we formed three departmental Committees, which have practically finished. One was on records and rules to be kept at these institutions; we wished to simplify them as much as possible. One of our Commissioners was Chairman, and that Committee have presented their report, and it is in process of being given effect to. There was another Committee on nursing: Dr. Bond was Chairman of it; it has concluded its report, but it has not yet been published. We have another very important Committee on dietaries, and that report is published.

670. So that over and above the statutory duties incumbent upon you, the Board has been concerning itself with large questions of policy in the administration of asylums?—Yes.

Sir David Drummond: May I ask whether this would be the proper time to raise the question of penalties attaching to medical men who retain a certifiable case.

671. *Chairman*: Yes, I think it would come appropriately now. Throughout the Statutes various duties and obligations are imposed upon various persons. Is the scheme of the Act to constitute disobedience to those obligations a misdemeanour?—Yes.

672. And are penalties of varying degrees of severity imposed for contraventions?—That is so.

673. Do you think that the penalties are adequate?—I should say they are. So far as my experience goes, I should say the provisions of the Act are being carried out scrupulously.

674. Have you any statistics of the number of cases that have come up where proceedings have had to be taken under the Act for contraventions?—I do not think they have been gathered together, but they would be very, very few. If we came across a case of a public official not complying with the Act we should communicate with him always. Usually it would be inadvertence—he had overlooked something, and we should say, "You must be careful to see that that does not occur again." It would be impolitic, directly you came across a case like that, to prosecute the man.

Sir David Drummond: My point was with regard to patients who may be possibly certifiable, and there may be a difference of opinion, and the patient is retained uncertified, and something happens. There is a penalty attaching to it. That is a very difficult question, and I should like to know how the Board views that side of the question, in the case of a private institution.

675. *Sir Humphry Rolleston*: Does that come under your control at all?—Yes, directly. We can authorise prosecutions.

676. *Earl Russell*: If there have been so few prosecutions, there would be no difficulty in giving us a return of them for the last five years, would there?—Yes, we could, but the case Sir David mentions is one of detaining a person who, some doctors say, is certifiable, and others say is not certifiable.

677. (*Chairman*): It arises in this way, that a medical practitioner called in privately may well say: "My patient seems to me to be in a very doubtful state, but it is very undesirable that he should be certified, and I will take the risk of looking after him in his present home." In point of fact he might well have been declared to have been certifiable?—Of course he can remain at home any length of time.

678. Take the case where he is sent to a nursing home: In point of fact he is a certifiable person, but in order to avoid the stigma of certification, the medical practitioner says: "I will shut my eyes to his state, and will just have him treated as an ordinary patient." If he is a certifiable person it is a contravention of the Act to have him retained uncertified in a nursing home?—That is clearly so.

8 October, 1924.]

SIR FREDERICK WILLIS, K.B.E., C.B.

[Continued.]

679. And very serious penalties attach?—Yes, and very often we should not know of the patient.

680. I suggest that we might consider that topic when we come to deal with the second branch of our remit, because it may be that a way of escape from that dilemma is in the treatment of the uncertified patient?—Yes.

681. That class of case at the present moment may involve a contravention of the law, and we shall have to consider whether that case shall be provided for under the voluntary treatment which we shall have to consider later?—Yes.

682. Of course the circumstances may vary infinitely; it may be a border line case?—If we came across a nursing home that was contravening the statute, we should put the papers in the hands of the Director of Public Prosecutions.

683. It would be useful if you would give us the number of prosecutions under the different heads of the Statutes in the last five years?—Yes;* we will do that.

Sir David Drummond: It is a matter of opinion whether the patient is certifiable.

684. *Earl Russell*: You go to the Lord Chancellor in this case, because the case not being certified, the Commissioners have no powers?—Quite, but he has the power to give us an order to go. Every year in our Annual Report we do set out what prosecutions have taken place during the year, and we can gather them together for you.

685. *Chairman*: Sir Frederick, let us pass to the question of insane persons in workhouses. The figures you give show that there is a substantial number of insane persons in Poor Law institutions?—Yes.

686. And a number of cases are permanently detained there?—Yes.

687. And others are passing through under the procedure you have indicated?—Yes.

688. I should like to have from you a reference to the Sections under which insane persons are detained, either temporarily or permanently in workhouses?—Section 20 is the first Section, I think.

689. Section 20 deals with the urgency case which you referred to in answer to Lord Eustace Percy a few moments ago?—Yes.

690. The next is Section 21?—Yes; the Justice can send a case temporarily for 14 days only, with no certificate as it were of insanity; it is merely his order. (*Mr. Macleod*): Under Section 21 (1) the order might be made; under Sub-section (2) the order has in fact been made.

691. In either case for 14 days the patient may be received into a workhouse?—(*Sir Frederick Willis*): Under Section 20 only for three days, and under Section 21 for 14 days.

692. Section 20 being the urgency case and Section 21 being a more deliberate case?—Yes.

693. Then what about the permanent detention?—That is under Sections 24 and 25. Under Section 24, if the medical officer of the workhouse certifies that the accommodation of the workhouse is sufficient for the proper care and treatment of the patient, and that the patient's condition is such that it is not necessary for the convenience of the patient or of the other inmates that he should be kept separate, he can then be permanently detained in the workhouse with a justice's order.

694. There must be a justice's order?—Yes.

695. And a certificate of an outside doctor, and of the doctor of the workhouse?—Yes.

696. *Sir David Drummond*: There is no provision with regard to where the justice would see that patient. In some places Dr. Bond knows of, the patient is brought to the police court where the justice is sitting; in others the justice visits the patient at the workhouse?—(*Dr. Bond*): If I might correct that, Sir David, under the Section you are dealing with at the moment I do not think that a patient is ever brought to the police court. The instances that you allude to, which we Commissioners dislike very much,

are those in which it is intended that the patient shall go to a mental hospital, and the justice has got to see the patient either at home or in a Poor Law institution. If the justice cannot go to the home, certain justices in certain neighbourhoods—about four neighbourhoods, taking England and Wales as a whole, have the practice which we object to, of getting the patients to the police court; and we write to them from time to time about it. Of course there are emergency cases which are brought in by the police; the circumstances do not give rise to any objection. But I do not think your point, Sir, arises under Section 24. That Section does not relate to a patient as to whom there is any thought that he will pass on to the mental hospital. Section 24 leads up to permanent detention in the Poor Law institution, and I have never heard of such a patient, when he has to be seen by a justice, being taken to the police court. (*Sir Frederick Willis*): As regards the workhouse cases that are detained permanently under Section 24, the justice is not obliged to see the case at all; he has to have two medical certificates.

697. *Chairman*: That is rather like the private patient case?—It is really.

698. There are two certificates, but one is the certificate of a medical practitioner not being an officer of the workhouse, and the other is the certificate of an officer of the workhouse?—Yes. (*Mr. Macleod*): In addition to the order of the justice and the certificates of two medical men, you have to comply with Form 11, which is contained in the Schedule to the Lunacy Act. This is the order under the Lunacy Act; the order of the justice here does not authorise detention unless something else is done. If you read that Form, it is: "I the undersigned, a Justice of the Peace for . . . being satisfied that A.B., a pauper in the . . . workhouse of the . . . is a lunatic (or idiot or person of unsound mind) and a proper person to be taken charge of under care and treatment in the workhouse, and being satisfied that the accommodation in the workhouse is sufficient for his proper care and treatment separate from the inmates of the workhouse not lunatics (or, that his condition is such that it is not necessary for the convenience of the lunatic or of the other inmates that he should be kept separate) hereby authorise you to take charge of" (that is all) "and, if the workhouse medical officer shall certify it to be necessary, to detain the said A.B. as a patient in your workhouse." He cannot detain him unless they get endorsed upon the back of the order a certificate from the medical officer of the workhouse that it is necessary to detain him.

699. And for his permanent detention there must be a certificate from an outside doctor?—Yes.

700. Now, is it through that avenue that all the patients who are found permanently detained in Poor Law institutions in this country reach their destination?—Yes. (*Dr. Bond*): Plus Section 25. (*Sir Frederick Willis*): That applies only when a case is sent to the workhouse from the asylum; but Section 24 is the ordinary way. (*Mr. Macleod*): And they can be sent there under Section 26 also. (*Sir Frederick Willis*): Section 26 empowers a visiting committee with the consent of the Board and the Minister of Health to make a contract with the Guardians to take suitable cases into the workhouse.

701. Now, will you tell us what determines whether an unfortunate pauper patient finds his way to a public asylum, a place devoted to that purpose, or finds his way to a Poor Law institution?—I am afraid it is very largely accidental. In some areas practically all the cases go for a part of the time to the workhouse; in other areas practically all the cases go straight to the asylum.

702. It seems to me that a question of policy arises here. Of course, the asylums provide means for treatment and the possible cure of cases?—Yes.

703. And no doubt they are now being more and more equipped with means for treatment?—Much more.

* See Appendix IV.

8 October, 1924.]

Sir FREDERICK WILLIS, K.B.E., C.B.

[Continued.]

704. One would think that *prima facie* the workhouse was not the proper place for the reception of patients who would benefit by those means of cure, but would be a more proper place for cases which are really hopeless, and where the patient cannot benefit by treatment at all?—The chronic harmless case—he is often happier in the workhouse than he would be in the asylum.

705. But surely it is desirable that there should be some means of discrimination, so that the kind of patient who can benefit from the equipment of an asylum should not be relegated to a workhouse where there are none of those advantages?—We entirely agree.

706. *Sir David Drummond*: I think it is very much a question of lack of accommodation?—It may partly be that.

707. *Chairman*: And yet the accommodation which is available might be occupied by persons in asylums who ought to be in the workhouse?—Quite.

708. It does seem to me that we are touching here upon a point of very considerable importance?—You are. (*Mr. Macleod*): The only means of removing them from the workhouse is provided under subsection 6 of Section 24. If the medical officer does not sign the certificate, or if an order is not made by the justice, or "if after such an order has been made, the lunatic ceases to be a proper person to be detained in a workhouse," then the relieving officer takes steps to have him removed to an asylum. The only other power is under Section 60, which is the limited power given to the Commissioners and which is very seldom exercised, but it has been exercised: "Where, upon the visitation of a workhouse by any two or more Commissioners, it appears to them that a lunatic or alleged lunatic therein is not a proper person to be allowed to remain in a workhouse, they may by order direct the lunatic to be removed to an institution for lunatics, and every such order shall have the same effect as a summary reception order."

709. I gather that you would welcome consideration by the Commission of this particular matter?—(*Sir Frederick Willis*): I should certainly, very much. Put shortly, I think the position is this: These cases that go to the workhouse very often are not seen at once by a person who is really skilled in dealing with mental cases. Sometimes, of course, there is a man of that kind, but we are not at present securing the best use of the total accommodation of this country, and unless it is under expert medical direction I do not see how you can secure it.

710. I suggest that as this topic is one of considerable importance, it might assist our deliberations if you would hand us in a memorandum on the subject of the utilisation of workhouse accommodation on the one hand, and of asylum accommodation on the other, because I think we ought to give you an opportunity of presenting to us a considered view on that matter. You might prepare a short memorandum for us on that matter, which we should carefully consider?—Yes; we will let you have a memorandum opening up the subject, but as to exactly in what way the difficulty can best be removed, it would be much more helpful if you had before you the views of the various witnesses whom you will hear.

711. Yes. We expect we shall have the pleasure of seeing you here again later on; at this stage we wanted to get into our minds an outline of the general system. As this is a matter of reform, you might consider this topic, because I and my colleagues attach importance to it?—(*Mr. Macleod*): Might I say as regards patients in workhouses, that none of the documents are sent to us, and there is no continuation order.

712. *Earl Russell*: I think all these differences ought to be brought out in your memorandum, so that we shall have them all before us?—Certainly.

713. *Chairman*: I just want to have from you now, to complete the matter, what are your powers and duties with reference to patients permanently detained in workhouses?—(*Sir Frederick Willis*): First of all, under Section 203, "Any one or

more of the Commissioners shall, on such day or days, and at such hours in the day, and for such length of time as he or they may think fit, visit all such workhouses in which there is or is alleged to be any lunatic, as the Commissioners by any resolution direct, and shall inquire whether the provisions of the law have been carried out, and also as to the dietary, accommodation, and treatment of the lunatics, and shall report in writing thereon to the Commissioners, and the Commissioners shall forward a copy of every such report to the Local Government Board." Now our visiting staff has been quite too small ever since I have had anything to do with the Board of Control, to visit these workhouses as often as I think they ought to be visited from this point of view. The Ministry of Health, of course, visit these places through their General Inspectors, and I think they are under statutory obligation to visit once a year. When we visit we make a report on our visit and sometimes, perhaps frequently, point out a number of things that we think exceedingly unsatisfactory. We send that report to the Ministry of Health; I think they would generally send it on to the guardians concerned, but I am sorry to say that very often nothing happens.

714. *Earl Russell*: I thought you were bound to send it on to the guardians?—No, we only send it to the Ministry of Health.

715. *Chairman*: You have no power to enforce your recommendations?—We have no power to enforce the matter.

716. Then this is a matter really upon which we must examine some guardians?—Yes, and the Ministry of Health will tell you better than I can what they actually do with those reports.

717. Now a question with regard to another matter. What about the discharge of persons from those institutions?—Under Section 81 the guardians have power to discharge any lunatic detained in a workhouse. We have no power to discharge a case, and I do not think anybody else has got any power; but of course here again the guardians have no inducements to detain a case at their expense—no financial inducement anyhow.

718. Does the code with regard to letters and communications, and so on, apply to these patients?—No. A lunatic in a workhouse has no right to write to us and have his letter sent unopened. Whether he has the right to write to the Ministry of Health or not, I cannot say. They will tell you.

719. Is it not rather striking that a patient may accidentally find his way either to a workhouse or to a public asylum? If his fortune has taken him to the public asylum he there finds, subject to your supervision, protection by a code as to his letters, whereas if an accident has relegated him to a Poor Law institution, he has none of those advantages?—Yes, I quite agree. Undoubtedly there are many cases in workhouses which ought to be in mental hospitals to-day, and there are many cases in mental hospitals who would be more satisfactorily dealt with in Poor Law institutions.

720. Do you consider that it would be desirable to have a more exhaustive series of statutory regulations for lunatics applicable to Poor Law institutions?—It is, of course, a very big question to say how that real difficulty should be removed.

721. We are there, of course, trenching upon the province of the guardians and the Poor Law administration?—Of course there has been talk lately of the abolition of the Poor Law. If any big scheme like that were carried out, this is one of the questions that would be dealt with.

722. I propose, if my colleagues agree, that we should postpone meantime hearing your evidence with regard to the early treatment of uncertified cases, and that we should have an opportunity, if you are agreeable, of seeing you later, after we have had the advantage of hearing the criticisms and so on which may be addressed to your Department. Therefore, I do not propose, if my colleagues agree, to carry my examination of your Department

8 October, 1924.]

SIR FREDERICK WILLIS, K.B.E., C.B.

[Continued.]

through you further to-day. I suggest that if any of my colleagues wish to ask you questions they should now do so. As I understand that Lord Russell has to leave for a public engagement, perhaps he would put his questions first.

723. *Earl Russell*: I do not know, Sir Frederick, whether it is my inattention or not, but I am still not quite clear about the Board of Control. First of all would you give us the Section of the Mental Deficiency Act which created the Board?—Section 22.

724. Now could you tell us shortly what the composition of the Board is, because to this day I do not know how many members there are, or how it is composed?—To-day we have three honorary Commissioners: Miss Darwin, Sir Marriott Cooke, and Mr. Forestier Walker, M.P. We have on the medical side as paid Commissioners, Drs. Bond, Rotherham, and Branthwaite. On the legal side we have Mr. Macleod, K.C., Col. Hodgson, and a vacancy, and we have got a lady, Mrs. E. F. Pinsent: that is to say, including myself, there are seven paid Commissioners to-day.

725. Are all those Lunacy Commissioners?—We are all the same; we all have the same powers.

726. An inspection of an asylum can be carried out by any one of those members?—Except that sometimes the section says a visit shall be paid by two Commissioners, one of whom shall be a legal and one a medical Commissioner.

727. Do you interpret that to mean two of your paid Commissioners?—Not necessarily. For instance, Sir Marriott Cooke is a doctor and was a permanent Commissioner before he was an honorary one.

728. With regard to your relation to the Ministry of Health, may I sum it up in this way: In the exercise of your powers and functions you are independent, and are only dependent upon the Ministry so far as estimates and finance are concerned?—As regards lots of our powers, we are of course under the Statute quite independent. As regards plans of asylums and contracts they require the sanction of the Ministry of Health, but we invariably negotiate the business beforehand, indeed we must under the Statute, and send our recommendations on to the Ministry. Our relations with the Ministry are of the most cordial character.

729. I am not suggesting they are not, but I really wanted to know to what extent if any you are under the Ministry of Health. The answer is that you are practically independent, in fact, entirely independent except in regard to expenditure, plans, and that sort of thing?—Yes. Of course the Lord Chancellor is also one of the Ministers who is concerned with our Department; he appoints the legal Commissioners, for instance.

730. He also appoints Judges of course. But having appointed, he can give you no orders?—But for certain purposes we have to get his sanction.

731. Now just to come to this question of documents. The documents sent to you in regard to patients admitted to asylums are copies?—Yes.

732. And as regards the disclosure of these documents, you could be compelled by the Court to disclose them in a legal proceeding?—Yes.

733. Let me take the case of a brother who has been in an asylum, certified, has recovered, and desires to bring an action for his detention against his brother, who he says has been responsible. In a case of that sort you would disclose the documents in Court?—Yes. (*Mr. Macleod*): We do not take the objection now.

734. Then I wanted to ask you about the pauper lunatic. As I understand the Act and what you have told us, and the Chairman I think brought it out too, a man who has been paying his rent and paying his way, and who does not owe anybody anything and is earning his wages, may suddenly be called a pauper when he comes to be certified, although in the ordinary sense of the word he is not a pauper at all?—Yes,

735. Supposing when he has got to the asylum his relations pay the full amount that the Guardians ask for as a contribution, he still is classed as a pauper?—Yes, I do not think we could compel them not to do so. The London County Council do, I believe, class them as private if they make some agreed contribution.

736. I do not think paupers are under any disability as to voting and so on?—No, I do not think so.

737. Now Section 13 is the half-way section, between the private patient and the pauper patient?—Yes, you might put it in that way.

738. In this case he is not a pauper and he is not wandering at large, but he is deemed by somebody to be a lunatic?—Yes.

739. And that somebody tells the relieving officer?—Yes.

740. And then he gets into the asylum. Now, when he gets there, you say he is treated as a pauper?—He has got to be. (*Mr. Macleod*): Under Section 3 of the Act of 1891.

741. In his case who pays for the certification and so on? Do the guardians pay when action is taken under that section?—(*Sir Frederick Willis*): The guardians would pay, yes. There is a section in the Act saying they shall pay.

742. So that that would be medical poor relief in the ordinary sense, I suppose?—(*Mr. Macleod*): If it is medical poor relief he is a pauper, and he may be a pauper under Section 18. (*Sir Frederick Willis*): I should doubt whether the fact that the guardians pay for the examination would make him a recipient of Poor Law relief.

743. It is rather comparable to paying the fees for a confinement?—Yes; that is rather a nice point. (*Mr. Macleod*): Section 285 provides for the expenses in the case of a pauper or not.

744. It provides that the guardians shall pay it?—Yes; the justices can make an order for it. (*Sir Frederick Willis*): But I should hardly have thought that the fact that they paid those fees made the man a pauper.

745. The scheme of the Act draws such a curious distinction all through between the pauper and the private patient?—It does.

746. *Chairman*: There is rather a curious provision in Section 18: "A person who is visited by a medical officer of the union, at the expense of the union, is, for the purposes of this section, to be deemed to be in receipt of relief" even although he is ultimately going to recoup the cost?—Yes, but these two certifying doctors are not medical officers of the union.

747. *Earl Russell*: But they are paid by the union?—It is a question whether Section 18 would require that the services of those two doctors should be regarded as affording medical relief.

748. Now, as I understand, the scheme of the Act for taking charge of a patient seems to start by looking at the patient as being created by and under the charge of somebody, either a petitioner or somebody standing in the position of a petitioner, and he seems to be both the person who sets the law in motion and who has the power of requiring discharge?—The relieving officer has nothing to do with discharge.

749. No, but the guardians have power of requiring discharge?—Nothing to do with discharging cases in an asylum.

750. As I understood it, we had the section just now?—"The guardians of the union to which a workhouse belongs may make an order for the discharge of any lunatic detained therein."

751. That is Section 81?—Yes.

752. I thought there was a section under which they had power to discharge their own patients?—If they are in a workhouse, but not if they are in a public asylum.

753. If a lunatic is in a public asylum the guardians who are paying for him have no power

8 October, 1924.]

Sir FREDERICK WILLIS, K.B.E., C.B.

[Continued.]

to require his removal from there to a workhouse or to discharge him?—No.

754. The view taken of a petitioner apparently is that he puts the lunatic away and is responsible for him, and he apparently on his own motion may require the discharge of a private patient at any time, subject to the barring certificate?—That is true.

755. To some extent the same power exists with regard to the pauper patients?—No. A relative or friend can apply for the case to be discharged. It is Section 79, I think.

756. Section 49 was the one I was thinking of?—I beg your pardon. That applies to any case.

757. I rather gather there that if any relative or friend or a friend who is not a relative satisfied the Commissioners and asks for an examination by two medical practitioners, and they are of opinion that the patient may without risk or injury to himself or the public be discharged, he must be discharged?—It is not that he must be, he may be. We have discretion.

758. Would you in fact exercise that power?—We should consider the case.

759. But you mean, apart from the certificate, you yourselves would consider whether you thought it would be without risk or injury to the public or to the patient?—Yes, but we lean towards discharging the case rather than detaining it.

760. Would you look at the last line of that section?—If you decide that the patient is to be discharged, do I understand that section to mean that you cannot discharge him until ten days have expired?—I should think that is the reading of it.

761. "May order the patient to be discharged at the expiration of ten days from the date of the order"?—Yes.

762. Can you tell me of any reason why you should not have the power to discharge him at once if you think proper?—No; I do not see why we should not.

763. There is no person likely to intervene in those ten days, is there?—No. I do not know the origin of that "ten days."

764. It seems to me a curious provision.—If adequate arrangements are immediately available for that case I see no reason why, having decided that he should be discharged, he should not be discharged forthwith. In some instances it would take some time to make arrangements.

765. It says you are to discharge him at the expiration of ten days?—Yes.

766. *Chairman*: It might take more than ten days to get arrangements made for him?—Yes, it might.

767. *Earl Russell*: Now, as to the ordinary discharge of patients, I think you know that I have had a good deal to do with London asylums, and was Chairman at Hanwell. There the Visiting Committee consists of about five, and two would be occupied in visiting the asylum and the others would be seeing any patient recommended for discharge; their powers in that case being to discharge a patient on two signatures of the members of the visiting committee, with the medical superintendent's consent?—Yes.

768. And as you know, I think, it is also their custom to consider what letters written by the patients should be sent on, other than those which have to be sent on?—Yes.

769. I daresay you know that the correspondence of these people is very often voluminous?—Very, and very objectionable, some of it.

770. They are of course themselves a public authority—the visiting committee, and they have an immediate public responsibility, I mean a direct public responsibility to the electors and to a public authority?—Yes.

771. And they, of course, have an opportunity of seeing at these regular visits what is going on in the asylum, and what patients ought to be discharged?—Yes.

772. May I just give you one or two cases about "trial" which occur to me as illustrating how the

system works. I recollect a case of a man who had a delusion, a grievance, which led him to break a certain window. The time came round for what you call one of these continuation reports. The Medical Superintendent said that it was quite impossible to certify that the man had shown any signs of insanity in the asylum during the past three months. In those circumstances if he sent up a continuation report of that sort you would have felt bound to discharge the man?—We should have corresponded about it, certainly.

773. He presented that aspect to the Visiting Committee, and said, "I do not know that the man is cured, but in the circumstances I recommend you to discharge him." You would have felt that that was the natural course to take?—I should have thought so.

774. He was discharged and the next day he broke the same window. He was taken by the police, re-certified at public expense, brought back to the same asylum, and six months later the same series of events happened. The Medical Superintendent said his conduct in the asylum was perfect. On that occasion we took further precautions. There was the method of trial which we employed. We found a relative living in Cornwall. We sent this man on a month's trial to this relative in Cornwall. We saw him safely off from Paddington, and we knew he got there. Four days later he broke the window again. That is a case which illustrates the difficulty of saying for certain that a patient is cured, and one of the difficulties that these continuation reports impose?—Quite.

775. Then to illustrate another of the uses of sending a person on trial—this illustrates two of your points—I recollect a case in which a husband was discharged on trial to the care of his wife, and before the month was up she came back and said that his health was bad, and asked us to take him back, and we took him back. That was a case of course where both parties were anxious that the trial should be successful, but the trial showed that in the circumstances of ordinary life it would not work, and that, of course you would agree, is one of the great objects of trial?—Certainly.

776. There is a great deal of difference in the effect on a patient when taken from the surroundings of an institution and entrusted to the care of his family or relatives. On the other hand, our experience as regards the people normally let out on trial was that a very large percentage were discharged at the end of the month permanently cured; that was in my time. Now I want to ask you just one question about a different subject, and that is the procedure by inquisition. There was a suggestion made that it was antiquated and not of much use?—On that I should like to say that I know very little about the procedure by inquisition; we have nothing to do with it.

777. I just want to put this particular phase of it. On a particular inquisition you may find a person able to control himself, but unable to control his property?—You can deal with that under Section 116, without that procedure. Under Section 116 (1) (d) the powers and provisions of the Act with regard to the management and administration of property may be applied "to every person not so detained and not found a lunatic by inquisition, with regard to whom it is proved to the satisfaction of the Judge in Lunacy that such person is through mental infirmity arising from disease or age incapable of managing his affairs"—so that under that section, without finding them to be lunatics, you can do it.

778. I am much obliged to you for referring me to that Section, because it really answers my question. You can do it without this elaborate procedure?—Yes.

779. Now I want to ask you some questions as to exactly what a patient can do who finds himself in an asylum and is satisfied that he is sane and wrongfully detained. He can write to certain people, as we know, and his letters must go?—Yes.

8 October, 1924.]

Sir FREDERICK WILLIS, K.B.E., C.B.

[Continued.]

780. That would lead to an inquiry by you?—Yes.

781. If he is a rich man and a private patient, can he send for his own solicitor and instruct him to take action?—I should think there would be no obstruction placed in the way of seeing his solicitor. At any rate, if he wrote to us and said he had wanted to see his solicitor and the medical superintendent had declined to allow him, we should take action.

782. If a man wrote a letter, apparently sane, and said, "I desire to consult my solicitors," if the medical superintendent had not permitted it, you would permit it?—We should very carefully enquire into it. We should have to hear what the medical superintendent had to say first. But I can hardly conceive that in a case like that the solicitor would not get to the man.

783. Would you give him access to his solicitor if the medical superintendent said he was quite irresponsible?—No, certainly not. The case you are assuming is that of a man who thinks he is sane. We should not place the slightest obstacle in the way, although we might think the man might be quite insane.

784. I want to know what rights he would have?—The man would first ask the medical superintendent to let him have his solicitor to see him. If he did not allow it and the man wrote to us, we should want very strong reasons indeed to support the medical superintendent in refusing to allow that solicitor to go.

785. I should be glad if you would be good enough to give me any reason that would be sufficient not to allow him to go?—If the medical superintendent said, "This man has seen his solicitor several times, and after every visit the man has become very excitable and distressed; it has necessitated the man being put in a padded room" and that kind of thing. If he says, "On medical grounds I think it is very undesirable that the man should see the solicitor just now," on the next visit of the Commissioners to the institution that case would be very carefully enquired into.

786. And in a case like that would you also communicate with the solicitor, if he had seen the man several times?—I think we should. We should say, "Is there so far as you know any reason why you should see this patient now?"

787. Now take the case of an application to see his own medical man?—I am sure the medical superintendent would always allow his own medical man to see him.

788. I want you to assume he did not?—If he did not, we should take the same sort of action, but I can hardly conceive any case where we should not require the medical superintendent to admit that man's own private doctor.

789. Has a patient in an asylum got power to instruct his solicitor to go for a writ of *habeas corpus*? (Mr. Macleod): I should think he has; there is nothing to prevent it.

790. What can the pauper patient do? He of course cannot send for solicitors and doctors. He can apply to have a relation visiting him, or a friend to come and see him?—(Sir Frederick Willis): Certainly he could.

791. Supposing he said he did not want his wife, his son or his daughter, but wanted his friends?—There is no difficulty in his friends coming to see him.

792. Then a friend could apply under Section 49 for a medical examination, which he would have to pay the cost of?—Quite.

793. Now you also recognise the same sort of right as the petitioner has in the friends of a patient—I mean the immediate relations can ask for a patient's discharge?—Yes.

794. Even if he is not cured?—Yes. They have got to satisfy the visiting committee that proper arrangements will be made for looking after the case.

The visiting committee have a certain responsibility to look after the interests of the patients under their care.

795. I fully appreciate that. I just wanted to know what they can do. They can remove the patient if they know there is a proper home for him, although the medical superintendent advises the visiting committee that it is not for the patient's advantage?—Yes.

796. The friends can take him into their care?—(Mr. Macleod): They can discharge without the consent of the medical superintendent.

797. Am I not right in saying that the lunatic's own immediate relations, if they satisfy the visiting committee that he is a proper case to go, can insist upon his discharge?—This is Section 79: "When application is made to the Visiting Committee of an asylum by a relative or friend of a pauper lunatic confined therein requiring that he may be delivered over"—

798. Those are the words I am laying stress on, "requiring that he may be delivered over."—"Requiring" only means "asking" there. (Sir Frederick Willis): I do not think there is an absolute right on the part of the friend to require that the patient should be handed over.

799. You think there still remains complete discretion in the visiting committee not to discharge him if they think it is not for his benefit?—I think so. The Section says "if they think fit."

800. It very often is not for the patient's benefit, I quite agree with you?—That is so.

801. Now about the notices that are put up: Did I understand you to say that notices were put up in every public asylum, practically?—In regard to several of these sections, such as Section 79, which we are referring to, we tell the asylum authorities that on the admission of a patient they are to send to the relatives and friends copies of these sections. What we felt was this, that if the sections were posted up in a room where the patient was seen by his friends, it might lead to difficulty. The patient sees it written up, and he says, "Look here, you can have me out."

802. Yes, I appreciate that, but the notices about letters are put up as a rule?—(Dr. Bond): In registered hospitals and in licensed houses it may be said that in every sitting-room, every room where they should or could be with advantage posted, they are posted; that in the county and borough mental hospitals, in the wards in which private patients are, they are posted; but it would be impossible to say that they are posted in all the other wards, where, perhaps, only rate-aided patients are. But it is a growing practice, and the number of wards in which they are not posted is getting less and less. There are, however, quite a number of wards where I am quite sure there is no notice.

803. Should I not be right in saying that as a general rule the inhabitants of these asylums know quite well they are asylums?—Yes.

804. Therefore, would it be inflicting any fresh injury upon them to put up notices saying they could send letters?—None whatever, provided the notice is suitably worded.

805. Does the Board not take the view that this notice should be put up wherever there is a patient?—We have never made that order, but we have verbally at our visits for a considerable time suggested the desirability of these letter boxes and notices; we have no power to make an order.

806. And does the Act not provide for them being put up?—Not unless there are private patients; but verbally we have recommended it a great deal.

807. That seems to me to be a lacuna in the Act, does it not, if that is not compulsory for public patients?—Yes. (Sir Frederick Willis): There are lots of things it is desirable to do that it is not necessary to put into a statute, where you find they are gradually being done.

808. I was asking whether you do not think the Act ought to so provide in the case of all patients?—

8 October, 1924.]

Sir FREDERICK WILLIS, K.B.E., C.B.

[Continued.]

(Dr. Bond): Personally, I like to see these notices and boxes everywhere.

809. There is an expression you used yesterday about out-door relief for the insane. I understood you to say this morning that it was for patients who were not certified?—(Sir Frederick Willis): Not certified.

810. But you did give it us in the return of the number of patients in receipt of relief?—Not in the number of patients in institutions. I think I did give you the figures in out-door relief; there were 3,554.

811. Those are not certified?—They are not certified.

812. Are they being treated as if they were medical cases?—Yes; they would be seen by the district medical officer.

813. They are not really under you, are they?—They are not under us at all. (Mr. Macleod): We have a return of them. (Sir Frederick Willis): They are part of the insane population, and we have to give statistics of them.

814. Are these harmless people?—In the view of the doctor I suppose they are. (Mr. Macleod): The sections referring to them are Sections 201 and 202 of the Act.

815. But these refer to lunatics, and a lunatic means a certified person?—Not necessarily; they are not certified.

816. You mean that in Sections 201 and 202 the pauper lunatics mentioned are not certified?—Yes, not certified. It is Section 202 really. (Sir Frederick Willis): The last part of it says practically that the medical officer must give notice when it appears to the medical officer that a pauper lunatic ought to be sent to an asylum.

817. They are presumably not certifiable, although they might be?—(Mr. Macleod): If they are living with friends they need not be certified. (Dr. Bond): There is no offence against Section 315.

818. Now I want to ask you about keeping a lunatic in your own house in the case of a rich man. Do I understand that a rich man or a rich woman could be kept uncertified in their own house?—(Sir Frederick Willis): Yes, but not in your house, for instance.

819. However mad?—However mad.

820. Without being certified?—Yes.

821. And without any report being made to you?—Without our knowing of it at all. (Dr. Bond): It is not a question of rich or poor; it is anybody. (Mr. Macleod): A wife can reside with her husband, or a child with the parent without being certified.

822. And although the relieving officer knows of this, it is not a case where he could lay information, assuming they were properly looked after?—Nobody can interfere, either rich or poor.

823. Not if the lunatic is a dangerous one?—(Sir Frederick Willis): Not if he is under proper care and control.

824. If there is any sign of his breaking out?—A public official could come in.

825. I have only one more question: With regard to mechanical restraint, do you call a padded room mechanical restraint?—(Mr. Macleod): No; that may be seclusion if the door is closed.

826. Then mechanical restraint in any other sense is almost extinct?—(Dr. Bond): I should not like to say that. The extent of its use is certainly small, and I think that more and more it is being confined to what one might call mechanical restraint of a purely medical nature, such, for instance, as the use of what is known as the wet pack, which is really a means of hydrotherapy, but it comes within the definition of mechanical restraint. If you were to take the number of hours per year in which patients have been subjected to mechanical restraint you would find that it was largely made up of that, and the small modicum of restraint represented by the use of the soft padded gloves put on to prevent mutilations and scratches and so on. But the use of what is called the straight jacket is getting less and less, and is quite rare.

827. You would not call merely thick clothing that could not be torn mechanical restraint?—No. That does not come within the definition of "mechanical restraint" at all. That, I may say in passing, is also certainly being used less than it was.

828. It has to be used in a padded room very often?—Certainly.

829. Sir David Drummond: What interpretations do the Board put upon the provision to the effect that doctors must see and certify the patient independently?—I do not know that the Board as a Board have ever considered that. We may each have our own opinions.

830. You know how it is interpreted; a doctor brings another doctor, and he just retires out of the room, or even goes to the far corner of the room. I wanted to know your view in the matter?—I can say this, that the Board are most particular on this point in seeing that the law is carried out as laid down about separate examination; but that we have ever discussed it among ourselves, as to whether this is right, or whether it is desirable that the two should consult, I do not know.

831. Chairman: The certificate says an independent examination. Do you, as a Board, go behind that statement and require a degree of independence?—If we see any evidence that possibly there has not been that independent examination, we make enquiry to see that it has in point of fact been independent.

832. It would appear on the face of the certificate if there were any want of independence?—One occurred a few mornings ago, and it led to correspondence and enquiry on the point. In the result it turned out that it was an entirely independent examination.

833. Sir David Drummond: The second doctor may be in the room at the time the independent examination is being made, or in the house, or just outside the door. Or do you imagine that the doctors visit the patient at a separate time?—We imagine that the examination of the patient by two doctors is separate, but we do not go into the question at all as to whether the two are far away. (Mr. Macleod): If you look at the certificate you will see that in many cases they are made on different dates. (Sir Frederick Willis): If a doctor said he had examined the man separately from the other doctor we should not question it.

(After an adjournment.)

834. Mr. Mackinnon: Of course there are a tremendous lot of documents coming to you every day, such as admission documents, reports and masses of letters?—(Sir Frederick Willis): Yes.

835. Do you have a staff of clerks who read the letters first, or are they handed to someone who is more responsible?—The letters would go to a clerk first. Of course there are a lot of letters which are addressed personally to me or to Mr. Macleod, or Dr. Bond, and they would come to us. I get at least every morning a dozen, and I make a practice of opening and reading them; some I deal with and

some I pass on to the clerk, who would pass them back to me again after dealing with them.

836. I suppose there are a heap of letters which on the face of them are not worth considering?—Yes.

837. And I suppose anything of a nature which the clerk cannot deal with he hands over to someone who is more responsible?—We have a Principal Clerk of the Lunacy Division, and he is responsible for seeing that everything is dealt with properly.

838. Is your staff provided under the Civil Service Commission?—Yes, they are Civil Servants. We have

8 October, 1924.]

SIR FREDERICK WILLIS, K.B.E., C.B.

[Continued.]

no First Division clerk, the office is not recruited in that way—we have no Class I clerks at all.

839. But they are appointed like the clerks of any other Government office?—Yes, just the same, and those holding important positions have been with us many years and are very highly trained in the technicalities of the thing.

840. What sort of staff have you, approximately, in numbers?—We have 35 clerks altogether of one sort and another, but many of them are engaged on Mental Deficiency work.

841. *Miss Symons*: On the second page of your *précis* you mention various matters which you have under consideration, and it might be rather useful if you could tell us briefly what statutory powers, or what control you have over questions of internal administration, such as staff, and so on?—We have no statutory power to say, “You shall do this,” or “You shall do that, you shall appoint a medical man,” or “You shall have a particular dietary or a laboratory.” As a matter of fact I think we gain more from not having any statutory power. My experience of Government Departments is that when you have power to mandamus local authorities you very often start a sort of fight, and we do very much more by simply advising them, and we find the response to any recommendations of the Board is very good, and our suggestions are generally accepted.

842. Referring to Section 52 of the Act, do those powers relate to your Commissioners?—Yes. (*Mr. Macleod*): There are no paupers in licensed houses or registered hospitals. (*Sir Frederick Willis*): They do not go to these places, so the section has no operation. We cannot regulate the diet of paupers in public asylums. We have a duty when we visit there to inquire into the diet and make a report and follow it up by correspondence.

843. So that if you have any criticism to make on such a question as diet, or think the staff is inadequate, you can only make recommendations and give advice?—That is so, but that is really a very effective way of dealing with the thing. (*Mr. Macleod*): Amongst other things we do is to see the patients have their dinners and teas, and we see exactly how they are served, and what quantities they get; we know their diets every day, and whether they have a fixed diet or otherwise, and if we are not satisfied with what we see we make a report in the visiting book, which is forwarded to the Board, and action is taken. (*Dr. Bond*): And I may supplement that by saying that we discuss these matters very freely with the medical superintendent, and sometimes we meet accidentally the members of the visiting committee, which gives us a further opportunity of verbal discussion, and verbal discussion can often do a great deal more than bare correspondence.

844. *Mrs. Mathew*: What is the procedure on the reception of a pauper patient into an asylum?—(*Sir Frederick Willis*): Perhaps Dr. Bond will explain in detail what takes place.

845. Yes, I want to know how the doctors satisfy themselves as to the condition of the patient?—(*Dr. Bond*): Immediately on arrival a medical officer—not necessarily the superintendent—sees the patient. The patient is undressed and put into bed either in the dormitory of the admission ward, or better still, a custom which is growing, in a clinical room attached to that ward; a preliminary physical examination of the patient is made there while the person or persons accompanying the patient to the hospital remain on the premises. They are not kept on the premises, but they have the opportunity, and are invited to remain while the examination is being conducted. That examination is specially directed to such matters as the state of cleanliness, or evidence of injury—every trivial injury is noted, bruises or scratches, or any evidence of recent or old injury. All these matters are noted there and then, and, in addition, a rapid physical examination of the patient is made with the aid of the stethoscope and other means.

No detailed examination is made then, but the examination is sufficient to at once describe in a small carbon duplicate notebook the state of cleanliness of the patient and any injuries, whether the health of the patient is good, bad, indifferent, or weak, and so on; and if the patient has been brought in on a stretcher or an ambulance because of bad health that would be noted also. Occasionally a patient is brought in actually under mechanical restraint and, if so, that is noted on a slip, a duplicate of which is handed to the person bringing the patient. Then ordinarily the patient is bathed, unless the doctor gives a direction to the contrary. You may take it there is no rule about it, but it is the universal practice to put the patient to bed in an appropriate dormitory, or in a single room in association with the dormitory. Then the patient remains in bed for at least a week, though not necessarily so, because we have been encouraging more and more treatment in the open air, if possible; and you will now find in a great many institutions there are glass-roofed verandahs where the patient spends a week, which time very often extends to several weeks according to the nature of the case. During that week a much more elaborate examination is entered into which may take up a whole week a bit at a time. For instance, it may be that on the staff of the hospital there is one man who is experienced in the examination of the eye, and he will probably do that one day; then again many of the neurological cases require an examination of the fluid which exists in association with the spinal cord, and that is done, or attempted to be done, during the week as far as possible, by a doctor who undertakes that kind of work. Then there are such things as counting the blood corpuscles, and the temperature would be watched throughout the week night and morning, and there are many other particulars of examination which I will not detail now, but it goes on all through the week. In the course of that week a statement, not a certificate, has to be sent to us of the mental and bodily condition of the patient, and that really in nine cases out of ten is done on the last day—that is, the seventh day. There is a tendency to postpone it as far as possible in order to make it as complete as possible. In the course of that time the mental state, by means of talking to and watching the patient, is investigated, and any changes are noted. I think that covers the main points. In addition, visitors are not encouraged to visit a patient under a month, although patients are encouraged to talk to the doctors, but that is not done until some later time.

846. So that the previous history of the patient, I take it, is well gone into?—Yes, it is a difficult matter, but efforts are made to get the previous history, though in some cases there is almost a blank. There are forms, and every hospital has its own form which it sends out, and sometimes they are never returned, or if they are returned they are so imperfectly filled in as to be useless, and the only chance is to wait until a responsible relative comes to see the patient, and then thrash the previous history out by cross-examination.

847. Is that examination repeated in the case of a pauper patient?—Yes.

848. At what intervals?—The rules made by the Commissioners are that entries are made in what is known as the Case Book, which may be a big book, or which may consist of loose sheets—it depends on what the clinical system of the hospital is. An entry has to be made once a week until the patient has been in the hospital a month, and after that once a month until—the words are rather indistinct, but it is sometimes until three or four or six months. Many mental hospitals ignore that altogether and make notes monthly, or even more frequently, for a year. At any rate there must be three monthly notes, and after that every patient must be noted up once a quarter. No breach of the rules is involved if this is not done. The notes do not contain a repetition of the physical examination, but there is a rule that all important changes should be noted. We think it

8 October, 1924.]

Sir FREDERICK WILLIS, K.B.E., C.B.

[Continued.]

would be medically inadvisable to prescribe exactly the time when a special physical examination is made, because we think it better to leave that to the discretion of the medical man, as you get far better results in that way than by attempting to describe at a particular date the condition of the heart and lungs, and so on, of the patient. We do enjoin weighing once a quarter, which is an important guide to a physical examination.

849. *Sir Humphry Rolleston*: I want to ask a question about the certification of private patients. What is the percentage of private patients as compared with rate-aided patients?—I have never worked it out, but on 1st January last there were 14,196 private patients (including 4,775 service patients) and 95,049 State-aided.

850. An alleged lunatic has the option of being interviewed by a judicial authority other than the one making the order?—Yes, there is no option on the part of the medical superintendent who is bound to draw the private patient's attention to his rights.

851. So that you do not go back to the man who made the order previously?—No, he would not be eligible under the Statute.

852. So that the judicial authority who expresses an opinion on the mental condition of a patient is expressing it on the state of mind at a period which is subsequent?—Yes.

853. As regards the two medical certificates, if you send back one of the medical certificates as not being properly filled up does it go back to the medical man who has failed to fill it up properly?—Yes.

854. Supposing that that medical man is away, what is done then?—It would depend—we might come to the conclusion to take no further action and pass the order; on the other hand, if it was *ab initio* bad on the face of it and in fact contained no statement at all of mental disorder, and he could not be got at to rectify it, we should declare the order invalid.

855. So that you would have to have both certificates again?—Yes, we should start over again.

856. How often has it happened that the first certificate being given by a man who is well acquainted with the person, the second certificate is given by a man who really is not an expert in mental disorders?—The certificate first mentioned is not always given by the medical attendant, but it is not always practicable and sometimes there is no regular medical attendant.

857. But it is desirable?—It is desirable, and if it is not done the reason why it is not has to be stated. I think the answer as to how often it is given by an expert in mental disorders depends very much on the locality. Taking the metropolis, it is frequently found that the second medical certificate is that of a well-known specialist in mental disorders, but when you get away from the metropolis, unless you happen to go to an area where there is a number of experts in mental disorders, it is very infrequent.

858. May I ask which scheme you think the best?—I think there you are asking me a difficult question, if I may say so. I do not know that I really have any view on the point. Though we have talked a good deal about medical certificates being imperfect in some way or other and of the action we take, yet there are extremely few cases of that kind in proportion to the many hundreds and thousands which come through our hands, and I do not think the medical profession as a whole need be ashamed of the medical certificates which are sent in. If there is a failure I should say that we do not officially see it, but where the lack of expert knowledge comes in is when we have a chance one of us ourselves of examining the patient from time to time, and not very infrequently we are astounded to hear that Dr. So-and-so has stated he could not write a medical certificate. That is where some amount of failure comes in, but we have never looked into it in a way to enable me at least to answer your question in the

way I should like. My view is, if there is a failure it is with regard to people not under certificate who we think ought to be under certificate. For instance, if you go to a house where there is a patient in single care we endeavour to go all over the house; we are not entitled to see any other people than the patient, but we do see other people, and we get into conversation with them, and we sometimes find cases whom we regard as quite obviously insane. When we go a little further into the matter, we are told the doctor said it was not possible to write a certificate of insanity in the case. Now that does suggest perhaps some lack of ability; I do not know, but there may be some other explanation, although that is the case. Then we go to the Poor Law institutions, and very constantly we come across cases not under any form of order. A cordial welcome is given us to examine these patients; we never have any difficulty put in our way, and we see at once that such and such a person is of unsound mind, and we make a note of it in our report and pursue the matter, and ask the medical officer about it; then we get a reply that he finds himself unable to write a certificate of insanity. We take that course with regard to the Poor Law infirmaries, and it is a growing practice which we pursue with the knowledge and concurrence of the Ministry of Health. We sometimes suggest that it would be a good thing if the guardians called in in consultation the medical superintendent of a neighbouring hospital, and that has been done.

859. *Sir David Drummond*: You have given us a very elaborate account of what takes place when the patient is admitted, but have you found in your experience that medical officers are so trained that they are incapable of carrying out these duties to which you have referred?—Well, it varies.

860. Would you suggest that it is desirable that the medical officer of an institution should be one who has some experience in these special matters?—We do that. We have done what we can to aid examining bodies in instituting special training.

861. That is not quite what I mean. No authority up to now, I take it, has insisted that a resident medical officer of a hospital, or a house surgeon, should have any special training?—It has not been insisted upon, but it was one of our recommendations in a circular which we sent out about two years ago. In addition we have for some years been pressing, and are now succeeding with growing rapidity, that all mental hospitals should have a full visiting staff, not so much a consultant in mental disorders, but a general physician and an operating surgeon.

862. But the officer who carries out the preliminary examination in every case would probably have some general knowledge on the subject?—I think the great majority are quite capable of making a good examination.

863. But you do not suggest that it should be a *sine qua non* that a medical officer should have some special training?—I think we would like to enforce it at once if it was practicable, but I do not think you would get the doctors.

864. You think it would be desirable?—Undoubtedly.

865. Do you also think it would be desirable that every medical officer appointed to an asylum should have some special training before appointment?—I would not say before appointment, but before he gains a responsible position.

866. *Mrs. Mathew*: Is a dentist any part of the staff of a lunatic asylum?—Not of the resident staff, but there are very few mental hospitals now without a fully qualified dental surgeon who visits according to requirements once or twice a week, or in small places once a fortnight; and for whom a properly equipped dental room exists with the necessary apparatus. There are some mental hospitals without it, but we have a note of them, and it is a thing we never forget on our visits.

8 October, 1924.]

Sir FREDERICK WILLIS, K.B.E., C.B.

[Continued.]

867. *Sir Ernest Hiley*: You, Sir Frederick, are going to prepare a memorandum, I understand, with regard to the classification of patients and the use of the existing accommodation in asylums and workhouses?—(*Sir Frederick Willis*): Yes.

868. Would it be possible for you in that memorandum to touch on the question of the liaison which exists, or which ought to exist, between a county council and a town council, or whatever authority provides the asylum, and the guardians who control the workhouse, and who provide the patients generally for the asylum?—Yes, certainly.

869. You will deal with that in your memorandum?—Yes.

870. In reply to Lord Russell this morning with regard to the constitution of your Board you referred to a Section of the Act—but the position of your Board is really defined in the Radnor Report, is it not?—They did set out what it was.

871. You set out a quotation on page 4 of your *précis* which I will not trouble to read now?—Yes, that is so.

872. May we take it that that is the sort of position which you now enjoy with regard to the administration of the Lunacy Acts?—Yes, that is so.

873. *Lord Eustace Percy*: I think you said that the Board have no control, or no power of enforcing advice on public authorities, but has the Board got, or does it discharge, any functions at all in conjunction with the Ministry of Health in connection with the Lunacy grant-in-aid?—No, that grant is a purely automatic thing—the 4s. grant.

874. In the case of the workhouse how does the Board know when there is a mental patient in a workhouse?—We do not always know. (*Mr. Macleod*): There are some workhouses which we visit once a year, and the small workhouses once in two or three years, but in the big workhouses there are, we know, chronic patients under the Lunacy Act. When we have been to a small workhouse and find there are no patients we probably question the master and ask if since our last visit he has had any patient, and if he says no, we do not proceed further.

875. I suppose there are a very large number of pauper patients who come to the asylums through the workhouses?—Yes, no doubt; I should think about 50 per cent.

876. I suppose an appreciable percentage of those patients pass through the hands of the police before passing through the hands of the Poor Law authorities?—A small number do.

877. But most of them are cases of wandering at large?—There are a large number, but not most of them, I should say.

878. And I suppose there are a good many instances where a policeman may have a case of obvious insanity brought to his attention in the streets?—Yes.

879. And he may take a man to the police station?—Yes.

880. Where he would be examined by the police doctor?—Yes, I suppose he would be.

881. In the case of a medical officer of health he has no experience in dealing with mental cases, I take it?—(*Dr. Bond*): No, he would have no experience of making a skilled examination into the mental condition, but an examination would be made. The policeman has ample power without a doctor to take a patient to the Poor Law institution, and on his order, or the order of a relieving officer or overseer, they can sign a three day order for the man's detention without any doctor.

882. Do you think there is any tendency in this system with regard to the admission to workhouses to do injury to a patient—I mean on the part of a doctor or any other authority forming an idea that a person is a lunatic?—I think I might say in many instances I have known of a patient strongly objecting, but, on the other hand, there are lots of instances in which it has turned out to be the right course to adopt.

883. But would you say on the whole that this passage through the hands of the Poor Law Authorities is the best or the only practicable way?—You are there opening up a large question. I understand the Commission are going to have a memorandum upon that subject, but I think we can at once give you the names of big areas in which it has been found; it is a very rare thing for anyone to go through the Poor Law institutions except it be in the vicinity of a large city. Of course when you come to a place like London and large places they stand on a different footing to other places. With regard to the system I originally accepted the explanation, but the more I go into it the less I believe in the inherent necessity that everyone must go through a Poor Law institution. I have been inquiring into it a great deal during the last two or three years, and the more I examine it the more I think it is a matter which is open to doubt, but I would rather not give expression to any strong feeling until the memorandum promised the Commission is ready.

884. I suppose we may take it that the promised memorandum will deal with the workhouses both as a collecting agency and as permanent places of detention.

885. *Chairman*: Perhaps, Dr. Bond, you will discriminate with regard to the two, and I think we might ask you to extend your memorandum in order to deal with the system of procedure of admission temporarily as well as permanently?—(*Dr. Bond*): Yes.

886. *Lord Eustace Percy*: The use of the Poor Law machinery should be fully explained?—(*Sir Frederick Willis*): Yes.

887. *Chairman*: You understand, Sir Frederick, what is desired?—Yes, I think so, and I should rather like to deal quite fully with all the points.

888. *Earl Russell*: There occurs to me a proposal which I remember being made during my time on the London County Council which has never been carried out for having a sort of clearing asylum to which these cases might be taken instead of to the workhouses—have you ever heard of that?—Yes.

889. I think there were some legal objections to the course?—Yes, I believe so, and I think the County Council made one or two attempts to get an empowering Act.

890. Perhaps you might deal with that in your memorandum?—Yes, but I think at this stage I would rather refrain from saying what system I consider best.

891. The proposal as I understand it was that a sort of clearing asylum should take the place of all the London workhouses, and that there the patients should be sorted out, classified, and sent to the appropriate asylum, and that three days' detention there should operate as though they were confined in a workhouse infirmary. Was not that the idea?—I think it was. There is one point as to our getting knowledge whether there are lunatics in workhouses or not which I should like to mention, and that is that the authorities are required to furnish a quarterly return of pauper lunatics who may be in the workhouse.

892. *Lord Eustace Percy*: To you?—To us. (*Mr. Macleod*): That is on a given date. (*Sir Frederick Willis*): The Rule is No. 32.

Chairman: Mr. Stewart, you have been good enough to hand me certain questions which you suggest in conformity with my proposal should be put to the witnesses. I understand that later on you will probably be calling some evidence, or placing some evidence at our disposal, on behalf of the society you represent, and I do not know whether you would be able to supply us with the names of the persons whose evidence you propose to bring forward.

Mr. Stewart: I should be quite willing to furnish you with a note for your personal information.

Chairman: And with a *précis* of the evidence they propose to give.

Mr. Stewart: That is a matter which has been the subject of discussion amongst us, but I may say it

8 October, 1924.]

Sir FREDERICK WILLIS, K.B.E., C.B.

[Continued.]

is not desired that the nature of the evidence should be disclosed until it has been given to yourself.

Chairman: When you say to myself do you mean myself and my colleagues?

Mr. Stewart: I should prefer, on the instructions I have received, to limit it to yourself, for this reason—that you might have some objection to take which it would be convenient to discuss as between you and counsel representing the society I appear for, and it might be quite easy to decide whether a witness should be heard under those circumstances; but if it became a matter of discussion with every member of the Commission collectively, or individually, with a great amount of preliminary investigation—

Chairman: Any witness who was going to be examined before the Commission would be expected to furnish a *précis* of the evidence which would be available for all the members of the Commission. I quite understand you might wish to consult me as *Chairman* as to the desirability of calling any particular witness, but I think you will appreciate that any evidence proposed to be given should be open to all the members of the Commission.

Mr. Stewart: I will convey that intimation, Sir, to the society, and perhaps it might be a matter of preliminary consideration for you as to whether, in certain cases, any proof should be put forward.

Chairman: Of course, any members of the public who are desirous of participating in this Inquiry may communicate with the Secretary of the Commission, and the Secretary of the Commission, if any question arises, would naturally come to me in the first instance, and I would consider the matter, and if it was a question of large importance, I would, of course, consult my colleagues. But I am rather anxious that we should have a view at the moment of the possible length of the inquiry and its ambit, and we should be grateful if you could, at the earliest possible moment, give us an indication of the probable length of the contributions you are likely to give us.

Mr. Stewart: I may say that we have about 30 proofs of witnesses which have been taken, and as the Commission sits it may be advisable that additional witnesses should be seen and proofs taken from them, but that is at present the number.

Chairman: Yes, but I doubt whether we shall be in a position to examine 30 witnesses, because you know in the course of examining witnesses one can easily eliminate certain matters.

Mr. Stewart: Quite—of course, duplication will be avoided, but, for instance, with respect to controversial matters, such as alleged acts of cruelty in institutions, it might be the view of the association that there should be corroboration, and that would necessitate calling on one case two or three witnesses.

Chairman: We have safeguarded the matter of dealing with any questions of fact—they would be dealt with separately, but I quite appreciate if any individual case arises for investigation in a more or less judicial manner you would be expected to bring more than one witness, but on questions of administration and policy we should certainly not want to hear more than one witness—your best witness.

Mr. Stewart: We will bear that in mind, Sir.

Chairman: I have considered the questions you have been good enough to hand me, and I think you will agree with me that most of them have been already put?

Mr. Stewart: I quite appreciate that, but I think with regard to the liberty of the subject there are questions which have not been put by the Commission in quite the form desired.

893. *Chairman:* I am quite prepared to put one or two of these questions, and I shall put them in my own form. (*To the witnesses:*) In the event of allegations being made of cruelty to a patient in any of the institutions we have been considering, what means would you have of knowing what was going on, and how would such acts be brought to your knowledge?—(*Sir Frederick Willis:*) In various ways—by letters sometimes, sometimes a person would call and say: “I was at such and such an institution yesterday,

and I was told this, that, and the other”—but more frequently it would be by letters.

894. Have you had many charges to investigate of cruelty to patients in institutions?—Yes, one gets a great many complaints of that sort.

895. From what sources?—I should think chiefly from the patients themselves.

896. Do these complaints come in letters to you?—Yes, generally in letters.

897. And have you investigated these cases?—We always investigate a case of that kind, and the length of the investigation would depend on what we found on our preliminary investigation. Sometimes the investigation would proceed to the length of holding an inquiry on oath.

898. In how many instances have you found charges of cruel treatment to be substantiated in recent times?—In very few cases—I should say in my recollection possibly once during the last three years, and I am not quite sure about that. You see what sometimes happens is this—a complaint may be made to the visiting committee who themselves may hold an inquiry, and if they think the case is proved against a particular attendant or nurse they themselves would discharge the attendant or nurse, and very likely prosecute as well.

899. Can you tell us in how many instances prosecutions have been instituted in respect of ill-treatment of patients?—During the last few years?

900. Take the year 1923?—In our tenth report, which is in the Press now and will be published in the course of three or four days, we give particulars of two prosecutions which took place during the year to which this report relates. Your question, I think, was how many prosecutions there have been?

901. Yes?—There was one case at Cheddleton Mental Hospital where the defendant, an attendant, was convicted at the Leek Petty Sessions for striking a patient and fined £2. That was the only prosecution of that kind in 1923.

902. Apart from prosecutions, how many cases have been brought to your knowledge of cruelty taking place on the part of attendants towards patients either in public asylums, or in licensed houses, or hospitals—cases which have been dealt with (without prosecution) by the dismissal of the offending servant or otherwise?—I should have to look that up.

903. Can you tell us whether there have been many?—No, I should say very few—not that there have not been many allegations, but I should think at the outside only half-a-dozen have been established.

904. In cases where allegations have been made have they been followed up?—Always. (*Mr. Macleod:*) In addition to that we get notices from the institutions of the dismissal of nurses and attendants, and sometimes those nurses and attendants are dismissed because they are alleged to have struck patients. (*See Rule 25.*)

905. *Earl Russell:* Do you keep a note of all the dismissals?—Yes, of all dismissals.

906. *Chairman:* Suppose a patient is ill-treated by an attendant, the patient's position is a difficult one, is it not, because he or she may not have anyone to turn to for assistance?—(*Sir Frederick Willis:*) Quite, I agree.

907. With whom would a complaint of ill-treatment be lodged?—The patient could always mention it to the doctor—he sees the doctor every day, and he could also mention it to the charge attendant who is a superior officer.

908. Or he could write about it?—Or he could write about it.

909. Or complain to a visitor?—Yes.

910. Have you ever heard of cases where a patient has been frightened to complain of ill-treatment which he has received?—That has been stated, but I have never heard it substantiated. Of course it is quite easy to state these things without any proof.

911. But is it a thing which could conceivably happen?—Of course it could happen; with 130,000

8 October, 1924.]

SIR FREDERICK WILLIS, K.B.E., C.B.

[Continued.]

patients under care it is almost inevitable that something wrong must happen occasionally just the same as in the case of 130,000 public school boys.

912. What one would like to safeguard would be the opportunities of complaining to some responsible person or body?—The opportunities are, I think, ample. Occasionally when the Commissioners are going round a patient makes a complaint about the treatment by some of the nurses, and forthwith they hold an inquiry.

913. There and then?—There and then. (Mr. Macleod): And report it, and if there is anything very serious we hold a sworn inquiry, but they are very few in number.

914. Earl Russell: Do not you find the difficulties in regard to holding such an inquiry almost insuperable?—They are very difficult indeed—there is nothing so difficult. (Sir Frederick Willis): I should like to tell you very briefly about the inquiry I held at Long Grove.

915. Chairman: I only wanted to get at what the machinery was which is available for bringing such cases to your notice. With regard to establishments which are licensed for the reception of patients, and therefore run at a profit, who appoints the heads of such establishments?—The licensee—it is like a business concern.

916. The licensee obtains a license, runs the house, and makes a profit by it?—Yes.

917. In the case of a licensee of such an establishment he need not be a doctor, need he?—Not the licensee himself, but there must be a doctor.

918. But would such a place be licensed unless there was a resident doctor?—The Act requires that there must be a resident doctor, or a visiting doctor.

919. According to the number of patients?—Yes.

920. But the licensee who may not be a medical man may own what we call the business?—He may own the property.

921. And conduct the business of accommodating patients in his house for profit?—Quite, and it pays him to do it well.

922. And it may also pay him well to do it?—Yes, both ways.

923. That is perhaps the reason why it is thought that that class of institution should not be multiplied?—Yes, some people think that.

924. Because of the possible risk that the desire for gain might interfere with the efficiency of the institution?—Yes.

925. I think one may say where a medical man, a practitioner, is mentioned throughout the Act it is nowhere prescribed that he shall have special qualifications other than that he shall be a duly qualified medical man?—No, in most Acts of Parliament it is implied that a medical practitioner knows about everything appertaining to a doctor.

926. In the same way as a barrister is supposed to know all about every branch of the law. But there has not been any special requirement in regard to medical practitioners?—No. Recently where there has been a vacancy for a medical superintendent we have corresponded with the committee, and have said that we shall be glad to help them in selecting a medical superintendent, and we have formed a small committee with one or two outsiders on it to go through the applications and select from 40 or 50 half-a-dozen applications which are considered to be the best.

927. I suppose they will be persons who have had experience, and who would be considered to be best adapted for such a post?—Yes.

928. But there is no special qualification required?—No, nothing at all.

929. Have you any statistics of the number of persons who have been discharged from detention on the ground that they were not insane when admitted?—Yes, we publish those in our annual report.

930. Are those cases numerous?—No, they are very small in number, and what it means is this—that some superintendents when they find a patient is no longer insane say, “Discharged, not insane.” That is what your question is directed to?

931. Yes.—And it has been assumed from that that the patient was never insane, but the medical man at the asylum, when saying that, you will remember, says it at a different period to the time the original medical practitioner said the patient was insane.

932. Will you tell us whether in your large experience you know of any cases where persons not insane have been wrongfully detained in an asylum. One might ask you a general question—in your own experience?—I should say I have no experience of that at all.

933. None at all?—None at all.

934. Do you regard the existing machinery in the matter of certification and provisions with regard to detention as adequately safeguarding the liberty of the subject?—I do, yes.

935. On the other hand, if ingenuity can suggest any additional reasonable precautions I suppose your Department would not resent their introduction?—Not at all, on the contrary; but one would only like to know what the working of those things might be.

936. Of course, I mean practicable means.—Quite so.

937. If such suggestions reach us later on, of course, we shall have an opportunity of putting them before you, but you would welcome, I take it, anything which is practicable and likely to be useful?—Yes, absolutely.

938. With regard to curative treatment in hospitals themselves, how far have you any responsibility for that?—Only in an advisory capacity.

939. You cannot direct that certain treatment should be introduced?—No, the responsibility for treatment must rest with the doctors at the institutions.

940. Supposing you saw an institution was lax, and that very little was being done for the patients, what steps would you take?—We should mention that in the report which went before the committee of the institution, and we should subsequently write to them and ask what they had done, and follow it up as much as we could, but we have no power to say, “You shall get an extra doctor,” or “You shall provide a laboratory or an X-ray apparatus.”

941. You cannot compel anything like that?—We cannot compel it.

942. But I suppose you can bring pretty strong pressure to bear on the medical superintendent or the local authority?—Yes, very strong pressure.

943. Have you ever done so?—Yes, and one would often ask the chairman of the committee to come and see one when in town and have a serious talk with him.

944. Is it in many cases a question of money?—Yes, when they do not do certain things it is largely a question of money.

Chairman: We are very much indebted to you, Sir Frederick, Mr. Macleod and Dr. Bond, for the assistance you have given us at this stage, but we shall, no doubt, have to ask your further assistance at a later date.

(The Witnesses withdrew.)

8 October, 1924.]

Sir CLAUD SCHUSTER, K.C.B., C.V.O., K.C.

[Continued.]

Sir CLAUD SCHUSTER, K.C.B., C.V.O., K.C., called and examined.

945. *Chairman*: You are Permanent Secretary to the Lord Chancellor?—Yes.

946. And as such are you conversant with his jurisdiction in matters regarding lunacy?—I think I may say that I am.

947. I think the Lord Chancellor's jurisdiction in lunacy is probably the oldest form of legal association with this matter?—I believe so.

948. He is the custodian of the prerogative of the Crown in this matter?—Yes.

949. And, as we know, historically lunatics were originally supposed to be under the protection of the King. What are the departments into which the Lord Chancellor's jurisdiction divides itself?—There is the direct control, if I may use the word, though it is not a true word, by the Lord Chancellor over the Lunacy Departments, as we call them, at and about the Royal Courts of Justice.

950. What are these?—The office of the Master in Lunacy and the office of the Visitors in Lunacy.

951. The Master in Lunacy is appointed by the Lord Chancellor himself, I think?—Yes.

952. Do his duties relate to the property of the lunatic?—Primarily, yes.

953. What concern has he with the person of the lunatic?—In effect he has great concern with the person of the lunatic, because the effect of finding by inquisition that a person is lunatic results presumably in his confinement, and, furthermore, patients who have come within the jurisdiction of the Master get a great deal of attention from the Master as to what actually happens to them personally. I expect really whatever jurisdiction he has is founded in property, and most of the overt legal acts done by the Master are acts connected with property. He has to concern himself enormously with the patients' comfort.

954. There may be a committee appointed for the property, and none for the person, of course?—You may have a person who is deprived of the management of his property and who is not considered unfit to have charge of his own person.

955. I should think such cases are rare?—They are rare, but I cannot give you any statistics.

956. Is this jurisdiction of the Master in Lunacy confined to persons so found by inquisition?—No; lunatics so found form a very small part of the number of lunatics with whom he has to deal; the majority are people with regard to whom an order has been made under Section 116 of the Act, who have not been so found, and with regard to whom no inquisition has been held.

957. There again he is dealing with their property only?—Primarily, but he has a great deal to do with what actually happens to every person.

958. But he has to do with the question of whether the property is being applied for their benefit?—That is his primary duty.

959. And that brings him into contact with the person's condition?—Quite. A constant subject of discussion, for instance, is whether a lunatic should be moved from place A to place B, or should be allowed out on parole, apart from questions as to whether he should have a new pair of boots or how his money should be invested, and so on.

960. The Master in Lunacy has become, has he not, practically the repository of the judicial functions of the Lord Chancellor?—Broadly speaking, yes.

961. Always subject to the Lord Chancellor's supervision, and, of course, that of the Lords Justices?—I should rather say subject to the supervision of the Lords Justices. The Lord Chancellor would consider, and does consider, the operations of the Master as judicial acts, and he would not consider he was entitled to supervise or control or take any step in relation to them that he would not take with regard to any other Judge.

962. Putting it technically, there is an appeal from the Master in Lunacy to the Lords Justices?—Yes.

963. And there might, I suppose, be an appeal beyond that to the House of Lords?—Well, I ought to be able to answer that, but I am afraid I cannot.

964. I am afraid I cannot, either. This jurisdiction of the Lord Chancellor and the Lords Justices is derived, I believe, from a Royal Warrant which is renewed on each Succession?—Yes I think I have sent you a copy of the Warrant. May I say I think it is desirable that everyone should understand that as far as the legal position of the Lord Chancellor is concerned in respect of the Lunacy Law or the doing of legal acts under the Lunacy Law, it is this—that he has no position at all, and he never does any legal act, beyond the powers he exercises as a Judge, because everything has been drained out of him, and nothing remains except the empty tank. I do not mean to say, therefore, that there is nothing to do, but what I mean to say is that any proceedings in lunacy never come before the Lord Chancellor.

965. But he still retains the reputation of being the repository of great powers?—Yes, and in many ways he has great powers, but as a Judge he never exercises any powers whatever.

966. *Mr. Mackinnon*: There is an appeal to the House of Lords, but it has never been exercised, I think?—I think that is so.

967. *Chairman*: Who are the Lord Chancellor's Visitors—who appoints them, and what do they do?—There are three of them, two doctors and one lawyer, who are appointed by the Lord Chancellor, and their duty is to visit at certain statutory intervals all lunatics so found by inquisition, and in fact they visit in addition a great many other lunatics not so found, whose property is within the jurisdiction of the Master—practically speaking, all of them, at one time or another.

968. Then the only persons visited at such times are firstly the patients so found by inquisition, which is a diminishing class?—Yes.

969. Or secondly the persons who are otherwise within the cognisance of your Department through their having property in the hands of the Master in Lunacy?—Yes.

970. Are the Visitors' services utilised in specially visiting any person whose case has been brought to the Lord Chancellor's notice?—They pay three classes of visits—the statutory visit to the lunatic, the non-statutory visits, and special visits made on the order of the Master on his own motion or on the suggestion of the Lord Chancellor—any Visitors, as such, of the Lord Chancellor may pay in any particular cases visits in regard to which special information may be wanted.

971. Those special visits may be to persons not so found and who have no property in the hands of the Master?—Yes, but we are not so much inclined, except in extreme matters, to send one of our Visitors to a patient with whom we have nothing to do, though we have done such a thing.

972. There is machinery for that under the Act?—Yes.

973. And there is that additional power in your Department to direct visits?—Yes. Of course, you know, the relations between the Lord Chancellor with regard to his duties and the Board of Control are so intimate that it is difficult to remember whether you have done a thing because you have power, or whether you have done it because you are asked to do it; and I have some difficulty myself in knowing sometimes whether I have been acting because I have the power or because I think it is reasonable under the circumstances.

974. With regard to the Board of Control, what is the Lord Chancellor's relation to them?—Primarily to appoint four Commissioners on it, who are to be, I think, barristers or solicitors, out of a possible fifteen members. Then there are a number of detailed duties cast upon the Board of Control in the way of furnishing information and such like things to the Lord Chancellor, which keeps the Departments together to a great extent. Those are the legal relations. The actual relations are in some respects very close. We constantly ask for the help of the

8 October, 1924.]

Sir CLAUD SCHUSTER, K.C.B., C.V.O., K.C.

[Continued.]

Board of Control, and they sometimes ask for our advice.

975. One very important matter, is it not, is that the Lord Chancellor or Secretary of State may direct the Commissioners specially to visit a lunatic or an alleged lunatic?—Yes, but there again I cannot call to mind ever having given a direction to the Board of Control to do anything at all—it is quite enough to ask the Board to do anything, and they, being sensible, do it.

976. But you have the big stick and you could use it?—Yes, we have the big stick, but we always keep it in the cupboard and keep the cupboard locked.

977. Then, further, are you brought into connection with Section 206 of the Act?—Yes.

978. Section 206 is with regard to persons detained without payment in charitable institutions?—Yes. We do get reports as to these.

979. And as the result of the reports the Lord Chancellor may order the discharge of a patient or his removal?—Yes; I am trying to think whether we have ever done it, but I cannot remember; but I expect we have made an Order.

980. That is another of the residual powers vested in the Lord Chancellor?—Yes. The powers I was speaking about were the prerogative powers and the powers conferred to some extent by Statute.

981. Then another Section, I think, with which you are concerned, is Section 199?—There again we do get reports from the Board of Control frequently of that sort of thing, but it is difficult to know what to do with them when we get them.

982. Then there is Section 221?—We have never had, in my time, a case in which we have been called upon to consider the question of revocation of a licence.

983. But still, there is that power?—There is that power, and I think the power rests in the Lord Chancellor only, as far as I remember.

984. Then in Section 39 there is a reference to the Lord Chancellor?—Yes, Section 39 is a very embarrassing section. It really looks as if the draftsman of it had endeavoured to work for some conclusion or other, and, having gone on a long way into the section, did not know what to suggest, except the concluding words, but the concluding words, with great respect, are nonsense. The Lord Chancellor could only indirectly bring an inquisition about, but it is inconceivable that he should do so, because to whom is he to hand over its conduct, and who is to pay for it? I wish something could be done with regard to the section, because it is a very embarrassing section, providing that these authorities when in trouble should turn the matter over to us, and we do not know what to do. We had a case the other day which gave ourselves and the Board of Control a great deal of trouble, and we did not know what to do, and we were relieved when the difficulty solved itself by a discharge.

985. You think the concluding words of the section are rather a lame conclusion?—Yes, they signify nothing; but it is not an important point, except that it is always rather important, especially from our point of view, that we should not appear in the eyes of the public to possess powers which we cannot properly exercise.

986. Your Department does frequently receive reports?—Yes, from the Board of Control, certainly, and of course we have very elaborate reports from the Visitors.

987. But there does not seem to be anything to prescribe what is to happen on those reports?—Nothing does happen—they are information reports, but I think the Lord Chancellor to-day is considering, and I am sure would consider, any views on the part of the Board of Control, or anything they wish to call attention to, and would consider what was best to be done. The reports from Visitors are of a very different character from the reports we have heard about—they are very serious documents which require very serious consideration.

988. Do you refer now to your own Visitors?—Yes.

989. What machinery have you, what staff and office facilities have you for dealing with these matters?—None specially. The volume of the work is not very great, but the trouble of reading the lunatics' own letters, which is another matter, is very great indeed. When any question does arise it is regarded as an important question quite fit to be dealt with, in the first place, by the Private Secretary, and then by myself. I mean if any question arises as to which the Private Secretary is in any doubt with regard to any patient, he would come to me, and I should go to the Lord Chancellor.

990. What follows on a Visitor's report received by you—would you confer with the Board of Control?—Yes; we should communicate with the Board of Control and ask them what they thought about it.

991. You would ask them to look up their records?—Yes, and ask them if they had any recent reports, and compare what they said with what our Visitors said. If there was a conflict between the two I do not know what we should do, because we have never had such a case. It would be a matter then subject to the Lord Chancellor's personal decision.

992. But I suppose you could call for additional reports?—Yes, if we were in any trouble or difficulty we could. For instance, if a difficulty arose on some report of Lord Sandhurst we should cause the lunatic to be visited by some medical man, perhaps, who was not a Visitor—we should call for an outside opinion, but we certainly should not drop the matter until we were quite definitely satisfied.

993. Has a case of that sort often occurred in your experience?—No, but it has occurred sometimes.

994. How often do you think it has occurred?—Well, I should only be guessing, but it is very rare indeed. It is not very rare that we cause a preliminary inquiry to be made on some report received—that is very common—but it is very rare indeed that one is left in any doubt in regard to a case.

995. With regard to letters written by patients to the Lord Chancellor, they have to be sent unopened, I understand?—Yes.

996. Do you find your postbag a very heavy one?—Very.

997. What happens to those letters?—They are all read by the Private Secretary.

998. It must be a severe task.—Yes, but it is not such a severe task as it sounds, because a great many people write every day, and you know exactly what they are going to say. Some of them do not write complaining about anything, but they write to tell you how they are getting on, and sometimes they write very elaborate essays on the subject of their delusions. They write such things day after day and day after day, and they obviously take a pleasure in committing their daily thoughts to paper.

999. So that a great many of the letters are immediately seen to have no bearing on matters of importance?—Quite. The difficulty, of course, is to pick out the particular letter which really ought to be further investigated.

1000. Who has the responsibility of doing that?—The Private Secretary. If he is attracted by anything in any one of the letters he at once asks for a report—he asks the Board of Control and asks our own Visitors, and if what he gets from them is not sufficient to discharge his mind of any doubt he entertains, he talks to me about it, and we take then the kind of measures I have indicated.

1001. What becomes of those other kinds of letters which you receive?—The great majority of them are destroyed. Any letter which, on the other hand, contains any complaint for the first time, is taken very seriously indeed, especially if it is a case of complaint of loss of liberty. A first letter of that kind would be preserved and filed, and the inquiry made on it would be preserved and filed, too, but if it is found a man makes the same complaint every day for a year, of course you would not pay any attention to it, once you had satisfied yourself that

8 October, 1924.]

Sir CLAUD SCHUSTER, K.C.B., C.V.O., K.C.

[Continued.]

he was properly detained. The real difficulty about the whole thing is this, that you have to deal with people who get better, and it is difficult to determine at what time that betterness has reached such a stage that the patient should be released, and we do not know how to deal with it. But when the question has been once determined it is a case in which we are bound to rely on medical advice alone.

1002. It is really from the point of view of being a custodian and responsible for the liberty of the subject that the Lord Chancellor's jurisdiction is of importance, apart from property matters?—Yes, that is so.

1003. Do you regard the retention of that sort of shadowy jurisdiction as being of any value?—I find that question extremely difficult to answer. I do not want you to think that we are so foolish as to imagine that we can supervise the actions of the skilled Board of Control, or even supervise our own Visitors or Masters. We are only there to retain a principle, I think.

1004. If one thought that it was an additional and effective check—and there cannot be too many checks in cases of this kind—there might be a good case for the continuance of the authority you possess, but do you think the authority you possess serves that purpose?—It is extremely difficult to tell. I think it would be a very great pity if there was no one left to exercise authority, and who did not look like a sort of champion. It is a great pity that it should be thought that there is nobody who is not some sort of champion in a position to look after the interests of these people, and to supervise what has been done by other people, who have, of course, done their duty effectively—I mean it would be ridiculous for us to retain an elaborate staff to check what has been done by the Board of Control.

1005. Undoubtedly the Lord Chancellor has occupied in earlier times a more prominent position as custodian of the rights of lunatics?—Yes, no doubt.

1006. Do you think the time perhaps may have now come when the statutory body, the Board of Control, might be safely entrusted with the whole of the duties?—I am not expressing the opinion of the Lord Chancellor, but I am expressing my own opinion, when I say that that depends to a great extent on the constitution of the body.

1007. Would you agree that a body comprised solely of persons of great responsibility would be a desirable body to set up?—Certainly.

1008. A body carefully chosen, and a body in a position of as great independence as possible?—Yes, and I really mean more than that. I think it is obvious that such a body must comprise upon it men of the highest medical experience and possessed of the highest science, particularly with regard to questions of lunacy—I think that is absolutely necessary, and it also should comprise other people.

1009. Do you regard the legal element as of any value also?—Yes, I do; not so much because there is anything legal to do, but because the legal mind is capable of looking at things from a different point of view from the lay mind.

1010. And you think it would be probably useful in sifting any evidence and arriving at the value of that evidence?—Yes, especially having regard to the kind of way in which doctors necessarily look at these things, and to the kind of way in which they express themselves.

1011. Probably where the professional medical man is called upon to administer a Statute it is almost essential that you should have the assistance of a legal mind?—Yes, but I should like more than that. What I want is to have some people in control who would be able to sit, in the case of a man who is lunatic, over the doctor. The doctor may think from the lunatic point of view he is able to cure the man of the disease, but it is possible that a man ought not to be looked upon *prima facie* as suffering from the disease. If a man was suffering, say, from cancer, the doctor knows he is suffering from

cancer; but in the case of a disease of the brain I think it is necessary that there should be some control which should be in the shape of a legal control, and that the person should not be deprived of the opportunity of producing evidence in a case which involves him in the deprivation of his liberty. If you read, as I do, a number of medical certificates relating to lunatics in the course of the year, you could not be but struck by the way in which they are drawn. I am perfectly certain that those certificates I have read are certificates which are honestly given by the men who sign them, and that they have come to the conclusion that the person concerned ought to be deprived of his liberty; but they are given in such terms that the lawyer, with his legal mind, would never act upon them. I do not want to be disrespectful, or to say anything against the doctors, but I do say that they are not able to express their thoughts sometimes in such a way as to carry conviction on paper to the legal mind.

1012. You mean with regard to the presentation and arrangement of the facts?—Yes, and the description of the facts. I mean, what constantly occurs is that we get a report or a statement of the history of the case which we do not like, and we say we do not like it, and, "You had better go into the matter again and report to us again"; then when you get from the same man another report, it discloses some reasonable ground on which a reasonable man would advise detention.

1013. *Sir David Drummond*: Does not this evidence rather conflict with the evidence which we have heard from Dr. Bond, when he referred to the rarity with which he found a certificate unsatisfactory?—The point is this: we only see cases in which there is some sort of reason that we should see them. Dr. Bond sees any number of certificates—many more than I do—in the course of a year, and his observations, I am sure, are justified, but all I can say is that there are an enormous number of certificates which are open to the criticisms I have been making.

1014. *Lord Eustace Percy*: A medical certificate under the Lunacy Act is a certificate that a person is of unsound mind, and is a suitable person to be detained for care and treatment, but it does not say on what ground he is a suitable person to be detained for care and treatment. In the case of a discharge there is the liability that the patient might do some injury to himself and others, and that, you say, from the doctor's point of view and from the legal point of view, is a different thing?—I do not say it is a different thing if it is accurately expressed, but it is differently expressed, and it is doubtful on the certificate. They do not express their views. They look at it from a different point of view. A doctor naturally looks to curing a man, and he thinks a man might be cured by being under supervision and by being shut up in an asylum, but lawyers would not consider that such a man ought to be shut up.

1015. *Chairman*: Form 8 requires, does it not, the grounds on which any conclusion has been reached to be set out?—Yes.

1016. And is it there that you say you find in certain instances which have come under your notice that the descriptions and the arrangement of the facts on which the certificate proceeds are sometimes lacking?—Yes, and I think everybody in the habit of reading those things would say the same.

1017. I mean it is not that you are questioning what the practitioner has actually said?—No.

1018. And you find, do you, that the practitioner, if his attention is drawn to the matter, is able to put it in a fuller and clearer way to you?—Yes. Of course, our own Visitors have been long trained in doing the thing.

1019. One could hardly expect a medical practitioner, of course, to go through a course of legal training in order to be able to prepare a proof of evidence?—No, but I think my suggestion might very simply be carried out.

8 October, 1924.]

Sir CLAUD SCHUSTER, K.C.B., C.V.O., K.C.

[Continued.]

1020. In regard to the matters to which our attention is specially directed, first of all as to certification, your department has nothing at all to do with it?—No.

1021. As regards detention, you have a certain tutelary power as the champion of the liberty of the subject?—Yes.

1022. And you have explained to us in what way you can intervene and be of public service in that matter. As regards the care of the lunatic, your department, I understand, has no jurisdiction, except possibly in this way—that through the Master the application of the moneys of a patient for his benefit can be secured?—Yes, and is very effectively secured.

1023. Have you anything to do in your department with the conduct of the establishment in which a lunatic may be detained?—Nothing whatever.

1024. Then really it is the liberty of the subject of which you are the exponent?—Yes, subject of course to the administrative arrangements of the Master's Office and the Visitors' Office.

1025. And the very important point that the Lord Chancellor appoints the legal members of the Board of Control?—Yes.

1026. *Earl Russell*: Who appoints the medical members?—The Minister of Health.

1027. *Mr. Mackinnon*: How many inquisitions do you think you held last year?—I really do not know.

1028. Would it be two, or 50?—It would be more than two, I should think, but I could let you have the figures at any time.*

1029. I only wondered whether it was a matter of fifty or more or less?—Well, I do not think it would be 50. If it were I do not think we could carry on.

1030. It comes to this, does it not, that really the powers of the Lord Chancellor are very similar to the powers exercised by the Board of Control, except as regards property?—Oh, no, because the Board of Control has any number of powers which we have not at all.

1031. But the powers you have got are similar powers to those of the Board of Control?—Yes.

1032. And the Lord Chancellor's Visitors discharge very much the same functions as the Board of Control Visitors discharge?—No.

1033. They do in the end?—No, I cannot assent to that. As I understand it, the Visitors of the Board of Control visit the institutions and the people in them, and I do not know how long they spend, but our Visitors visit each patient singly and spend some time with each patient. Sometimes they will be a long time interviewing particular persons, and they go into all sorts of details about the management of their money, and as to their clothing, with their relatives outside, as to whether they should go out for drives, as to whether they should have pocket-money—every conceivable sort of thing.

1034. Your Visitors visit the individual residents in the institutions?—Yes.

1035. Whereas the Board of Control Visitors visit the institutions and incidentally visit the patients?—I must not say yes to that, because I do not know.

1036. I suppose you are not influenced in your view with regard to the continuance of your duties in any way?—Well, my mind as regards that is that it would depend on what solution was thought of for the controlling body, and even then I do not know what I should think about it.

1037. At any rate you are clear that the controlling body should not become too exclusively medical?—Yes.

1038. *Miss Symons*: Are there many cases in which you have been asked to deal with the complaints of patients?—I cannot give you any figures with regard to that, but we should naturally do it in the case of frequent complaints from patients, and our practice would be to ask the Board of Control to pay a special visit.

1039. I suppose complaints really arise more out of correspondence?—Yes.

1040. *Earl Russell*: How many contested inquisitions have there been held with a jury in your experience?—If you would not mind, I think Master Hildyard could give you that information—I would not have the information, but the number is very small.

1041. *Mr. Mackinnon*: I think there is only one that I can remember?—I think there is more than one.

1042. *Earl Russell*: Supposing a Judge in Lunacy appoints an independent person to pay a visit, do the Lord Chancellor's Visitors remain to pay their visits under the terms of an order of the Master in Lunacy? If so, is there necessity left for retaining the authority of the Lord Chancellor?—I think the Lord Chancellor must always remain in control of the administrative arrangements with regard to the Visitors and also the Master. Really that is the only control we have now. We do not actually control the Visitors, but we appoint them.

1043. Are there any other powers of any consequence remaining in the Lord Chancellor?—There are, but they are of no advantage to us.

1044. Nor, I take it, to the public?—I would not quite say that, because I cannot make up my mind whether you might not want some outside body who represents the idea of personal liberty.

1045. *Mrs. Mathew*: What is the position of an alien in one of our institutions?—I do not know, but I should think that it would be exactly the same as the position of an ordinary British subject.

1046. Would that answer apply to a criminal alien?—We have nothing to do with criminals.

1047. That comes under the Home Office?—Yes. When I say we have nothing to do with them, I mean we do not exercise any functions. If there is any ground for taking out a summons under Section 116 in the case of an alien or for holding an inquisition it would be taken out, if they are within the jurisdiction. There are aliens who are Chancery lunatics, or, if not Chancery lunatics, are subject to Section 116.

1048. *Sir David Drummond*: In what proportion of the cases into which you have made inquiry have you found the certificates have been imperfect?—None.

1049. How do you decide whether the certificates have been perfect or not?—It causes me uneasiness if I find anything is done to any man by which he is deprived of his liberty, and if I find that anything has been faultily expressed I am entitled to know if there is any fault to be found with it.

1050. But you have never found any such case in fact?—Certainly not.

1051. *Chairman*: I am asked to put this question, which I think is quite a proper one. Do you know of any statutory or other right by the terms of which a person once deprived of his liberty as a certified lunatic can demand a public trial by an independent tribunal to determine his sanity or insanity?—Do you mean can demand an inquisition?

1052. If a person is certified as a lunatic already, can such a person demand an absolute right to a trial?—No.

1053. The suggestion of the question seems to me to go to the means by which a public tribunal can be invoked to determine the sanity or insanity of a particular person who is detained?—I hope not, but I do not know. There are two things I ought to have said. There have been from time to time suggestions made that the Lord Chancellor's Visitors and the Board of Control Visitors should be amalgamated. If the Commission at any future time should come to consider any such question as that, I may say we should be very glad to be allowed to tender evidence upon it, but I do not want to take up time now by saying anything about it.

1054. But you might guide us now with any suggestions you have to make. Do you consider there is an overlapping of these functions?—I think there is.

* See Appendix V.

8 October, 1924.]

SIR CLAUD SCHUSTER, K.C.B., C.V.O., K.C.

[Continued.]

1055. And is it an undesirable overlapping?—That is what we often have difficulty in determining. I think we should be satisfied with such an amalgamation if the Commission recommend it, and subject, of course, to what the very learned Visitors might have to say on the subject themselves. If we had an assurance that we were in future able to get the same individual care given to our lunatics as has been given in the past; we could not stand anything which would put our lunatics in a less favourable position than they are in now; but subject to that we have no interest in maintaining two separate establishments, as it were, and the bias, I think, of the Lord Chancellor is, and would be of successive Lord Chancellors, that it is foolish to have two people doing the work instead of one.

1056. Unless such overlapping is desirable?—Yes, quite. I think the Master would require, and we should require, that our lunatics should have the same treatment. Then there is another matter, and that is that Master Hildyard is strongly of opinion that I should mention the cases which ought to be in Chancery, but are not. He thinks that a great effort should be made, and he has from time to time tried to devise plans whereby some machinery could be devised to draw the net closer.

1057. That is on the topic of the protection of a lunatic's property?—Yes. There are undoubtedly many cases where the relations manage to get on

without coming to us at all, and that is, of course, a very good thing; but when we find in cases which do come to us that the relatives are not always friendly, it seems a fair inference to draw that there are many cases where they do not get on in a friendly way which do not come before us.

1058. You mean that the patients are not getting the full benefit of any property which they may have?—Yes.

1059. *Earl Russell*: Does that observation apply to non-pauper patients only?—It would apply to anybody who has property at all, and, as you know, it might well be that there might be some property even in a pauper.

1060. In these cases is it your suggestion that the relatives squander the property, or is it administered by the Board of Guardians?—I was not speaking specially about the Board of Guardians, nor would I make any general charge of squandering against relatives as a class, but I would say that a certain proportion of the relatives of Chancery lunatics are not always wise, and it seems reasonable to suppose that in a proportion of those cases which do not come to us the relatives are not wise—that is the whole point.

1061. But you recognise the public prejudice there is about anything getting into Chancery?—Yes, I quite agree that there are great objections to that, but there is the point.

(*The Witness withdrew.*)

(*Adjourned to Tuesday, 21st October, at 10.30 o'clock.*)

5, OLD PALACE YARD,
WESTMINSTER.

THIRD DAY.

Tuesday, 21st October, 1924.

MEMBERS PRESENT :

THE RT. HON. H. P. MACMILLAN, K.C. (*in the Chair*).

THE EARL RUSSELL.

SIR HUMPHRY ROLLESTON, BART., K.C.B., M.D.

SIR THOMAS HUTCHISON, BART.

SIR ERNEST HILEY, K.B.E.

SIR DAVID DRUMMOND, C.B.E., M.D.

MRS. C. J. MATHEW.

MR. P. BARTER (*Secretary*).

MR. W. FAIRLEY (*Assistant Secretary*).

Sir CLAUD SCHUSTER, K.C.B., C.V.O., K.C., recalled and further examined.

1062. *Chairman*: I think I should inform the Commission that after Sir Claud Schuster left the witness chair, he was good enough to address a letter to me in which he expressed a desire to amplify an answer which he gave to Q. 1053, just at the close of the proceedings on the last occasion. As his letter contained, in my view, important additions to his evidence, I have ventured to ask him to attend here this morning in order that he might fully place before us his additional views. Perhaps, Sir Claud, you will be good enough to expand the answer to that Question. The Question was directed, you will remember, to the desirability of a right to demand a public trial by an independent tribunal to deter-

mine the sanity or insanity of an inmate of an institution?—Perhaps, Mr. Chairman, I might read my letter to you.

1063. I think that would be the most convenient way?—It is rather long, that is the only trouble.

1064. I think it is all of value, if I may say so?—“Towards the close of my examination on Wednesday, 8th October, you, upon the suggestion of a gentleman among the public, asked me whether a lunatic in confinement had a right to demand a public inquiry as to whether he had recovered. I replied, “I hope not.” As my reply conveyed, and was intended to convey, my opinion that such a right ought not to exist, I think that I ought in courtesy,

21 October, 1924.]

SIR CLAUD SCHUSTER, K.C.B., C.V.O., K.C.

[Continued.]

both to the Commission and to the gentleman upon whose motion the question was put, to explain why I hold that opinion, and as I failed to do so at the time, I venture now to write to you upon the subject. I interpreted the question as suggesting that every lunatic who thought that he had recovered ought to have, as of right, access to some person or body sitting in public who would inquire whether he had recovered. I should regard the conferment of such a right as unfortunate for the following reasons: 1. A lunatic is detained, not because he has committed an offence, but because the State is conceived as having a duty, (a) to protect from himself a person who might injure himself if at large; (b) to protect the public from the acts of a person who might do injury to the public if at large; (c) to effect the cure of the disease of the mind from which the person is suffering, or at least to effect a partial cure if the disease is of such a nature as to be capable of being cured or alleviated.

Lunacy is a disease which may or may not be curable, and, like other diseases, its cure or alleviation is a gradual process. Pathologically, as I understand, its cause is obscure, and the progress of the patient—whether towards improvement or deterioration—is difficult to detect, and is frequently only ascertainable by the patient's overt acts and not by any examination of the patient's bodily condition, or at least only imperfectly by such an examination.

There is, therefore, nothing more difficult in many cases than to determine the point at which the patient may be said to have been cured or to have made such progress towards recovery that, in the discharge of the State's duty to protect the patient and to protect society, the patient may properly be released. This is, therefore, a matter peculiarly unsuited, in most cases, for public inquiry.

2. Again, as the function of those who have to determine whether the patient is to be released or further detained is not to investigate any charge made against the patient as if he were an alleged criminal, but to consider whether in all the circumstances of the disease certain action should be taken in the interests both of the patient and of the public,

(The Witness withdrew.)

Mr. L. G. Brock, C.B., called and examined.

1066. *Chairman*: Mr. Brock, you are an Assistant Secretary of the Ministry of Health?—That is so.

1067. And you are aware of the terms on which this Commission is conducting its inquiry?—I am.

1068. I think that you have prepared yourself to assist us on the matter of the functions of the Ministry of Health in relation to the administration of the Lunacy Laws?—That is so.

1069. And, in particular, at this stage of the inquiry, you have directed your attention to an exposition of the existing system rather than to suggestions for its improvement or answers to any possible criticisms?—Yes.

1070. Now will you tell us from what sources the existing powers of the Minister of Health in relation to lunacy administration are derived?—They are inherited powers which come from two sources. They are partly powers exercised previously by the Local Government Board, all the powers of the Local Government Board were transferred to the Minister; and they are partly powers previously exercised by the Home Secretary.

1071. By what statutory provisions were those powers transferred from the Local Government Board and the Home Office to your Ministry?—The powers of the Local Government Board were transferred under Section 3 (1) (a) of the Ministry of Health Act, 1919.

1072. Was that the statute which set up the Ministry of Health?—That was the statute which set up the Ministry of Health, and which endowed the

the matter is peculiarly unsuitable for forensic treatment. There are no parties, for there is no one whose interest it is to detain the patient further except in the execution of public duty, and it would be most undesirable that the local authority, or the person in charge of the asylum in which the patient is detained, should be forced into an office analogous to that of prosecutor.

3. Lastly, but in my view most important, the experience of all those who have to do with lunatics is that a very large proportion of lunatics consider that they are wrongfully detained. Every one of these people, upon the hypothesis of the question, would have a right to demand an inquiry, and many of them would exercise it. The inquiry, upon the hypothesis, is to be in public. The discussion of a lunatic's condition is peculiarly unsuitable for discussion in public. The pathological condition of the patient and many of the patient's overt acts relevant to the consideration of the question are unpleasant, in many cases humiliating to the patient, and in many cases disgusting. I am not concerned to protect the public from themselves by prohibiting the discussion in public or the publication of such details. People can read them or not as they think fit. Their disclosure and discussion, however, in public must necessarily be detrimental to the patient's interests, and upon the assumption that many or some of the applicants for such an inquiry are still insane (which is, I think, a perfectly safe assumption), many of these unfortunate creatures and their relations would cause—without a full apprehension of the result—these matters to be made the subject of public knowledge.

Again, I should have thought that in the case of a patient of whose recovery there was any hope, and specially of any patient who was making progress towards recovery, nothing could be worse than the excitement induced by such a public inquiry and nothing would be more likely to retard or possibly to prevent the recovery or the alleviation.'

1065. We are much indebted to you for that reasoned statement of your views?—Thank you.

Minister with the powers previously exercised by the Local Government Board, among other powers, of course, transferred to him.

1073. He became the repository of a large number of powers collected from other sources in addition to new powers that were conferred upon him?—That is so.

1074. Now with regard to the powers transferred from the Local Government Board to the Minister of Health, to what topics did those powers relate?—The transferred powers under the Lunacy Acts related mainly to the administration of the Poor Law, but they also include certain powers in relation to Audit and Finance, analogous to the powers enjoyed by the Local Government Board in relation to the accounting and expenditure of other local authorities.

1075. Then as regards the powers transferred from the Home Office, what was the character of those powers?—There the position was rather more difficult. It would not have been possible to transfer the powers of the Secretary of State *en bloc*, because they related not only to lunacy questions, but they also involved other matters which remained within the administration of the Home Secretary.

1076. A conspicuous example of course, is his jurisdiction with regard to aliens?—Yes. After all, an insane alien might be regarded either as a person suffering from mental disease who happened to be of foreign nationality, or the important point might be the foreign nationality and the other issue might be secondary. If we had taken over the

21 October, 1924.]

MR. L. G. BROCK, C.B.

[Continued.]

Secretary of State's powers *en bloc*, it would have meant that we should have been involved to some extent in the administration of the laws relating to aliens.

1077. Accordingly, a selection was made of the Home Secretary's powers for transfer to the Minister of Health?—Under an Order in Council made in 1920, entitled "The Ministry of Health (Lunacy and Mental Deficiency Transfer of Powers) Order."

1078. Now when one examines that Order, in regard to the powers which were transferred from the Home Office, what do we find to be the class of powers selected for transfer?—I think the most striking point about them is that the Secretary of State's powers, the transferred powers, are much more limited than they are commonly supposed to be. The powers that really occupy most of our time are very largely financial powers, mostly of a restrictive nature, somewhat similar to Treasury powers, of control over the expenditure of visiting committees.

1079. Such as sanctioning borrowing, I suppose?—Yes, sanctioning borrowing, approving plans, approving extensions, and approving purchase of real property.

1080. I think these topics are only very indirectly related to the subject of our remit, which is confined, as you know, to certification, detention and care. It is only in so far as the provision of suitable buildings is an element in care that that topic seems to relate itself to our inquiry. I do not think we shall pursue that to any great extent. Of course the Ministry of Health has the general charge of public health throughout the country?—That is so.

1081. And mental disorder is related necessarily to that subject?—Certainly.

1082. But the code dealing with the insane had already been brought to considerable elaboration in the statutes which were in existence before your Ministry came into being?—I think it is at least arguable that had the Ministry of Health been in existence before the Board of Control in its present form was created, the relation between the two might have been somewhat different.

1083. Yes; but when your Ministry came into existence, there was already functioning the Board of Control, set up under previous statutes?—It was a going concern.

1084. And it, in its turn, was the inheritor of an important code which had been the result of legislation in the past?—Yes.

1085. But your Minister, I understand, is the Minister who answers in Parliament for the Board of Control, does he not?—That is so; he defends their estimates, and he also answers Parliamentary Questions relating to the administration of the Lunacy Laws.

1086. In your day to day work are you in close touch with the Board of Control?—Oh, yes, we are in constant touch.

1087. Do you find that the distribution or division of functions between the Board of Control and the Ministry of Health leads to any overlapping or any awkwardness in administration?—I think it is bound to lead to a certain amount of overlapping, though I am not sure that that overlapping is necessarily harmful, but it must happen in the examination of plans relating to new buildings or extensions. There is a statutory obligation on the Board of Control to report on those plans to the Minister; they are examined by their technical officers. Sometimes when they come across to us they have to be examined by our technical officers, but, from another point of view. The Board of Control are concerned to see whether, from the point of view of treatment, the proposed buildings, for example, are entirely suitable. We may sometimes have to look at it from a different point of view. We may sometimes have to consider whether, in view of the shortage of building labour,

it is absolutely necessary that labour in that area should be diverted from housing to additional accommodation in asylums. Of course, if it were a question of accommodation for additional patients, there is no option; patients have to be provided for. If it were a question of additional accommodation for staff or the erection of some building that was not absolutely necessary, then, if labour was very short in the area, the Minister might say: "Well, we think this should be postponed until the situation is easier."

1088. Of course, the view of the Board of Control is a specialised view, but you have a larger survey in your Ministry?—Exactly.

1089. Therefore, do you regard the fact that these plans come under your consideration as a useful check from the public point of view?—We sometimes have to take other considerations into account.

1090. Yes, I follow. Now, while certain powers were transferred from the Home Office to the Ministry of Health, certain powers were retained by the Home Office, were they not?—That is so.

1091. It might be convenient if you took first of all the powers which still reside in the Home Secretary and have not been transferred. To what subjects do they relate?—I think the most important of the powers retained by the Home Secretary was the power under Section 205 of the Act of 1890, under which, by an order directed to the Commissioners or any other person, he may require the person or persons to whom the order is directed to visit and examine a lunatic.

1092. Those are the visits which the Secretary of State may order. That power is still retained by the Home Secretary, is it not?—As the order was originally introduced, it was proposed to transfer that power from the Secretary of State to the Minister, but objection was taken to that in the House of Lords, and the Order was subsequently modified.

1093. So that the Home Secretary has still this independent power of ordering a visit to be made and enquiry to be taken into the case of a particular lunatic?—That is so.

1094. It is "a Secretary of State." The Home Secretary is a Secretary of State, but the Minister of Health is not a Secretary of State?—That is so.

1095. Exactly. Then the Secretary of State has powers, has he not, with regard to criminal lunatics?—Yes; they were not touched by the Transfer Order.

1096. They do not really come within the purview of our inquiry at all. Then as regards the powers and duties which were transferred to the Minister under the Order, perhaps you might just classify those powers for us and describe them to us?—I think first it might be convenient to take the personal powers. Those powers are very limited; the Minister has no power to order the discharge of a patient; but there is an important provision in Section 41 (1), which requires the manager of every institution to forward unopened all letters addressed to the Minister, and in fact we do receive a substantial amount of correspondence in that way.

1097. A little later I shall ask you how you deal with that correspondence; but your Department is one of the Departments to which an insane person may direct a letter unopened?—That is so.

1098. Then next with regard to local authorities and visiting committees have you certain powers?—Those are powers of sanctioning agreements, approving new buildings and extensions, purchase of land, raising of loans for the purpose of purchasing land. In all those cases our sanction is required, but of course it is a restrictive power. We have no power except in case of default to require or even to encourage local authorities to incur expenditure. If they of their own motion wish to incur expenditure, then before the expenditure can be incurred, they have to come to the Minister to obtain sanction; it is like Treasury sanction.

21 October, 1924.]

MR. L. G. BROCK, C.B.

[Continued.]

1099. But these local authorities have a statutory duty to make provision for the cases in their area?—They have.

1100. Then when they select the means of performing their statutory duty, their proposals or plans have to come under the scrutiny of your Ministry?—Through the Board of Control.

1101. That is the machinery provided?—Yes.

1102. And when you consider these questions that come before you in that shape, I take it you do not criticise plans from the point of view of whether the proposed buildings are best adapted for the treatment of lunatics, but look at them from rather a different point of view?—In general, if the plans were reported to be satisfactory by the technical officers of the Board of Control, we should accept that without question.

1103. That is, in relation to the accommodation for the patients who are to be inmates of the institution?—That is so. There have been occasional exceptions, where for example there were proposals for accommodation for patients suffering from tuberculosis; those were in fact also examined by our experts; but in general the Board of Control report is accepted without question as to the suitability in relation to the needs of the patients.

1104. You do not have on your staff medical men who are skilled alienists?—No, we do not.

1105. You have the advantage, of course, as we know, of medical advice, but it is not specially alienist advice?—The medical staff does not at present include any expert alienists.

1106. Then the Minister has certain important powers, has he not, in relation to the Board of Control itself?—He appoints the medical members of the Board; he appoints the Chairman of the Board, and, subject to the sanction of the Treasury, he settles the staff and rates of remuneration—what one might call establishment questions.

1107. And he would, of course, have to answer in the House, would he not, any criticisms that might be made on the selection of the personnel of the Board?—Certainly.

1108. Or his selection of the Chairman?—So far as they were appointed by him, of course he is directly responsible; so far as there is any criticism of an appointment by the Lord Chancellor—I cannot imagine such a thing happening—questions in the House of Commons could only be addressed to him.

1109. Then I think there also resides in the Minister a special power to direct the Attorney General to prosecute any person alleged to have committed a misdemeanour under the Act?—That is so; but since the Ministry of Health came into existence I cannot recall any case in which that power has had to be exercised.

1110. Of course, there have been a number of prosecutions for misdemeanours, but they had not to be directed from your Department?—I do not remember any one by special direction of the Minister.

1111. Then, in succession to the Local Government Board, you have certain powers relating to audit, I think, have you not?—Yes; they are analogous to the powers of the Minister in relation to other branches of expenditure by local authorities. The consent of the Minister is required to borrowing; the Minister appoints the date up to which accounts have got to be made up; and he can require the abstract of accounts to contain such particulars and to be in such form as he directs; the object of that is to secure that statistical material is in a form which admits of comparison with expenditure of local authorities in other directions.

1112. Then, of course, the old Local Government Board was specially concerned with the administration of the Poor Law?—That is so.

1113. And you are the inheritors of its Poor Law jurisdiction?—We are.

1114. And, of course, incidentally, of such portions of the Poor Law as related to the insane?—Quite so.

1115. That we shall develop a little later. Then, I think, just to complete the enumeration of the statutory powers, the Minister has power to appoint an arbitrator under section 13 of the Act of 1891 with regard to the contribution to asylum expenses payable by a borough annexed to a county?—That is so.

1116. That is rather remote from our inquiry, and I do not propose to go into questions of that type. Now, apart from Poor Law, which we have reserved in the meantime, will you give us some idea of the day to day work in your Ministry, in this department of your activities. You have referred, first of all, to the letters which come to you unopened from patients?—We get a considerable number of those letters, and of course, in addition to the letters sent unopened under Section 41 of the Act, the Minister also receives a large correspondence through Members of Parliament, and those letters in fact are dealt with in the same way.

1117. And you receive letters also from relatives and others?—Yes.

1118. So that you have a miscellaneous correspondence relating to patients who are in institutions?—Yes, of course the number of letters fluctuates very considerably. Any incident that draws special attention to the administration of the Acts always results in a considerable increase of correspondence; the appointment of this Commission, for example, led to a sharp upward curve in the amount of our correspondence.

1119. I think all our individual post-bags have also been considerably increased?—I am glad to say that our post-bag is getting more normal.

1120. I would like to know particularly how those letters are dealt with. First of all, what is the character of the letters that you receive? Who receives them, who deals with them, and what action is taken upon them? I would rather like to explore this matter a little closely?—As to the character of the letters, the majority of them are statements by patients that they are improperly detained. Some of them—not a very large number—contain allegations of ill-treatment and cruelty; some of them contain complaints about the dietary; those are not frequent; the bulk of the letters are statements by patients that they are sane persons and improperly detained.

1121. Do they all relate to complaints either of improper detention or of deficiencies in diet, or of ill-treatment, or are some of them just letters really of no particular point at all?—A certain number of them of course are almost undecipherable. Others are so incoherent that it is difficult to say what they are about; but a considerable number are quite lucid and quite clearly expressed.

1122. Now when those letters come into your Ministry how are they dealt with?—They go, in the first instance, to a comparatively junior clerk, whose business it is to see that any previous correspondence is attached, and to clear up any minor points; then they go to a Principal Clerk, and generally, not invariably, he brings them to me before any decision is reached as to what action, if any, should be taken.

1123. Then you yourself are brought closely into contact with this branch of your work?—For a good many months I think I have looked at very nearly all these letters, unless, I mean, they were so hopelessly incoherent that it was not worth while wasting time on them; I have looked at all readable letters. I do not mean to say I have read them right through, but I have looked at the case.

1124. But they have been, so to speak, sifted and classified, I suppose, before they reach you?—Oh, yes; and a report, where necessary, has been obtained from the Board of Control.

1125. Then, when they reach you, how do you deal with them?—In most cases, if it is clear from the medical report that the patient is properly detained, we should simply write a letter indicating that the Minister was not able to take any action.

21 October, 1924.]

MR. L. G. BROCK, C.B.

[Continued.]

1126. You send a reply to the writer of the letter?—Generally.

1127. But what are the means which you take to satisfy yourself whether the statements in these letters are well-founded or ill-founded? Take a concrete case: A patient complains that he or she has been ill-treated in a particular institution: what steps do you take to verify that statement?—Really our only means of verification is to ask the Board of Control for the latest information about that case. If they do not appear to have any recent medical report, then we should ask for a special report to be obtained. If on the face of that report there still seemed room for doubt, then from time to time we have asked, either that a special visit should be paid by a Commissioner, or that the case should be noted for a special interview when the Commissioners were next visiting in the ordinary course.

1128. Then the vehicle of your information in all cases is the Board of Control?—That is so, in practically all cases. The one exception is that if a case arose in which there was any suggestion that the medical treatment, apart from such treatment as was necessitated by the patient's mental condition, had not been satisfactory, then we might ask a member of our medical staff to visit the asylum and enquire into the case; but I can only remember one instance in which it was necessary; and of course we have no power to do that; it is only done by consent, as a matter of courtesy.

1129. Let us be clear about that. That is to investigate the medical condition of the patient?—Yes. As I have explained, in regard to the mental condition of the patient we are entirely dependent upon the reports obtained for us by the Board of Control.

1130. And if you are not satisfied with the material which you receive from the Board of Control, what would you do? Suppose the report seemed to you not adequately to meet the allegations contained in the letter before you, what would you do then? What powers have you then?—We should ask that more specific information should be obtained on the particular points which we should indicate as requiring elucidation.

1131. You would still be dependent of course on the Board of Control for furnishing you with that?—Absolutely.

1132. Then you spoke of requesting a special report. Can you do that?—We have no power to do it. Of course, the Board of Control work most harmoniously with us, and if we asked for a special report I cannot imagine that they would refuse to obtain it. Certainly there has not been any such refusal.

1133. Now do you refer all the intelligible letters which contain complaints to the Board of Control for enquiry or not?—No, it is not necessary to refer them all, because we have always got a certain number of correspondents who write to us at such very frequent intervals that we are really acquainted with the facts of their cases; and there are in fact a good many cases in which the mental condition of the patient is apparent on the face of the letter. It is a frequent thing to get a statement that the patient is being poisoned by wireless. I can even recall one case of a man who said he was having Communism injected into him by psycho-analysis. In those cases it is not generally necessary to make any further enquiry, unless the letter contains an allegation of cruelty.

1134. Then you spoke of having before you what we may call the office file of this man. Your junior clerk has attached the previous letters: you are therefore in a position to see if this is merely a vain repetition of what you have previously considered; but when you receive a first complaint from a patient, it will have no history behind it in your office: what do you do then?—That would be referred to the Board of Control for the latest report.

1135. Then the cases which you do not refer to the Board of Control are either cases in which on the face of the letter it appears that the complaint is groundless, or cases in which you have on your file material

relating to that case, which shows that it has been previously investigated, possibly more than once. Does that accurately represent the position?—Of course, in some of those recurrent cases we do not make any attempt to reply to every letter that we receive. We reach a point at which further correspondence is simply a waste of time.

1136. Then apparently the position is this, that you discharge your duty by examining the letters and, in all cases where there appears to be any ground for enquiry, referring to the Board of Control for information?—That is so.

1137. What proportion of cases do you think you refer to the Board of Control? Do you frequently refer complaints to them?—I have not got any statistics. I should think probably rather more than half.

1138. In any cases where you have received a report from the Board, have you been dissatisfied with the adequacy of the reply?—There have been cases where it appeared to us that the report by the Medical Superintendent was not adequate, and we have asked the Board to obtain further information.

1139. Have you ever had the case to consider where even upon those further enquiries the position still seemed unsatisfactory to you?—No, I could not say that I have. The correspondence does not suggest to my mind that in any case the patient has been detained any longer than was necessary to arrive at an accurate diagnosis. I have not found any evidence of patients being improperly detained.

1140. Have you not found any in your experience?—No.

1141. But, again, in forming that judgment in any particular case, you are dependent upon the Board of Control for information?—That is so; it is all paper information.

1142. How often in your experience have you sent down a medical officer from your own Ministry to see a person detained in an institution?—I can only recall one case.

1143. It would be interesting to know why you did it in that case, and did not rely merely upon the paper information that "you had with regard to the case?—Because in that case the patient at the time of her admission was pregnant and complaint was made that in fact she did not receive proper attention at the mental hospital.

1144. Did you receive a report from your medical adviser in that case?—We did.

1145. Will you tell us whether it was satisfactory or not?—No; I could not describe it as an entirely satisfactory report.

1146. The question which she was investigating was whether this woman had had proper treatment at the time of her confinement?—So far as I can remember it was a question of the treatment during pregnancy.

1147. And was the report unfavourable?—It was rather unfavourable.

1148. What kind of institution was she in? — A public mental hospital.

1149. Is that the only instance you have had?—Yes, I think that is the only instance.

1150. Had you previously asked from the Board of Control for a report on that case?—Yes; we had had a report through the Board of Control on the case.

1151. And had their report been satisfactory?—We did not think that the explanation offered by the asylum authorities was satisfactory, and it was for that reason that it was decided to ask for a report by one of our medical officers.

1152. I may take it that that is the only case where you have thought it necessary to resort to an independent medical enquiry?—That is so, and there of course we had no power to send our officer; it could only be done by consent.

1153. That is rather important. You would have of course to make arrangements for your medical officer to go down there?—Yes.

21 October, 1924.]

MR. L. G. BROCK, C.B.

[Continued.]

1154. Was there any opposition to your sending her?—No, there was no objection; the asylum authorities were perfectly willing.

1155. And did she receive all the necessary facilities to make her enquiries?—Yes; no obstacle was put in the way.

1156. I think it might be interesting to examine this case a little further, because it is the only case we have had as yet of unsatisfactory treatment. Was the complaint that this woman had not had proper treatment appropriate to her condition, or was it the absence of facilities for treating a lying-in case?—I am speaking from memory, I have not had an opportunity of referring to the case recently, but as far as I can recall, the complaint was a complaint from the husband that his wife's condition had not been detected as early as it should have been.

1157. Did the complaint not relate to the actual attendance during the labour?—No, not the attendance during the labour.

1158. It was not that?—No.

1159. Was it rather the treatment of the patient before delivery that was in question?—Yes. The suggestion was that the patient's condition should have been discovered at an earlier stage, and that she should have been specially looked after in view of her condition.

1160. What I was concerned to know was whether it was a complaint that during the confinement she had not had proper medical attention—the want of sufficient medical attention during the actual confinement?—No, it was not that.

1161. Was the visit made by your medical adviser alone or in conjunction with anyone?—I cannot recall that. The report was made to the Minister by Dame Janet Campbell; it is very likely that she did in fact visit with a member of the Board of Control, but I cannot trust my memory on that.

1162. I suppose, if desired, you can make available to us the papers relating to that case—Certainly.

1163. Have you come across cases in which persons, though still remaining certifiable, might have been discharged to their relatives if there had been means of looking after their welfare?—I think there is no doubt that cases of that kind are fairly numerous. In many instances the home circumstances do not make it possible for the family to give the patient the care that he would need if he were to be safely discharged. In a certain number of instances no doubt the main difficulty is the fact of marriage. I can recall one case in particular which was raised in the House of Commons of a Service patient, who was therefore a private patient, in which the parents wanted to get the man home, but the right of discharge was vested in the wife, and the wife was not willing to apply. In a case like that, where there is a wife of child-bearing age and no means of preventing the husband returning to her in the event of his discharge, you can understand the wife's objection to apply.

1164. We are dealing with the cases for the moment which are not improperly detained?—There was no doubt in this case that the man was properly detained and the chance of recovery very small.

1165. It was merely a question of whether the lunatic should be detained in the institution or should be handed over to his family?—Quite so. Probably he would be better in the institution.

1166. That raises rather a question of policy; it does not raise any question of wrongful detention?—No; there was no suggestion of wrongful detention in that case. Of course, there is a certain class of patients who, after a considerable term in an asylum reach a condition of what is sometimes called "asylum sanity"; they are fairly stable; they are fairly normal, as long as they remain under sheltered conditions, but if they come out into the world they could not stand any stress. It is comparable to the condition of some tuberculosis patients who remain stable and do not get, at any rate, noticeably worse

as long as they remain in a sanatorium, but if they return to ordinary working conditions they break down again.

1167. Of course, the institution gives shelter and protection?—It gives a shelter, yes.

1168. Do you find in your letters from relatives that they frequently state that they have themselves seen their unfortunate relative and have satisfied themselves that the patient has recovered?—Yes.

1169. Often?—Those cases are quite numerous, and the remarkable feature about them is that where the relatives are most confident that the patient is improperly detained, the prognosis is very often most unfavourable.

1170. How do you explain that?—I think it is probably due to the fact that some forms of insanity develop slowly, and that there are periods of remission. The relatives are only allowed to see the patient on a good day; if they went on a bad day, they would not see him.

1171. So that they have no real opportunity of forming a judgment as to his condition?—That is so. On the other hand, there are cases of insanity that develop very rapidly; the curve rises steeply and then falls again almost as steeply afterwards. Once the relatives have seen the man violent or raving, they do not feel any further doubt about his insanity. I believe it is the case that those forms of insanity where the curve undulates, and there are periods of excitement followed by periods of remission, are the cases which are very often the least hopeful.

1172. Now you tell us what you can do and what in practice you do do in relation to correspondence you receive, and you have told us of your relations with the Board of Control in this matter. You have, however, no powers yourselves, have you, to discharge a patient?—None.

1173. Do you regard the powers, however, which you do possess as forming an important safeguard?—I think they have a certain tonic effect; I think they are useful as a reminder to the mental hospitals that the cases are being watched.

1174. You have, however, in your experience not come across any case where you were satisfied that there had been improper certification or improper detention, have you?—No, I have not. I think it is possible that in an occasional case the fact of calling for a report has had the effect of drawing the attention of the superintendent to an improvement in a patient's condition. Of course, one of the difficulties in dealing with all these cases is that a man does not suddenly pass from a condition of insanity to a condition of sanity; there is a period of convalescence; and it is very difficult to determine the exact point in that progressive improvement at which it might be safe to discharge him.

1175. It is a question of degree, is it not?—It is a question of degree.

1176. And I suppose that some people may be more cautious than others?—They are bound to be; it is a matter of temperament. Some superintendents no doubt are a little more inclined to play for safety than others.

1177. Of course, one has to have regard to this, that in the interests of the patient and of the public premature discharge may be very dangerous.—It may; and, of course, it may result in suicide.

1178. Therefore, it is a difficult and responsible duty to perform?—Extremely responsible.

1179. There would appear to be a balancing of considerations which must be taken into account?—That is so.

1180. Do you think it would be of any advantage that your Ministry should have a power of discharge?—No, I do not; I do not see how in practice if we had such a power it could be exercised.

1181. Then the real value of your intervention seems to be as an authority which may be invoked by the public and by patients, and which has a certain authority in dealing with the Board of Control and the institutions?—I agree.

21 October, 1924.]

MR. L. G. BROCK, C.B.

[Continued.]

1182. And the further advantage that you are answerable to Parliament?—That is so.

1183. I do not know—it is a mere matter of curiosity—but are questions frequently put down in the House on the position of individual lunatics?—Not very frequently. There are a certain number of cases which crop up at fairly frequent intervals, but as a rule, if a Member of Parliament wants information in regard to a particular case, he would write to the Minister rather than put down a question on the Order Paper.

1184. That one can see at once would be a more considerate course, as it would not involve publicity for a particular case?—That is so, although, of course, when questions are put down relating to specific individuals, the Speaker has always allowed them to be referred to by initials and not by the full name.

1185. I must say I have not seen many questions set down relating to your Department. One is more familiar with questions about prosecutions and so on. How often do you have questions to answer in the House?—Questions about specific cases?

1186. Yes, specific cases.—They come at fairly long intervals. I do not think I care to commit myself to any figure; they are infrequent.

1187. But Members of Parliament, on the other hand, I suppose communicate with you fairly frequently, do they not?—Yes; we get a great many letters from Members.

1188. Who have been stimulated to take action by their constituents, no doubt.—That is so, the common fate of Members.

1189. Now you have told us how you deal with the correspondence and all that follows upon it. In what other way are you brought into contact with the administration of the lunacy laws?—Through our power of appointment of the medical members of the Board of Control; and, of course, we have a certain financial responsibility for them, because the Minister has to approve the expenditure on staff and the scales of remuneration, subject always to Treasury sanction.

1190. That is the Board of Control. Then I think your other relationship is also with the local authorities?—That is so.

1191. And in relation to the local authorities, you are not concerned with the care of the patients, but are concerned rather with the provision of premises and financial arrangements?—And even there, although some local authorities do write direct to the Minister from time to time, we are not directly in relation with them, because under Section 272, I think it is, the plans have to come through the Board of Control, and we reply to the Board of Control. It is the Board of Control that is in direct personal touch with the authority, except in regard to the approval of loans.

1192. Then you are not really brought into contact with the local authorities in relation to the care of the patients under their charge?—No, we are not, although as a matter of courtesy if the Board of Control were issuing any circular of special importance, they would refer it in draft to the Ministry.

1193. What in practice have you found to be your relations with the Board of Control?—Entirely harmonious.

1194. Have you been able to get from them always the information you desire?—Always.

Chairman: I think that really covers all that you have to tell us. I am very much obliged to you.

1195. *Earl Russell:* There is only one subject that I want to follow a little more, and that is with regard to complaints of ill-treatment received in letters from patients. Assuming that you get a letter which is apparently coherent, from a case you have not heard of before, making a complaint of ill-treatment, do you send that to the Board of Control for a report?—Yes, we should.

1196. And what do the Board of Control then do? Do they ask the asylum authorities to report?—In

the first instance they would get a report from the medical superintendent of the asylum.

1197. And he, I suppose, would have in turn to obtain that from one of his junior officers, would he not, the doctor in charge of that particular ward, probably?—He would certainly have to see the doctor in charge of that particular ward; but he would probably also see the nurses.

1198. But supposing the ill-treatment was such as to have left no permanent mark on the patient, no bruise and no broken ribs, the report that came back to you would not be more than the statement of the people who were accused of having ill-treated the patient, would it?—That, of course, is always one of the difficulties in arriving at a definite conclusion as to the truth of these allegations; that the patients are very often persons who are not credible witnesses, because they may not understand what they see. Suppose, for example, one patient sees another patient undergoing any sort of massage; to a disordered mind that may very easily look like an assault.

1199. I agree, too, that patients are not necessarily credible witnesses. If they were the task would be very much easier in these cases. But I want to know this: You are ultimately satisfied, I take it, that there is no ground for the accusation of ill-treatment, and I am trying to get what that satisfaction rests upon and whether it amounts to anything more than a statement by the person against whom the accusation is made?—I should say that probably in the majority of cases where cruelty is alleged, the acts stated to have been committed are such as would have left some mark on the patient; but of course if they were not I think it is impossible to arrive at a definite conclusion, especially if the complaint reached us some little time after the alleged ill-treatment had taken place.

1200. Have you ever had a case in which you have had a succession of complaints, either from the same asylum or from the same ward of the asylum?—No, I cannot recall any case of a succession of complaints against the same individual or set of individuals. You may, and we sometimes do, get a long series of letters making very vague general statements.

1201. From the same patients, or from different patients in the same institution?—From the same patients.

1202. I was rather speaking of a case where you had two or three patients making complaints. If you got a case of that sort, you would then feel that there was something to investigate, would you not?—Certainly, but I do not remember any case of a confirmatory series of letters of that sort.

1203. The people of course who are charged with the cruelty are the actual attendants, the nurses in the asylum, either the male or the female attendants, as the case may be?—Yes.

1204. And they are examined, as I understand, only by the superintendent of their own asylum—no outside authority questions them upon the allegations?—If it was considered that there was a *prima facie* case for a judicial enquiry, the Board of Control would hold one.

1205. If you found something definite, like a broken rib?—Yes, and of course if any case came to the notice of the Minister which seemed to call for investigation, he would suggest to the Board of Control the propriety of exercising their powers in holding an enquiry in proper form. There has been one such case within my recollection.

1206. I entirely agree with you—do not think I am differing from you at all—as to the extreme difficulty of getting at the truth of these allegations; I only want to know what are the steps that you take before you are satisfied, and if there are any steps you think you could take beyond those that are taken?—In the ordinary way the only steps that are taken are to ask the medical superintendent to investigate the matter to the best of his ability and to report to the Board of Control.

21 October, 1924.]

MR. L. G. BROCK, C.B.

[Continued.]

1207. *Mrs. Mathew*: I want to get this quite clear, Mr. Brock. Has the Ministry of Health no alienists on the staff?—No. I believe we have on the medical staff one medical officer who has had some experience in a mental hospital, and for a time Sir Maurice Craig acted as a part-time adviser of the Ministry on mental questions, but at the moment we have no alienists on the medical staff.

1208. Does no doctor see these letters from the patients?—Not in the ordinary way at the Ministry.

1209. I wanted to know about that woman in the public mental hospital to whom you referred. How long before her baby was born did you have this complaint?—I could not say from memory; I have not the case here, but the file is at the disposal of the Commission; I will see that it is put in.

1210. *Sir Humphry Rolleston*: I have two rather different questions that I would like to ask. The first one is as to whether you will explain a little further as to the need for and the advantages which are derived from the existence of the Board of Control as a separate authority, rather than as being one special department of a single inclusive Government Department which would deal with the whole thing. I mean there may be advantages in having independent action, taking a broader view of it, or it may be that it would be much more advisable and economical and more rapidly effective if the whole thing were under one roof, so to speak?—Well, Sir Humphry, that is taking me into questions of policy on which I am not instructed at this stage, and it is a little difficult to answer it, but I might perhaps suggest that there is at any rate a case for bringing the questions relating to the medical treatment of patients within the purview of the Chief Medical Officer. At present so far as there are any relations between him and the medical members of the Board of Control, that is done as a matter of courtesy and of administrative convenience rather than as a matter of constitutional arrangement or of right.

1211. But with regard to the general broad question, you prefer to reserve your answer?—I prefer to reserve the reply.

1212. The other question I wanted to ask you is this: You have to do with the construction and financial position of any new asylums that are put up?—That is so.

1213. As bearing on that from a medical point of view, there is the important question as to whether you have any control over the transfer of patients from an old over-crowded and possibly infected asylum as regards asylum dysentery, to a new asylum. That is the point of importance. One sometimes hears that the dysentery which did exist in some of the old asylums has cropped up in a new asylum as a result apparently of the transfer of patients from the old asylum to the new. Now that being a medical rather

than a mental disease, have you any say as to whether patients should be transferred from old hospitals to new hospitals?—None at all.

1214. *Sir David Drummond*: Do you not concern yourself with the mental health of the patients, that is to say, the treatment of the patients?—I am afraid I did not quite catch your question.

1215. Does the Ministry of Health not concern itself at all with what I call the mental health of the patients, the treatment of the patients, in an asylum?—No; I would not say that at all. What I have tried to indicate is that the Minister and his staff have no power in relation to the medical treatment of the patients. Of course our medical staff are in consultation with the medical members of the Board of Control; and important circulars, for example, the circular relating to the recruitment of asylum medical officers and the necessity of improving their general position, are issued after consultation with the Ministry.

1216. Do you hold direct communication with superintendents of asylums at all?—In particular cases where there have been epidemic outbreaks—*asylum dysentery*, for example—a Medical Officer from the Ministry has been associated with the member of the Board of Control in making enquiries on the spot.

1217. How do you regard your connection with the whole question of lunacy—that is to say, is it a large or a small part of the duties of the Ministry of Health?—As things stand at present a very small part.

1218. Do you think it is desirable that specialists and alienists should be on your staff?—I think there would be a considerable advantage in it, but perhaps it is not for me to say.

1219. *Sir Ernest Hiley*: I have only one question. In your answer to Sir Humphry I was not quite sure whether you were suggesting that the Chief Medical Officer of the Ministry should, as it were, be put in control of the alienists on the Board of Control?—I did not intend to convey that.

1220. I was not quite sure whether you did. As things stand at the present time the Board of Control are independent?—That is so.

1221. And it is only when cases of medical treatment come into question that you put your Medical Officer in communication with the Board of Control?—Yes.

1222. As regards the mental treatment in the hospitals, that is a function of the Board of Control with which you do not interfere?—Of course in the main it is the function of the local authority, because on the treatment side the Board of Control are, after all, only in a position to make suggestions.

Chairman: Thank you, Mr. Brock.

(*The Witness withdrew.*)

MR. H. W. S. FRANCIS, O.B.E., called and examined.

1223. *Chairman*: Mr. Francis, are you an Assistant Secretary of the Ministry of Health?—Yes.

1224. We have just heard from Mr. Brock that the Ministry of Health, as the successor of the Local Government Board, is the central authority dealing with the administration of the Poor Law in this country. Is the Poor Law, in one of its branches, concerned with the insane poor?—The Poor Law is concerned with the relief of everybody who is destitute, and an insane person is very frequently destitute, either because of his insanity, or apart from his insanity.

1225. Therefore the Poor Law is necessarily brought into contact with the destitute lunatic?—Yes.

1226. And has that department of the Poor Law been the subject of legislation and of administrative regulation?—Yes.

1227. Will you tell us in general, before we come to detail, what is the relation of your Minister to

the destitute insane population of this country?—Perhaps the best way of answering is to say that the Minister's concern is with the Poor Law and with the relief of people who are destitute. If they happen to be insane, that does not greatly differentiate his duties with regard to them.

1228. But he will have, I suppose, to administer special statutory provisions and special administrative regulations, which have been framed to deal with that class of the destitute which happens also to be afflicted with mental disability?—Certainly.

1229. Once a lunatic in receipt of relief has been placed in an asylum, does your departmental responsibility cease?—Practically. The only point upon which we could come in might be on a visit being paid to that lunatic by a board of guardians who might complain to us. In that case we should refer the matter to the Board of Control.

1230. Now will you give us a sketch of your functions in exercising the general control of the

21 October, 1924.]

MR. H. W. S. FRANCIS, O.B.E.

[Continued.]

provisions made for persons in receipt of relief who happen to be afflicted mentally?—I am sorry if I go back too far. The Poor Law was a new service formed in 1834, very largely formed by the energy of the men who made the central department, and it has always been very closely run from headquarters. The details and the management of the Poor Law are controlled by regulations in a way in which no other service that is carried on by local authorities is controlled as far as I know; and the individual pauper has the protection of the Minister of Health, somewhat in the same way as the individual lunatic is entitled to the protection of the Board of Control.

1231. Then you regard a destitute and insane person as coming under the special charge of your department?—So long as they remain in a Poor Law institution.

1232. Quite, until they may be transferred to a public asylum?—Yes.

1233. Now do the Lunacy Act of 1890 and the subsequent Act of 1891 at various points deal with the functions of your department?—Yes.

1234. It might be useful if we were to group those statutory functions which you exercise?—As a matter of fact there is only one provision I think in the Lunacy Act which specially refers to the Local Government Board, as it then was.

1235. That is Section 26?—Yes.

1236. Let us just look at that for a moment?—The section enables the Local Government Board, now the Minister to approve arrangements for the reception of chronic lunatics in the workhouse if the lunatics are not dangerous. There are no such arrangements in existence at the present time.

1237. Let us consider what is the purpose of this?—To relieve the strain on the asylums by removing from them people who are probably not curable, and who do not require any special care.

1238. We have heard from preceding witnesses that the accommodation in this country for the insane is rapidly approaching its limit. Have you any view as to whether there are in the public asylums of this country any cases, or many cases, which are chronic and harmless, and which are occupying beds in those asylums but might quite well find a place in your workhouses?—That is a point upon which I could not have any knowledge, but I understand the Board of Control to take the view that there are.

1239. Under Section 26 of the Act which we are dealing with at the moment, provision is made for the visitors of any asylum arranging with the local Poor Law authority for the transfer of patients from the public asylum to the workhouse?—Yes.

1240. If it be the case that beds in public asylums are occupied by persons who might quite well be in workhouses without any detriment to themselves or to the public, would it not be an advantage to utilise that section?—I should say in a certain rather limited number of cases.

1241. I observe that the initiative does not lie with your department here, however?—No, not formally.

1242. You have merely to consent if you approve of such arrangements as may be made between visitors on the one hand and guardians on the other?—Of course, the formal position differs rather from the actual one. As a matter of form the initiative lies between the local authority and the board of guardians. As a matter of practice I have discussed with the Board of Control the possibility of making arrangements from time to time, but we have not been able to reach anything sufficiently clearly right to be pressed on the local authorities.

1243. One is familiar with the expedient resorted to in most of the departments, of issuing circulars from time to time to the local authorities under their jurisdiction. Have you issued any circular drawing the attention of the guardians to Section 26?—Not since 1890. On a point of that kind we should rather expect the Board of Control to tell us they would like us to do it. And it is doubtful whether it would be of very much use.

1244. Of course it would depend largely upon whether the numbers were great and whether relief could be obtained in this way to any appreciable extent?—Quite. The difficulty really is that to make a satisfactory arrangement of this kind you want to take a whole workhouse, and it is not easy to get hold of a whole workhouse that is a good one.

1245. I observe that if a lunatic is transferred from an asylum to a workhouse under this section, he still continues on the books of the asylum?—Yes.

1246. Then I think the only other place where we find the Local Government Board referred to is in the 1891 Act, a comparatively minor matter?—That is a purely minor matter of administration. It enables one relieving officer to do certain work instead of it being divided among the relieving officers of the union.

1247. That is a matter of machinery?—Yes.

1248. You have certain statutory duties in relation to the Mental Deficiency Act of 1913, have you not?—Yes.

1249. They do not fall within our purview. Has your Minister the duty of scrutinising the plans of Poor Law institutions?—Yes.

1250. And has he to approve of the expenditure made upon them?—He approves of the expenditure, whether it is borrowed or whether it is spent out of revenue.

1251. The plans of those institutions, I suppose, will contain accommodation for the insane poor as well as for the sane poor?—Not in all cases. That is to say, there would not be accommodation set apart for the insane poor cases.

1252. Is it one of the matters to which the Minister on advice attends, as to whether there should be separate accommodation?—Yes, and any question of building a new institution.

1253. And has he a certain power in relation to the removal of Poor Law officers from their positions?—He can dismiss any Poor Law officer.

1254. From what quarter and on whose initiative does the complaint come?—The complaint may be very often an audit matter, a question of misappropriation of money; it might be a question of ill treating inmates; it might be a question simply of incompatibility of temperament.

1255. I think the Minister can act on his own initiative?—Entirely. He would ordinarily hold an inquiry first.

1256. Naturally, in fairness. Has the Minister or any of his predecessors made regulations for the government of Poor Law institutions?—Yes.

1257. Under what authority are those regulations made?—I think it is Section 15 of the Poor Law Act, 1834.

1258. What do those regulations relate to?—You are concerned primarily with institutions, I think?

1259. Yes.—The regulations control the method of admission of a patient. They say he is to be bathed and to be seen by a doctor and so on; then they control his dietary; they say what records are to be kept; they make certain provisions for the discipline of the institution, and they say how the man may be discharged.

1260. I think it might be useful if we had a set of the current regulations. I suppose you can furnish us with a copy of the current regulations?—Certainly.

1261. Do these regulations relate specially to the insane, or are they general regulations?—They are general regulations, but they do include certain provisions which mention the mental wards. They practically take the mental ward out of the category of a general ward, and place it under the special charge of the doctor.

1262. How is your department in Whitehall kept in contact with the administration of the Poor Law throughout the country?—There is a body of General Inspectors each with his own district in England and Wales, and besides that there are Medical Officers also with districts spread over the country, and women Inspectors.

21 October, 1924.]

MR. H. W. S. FRANCIS, O.B.E.

[Continued.]

1263. And do these Inspectors or Medical Officers report to you?—Yes.

1264. How often do they visit the institutions under your charge?—There is a minimum requirement that they shall visit each institution once a year. Actually an institution is visited probably more often. Of course the institutions are also visited on the point you are concerned with, by the Board of Control.

1265. Do they report to you specially with regard to the provision made for the insane patients?—The Medical Officers make a report on a form which draws special attention to that point.

1266. Do I gather that throughout the workhouses in this country there is not separate provision made in them for the accommodation of the insane poor?—No.

1267. On the other hand, in some institutions there is?—In the majority.

1268. May I take it that the more modern ones do make such provision?—I think it is more a question of size than of age.

1269. In the case of a poor person, a pauper, who is mentally afflicted, it is a question for consideration, is it not, whether such person should be separated from the other inmates or not?—Yes.

1270. Will one find in the workhouses of this country persons mentally disabled who are living along with the other inmates?—Yes; I will not say that they are necessarily certified persons.

1271. No; persons who might be described as mentally weak or afflicted will be found among the ordinary inmates of the workhouse?—Yes. I do not say in a very large number of cases.

1272. May I take it that the workhouses have no special facilities for dealing with mental cases?—I am not quite clear what you refer to. By facilities do you mean in the way of skilled staff?

1273. I had in mind first of all skilled staff; then I was thinking of facilities for treatment. Workhouses are not primarily designed for the detention of cases of insanity?—A large workhouse has probably wards designed for that purpose.

1274. A large workhouse?—Yes, and a staff. Of course, in no workhouse are the numbers so large as to get as skilled a staff as one would like to have.

1275. But it is the case, is it not, that the policy pursued is not to have in workhouses cases which are acute and which require special treatment?—Cases which are acute in the sense of being violent, certainly.

1276. I mean, is the workhouse utilised as a place of residence rather for chronic cases than for acute cases?—They fall into two classes. There are chronic cases such as might be transferred under Section 26, and people who come in on 3-day or 14-day orders on their way to an asylum. A large proportion of the latter do not get to the asylum.

1277. But are the workhouses, even those which have special mental wards, in your opinion places appropriate for the permanent detention of acute mental cases?—No; the wards are not designed for the permanent accommodation of acute cases.

1278. Then are the wards which you speak of, which we find in the larger workhouses, designed really for housing persons who have been brought in under the statutory provisions, pending observation and possible transfer?—That is one class, and the other class is the chronic case.

1279. So that what you may call the permanent inmate will be found generally to be a chronic case?—Yes, invariably a chronic case, I should say.

1280. With regard to those cases where there is a mental ward, what provision is made as regards staff?—They will have a special staff for the ward, according to its size, a head attendant and a certain number of men under him.

1281. Would the duties of those persons be confined to that department?—Yes, in any place of any size.

1282. And what about the medical staff?—They would be under the general charge of the medical

officer of the workhouse, or the medical superintendent of the infirmary, as the case might be. The term "workhouse," of course, includes an infirmary and any other building provided at the cost of the poor rate.

1283. Does your central department receive complaints of wrongful detention?—Very seldom. Our correspondence is quite different from that which Mr. Brock has been speaking of.

1284. One would assume that to be so from the answer that the cases which are permanently resident in such institutions are chronic cases?—Yes.

1285. Do you receive complaints relating to the treatment of the cases in your workhouses?—Yes, but not a large number; they are much fewer than they were 15 years ago. I do not know why.

1286. Now you might tell us how the correspondence which you receive is dealt with?—It is read by a clerk of some experience in my division; it is then referred to the General Inspector, and a reply is usually sent on his advice. In a large number of cases the reply sent is to refer the complainant to the visiting committee of the guardians. He is not ordinarily insane. At the same time, the General Inspector makes a note of the case if he does not know the man already.

1287. And on his next visit would the General Inspector specially attend that case?—He would probably see him.

1288. Have you ever had complaints of detention?—I made inquiries the other day, and there has only been one case in the last three years.

1289. Did that complaint emanate from a person permanently in the workhouse mental department?—Yes, I think so; I am not quite sure.

1290. Will you tell us, just as an example, how you dealt with that case?—We referred it to the Board of Control.

1291. For report?—No, for action.

1292. Did you follow it up?—I think the Board of Control visited the case. I am not quite clear what happened. The Board of Control visited the case and made some inquiries about it, and informed us what had been done, and the matter dropped.

1293. You got a report from the Board of Control, of their investigation and were satisfied?—Yes; their report showing quite clearly that there was no ground for discharging.

1294. Would that case be particularly noted by your Inspector for his next visit?—No doubt.

1295. As regards complaints apart from illegal detention complaints, how are they dealt with?—The procedure would be the same.

1296. Do you refer them to the Board of Control?—No.

1297. In such a case you use your own staff, I suppose?—Yes.

1298. Do these complaints relate to diet, bedding, and things of that sort?—Yes, and very often to a question of classification; a person dislikes the ward he or she is put to sleep in.

1299. The associations are undesirable?—Yes.

1300. Then what action do you take upon that?—We treat them in the same way.

1301. An Inspector goes and inquires?—Yes.

1302. In the course of your inquiries, have you found in recent times instances where the complaint seemed to you well founded?—Yes, a small proportion of them were.

1303. And if the complaints seemed to you on investigation to be well founded, what power have you to put matters right?—I am afraid I cannot say exactly what powers we have, but I know we should get it put right.

1304. How would you get it put right?—We should expect the Inspector to settle it.

1305. If he found a recalcitrant authority to deal with, what then?—He never does practically, not on a point like that.

1306. Has your experience been that when you investigate anything that is complained of and your

21 October, 1924.]

MR. H. W. S. FRANCIS, O.B.E.

[Continued.]

Inspector goes down to see about it, he can put it right?—Yes.

1307. In short you have not found reluctance among the local bodies to act upon the recommendations of your central authority?—No. I do not know whether it would be quite the same if we made a formal recommendation in a letter.

1308. There are tactful and tactless ways of doing things, no doubt; but you have achieved the result in every case where you have found anything wrong?—I think I can say that quite safely.

1309. Have your Inspectors a power of holding inquiries on oath?—Yes.

1310. And can they call witnesses?—Yes, they can call witnesses within five or ten miles.

1311. And can they call for documents under a subpoena?—Yes.

1312. Have you held any such inquiries—have your General Inspectors held any such inquiries in recent times?—Oh yes, a number of inquiries are being held at the present time or are in process of being held.

1313. Do those inquiries relate to persons of unsound mind to any extent?—Not to a very large extent. There have been two inquiries, I think, in the last two or three years, one in 1920 and one in 1923, on the subject.

1314. Just tell us what was the occasion of those sworn inquiries being set on foot?—The first inquiry was a complaint of unnecessary, *i.e.*, brutal force used in the restraint of a mental patient.

1315. Who complained of that. I want to know how it started?—If I may speak subject to verification, the patient was admitted eventually to the asylum and was found to be badly bruised.

1316. So that I take it the complaint must have started as the result of the examination of the patient on reception in the asylum?—Yes, that was so.

1317. What was done?—An inquiry was held by the General Inspector with an Assessor, representative of the Board of Control. The Minister was not satisfied with the explanations offered by the attendants concerned, and required them to be dismissed.

1318. One may take it, then, that in that case the allegations were found proved?—I remember that part of the case fairly clearly. I cannot say they were found proved; it was very nearly a not proven verdict, but it was quite unsatisfactory.

1319. But the step was taken, was it, of dismissing the attendants implicated?—Yes.

1320. Who dismissed them?—The Minister required the guardians to dismiss them.

1321. And these people were therefore eliminated from the service?—Yes.

1322. That is the 1920 case, is it?—Yes.

1323. What was the 1923 case?—The 1923 case was part of an inquiry held mainly on another charge.

1324. What was the charge this time?—We were holding an inquiry on another charge, nothing to do with a lunatic, and a separate case was brought up, a complaint that a lunatic had been ill treated by the man already under suspicion. The Board of Control were not represented at that inquiry, but the charge was not proved. It was less than not proved.

1325. It was investigated, was it, by your Inspector at a sworn inquiry?—Yes.

1326. It was an additional charge brought up, additional to the matter which he had been sent down to investigate?—Yes.

1327. And was it looked into by him at that time?—Yes.

1328. And did he report that the charges on this matter were without foundation?—Yes. On the other matter the man was dismissed.

1329. So that it did not much matter—he was dismissed anyhow?—Not very much.

1330. On the matter of the treatment of an insane person, the charge was not brought home?—It was not well founded.

1331. But on the other matter it was found that he had been neglectful, and was accordingly dismissed?—Yes.

1332. These are the only two cases you can recall in recent times in which an insane pauper was concerned?—The only two cases in which we have held a formal inquiry; but I have notes of two other cases, in 1921 and 1924, of lunatic patients when admitted to an asylum being found to suffer from broken ribs or bruises. In those cases no sworn inquiry was held because it was thought that nothing possibly could be added to the guardians' inquiry.

1333. And what action was taken in those cases?—No satisfactory result really emerged.

1334. I am a little puzzled. A patient is found on admission to the asylum to show evidences of violence?—Yes.

1335. Do you mean that the persons who had committed that violence were not ascertained?—No. It might quite well not have been in the Poor Law institution at all, you see.

1336. Do you mean the violence may not have been suffered in the Poor Law institution?—Yes.

1337. Were they persons who had passed through the Poor Law institution on their way to an asylum?—Yes, in both cases.

1338. Why was an inquiry not held in that case?—Only on the ground that the guardians' inquiry was as exhaustive as anything that could be thought of.

1339. What I want to get at is this: I do not quite understand the inquiry that was held in this instance?—The guardians, as owners and managers of the institution, held their own inquiry.

1340. With what result?—With no satisfactory result, I am afraid. A satisfactory result is either to show that something did happen, or that something did not happen.

1341. I should have thought that the subject matter of the investigation was how did this particular person come by the injuries which were found upon him?—The subject matter is, did that particular person come by these injuries in the Poor Law institution?

1342. Was that the issue tried?—Yes.

1343. What was the result—they could not say?—It could not be established either way.

1344. And was nothing done in that case?—No further action was taken.

1345. It does not seem very satisfactory, does it?—I do not quite see what more could have been done.

1346. Would it not have been possible to have ascertained by inquiry when and where this particular person came by those injuries?—You cannot always.

1347. This was one of those cases which perhaps we are familiar with in the Law Courts also, where the investigation resulted in no ascertained facts?—Exactly.

1348. Have you had other cases like that?—There are no other cases in the last four years except those which I have mentioned, but I believe it is notorious that it is very difficult to say where a lunatic broke a bone.

1349. We are concerned, of course, with the machinery of the investigation, to know whether adequate means exist at the present moment for investigating any such cases. So far as your department is concerned, your only powers of investigation are through the medium of your Inspectors or through the Board of Control?—Yes. We should not ordinarily hand a case over to the Board of Control.

1350. Are there cases where your Inspector reports an unsatisfactory state of affairs which is remedied without resort to a sworn inquiry?—Yes.

1351. How many institutions are we dealing with, how many are subject to your inspection throughout the country?—There are 643 boards of guardians, I think; say about 700 institutions, the bulk of which would not come in, probably.

1352. Then through whose hands do these Inspectors' reports pass?—The reports are addressed to the Minister.

1353. Then they are dealt with departmentally?—They come through the Chief Inspector and through me.

21 October, 1924.]

MR. H. W. S. FRANCIS, O.B.E.

[Continued.]

1354. Do you yourself handle all the reports from all these 600 or 700 institutions?—I thought you were referring to reports of inquiries.

1355. I just want to get the general routine work?—They come to the Poor Law Division.

1356. And are these reports the means whereby information is brought to the department of any irregularities or unsatisfactory conditions?—They are one means.

1357. What other means have you?—If there is a serious matter the Inspector would probably write to the Chief Inspector, or come and see him.

1358. If there is anything serious, is that made the subject of a special report by the Inspector and dealt with by you?—Certainly.

1359. On the other hand, are the routine reports of the annual visit subjected to scrutiny in your department?—Yes.

1360. And from them can you gather the state of efficiency in those institutions throughout the country?—Fairly well.

1361. Do those reports contain recommendations, for example?—Yes.

1362. How are they dealt with?—The routine reports are read in the department and referred, if necessary, to me or to the Chief Inspector. The course recommended by the Inspecting Officer is generally taken.

1363. Are they communicated to the local authority concerned?—Yes, so far as is material.

1364. If there is any matter amiss is the local authority asked to explain it or to state what steps they are taking?—Probably the Inspector would have dealt with it informally before he makes the report.

1365. He would report to you sometimes that he found so and so existing, drew the attention of the guardians to it and succeeded in having it put right. In other cases he has noticed a state of matters which is not satisfactory, but is not able to get it put right. In such a case would you take action?—Yes, we should write.

1366. Of course, a large number of these matters do not have relation to the insane at all, I suppose?—I am afraid that is one of the difficulties of the position. The insane are a small portion of the things the Poor Law Division has to deal with.

1367. The relieving officer, of course, is related to your department, is he not?—He is appointed by the guardians with our approval: our approval is now only required when an increase of salary is proposed.

1368. And he has statutory duties?—Yes.

1369. We are going to see a relieving officer shortly. He has certain more or less independent functions?—His functions under the Lunacy Act are regarded as being independent entirely.

1370. But has the Minister certain powers with regard to relieving officers?—The Minister, through the General Inspector, would hold an inquiry as to the conduct of a relieving officer or any other officer, and he has held such inquiries into their conduct.

1371. I think that he has a statutory power over the relieving officers, has he not?—Yes.

1372. I understand that the last formal inquiry into the conduct of a relieving officer that you had in your department was in 1901?—Yes, on the conduct of relieving officers under the Lunacy Acts.

1373. In that case it was merely relating to certain fees they had received. It was not their conduct towards patients?—No.

1374. Now I would like to get from you some figures. How many persons in all were in receipt of poor relief at the 1st January, 1924?—1,372,000.

1375. That is about a million and a third?—Yes.

1376. How many of those were receiving relief on account of lunacy or other mental infirmity?—126,000—125,972 to be exact.

1377. That looks something like 1 in 10, does it not, roughly?—Yes. Of course, the total number of persons in receipt of relief has been very high lately owing to unemployment. The ordinary proportion would be higher than 1 in 10.

1378. Then the cases where mental disability is either the cause or the consequence of poverty, seem to be at the present moment somewhere in that ratio of 1 in 10?—At the present moment 1 in 10.

1379. Now of the 126,000, whom we may class in receipt of relief on account of mental disability, how many were inmates of lunatic asylums at that date?—93,783.

1380. That is far the greater proportion.—Three quarters of them.

1381. And had the responsibility, therefore, for the care and well-being of those persons passed from you to the Board of Control?—Yes.

1382. Subject, of course, as we know, to the guardians' right of visit?—Yes.

1383. I think there have been no pauper lunatics either in registered hospitals or licensed houses for some time?—No.

1384. We shall find them, therefore, all in the public asylums, in the workhouses, and in some instances, boarded out?—Yes, or in charitable institutions or on out-door relief.

1385. That exhausts the various categories?—Yes.

1386. Now of the residue how many were in receipt of out-door relief?—4,757.

1387. Are these persons residing with their relatives or other private persons?—Yes.

1388. Are these cases of persons who are certifiable?—I should not like to say. The word "certifiable" is one that is very difficult to interpret.

1389. Are they all certified persons?—No, they are not certified at all; except in asylum cases placed in the care of relatives under Section 57 of the Lunacy Act.

1390. Then this does not cover the case of a person who has been sent from an asylum to the care of relatives, although a certified person all the time?—It includes 1167 such cases.

1391. Then that leaves I think a balance of 27,432 inmates in Poor Law institutions provided by Poor Law authorities?—Or institutions not provided by Poor Law authorities—institutions not asylums.

1392. But institutions, either provided or not provided by the Poor Law authorities?—Yes.

1393. I do not quite understand about the institutions not provided by the Poor Law authorities. What do you mean by those?—They might be charitable homes in which the guardians place the case and make a payment for it.

1394. Now these are all cases in which the burden of maintenance of the pauper is upon the rates, I take it?—Yes, primarily.

1395. Again, analysing the figures still further; of the 27,432 which you have just mentioned, how many were inmates of Poor Law institutions provided solely for mental cases?—8,763.

1396. And how many were inmates of institutions provided otherwise than by the Lunacy or Poor Law authorities for persons suffering from mental disease?—Just under 2,000—1979.

1397. Then further to exhaust the figures: were some accommodated in other institutions provided by charitable and other bodies?—Yes, 246, a small number.

1398. And where will we find the rest?—The rest are in Poor Law institutions.

1399. And are they all to be found either as inmates of sick wards or other wards of the Poor Law institutions?—Yes.

1400. I think you have already told us that some workhouses have wards specially set aside for mental cases?—The majority of the larger institutions—practically all the larger institutions.

1401. In some instances, in the case of the smaller institutions, would we find the mental cases mingled with the others?—The chronic cases, yes.

1402. Now you spoke of quite a large number, 8,763, being inmates of Poor Law institutions provided solely for mental cases. What sort of institutions are those?—They are institutions provided by

21 October, 1924.]

MR. H. W. S. FRANCIS, O.B.E.

[Continued.]

the Metropolitan Asylums Board for harmless imbeciles, feeble minded children. There are a certain number of institutions provided for mental defectives, places like Monyhull, which belongs to the Birmingham Guardians, or the Great Barr Colony, which belongs to another Poor Law authority. Of course they are mental defectives.

1403. So that going back to your leading figure of 126,000 mentally afflicted paupers, I take it that a large proportion of those are cases which have not been certified at all?—Under the Lunacy Acts. They may have been certified under the Mental Deficiency Act, or they may again, be mentally defective or lunatics and not certified at all. The number given is the number given by the boards of guardians as being relieved on account of mental infirmity.

1404. And of course there may be many cases of persons the cause of whose coming on the rates is mental incapacity, who yet may not be persons whom you would describe in the legal sense as lunatics at all?—Certainly.

1405. They may exhibit varying degrees of mental incapacity or disability?—Yes.

1406. Therefore we must not derive the impression that this large number represents actual certified lunatics on the rates?—Certainly not.

1407. I wonder whether it would be possible to know how many are certified and maintained out of the rates?—You begin with 94,000 in lunatic asylums; they are all certified. You have got 30,000 doubtful ones.

1408. The bulk of them are certified cases, then?—I thought you were speaking of the number in the Poor Law institutions.

1409. I was thinking of all—to what extent certified lunatics in this country are maintained out of the rates?—The vast bulk are.

1410. The institutions provided solely for mental cases under the Poor Law are to be found, are they, only in London, under the Metropolitan Asylums Board?—No, not only in London. The Metropolitan Asylums Board is the principal authority; it has 8,000 beds nearly. The other principal authorities are Bristol, Birmingham, Manchester, and West Derby (Liverpool). Bristol, Birmingham and Manchester all have more than 500 beds for persons of unsound mind of one kind or another.

1411. I suppose the question whether they are to be dealt with in a separate institution or not is a matter of administrative discretion on the part of the Poor Law authority; it may not be worth while providing a special institution unless you have sufficient numbers?—It rests with the discretion of the Poor Law authority and the Ministry, which can either refuse to allow them to build or can put great pressure upon them to make them build.

1412. But one can imagine that economically and administratively it would not be desirable to have a specialised institution except in large centres?—It would be quite absurd to have one in most unions.

1413. And the problem is solved in many unions by having under the same roof a ward for such cases. Is that how it is done?—Yes, or several wards.

1414. When you speak of the number in the Metropolitan Asylum Board's institutions, they are not all chargeable, are they, to the guardians?—No; there are nearly 2,000 cases of mental deficiency sent by the authorities under the Act of 1913. These are not chargeable to the guardians.

1415. These are not private cases, are they?—No.

1416. Who defrays their maintenance?—The local authority under the Mental Deficiency Act by whom they are sent.

1417. Of course many specialised institutions are provided and are in course of being provided, are they not, under the Mental Deficiency Act?—Yes.

1418. Now have you told us all that your department has to do in relation to persons of unsound mind?—Yes, I think so. The only other function of the department in connection with lunacy relates to

the superannuation of asylum officers. I take it you are not interested in that question.

1419. No, that is a department we are not concerned with. What we are concerned with is the question of the detention and care of persons in Poor Law institutions. It is not a matter you have dealt with in the *précis* you have been good enough to give us, but I think both I and my colleagues have been rather concerned with an aspect of the lunacy administration whereby a person who becomes mentally afflicted seems to be classified as a pauper on becoming afflicted. I want to put this point to you and to ascertain your view upon it. A person who is perfectly respectable and a self-supporting man, in no way chargeable to the rates, suddenly becomes mentally afflicted and gets the benefit of medical attendance and so on, and then may be removed temporarily to one of your institutions, and ultimately to an asylum—apparently all in the guise of a pauper. Why is that regarded as appropriate?—The word "Pauper" is used throughout the older statutes simply as a shorthand expression for a person in receipt of relief. A pauper lunatic, who, by the way, may dislike the stigma of being a lunatic even more than he dislikes the stigma of being a pauper, is a pauper in exactly the same way as he would be if he had an attack of appendicitis and was removed to an infirmary to have his appendix cut out.

1420. A person who has his leg broken and is taken to the hospital is no doubt for the time being unable to earn his livelihood, but you would never relegate him to the category of a pauper?—I do not know why he should not be called a pauper, if he is one.

1421. Of course, there is a certain dislike to harsh words which have unhappy associations, but it does strike one as being rather unnecessary that a person, merely because of his affliction, should be described by a term which seems quite inappropriate to his state.—But as a matter of fact "pauper" is a statutory term; that is the only reason it is used. In all our publications we never speak about a pauper; we talk of a person in receipt of relief. It means exactly the same thing.

1422. You think it is more a matter of sentiment than objection to the expression?—I do not think you are ever going to find a word that will not acquire the same objectionable meaning as the word "pauper" is held to have now. It is a question of association, but as I say, we never use the word ourselves.

1423. One knows that circumlocutions much commend themselves to draftsmen of the present day, but in this instance it has rather struck us that it is a little unfortunate to stigmatise (if one may use that expression) a person who is a perfectly self-supporting person, as a pauper, merely because of the affliction that has overtaken him?—Personally I have very considerable sympathy with that view, and, as I say, we do not use the word; but you cannot help the word being in the statute.

1424. We can recommend a different formula.—Yes, but I think myself if you called it "rate aided" or anything else, the word will sooner or later have exactly the same flavour.

1425. We are told that a rose by any other name would smell as sweet. The real distinction is between the case which is dealt with at his own charge and the case which is dealt with out of public moneys?—That is a slightly different point. You may have a case dealt with on its own charges, as some of these Poor Law cases are. There ought to be some way of removing it from the pauper category.

1426. That is the most odd case of all, that a person who may ultimately be found to have adequate means for his own treatment is temporarily placed under treatment in the guise of a pauper?—It is the only thing the guardians can do.

1427. Because there is temporary resort to rate aid, and for the time being the person is a rate-aided case; then it is found afterwards that the expense of treatment can be defrayed out of that person's own means; but you have to pass through a stage

21 October, 1924.]

MR. H. W. S. FRANCIS, O.B.E.

[Continued]

of being a pauper, putting it in the blunt language of the statute?—I must not ask a question, but do you think the man feels a bit the worse for having been a pauper in the intervening period?

1428. We are assured that sentiment has some effect in these matters, and it is more a question of classification of the patient at the different stages; but this seems a kind of chrysalis stage through which the patient must pass with the character of poverty attached to it.—If you were to get run over as you left here you would be taken to Lambeth Infirmary and you would be a pauper.

1429. So I am informed, and you know I rather resent the idea. That is a very good illustration of it. Suppose I became mentally afflicted just now I would at once become a pauper, would I?—Not at once. You would be removed to the institution first.

1430. I would be taken to Lambeth and there I would receive the attention of the Medical Officer, would I not?

Sir Ernest Hiley: If you were a mild case

1431. *Chairman:* Let us assume the worst! Let us assume I am a violent case: I would be removed to Lambeth, where I would be dealt with by the Medical Officer there?—Yes.

1432. He is a person whose salary is paid out of public moneys, and I would then be receiving treatment at the public expense. I would then be detained until my case is dealt with, and during that time I am treated as a rate-aided case?—You are treated as a case. The only kind of case they have got is a rate-aided case.

1433. But the statute says that any person who receives medical treatment from a public authority is to be regarded statutorily as a pauper?—Yes.

1434. It seems rather a matter of machinery. The question is whether it is possible to rearrange the terminology?—Is it not possible simply to remove that section from the Act?

1435. That sounds attractive, if that would achieve the object?—It is only the question of a name.

1436. It does appear essential, of course, in emergency cases, that there should be public machinery, and therefore rate-aided machinery, to deal with such cases from whatever source they come. The whole point seems to be that once resort is made to the rates for any purpose, the person who benefits by that expenditure is regarded statutorily as a pauper?—He is statutorily a pauper, but I do not think anybody regards him as one.

1437. I should have said rather, that he is defined as a pauper by the statute.

1438. *Earl Russell:* And has been a pauper even if he repays the costs?—Yes, certainly. It is merely a question of draftsmanship.

1439. *Chairman:* It is a question of nomenclature, is it not?—Yes.

1440. *Mrs. Mathew:* How many women Inspectors have you got, Mr. Francis?—Six, I think, at present.

1441. And what sort of class are they?—They have been nurses and assistant matrons.

1442. Another thing I wanted to ask you about was the reception of lunatics. Are these two classes mixed? I mean the Section 26 cases and Section 24 cases?—There are no cases under Section 26 at the present time.

1443. But I understood that there were a lot at the workhouses?—They have chronic cases in them.

1444. That is what I mean?—I am sorry, they are not technically Section 26 cases.

1445. I beg your pardon. Are they mixed together—those two classes of lunatics?—They may be; it depends upon what accommodation there is and what numbers there are.

1446. Does that often happen?—I should not say so.

1447. When there is an inquiry or a need for an inquiry as to ill-treatment, do we understand that it starts with the guardians, goes on to the Board of Control, and can go up to the Minister of Health?—No. As far as the Poor Law is concerned the

Board of Control, with no disrespect to them at all, come in if we ask them to.

1448. It is just you and the guardians, and lastly the Board of Control. I just wanted to know what the procedure was?—Yes.

1449. *Sir Humphry Rolleston:* I have two questions, Mr. Francis. The first one is with regard to the reception of lunatics in the workhouse infirmary, some of which are most admirable buildings now. I understand that the policy is to retain permanently there only a certain class of chronic lunatics, but is it not the fact that in practice it is a great advantage, and that that advantage is considerably employed, to take in acute cases for the time being?—There are two advantages, I think, alleged for that. One is that you can go to an infirmary for a number of different reasons. There is only one reason for going to an asylum. The second is that a considerable proportion of these cases on their way to the asylum will recover in the infirmary and never get on to the asylum.

1450. And that is taken very considerable advantage of, is it not?—Yes.

1451. The point I was leading up to was this: I think you rather gave us the impression that there were no special arrangements for such acute cases. Is it not true that there are rooms which are protected or padded?—Certainly.

1452. So that in a way they are very well provided for?—I think so.

Sir Humphry Rolleston: I am not sure whether the Chairman would rule out of order the other question I wanted to ask, but I should like to know whether I could bring it in as bearing on the care of the lunatic. That is with regard to the superannuation under certain circumstances of superintendents and medical officers of asylums and workhouse infirmaries—whether the power exists in the Ministry of Health to initiate the premature superannuation of an officer who, perhaps from illness or from premature age, is no longer so capable as he was when he was appointed. Does that question bear on the care of the patient?

Chairman: I think myself that we should not be pedantic in construing our Terms of Reference. Your question does seem to have a bearing upon them because it relates to the efficiency of the staff. Personally I should welcome your putting the question, Sir Humphry.

1453. *Sir Humphry Rolleston:* If I might do so, the question I wanted to ask was as to whether circumstances do arise in which a most capable medical officer or superintendent does become, before the time that he should be superannuated, not quite up to his work? I am speaking of both asylums and of Poor Law institutions?—Asylums would not concern us at all; that is a matter for the Board of Control. Perhaps I might say that you ought to put that question to the Board of Control.

1454. As far as Poor Law institutions are concerned, of course there are cases of that kind in which the Ministry could initiate the movement for a man receiving his pension prematurely?—Yes, I think you might say that the Minister might initiate the movement. It would rest with the guardians and the officer, but it sometimes happens when it is wanted to happen.

1455. But the Minister could set the ball rolling?—It might happen and does happen.

1456. Is it within his power to do so?—It is in his power to dismiss any officer of a Poor Law authority.

1457. I do not mean dismissal?—I meant that is the ultimate sanction under which he might possibly act. If it is in your power to dismiss a man, it is in your power to suggest that he might usefully and wisely go.

1458. *Sir David Drummond:* Do you concern yourself with the qualification of the medical officer to look after patients in Poor Law institutions? Have you anything to do with the appointment of medical officers?—No, there is no formal requirement as to what his qualifications should be, but our Medical

21 October, 1924.]

MR. ERNEST JAMES LIDBETTER.

[Continued.]

Officers do advise the guardians on questions of that kind very largely.

1459. But you do not interest yourself in the appointment of him? You have nothing to do with the appointment of a medical officer?—The appointment of a medical officer requires our sanction if the guardians propose to pay him a salary higher than his predecessor had received.

1460. Only to that extent?—Yes.

1461. *Sir Ernest Hiley*: He is not subject to your approval, then?—Except in so far as we can in the last resort dismiss him.

1462. Suppose the guardians want to appoint a new medical officer; does their appointment require your approval?—Not now, unless the salary is higher than the previous salary.

1463. Then really the qualifications and attainments of the man appointed are not known to you until you have had experience of his work?—Not officially, but our Medical Officers would very often be consulted by the guardians before they proceeded to an appointment.

1464. If he proves unsatisfactory then you have power to dismiss him, although you have no power to sanction the first appointment?—We had power to sanction all appointments, but we modified our regulations recently.

1465. You did that; it was not done by Parliament?—No.

1466. Just one question about the inquiry by the guardians which turned out to be an abortive inquiry: Was the inquiry initiated by the guardians?—I am afraid I have not the actual papers here. I could give the Secretary a note of the case.

(*The Witness withdrew.*)

(*After an adjournment.*)

MR. ERNEST JAMES LIDBETTER, called and examined.

1474. *Chairman*: Are you President of the National Association of Relieving Officers?—Yes.

1475. And are you General Relieving Officer of the Parish of Bethnal Green?—Yes.

1476. You are good enough to attend here to-day to give evidence on behalf of the Association?—That is so.

1477. Your Association, I take it, is representative of the relieving officers of England and Wales?—Yes; we represent about 60 per cent. of the eligible members, many of the others being in remote districts where no association could survive.

1478. We may, therefore, take your evidence as representative of the views generally of the relieving officers of this country?—Yes; and supplementing that I may say that we have eleven branch associations, and, as far as possible, their suggestions are embodied in the memorandum now before you.

1479. It is desirable that the Commission should know the part you play in the administration of the Lunacy laws of this country, and perhaps you will be good enough to devote your evidence to that aspect. You have, have you not, as a relieving officer, certain duties to perform under the Lunacy Act?—Yes.

1480. Will you tell the Commission how you are appointed?—We are appointed by the boards of guardians, who recommend the appointments to the Ministry of Health, and the latter body sanctions the appointments.

1481. Are the appointments made on competition, or how?—Generally an advertisement is issued, and the candidates appear before the board; a certain number of candidates apply for the appointment, a smaller number is required to attend the board, and a vote declares who is the successful applicant.

1482. What sort of qualification is required in a candidate?—None at all, unfortunately. In recent years we are doing what we can to establish a certificate of efficiency, which is now being given by the

1467. Do you know whether it was an inquiry with evidence on oath?—It would not have evidence taken on oath.

1468. After the result had been so unsatisfactory, did the Ministry allow the matter to drop, or did they go on with an inquiry of their own?—We did not hold any further inquiry, on the ground that we could not see any possible advantage to be got from it.

1469. Then really the cause of the patient's injury remained undiscovered?—Yes.

1470. *Earl Russell*: And you considered that, although inconclusive, the guardians' inquiry had been properly conducted?—Yes, or we should certainly have held one.

1471. *Chairman*: Just one other question: There is no requirement, is there, that the medical officers of workhouses who have in their charge mental wards should have any special qualifications?—No. An attempt is being made in a few cases to secure a consultant alienist.

1472. Take the case of the institutions under the Metropolitan Asylums Board, which are devoted exclusively to mental cases: are they under the charge of specialists?—I do not know what their qualifications are, but they are certainly specialists.

1473. You have been good enough to append to your *précis* a very useful little summary of the powers that were transferred to the Minister. I propose, if you agree, that we should print that as an appendix?—If you please.*

Chairman: It is a very useful reference to the sections of the Acts of Parliament. Thank you, Mr. Francis.

Poor Law Examinations Board, a voluntary organisation which has been in existence for about 25 years; but, with the exception of the possession of that certificate, there are no qualifications.

1483. The guardians consider the suitability of the applicant after an interview, and the reading of testimonials as to character, and so on?—Yes, and past experience, as shown in the application.

1484. Being established as a relieving officer, a person has at once to acquaint himself with the statutory duties, I take it, and he has certain functions to perform at different stages in connection with the administration of the Lunacy laws?—That is so.

1485. It would be useful, I think, if you told us what are the duties of the relieving officer under the Acts of 1890 and 1891?—Every relieving officer must take action under the Lunacy Acts if he has knowledge (a) that any person within his district not a pauper and not wandering at large is deemed to be a lunatic and not under proper care and control, or is cruelly treated or neglected. That is under Section 13. Or (b) that any pauper resident within his district is deemed to be a lunatic. That is Section 14, Sub-section (2). Or (c) that any person wandering at large within his district is deemed to be a lunatic—that is Section 15.

1486. The initiation of any step appears there to be left with the relieving officer in the cases you have mentioned?—The initiation is, subject to what takes place, to bring the matter to his knowledge.

1487. But he is the first functionary, so to speak?—Yes, he is the first functionary.

1488. We have heard a good deal already with regard to the operation of Section 13—is that a section under which in your experience many cases are dealt with?—No; nearly all the cases with which a relieving officer deals come under Section 14—Section 14 for process, and under Section 16 for certification. If I may say so, Section 13 is a rather misunderstood section in many respects; Sections 4 to 8 have already

* See Appendix VI.

21 October, 1924.]

MR. ERNEST JAMES LIDBETTER.

[Continued.]

described the processes by which a non-pauper person may become a lunatic, and under these sections process must be taken by the relative, a step which ultimately results in the alleged lunatic being taken to an asylum. That is a duty which would be repugnant to a large number of people, and I think Section 13 contemplates three classes of case; one, where the relatives feel that the duty is so repugnant that they would defer taking action until the point of danger has been reached; secondly, where they flatly refuse to perform the duty; and a third class of case is where the lunatic has been left in the care of friends as a patient and is cruelly treated or neglected, so that it is necessary for someone to interpose. It is necessary for an official to act in all those cases, and the machinery is provided for that purpose generally.

1489. It is rather a remarkable section, for it expressly deals with persons not paupers, and the relieving officer is brought in to deal with them?—It is remarkable in that respect, and also in that you commence with a non-pauper and finish by sending him to an asylum as a pauper lunatic.

1490. We have had evidence that Section 13 in some places is taken advantage of quite largely?—Yes, but that, I think, is due to the misunderstanding I have referred to, in this—that the expanded definition of “pauper” which you get in Section 18 is not generally accepted. If you refer to Section 18, it provides that “A justice shall not sign an order for the reception of a person as a pauper lunatic into an institution for lunatics, or workhouse, unless he is satisfied that the alleged pauper is either in receipt of relief, or in such circumstances as to require relief for his proper care.”

1491. Yes, that is prospective?—Yes. The definition section defines a pauper as a person in receipt of relief, and here you have an expansion of that term which enables you, where a case is brought under Section 13, to look into the future to see if it is a pauper case, and to act in that sense.

1492. I think you put it very strikingly when you point out that though you begin with a person who is not a pauper, the result is that under the section he is converted into a pauper?—Quite. While he is earning he supports himself; directly his liberty is restricted he becomes a pauper.

1493. Because he is a person who requires a relieving officer's care?—Yes.

1494. And then by the definition it dubs him a pauper?—Yes, and automatically the section lifts him out of those three categories I have indicated.

1495. In your experience, then, resort has not been frequently had to Section 13?—No.

1496. It has been put to us that it provides an intermediate procedure between the case of a private person and a pauper case?—I think it is so used a good deal in certain areas, but that has not been my experience. I think restriction to the three classes I have referred to is its proper sense. If the relieving officer is called to a case where there are sufficient means to make the case a private case, if he talks the matter over with the relatives he generally persuades them to present a petition, so that action under Section 13 is not necessary at all.

1497. One is struck on reading this section with the phrase “the relieving officer has knowledge.” He will have knowledge (a) in respect of a pauper actually in receipt of relief outside the workhouse by notice from the medical officer under Section 14, Sub-section (1), or otherwise under Section 14, Sub-section (2). The first sub-section contemplates a case which is already under the care of the medical officer, and he will give the relieving officer notice, but that case very seldom arises; under Sub-section (2) to Section 14, the relieving officer is to act, whether he has had notice “or otherwise,” and then within those last two words the relieving officer gets intimation of cases.

1498. But we are dealing here under Section 14 with paupers—Sub-sections (1) and (2) both deal with pauper cases?—Yes, I think in the wider sense of

Section 18, to which I have already called your attention.

1499. One would naturally assume that under Section 14, if a person is a pauper, he is already, so to speak, under the supervision of an authority, and that his condition would necessarily come to the knowledge of the medical officer?—Quite.

1500. But you say that is not so necessarily?—No. A very large number of the cases are brought under the second sub-section; that is, cases brought to notice by relatives or other persons.

1501. How does the case of a person who has the misfortune to be so afflicted come to your notice—how is it done in practice?—In practice, in the great majority of cases the nearest relatives have consulted a medical man, who sends them to the relieving officer with either a written intimation or a verbal statement that observation is necessary. In that way the majority of cases come to notice, but there are a fair number of cases which come without reference to any medical man at all.

1502. You have an office, I suppose?—Yes, every relieving officer has an office, and the place would be well known in the district, and where he is to be found.

1503. You have said your notice may be served under Section 14, and then you might also get notification of cases from the medical officer of an institution?—Yes, that would be under Section 24, Sub-section (6).

1504. Where people are already in an institution?—Yes. It may be that he is a permanent inmate of a workhouse in the normal sense, or it may be with regard to people who have been admitted to the hospital where the relieving officer has been doubtful whether it was a mental case which it was proper for him to handle.

1505. The intention of notifying you under Section 24, Sub-section (6) is really to get your services in order to have the insane person removed from a workhouse to an asylum?—Yes, it is an inside supervision; outside the workhouse the relieving officer would always be able to initiate proceedings on the ground that the person is not under proper care or control, but I think there would be a presumption of law that a person already in an institution is under proper control, and Sub-section (6) requires that the notice should say, not that he is not under proper control, but that he is a person proper to be sent to an asylum.

1506. Then your services as executive officer are invoked by the medical officer of the institution?—Quite, and that notice from the medical officer throws us back at once to Section 14, Sub-Sections (2) and (3).

1507. Then you have occasions on which relatives directly bring a case to your notice, which you have already told us about?—Quite.

1508. When you are made aware of a case, what is your procedure?—The usual procedure is for the relieving officer at once to visit the alleged lunatic.

1509. You have ascertained from the person who has given you the information about the case where the alleged lunatic is?—Yes, and we take such statement as the person bringing the information is prepared to give. If it is a husband or a wife, they will tell you of things which have happened as between the parties, which enables the relieving officer to form some opinion.

1510. Then having got such information as your informant can give you, is your first step to go and see the person concerned?—The first step is to go and see the person concerned.

1511. And you may find him either in his own home or possibly in an institution?—Yes.

1512. Then when you see the alleged lunatic, what do you do?—The rule is for the relieving officer to talk to the lunatic and satisfy himself that he is a case to deal with. On that point I ought to say that the relieving officer regards himself as having a certain amount of discretion. The sections of the

21 October, 1924.]

MR. ERNEST JAMES LADBETTER.

[Continued.]

Act may perhaps read in an imperative sense, but the relieving officer does not always hold himself bound by that. For instance, the information that is brought may be brought by some prejudiced person. Many of them are the result of family quarrels, little drinking bouts, and so on, and the officer must exercise some discretion with regard to that. For instance, in two cases in my own experience wives have come to the office and given notice that their husbands are mentally affected, but the relieving officer who has investigated the case has come to the conclusion that the person who has given the information is really the person afflicted, and in two cases the person giving the information has been sent to the asylum, and the other parties have not. In one case both parties were sent. So that a relieving officer has discretion.

1513. He may find out that the complaint is a bogus complaint?—Quite so; or he may find out that there has been a family quarrel, and more particularly must he exercise his discretion in those circumstances if one of the parties has been in an asylum before.

1514. If, on the other hand, you find the case is an appropriate one for further investigation and procedure, what do you do next?—The relieving officer almost invariably removes the case to the workhouse under Section 20. In all urban areas that is the practice. It is not a rule which is absolute, but in nearly every case it is so.

1515. The Statute contemplates that removal to the workhouse shall take place if it is a matter of urgency, but do you generally do so?—It is generally done, and it has been ever since the Act of 1890 was passed.

1516. That is a physical act—you remove the person, if there is a *prima facie* case, to the workhouse?—Yes.

1517. *Earl Russell*: Do you remove them by ambulance?—It is always done by ambulance, or if you cannot get an ambulance you use anything that comes along—a cab; and in the case of females there is always a female attendant.

1518. *Chairman*: Then the person is received into the workhouse, and I suppose up to this time you have no warrant of any kind?—No, no warrant of any kind.

1519. And the patient is handed over to whom—the master of the workhouse?—Yes, or his staff; in most cases he is taken direct to the mental ward, and a notice is served on the master that the case is brought under Section 20, which, of course, binds the master to retain him.

1520. What would be done in a case where there is no mental ward?—In nearly all urban areas there is some sort of accommodation in the workhouse, though it is not always the best accommodation. In rural areas it may be there is not, and in those areas the case is generally certified and taken straight off to the asylum.

1521. You have disposed of the person of the lunatic; now what legal steps do you take to legalise the position?—We notify the justice.

1522. And I think for this purpose your notification must be to a judicial authority, must it not?—If the case is one under section 13, then it will be to a judicial authority. Shall I take section 13 first? In that case notice is given to a judicial authority; the judicial authority will then appoint two medical men to examine the lunatic. The judicial authority is to proceed in the same way as if a petition had been presented; that is Section 13, sub-section (2).

1523. We have on our notes already a pretty accurate description of what happens on a petition, so we will not deal with that. But the difference arises here, I think, that it does not require the judicial authority to visit the patient?—No, he is not bound to, but he may.

1524. On making the order, assuming him to be satisfied with the result of the certificates of the two medical men, I do not think he is required, to state whether he has himself seen the patient or not?—I think he need not say that in the order.

1525. He gets on the lines of the normal procedure?—Yes, quite. The only other point where we differ

from the petition process is that, if he makes a reception order, the lunatic is to be sent to any asylum to which, if a pauper, he could be sent.

1526. In contradistinction to the case of a private patient who may be sent to a private house?—Quite, and then finally the relieving officer is to remove the lunatic to the institution named in the order. There is one point there I should like to mention with regard to the order made on petition, which is the parallel to this case, which does not require the removal of the patient to the asylum. It is a mere authority to remove the patient; but the order made under Section 13 or under Section 16 or under Section 23 provides that the patient is to be removed by the relieving officer. Under those three sections there is a directory order, but under the process on petition it is mere authority to do a thing.

1527. Under the process on petition, who actually does remove?—I take it the relatives would; I think as a rule those arrangements are made by the institution about to receive.

1528. If the patient in question is in a workhouse, which seems to be the normal case, pending these proceedings, do you then take the person from the workhouse to the asylum which is mentioned in the order?—Yes.

1529. And on handing over the person to the custody of the asylum your functions are at an end, are they?—So far as the person of the lunatic is concerned, but we may still have to manage part of his affairs; so far as he is personally concerned we have finished with him.

1530. You know we are especially interested here in safeguarding that persons shall not be taken to and confined in asylums without proper precautions. This procedure you have been describing would appear to exhibit these points at which the person is protected—there is first of all the fact that the relieving officer at once sees the person alleged to be insane?—Yes.

1531. Do I gather from you that a certain number of cases are eliminated at that point as being cases of no importance?—Yes.

1532. The next safeguard appears to be the medical examination by two medical men?—Quite.

1533. Coupled with the judicial authority's right to see the patient if he pleases?—Quite.

1534. And in those cases if the judicial authority has not seen the patient, will the patient have the right within a short time of admission to demand to be confronted with another judicial authority?—I think Section 8 applies to that case as to a case on petition.

1535. One wants to see at how many points in the course of the proceedings the unfortunate person may be examined by independent persons?—There are two other points beyond those you name—the first is that the relieving officer very seldom acts on merely seeing the lunatic; he is taking the statements of near relatives and friends as well at all stages; and further than that, the judicial authority is empowered to make such further inquiries as he thinks proper if he is not satisfied, and in many cases he does that.

1536. Are you, so to speak, a participator in those proceedings before the judicial authority?—Yes, the relieving officer is in attendance always.

1537. In fact you are very much in the place of a petitioner?—Yes. The only difference between this process and the petition is that instead of the petition you have a sworn statement of the relieving officer, because under the section the statement of the relieving officer must be a sworn statement.

1538. That is Section 13, which you say in your experience is not very frequently used?—It is not very frequently used.

1539. But Section 14 is your normal procedure, I take it?—Section 14 is our normal procedure.

1540. Will you tell us what you do there?—Under Section 14 we give notice to a justice of the peace within three days; that is under Sub-section (2).

21 October, 1924.]

Mr. ERNEST JAMES LIDBETTER.

[Continued.]

1541. That need not be a judicial authority?—No, it may be any justice. The judicial authority is a person without limits to his area of jurisdiction; a justice of the peace must have authority in the place where the pauper resides.

1542. You give notice to him within three days of the facts coming to your knowledge?—Yes.

1543. And in the meantime the patient may well be in the workhouse?—Yes.

1544. What happens next?—We bring the justice to him—the justice of the peace has to appoint a medical man to examine the lunatic, and to fix a time within three days to so examine him.

1545. One is struck at once here with the fact that one medical man alone is required, but, on the other hand, the justice of the peace must actually see the person in question—can you suggest any reason for this difference of procedure in the two cases?—No, I cannot, and I have never been able to understand the difference, and may I point out that under the head of recommendations we are suggesting that there should be no difference in the two processes.

1546. Simplification of procedure, you think, in these matters is very desirable, provided proper safeguards are maintained?—Yes. There are other differences between private and pauper cases of considerable importance. May I enumerate those differences? The non-pauper will be certified by a judicial authority; the pauper by a justice of the peace—any justice of the peace having jurisdiction. The non-pauper will have two medical men to examine him, that is to say, two medical certificates, each signed by a different man, and the pauper only one. The non-pauper need not be seen by the judicial authority signing the certificate, but the pauper must. The relieving officer in the case of the non-pauper proceeds by information on oath; in the case of the ordinary pauper he simply tells the justice he has a case. Then finally in a non-pauper case if a reception order is not made, the documents must be sent to the Board of Control, and the justice must state his reasons for not making an order in writing, but in the case of a pauper he simply takes no action, and the matter ends there.

1547. *Earl Russell*: If the justice makes no order?—If the justice makes no order, the matter ends.

1548. *Chairman*: Do you then go back to the workhouse where the man is temporarily detained and tell him to go?—Yes, on the justice intimating that he will make no order there is no further power to detain the man any longer, and he is discharged.

1549. If, on the other hand, the justice is satisfied on the one medical certificate, plus his own visit, he will then pronounce an order?—Yes.

1550. Are you then armed with this order, and do you carry out your executive function of conveying the person from his home or from the workhouse to the asylum?—Yes.

1551. And there your functions are at an end?—As far as the person of the lunatic is concerned.

1552. In working the Act have you discovered any reason for this differentiation of procedure you have mentioned?—No, and we are unanimous there should not be this distinction, bearing in mind the very thin line which in many cases divides the pauper from non-pauper cases.

1553. Of course, unnecessary elaboration of procedure makes mistakes more likely?—Quite; and you will observe, too, if the case is one for the detention of the lunatic in the workhouse he has to have the benefit of two medical certificates.

1554. I think we have not dealt with the case of the lunatic wandering at large?—Yes. There, under Section 15, if the relieving officer has any knowledge that a person wandering at large is deemed to be a lunatic he can apprehend him and take him before a justice.

1555. In this case you do not take him to the workhouse?—We do, as a matter of fact; we put Section 20 into operation and so bring him into line with the other cases.

1556. Then, again, in your experience there is no need for a specialised code applicable to the lunatic wandering at large?—No. Section 15 is redundant in practice, because cases arising under it are invariably dealt with under Section 20.

1557. The classification of the persons you have to deal with according to their circumstances does seem a little arbitrary. The lines of demarcation among the various classes—a person who is to be deemed a lunatic and wandering at large, and a person who is not a pauper and not wandering at large, but is not under proper control, or who is being ill-treated, and a pauper who is brought to the knowledge of the relieving officer as being a lunatic—are not very clearly drawn, are they?—No, and the relieving officer gets over that difficulty in two ways, first by the application of Section 20, and second by the words to which I have referred in Section 18. He draws a distinction between the man who has means for his maintenance as a private patient and the man who must be, if he becomes a lunatic, maintained at the public charge.

1558. In practice would there be any difficulty in all the cases being dealt with by the relieving officer, followed by two medical certificates; in short, a uniform process applicable to all reception orders?—None at all; that, in fact, is what we recommend a little later.

1559. Simplification, of course, is one thing, but would that simplification in your view reduce the safeguards in any way?—It would not, subject to some clear understanding as to what is to happen when you have two medical men not in agreement.

1560. But would it lessen the safeguards or not?—No, I do not think it would lessen the safeguards.

1561. We are concerned to maintain all the safeguards, and when one finds a statutory provision in an Act one assumes it to be of some value; but do you find in practice that there is no special virtue to be found from the point of view of protection of the public in the differentiation of the procedure?—No, I see nothing in that.

1562. I should have thought in a case where you have two medical certificates, you have probably more protection than you would have in a case where there is one medical certificate only, plus the compulsory visit of the justice?—No, I should not think that; I think one medical man plus the justice would be as good as the certificates of two medical men and no justice.

1563. Then you attach importance, do you, to the lay magistrate seeing the patient?—Generally I do, and bearing in mind the possibility that the medical men will not be in agreement; and I ought to mention that that is one of the practical difficulties under Section 13, where two medical men are called in and do not agree. Now what procedure is to be adopted? The section, to my mind, limits the powers of the justice of the peace to two medical men, but in several places I know it to be the practice that if the two medical men do not agree they call in another one—they may call in another medical man and take the opinion of the majority of the three; or if the justice of the peace feels the man is a lunatic—it may be a matter of mere observation, or it may be a matter of prejudice—but if he feels the man is a lunatic and if he may employ more than two, he may bring in all the doctors he can, until he finds one who will be in agreement with his views. That is one of the difficulties which practical men have under this Act—does the section limit the justice of the peace's action to the certificates of two medical men?

1564. I should have thought if two medical men called in by the justice found themselves in disagreement, he might well think it a border-line case, and that the case would necessarily collapse because the requisites for the order did not exist?—I should have thought so, too, but I know it to be the practice in many cases to call in extra medical men and to take the opinion of the majority.

21 October, 1924.]

MR. ERNEST JAMES LIDBETTER.

[Continued.]

1565. I do not see any justification for that in the Statute?—No, I see nothing at all in the Statute to justify that. It seems to me the intention of the Statute is this, that if two medical men cannot agree then the case is not so bad as to be sent to an asylum.

1566. I should have drawn the same inference myself.

1567. *Sir David Drummond*: Why do you put the justice's opinion before the opinion of the doctor?—Only because he is the deciding authority.

1568. But his knowledge of the subject will not be equal to that of the doctors?—Quite; I agree; but a justice refusing to make an order when the doctor says the case is one for an order would be taking risks.

1569. *Chairman*: Of course, in a private case you may have the two doctors and the magistrate visiting the case also, but not necessarily?—Quite.

1570. But as a safeguard you rather express a preference for the one doctor plus the justice seeing the patient rather than the provision of the two medical certificates and no visit?—I should prefer to see two doctors and the justice.

1571. That is the ordinary procedure?—That is the ordinary procedure. I think I might put it in this way: I think no reception order should be made without the justice who signs that order seeing the case.

1572. That is your view?—That is my view, and I would add to that that I think two medical certificates are better than one.

1573. But I can quite understand you think from the public point of view the actual seeing of the patient by the committing magistrate is very important?—I do.

1574. *Sir David Drummond*: At present, supposing there are two doctors seeing the patient and one does not agree with the opinion of the other, and the justice gives an opinion which agrees with that of the one doctor who is prepared to certify, would you therefore conclude that the justice has a right to sign the order?—No, not without the two certificates.

1575. *Chairman*: The two certificates must be concurrent?—Yes. In my submission, if he calls in two doctors and they are not in agreement the patient is entitled to his discharge.

1576. I think what you were anxious to bring out was that you would rather have a justice make an order regarding the patient he is dealing with, with the assistance of one doctor, than have a justice relying on the opinion of two doctors as to the condition of a person he may not have seen?—That is so.

1577. But you regard the most perfect method as being to have a justice with two doctors' opinions?—Yes, especially if that could be developed in association with a system by which the justice of the peace should be an experienced person.

1578. *Sir David Drummond*: But supposing the doctors disagreed?—Then if the doctors disagreed the patient should have his discharge.

1579. *Earl Russell*: By Section 13 the justice is not bound by the medical certificate?—There is no section of the Lunacy Act which requires a justice to make an order.

1580. *Sir Ernest Hiley*: Have you ever known of a case in your experience where the justice has dealt with a man wandering at large?—No, not in my experience, but I know at least of one place in London where it is the practice to call in another medical man.

1581. *Chairman*: But you gave us a picture just now of a justice perambulating the country in order to find a medical man who would agree with one of the two medical men, because the justice himself was of a certain way of thinking?—Yes, I was rather attacking the system which permits a justice of the peace to wander beyond what I regard as the proper conditions of the Statute.

1582. But I understand you do not suggest such a thing has happened?—No, I do not know that it has ever occurred.

1583. You merely point out what might occur?—Yes. If he may call more than two doctors, why not any number? I know it occurs that they sometimes call in a third doctor.

1584. But even for that there appears to be no statutory warrant?—No authority at all.

1585. And your view is, and I think it is a correct view, if I may say so, that if there are not two concurrent certificates as to the case in hand, the justice, although he has power to deal with the case, would not, or ought not in practice to pronounce an order?—I agree.

Earl Russell: There is an important point in this, namely, whether if there are three certificates the whole of them are brought before the Board of Control?

1586. *Chairman*: Yes. (*To the Witness*): Supposing there is a third certificate, would the Board of Control be provided with all three opinions, or with only the two opinions which prevailed?—I cannot tell you. Of course, it is provided by the Lunacy Act that the medical certificate shall be exhibited to the order in every case. In the case we are referring to, the order only provides that the positive certificates should be put in. I do not know, but possibly the medical man who does not agree would not sign a certificate at all, because the form requires a statement that the person is a certified lunatic. If the case is under Section 13 and no order is made, all the papers must go to the Board of Control, and there must be a statement that a certificate has not been given.

1587. There cannot be a negative certificate, can there, but there may be a refusal to give a certificate?—There is, and in that case no document is signed at all—the medical man simply says, "I will not certify," and nothing is done.

1588. *Earl Russell*: Is it merely because no document is signed that the fact has to be reported to the Board of Control?—No; Section 13 requires the reasons for the refusal of the order to be sent to the Board of Control.

1589. I am assuming the case where an order has been made on the opinion of a third doctor?—I cannot tell you what happens there—I have no information.

1590. *Chairman*: Of course you can conceive three doctors investigating a case and two of them being of opinion that the case was certifiable, and that they could sign a certificate, while a third might say, "I do not agree with the views of my colleagues." In that case there would be in existence two certificates which would be utilised as the basis of an application to a justice, and he would proceed on them, but he would not know that a third medical man had been called in?—He would under Section 13, because he appoints them.

1591. And you rather suggested that he would know the views of the people he had invoked. But if he had only called in two medical men and one said he could certify and the other that he could not, in that case he would dismiss the application?—Yes.

1592. But there is the other case—if he said, "I shall go further, and see a third person"—has that ever happened in your experience?—Never in my experience.

1593. To what extent has such a practice obtained, do you think?—I know of one place in London and I know of one place in a large city in the North where it happens, and I have asked in the last few months, in discussing the matter with my colleagues, and been surprised to find in many cases that it is considered a proper practice.

1594. *Sir David Drummond*: Supposing the justice sees a patient and that there are two certificates, but only one is effective, what happens?—Then in my submission he cannot make the order.

1595. But is it not strange that in the other case only one certificate is necessary, because it seems to me it all turns on the discretion of the doctors?—Quite so.

21 October, 1924.]

MR. ERNEST JAMES LIDBETTER.

[Continued.]

1596. *Chairman*: I take it the main trend of your argument is in favour of a simpler and more uniform method of dealing with all the cases?—Quite, and we are unanimous as an Association in recommending that there should be one method.

1597. And the adoption of one method would not in your view lessen the safeguards of the public?—No, I do not think it would do that.

1598. There are one or two small matters of detail which I want to deal with. There is provision made, is there not, for one relieving officer being specially designated to perform the duties under the Lunacy Acts?—Yes, that is contained in Sub-section (2) of Section 2 of the Act of 1891.

1599. As regards the actual conveyance of a lunatic to an asylum, that would be after an order has been pronounced?—Yes.

1600. And you may employ someone to do that?—Yes, and it is the common practice to do that now. That section, I think, has no virtue from the certification point of view; it is simply a provision to enable the relieving officer to remain in his district. Formerly the relieving officer had to leave his district, and that was held to be undesirable, and so this provision was made.

1601. You have been dealing with the person of the lunatic up to this point—have you also some responsibility with regard to the property of the lunatic?—Yes, there are duties as regards property, and then there are duties as regards settlement and legal chargeability and such like matters.

1602. I do not think we need go into that at length, because we are really not concerned with it.—I was just putting that in to complete my statement. Again, if the patient is discharged from the asylum the relieving officer may be required to bring him home, or if during the period of his detention he is transferred from one institution to another, the relieving officer is the proper person to make that transfer.

1603. Your aid seems to be invoked whenever anything executive has to be done?—Yes.

1604. As regards the lunatic's property, which may have some bearing on our inquiry, I think under Section 132 you have certain powers and you may take possession of the property of the lunatic?—Yes, that is so.

1605. I suppose in such cases you would see to the application of the moneys of the person for his benefit?—No, we should only seize so much of the property as might be necessary to recoup the guardians for the cost of maintenance, or to meet expenses—we have no power with regard to the management of the estate of a lunatic—it is simply a power to recoup the rates the amount of the necessary expenditure.

1606. You do not administer the estate in any way? No, we have no power to do that.

1607. I see under Section 66 of the Act of 1890 where the visitors make an order for the removal of a pauper lunatic they may require the relieving officer to execute it?—Yes, that is so.

1608. Having given us this account of the existing law and procedure, we should be glad if you would draw our attention to any difficulties which you find in carrying out your work.—I should first like to call your attention to the ambiguity of the language of Section 20.

1609. That is with regard to the detention for three days?—Yes. That is the section which is now generally put into operation for removing a lunatic to the workhouse, and his detention. The Act provides that: "No person shall be so detained for more than three days, and before the expiration of that time, the constable, relieving officer, or overseer shall take such proceedings with regard to the alleged lunatic as are required by this Act." Now what is really meant by that section, and what will satisfy those words, "No person shall be so detained for more than three days"? Then the relieving officer, having put Section 20 into operation, is thrown back to Section 14, under which he is to give notice to the

justice within three days. Now the justice is to appoint a time within three days from the time he receives the notice from the relieving officer.

1610. It comes to this, of course, that you cannot complete the proceedings which you take within the three days of detention?—Quite.

1611. But may I suggest that "No person shall be so detained for more than three days" means before the expiry of the three days you must set in motion the procedure?—If that satisfies the requirements of the Statute we should not feel a difficulty.

1612. You have a right of detention for three days. Within that period you will have set in motion a certain procedure contained in an earlier section. These proceedings would take more than three days, no doubt, and what authority have you for any detention after the three days have expired—do you get some further authority?—We only get further authority by resorting to Section 24.

1613. There the medical officer of the workhouse comes in?—Yes, we go to the medical officer of the workhouse and say, "We have not been able to deal with this case within three days. Will you therefore give a certificate under Sub-section (1) of Section 24?"—But there the practical difficulty is this, that the medical officer for the purposes of Sub-section (1) of Section 24 has got to say that the person is a proper person to be allowed to remain in the workhouse.

1614. And he has also to certify that he is a lunatic?—He has also to certify that he is a lunatic, and then he has to say that he is a proper person to be allowed to remain.

1615. *Earl Russell*: He has to say a lot of things which might not be true?—Yes.

1616. *Chairman*: And he has, as it were, to pre-judge the issue?—Quite. May I say at once that the general view of Section 20 in regard to certificates is that it gives a maximum of three days which you have to get the justice in, and that, of course, deprives the justice of the three days which Section 14 gives him. Section 14 says that the justice is to have three days in which to appoint a time.

1617. *Earl Russell*: What do you actually do in practice?—In practice we run round to the justice and beg him to come within the prescribed time; but here is the difficulty—the Act is based on the assumption that he can call in any medical man who can look at any patient whom he has never seen before and decide out of hand whether he is a lunatic or not; but experience has shown that considerable periods of observation are necessary, which Section 20 will not permit. Therefore we have to resort to Section 24, Sub-section (1).

1618. *Chairman*: We shall no doubt hear a great deal with regard to the desirability of having an intermediate stage in dealing with an insane or an alleged insane person before an absolute detention order is pronounced, whereby there may be a period of observation. I suppose some of your difficulty would be removed if there was a provision made for all cases to be detained for a time provisionally for observation?—Yes.

1619. Because, of course, if that provisional order ran for a month or three months or whatever period, during that time of investigation or observation the necessary steps could be taken and permanent orders obtained if necessary?—Yes.

1620. It does appear, however, that you are confronted with a very sudden determination under these sections—you must act very quickly in a matter of very grave importance.—Yes. In practice it resolves itself into this, that the three days limit imposed by Section 20 is often extended to something over 20 days or more. Under Sub-section (1) of Section 24 we get 14 days, and then at the end of that time the medical officer gives us notice under Sub-section (6) of Section 24, which sends us back once more to Section 14, Sub-section (2), under which we get three days to notify the justice. Then the justice gets three more days to come and see the patient; so

21 October, 1924.]

MR. ERNEST JAMES LIDBETTER.

[Continued.]

that you get three days, plus 14 days, plus three days, plus three days.

1621. Before you get a final formal order of detention?—Yes.

1622. But during all that accumulation of periods is the person in lawful detention?—Yes, that is, if that reading of the Act is correct. My personal view is it was never intended that Section 24 should be used to fortify Section 20—in other words, I think Section 24 is an entirely separate provision.

1623. It is obvious that there must be means of dealing immediately with emergency cases?—Quite.

1624. So that you must have very strong powers to enable you to deal with emergency cases, which powers may be quite inappropriate to cases which require more deliberate treatment?—Yes. You will notice, too, that the opening words of Section 24 deprive us of the common law power of detention in the workhouse. It is not only that no person shall be detained, but that no person shall be allowed to remain, so that we are deprived of the common law power.

1625. Even if a person wanted to remain in a workhouse you could not have them?—We could not have them.

1626. May I say you have done us a service in pointing out the anomalies of the position which will be a matter for us to consider?—The position of course is a very difficult one. There is one other point on Section 20 to which I should like to call your attention. The section may not be employed if, in the view of the master, he has not sufficient accommodation—no proper accommodation. It says: "The master of a workhouse shall unless there is no proper accommodation"—and the word "proper," I take it, means sufficient or appropriate, having regard to the condition of the patient.

1627. What difficulty do you find there in practice?—In practice we have no difficulty in the larger workhouses, especially in London, but difficulties have arisen in other parts of the country. For instance, there was one case at a place just outside London where the guardians passed a resolution that under no circumstances was the relieving officer to bring in a case under Section 20. Now that particular relieving officer had only a few days before had notice from the county asylum that there was no accommodation there, and he found, in other words, that both the workhouse and the asylum were closed against him.

1628. *Earl Russell*: But that general resolution closing the house was *ultra vires*, was it not?—Yes, it was, but the relieving officer is not in an independent position in these matters. Then there was another case, which I might mention while on the point. At one of the West of England ports it was not an unusual thing for a ship to call in with a lunatic on board. Then as soon as the lunatic is on shore the relieving officer has a duty to perform; and Section 20 is his only instrument, because the patient is not only dangerous but homeless too, and must therefore be lodged at the workhouse. In this case the master required the relieving officer to supply nurses to look after such patients.

1629. But surely in a small rural workhouse it might be reasonable for the master of such a workhouse to say: "I have no staff and I have no room to give accommodation to a dangerous lunatic in the workhouse"?—But however poor the workhouse may be, I submit it is much better than the man's home in those circumstances.

1630. *Chairman*: You mean that he must be disposed of somehow?—Yes. I am not thinking of the authority of the relieving officer or the duties of the master, or anything of that sort. What I am thinking of is the safety of the patient.

1631. *Earl Russell*: So am I, and of the other inmates of the workhouse. Unless the master has accommodation it might be dangerous to the other patients?—Yes; but a master is bound to have some staff there who would be available in a case of extreme emergency, whereas in a man's own house there would be no one. There is the position to be dealt with. Assuming that the master is entitled and justified in

refusing to take in a case, it seems to me the Commission have something to consider. The relieving officer cannot carry the man round with him or stay and look after him, and something must be done for him.

1632. Will it be illegal to take him to another and larger workhouse if they were willing to receive him?—Yes. The relieving officer can only take him to the workhouse of the union in which he is; he has no jurisdiction outside his own union.

Sir Ernest Hiley: Could he not be transferred by agreement to another union?

Earl Russell: I think not under Section 20.

Chairman: Section 20 refers to urgent cases. Then Mr. Lidbetter says the man cannot be kept at home or he may not have a home, and also that there is no proper accommodation in the workhouse of the locality, and the relieving officer cannot be expected to take him to his own home, so that there is a deadlock there.

(*Witness*): Yes.

1633. (*Earl Russell*): Could you not get an immediate order under Section 20?—Yes, but the practical difficulty there is that there are no vacancies in the asylum.

1634. (*Chairman*): Does this difficulty arise in practice?—Really it does arise and did arise in the case I have spoken of.

1635. What was ultimately done with the unhappy patient then?—I do not know. The relieving officer made arrangements subsequently, I think, for the removal of cases direct to the asylum as far as possible. In this case I have been referring to the relieving officer wrote to us for advice and so we became cognisant of the facts, and we gave him some advice and since then we have heard nothing about it.

1636. You see you are recommending us to provide some remedy for a difficulty which you suggest exists under the Act, and one would like to know how it has been met in practice, and you say it has not been encountered by yourself?—We can inquire and communicate with the Secretary, if we may, and tell him what was done in the case.

1637. Certainly. One would like to know what was done because we want to know if it is a practical difficulty before applying our minds to its solution?—Quite. Whilst we are on the point of providing accommodation under Section 20, I might refer to Section 21 which seems to me to give a justice of the peace power to review the decision of the master in that respect. Supposing the master says he has no proper accommodation, then Section 21 provides the justice with power to go into the matter and decide the point.

1638. He is made the judge as to whether there is proper accommodation or not?—Yes.

1639. But supposing he and the workhouse authority are in agreement that there is no accommodation, what happens?—Then the relieving officer's only remedy is immediately to get a reception order and remove the patient to any place in the county where there is a vacancy, and it may result in the patient being taken hundreds of miles away to an asylum.

1640. But he cannot be taken to an asylum until a justice's order has been obtained?—Quite. This is only likely to happen in a rural area where the justices are fairly accessible, and it is possible that an order might be immediately made and the patient got off.

1641. *Earl Russell*: Still, the result would be that the patient would get a different kind of treatment merely because there was no accommodation?—Yes, and it is not fair to suggest his examination and certification has been properly conducted in those circumstances, but it is the only way the relieving officer has of meeting the emergency.

1642. *Chairman*: It would only be in acute cases that the difficulty would arise, would it not?—Yes.

1643. Because in other cases you could go through the procedure of getting a patient taken to the

21 October, 1924.]

MR. ERNEST JAMES LIDBETTER.

[Continued.]

asylum.—Yes, it would be possible in those cases for a relieving officer to get a nurse to look after the patient—he is not barred from that.

1644. While pointing out these difficulties in what one may call the legal code, I should like to know whether you think in practice, apart from the legal aspect of the matter, any people have suffered through the form of existing legislation?—Do you mean as to Section 20?

1645. On any section. Have you any practice which would tend to surmount the difficulties you have pointed out?—Yes, by evasions and so on we have always in the interests of the patients succeeded in getting round the difficulties.

1646. I want to know if you know of any patient who has suffered hardship because of those defects which you allege?—No, except possibly in a way we know nothing about, that is, in the improper discharge of a patient who ought to be certified. When you have exhausted your powers, you must let the patient go, and in that you have a real difficulty.

1647. But you have been able to surmount the legal or technical difficulties in the interests of patients in your own experience?—Quite.

1648. But you do not like to have to administer a code which requires you to do so?—That is so.

1649. You would like the code brought into consonance with the interests which you are enabled to serve by disregarding sometimes the strict letter of the law?—Quite; we should like to feel that we are doing what we are doing under proper authority, instead of under a system of evasion such as I have disclosed.

1650. Are there any other observations you wish to make?—With regard to Section 21, this section can only be put into operation after proceedings have been taken. If proceedings are commenced then only the justice can send the alleged lunatic to the workhouse. That is Section 21. We think Section 21 should be amended so that the relieving officer should be able to exercise these powers at any stage of the proceedings, and we think that is necessary in the interests of the patient.

1651. It may be suggested that once the matter is in the hands of the justices?—Yes, Section 21 gives the justices those powers.

1652. Your duty is to bring the matter to the cognisance of the justice?—Yes, but in the meantime if the patient gets suddenly bad, you cannot remove him until you have the authority of the justice, which may take some time. In London, for instance, where many of the justices live outside the county, at some distance, and often do not come to town during the week-end, and are away from Friday late in the day until Monday, you get that delay before you can see any justice at all.

1653. I thought Section 21 said “any justice”—cannot you call in another justice?—Yes, apparently you can. Supposing you have given one justice notice under Section 14, in case of emergency you can go to another justice, if you can get one.

1654. That involves some inquiry into the supply of justices, I am afraid.—Yes; I deal with that later on. The point is the whole process would be greatly facilitated if the relieving officer could remove his patient to the workhouse at any time.

1655. Is there anything else to which you wish to draw our attention?—Then on the question of classification, the Act makes provision for paupers and for non-paupers, but it makes no provision for the most numerous class of all, those who, not being paupers, must become so as soon as their liberty is curtailed. We have explored that and we have also explored the next point, that is, the absence of provisions in the Act of periods of observation. You see how we do it. The period of observation is secured by passing from one section of the Act to another.

1656. You mean you can accumulate a period of 23 days altogether by that process?—Yes, and even that may be extended where the patient will consent either by himself or by his friends to remain. The

absence of provision for observation in the Act has led to a system of evasion more or less. I do not know whether you would like to hear more about that. For instance, at one place I know of where they have a lunatic and the justice is not satisfied that he ought to certify, they resort to the expedient of taking a reception order and suspending its operation under Section 21 and then allowing it to lapse if it is thought that the person should not be sent to an asylum.

1657. That is designed, of course, in the interests of the patient so that he shall not be subject to a permanent detention order when it does not prove necessary?—Yes.

1658. And all that might be obviated if provision were made for what I might call a transitional period?—Yes. On the statistical statement to which I think you referred a moment ago you will see that out of about 180 cases—because you must supplement the 133 total by a matter of 34 appearing lower down—only 51 were certified within the three days.

1659. With regard to the others, I see the cases are apparently kept under observation even up to the sixtieth day?—Yes.

1660. Is that the sixtieth day after they have reached the workhouse?—That is the sixtieth day after admission.

1661. But how can they be kept there so long?—May I call your attention to the note at the head: “These persons are not detained in the legal sense after the period authorised by law. They remain as patients for treatment or observation with their consent or that of their relatives.”

1662. For what period could you detain them whether they wished it or not?—That depends on the construction of Section 20; if Section 20 is to be strictly interpreted, three days is the maximum, but if the system of passing from one section to the other is adopted, 23 days.

1663. *Sir Ernest Hiley*: Does that include the 14 days mentioned in the third sub-section of Section 21?—That is after the reception order is made. I am speaking of the period without the reception order.

1664. *Chairman*: After the order is made that is an irrevocable step—that is the effective order?—Yes.

1665. But you are concerned if you can to avoid the making of an order?—But it is not detention or continuing to keep the patient in a strictly legal sense.

1666. But it is in the hope that you will not have to make the order at all?—Yes, and may I point out that the great majority of those who are kept over the three days get their discharge.

1667. There is an ambiguity in your headnote. It suggests that persons may be kept there with the consent of their relatives but not with their own consent?—The consent would be generally that of the head of the family; where the head of the family is in, his consent would be taken; if it was any other member of the family, his consent would be taken. After the period of detention legally authorised, if the patient said: “I insist on going out” he would go, and no one would be kept who demanded his discharge after the legal period expires—you may take that as an absolute rule.

1668. Of course we may have to consider the legalising of a system to which you apparently have been trying to approximate in practice?—Yes, which has resolved itself very largely into a system which has automatically grown up out of sheer necessity.

1669. Your table, which I think we will append* to your evidence, is interesting as showing that this period of observation up to 60 days after the first three days, which is the time when the acute cases are dealt with, is valuable. You have a certain number of cases after the three days, and one finds as time goes on you are able to discharge from the

* See Appendix VII.

21 October, 1924.]

MR. ERNEST JAMES LIDBETTER.

[Continued.]

workhouse a considerable number of cases without any order being pronounced at all?—Yes, that is the case.

1670. And these are persons who would never be characterised as lunatics at all—they have been simply in the workhouse for a period of observation and have been found to be uncertifiable and have been passed back into ordinary life?—Yes, and out of 62 dealt with in that way no less than 54 after the first three days.

1671. Showing the value of a prolonged period of observation?—Quite, and the value to the patient in particular.

1672. Of course, it is entirely for the patient, although at the same time it has the incidental benefit of not burdening the asylum with costs in the case of a patient who might recover very shortly and be discharged?—Yes.

1673. Should not one complete this matter by looking at the instances you have given us of recurrence?—Yes. I think the chief value of this table is to show that the examining officials, at any rate, are not prejudiced by the fact that there has been previous observation of the cases. Here is a man discharged on the second day, having been three times in the asylum. Then another is discharged on the second day, having been four times in the asylum, and here is one discharged on the ninth day, having been once before under observation and twice before in the asylum.

1674. *Earl Russell*: Are those drink cases?—No, they are general cases—there are very few drink cases in this list.

1675. *Chairman*: Does that mean that *prima facie* the case seemed to be one requiring to be dealt with, but under this observation it recovers, or is found not to be so serious as apprehended?—It is found not to be so serious as apprehended. There is this point which should be mentioned—these cases are generally brought in for observation, and, usually speaking, it is observation they receive, and not treatment. The workhouse wards are unsuitable for treatment, in my opinion, and you may take it that, while these cases are there for observation, they may get such treatment as the medical officer can afford, but it would not be comparable to what they would get in a proper institution. The probability is if these cases were treated at the first indication of insanity some of them might be found not to be insane cases at all.

1676. If you had observation coupled with treatment you mean you might further extend the usefulness of the section?—Yes, that is the point.

1677. You have shown us by your previous table that a considerable number of persons are discharged after the third day?—Yes.

1678. In virtue of what circumstances do the great majority of those kept for more than three days succeed in recovering their liberty—is it on the ground of improvement of health or on the ground that they are found not to be cases requiring treatment?—It is on the ground that the medical man has failed to find any condition to satisfy the requirements of Form 8. The medical man has to certify facts observed by himself and facts communicated by others. He can certify on the former alone, but not on the latter alone. He must himself observe facts to satisfy the requirements of the certificate. Now we may have a communication from some other person of a really serious kind against the patient which is not substantiated by observation, and prolonged observation and treatment fail to confirm. In that case, however bad the statement of the third person, it cannot be regarded as of any value for the purpose of certification.

1679. There are two ways of looking at the matter, one of *prima facie* investigation of the grounds, and, on the other hand, there is the point that the person who is admitted on all hands to be appropriate to be taken to the workhouse might in a short period improve. It might be a case where the malady was sharp and sudden, and equally quick in disappearing. Do you have cases for observation of that kind, that recover?—Yes; and there is no doubt that there is a

certain percentage which ought not to be taken in at all.

1680. This is a precautionary step, and therefore you may well have a *prima facie* case which turns out not to be a real case at all on further investigation; but would not the chances of the patient be greatly improved if you had not only observation but also treatment?—Yes.

1681. *Sir David Drummond*: Within your knowledge in how many of these cases discharged after a few days has there been an error in diagnosis?—In some, but that, of course, depends on whether you dignify the opinion arrived at by the relieving officer by the word "diagnosis."

1682. But there is someone who makes a diagnosis? No, the relieving officer removes under Section 20 without any medical advice. The relieving officer is called in and on the statements of the relatives and on his own observation removes the case under Section 20.

1683. And it is not on a medical opinion?—Not on a medical opinion, and it has been held that a medical certificate given in those cases is only an opinion though signed as a medical certificate.

1684. *Chairman*: It is not a statutory certificate?—It is not a statutory certificate.

1685. *Sir Humphry Rolleston*: Of course, it is highly desirable that a relieving officer should have the discretion of putting a person in a place where he is safe, but does the man or woman then remain there for three days?—Yes.

1686. Is there any machinery by which a man can get out?—Within the three days?

1687. Yes?—Yes, directly a justice has intimated that he will make no order, the man is at liberty to go. The three days suggested by Section 20 does not mean that you must keep him three days. As soon as a justice says "I am satisfied, I shall make no order"—the man is given his liberty forthwith.

1688. Is that so in practice?—Yes.

1689. And does that often happen?—No, because if you look at my table you will see that there are only seven men and one woman who got their liberty within the three days.

1690. So that if a medical man in a workhouse saw a case was obviously fit to go out he has no power to order it?—He has no power to order it—the justice must come as well. It means of course that a justice is sometimes called unnecessarily, but once the relieving officer has put the section into operation and brought the man in, all the doctors will not grant a release—you must have a justice to do that. The relieving officer is compelled to act quite without advice.

1691. *Chairman*: No doubt the short period of three days is named for the reason that up to that time there is no medical intervention, but even a three days' detention may be serious?—I quite agree.

1692. The only protection there seems to be is that the relieving officer has a discretion to let the person go, if he thinks the case is one of mere frivolous complaint or a mere piece of spite?—That is so.

1693. *Sir Humphry Rolleston*: On the other hand, if it is a question of doubt the relieving officer is almost driven to send a man into the workhouse?—The relieving officer has on the one side the protection afforded by Section 330—there is suitable protection there. It has been held indeed that under Section 20 he need not exercise reasonable care, but, on the other hand, he has always the fear of the result of a Coroner's Inquest as a consequence of his refusing to act.

1694. *Chairman*: Of course you have to deal with certain conditions in this phase of human life—on the one hand you have to infringe liberty, and, on the other hand, you have to protect the individual against himself and the public; and you may find, if you do not err on the safe side, that the unhappy case you decide not to remove has committed suicide or homicide possibly that very night; so that you are in a responsible position under Section 20?—Quite, a

21 October, 1924.]

MR. ERNEST JAMES LIDBETTER.

[Continued.]

responsibility which is fully appreciated by the relieving officer.

1695. *Sir David Drummond*: Which points to the desirability of having an expert who can be called in?—Yes.

1696. *Sir Humphry Rolleston*: Does the difficulty about detention for three days really exist, because as I look at Section 20 it does not say he shall be detained three days, but for not more than three days; and assuming the medical officer of the workhouse said to the master in 12 hours, "This man is perfectly sane," would the master commit any offence in letting him go?—Yes, he would. You see there, there is an overlapping between the master and the relieving officer.

1697. The Act does not say he shall detain the person; it says no person shall be detained for more than three days.—But Section 20 is to be put into operation by the relieving officer in any case in which he has a duty to perform.

1698. *Earl Russell*: What the section says is that he must not stay more than three days.—There is nothing by inference to suggest that the relieving officer can put Section 20 into operation and then not act under Section 14.

1699. I agree, but even while supporting your action under Section 14, it seems to me if the master chooses to discharge the man he has not committed any offence against the Act?—No, I do not think he has.

1700. So that in a case where he was satisfied the man might be injured by further detention, he might discharge him without breaking the law.—He might discharge him without breaking the law, but I do not think he would take the risk.

1701. That depends on the medical officer, does it not?—It does to an extent, but neither of them is in the position to discharge the patient.

1702. *Sir Thomas Hutchison*: Under Section 81 could not the matter go to the guardians?—No, because Section 81 in my view only applies to persons detained under Section 24.

1703. *Chairman*: It does not necessarily mean that, because it says a lunatic may be discharged by the guardians, but I understand a person once lodged is presumed to be a lunatic.—In Section 81 there are the words, "detained in the workhouse," and Section 81 enables the guardians to discharge a person detained in the workhouse. Now undoubtedly that must have reference to a person who has been regularly detained under Section 24, it does not mean any lunatic who is there in a sort of interregnum as in Section 20.

Earl Russell: I think that is arguable.

1704. *Chairman*: We do not mean to solve that at the moment; one is concerned now with the period of three days during which any person may be lodged in the workhouse, pending proceedings being taken and without apparently any skilled intervention on his behalf—I mean no doctor may see him. Now suppose this person is taken as a precautionary measure—because it may be a case which is very doubtful, and suppose he is removed by you rather than run the risk of his doing himself harm, during his three days' detention in the workhouse he seems to me to be rather outside the community of ordinary citizens and to have no rights at all. During the three days are not his civil rights more or less in suspension?—As I see it, what is in suspension is his liberty, but beyond that I am afraid we cannot go here, can we?

1705. No. It comes to this then, that the responsibility which is reposed in the relieving officer is in acting on matters coming to his knowledge—matters requiring him to act?—It is a very responsible position altogether. Nothing that is said here would tend to impress that fact on relieving officers more than they already appreciate it.

1706. It is only right I think to say that there has been no public complaint that I know of regarding this, and up to this stage of the proceedings I have not heard—I do not know whether others have heard

—any complaint, so that it must be a testimonial to the efficiency of your service. However, the position is as you have disclosed it to us.—Yes, and I am obliged to you for the statement you have made with regard to there being no complaints.

1707. Of course, your proposals as to reform would obviate a good deal of the difficulties you have been pointing out, and if there is a period of observation under the provisional system, then the problem would disappear?—Yes.

1708. And you advocate, I understand, that a period of provisional observation is the real remedy?—We do. Will you go on now to the next point, Sir? I think the guardians' failure to provide proper accommodation we have already dealt with.

1709. Yes.—Then there is the difficulty we all have in the absence of sufficient accommodation in the public asylums, a position which I might say has become a very acute and very difficult one in London.

1710. That would be relieved, would it not, to some extent if the chronic cases could be taken from public asylums to workhouses?—Quite.

1711. If an arrangement were made, so to speak, for a consideration of cases from time to time as between the public asylum on the one hand and the workhouses on the other, the chronic cases, as to which there was no hope, might well be dealt with in the workhouses?—That is so, but we, as relieving officers, are not so much concerned with how the difficulty can be met as in showing how acute the difficulty is, and how harmful it is to patients and the difficulty it imposes on us as relieving officers. That is the side we are concerned with rather than the method of providing the accommodation.

1712. What do you do if you find that there is no public asylum available to which a patient may be sent?—The common practice is to keep the patient until there is accommodation, and that very often means that you first get your reception order and then hold the case over until you finally get a vacancy, which very often means that you keep it illegally, and ultimately you may have to get it re-certified because the certificate has lapsed by time.

1713. But there is a provision, is there not, under the Act for keeping certified mental cases permanently in workhouses?—Not after a reception order; the only power is in Section 24. Where a reception order is made under Section 13 or Section 16, a relieving officer has to remove the case forthwith, and then under Section 36 the lifetime of the order is limited in ordinary circumstances to seven days. Now it is not always possible, especially in London, to get a vacancy within the three days allowed by Section 20, and the only alternative therefore is to keep your patient on a reception order and ultimately get it re-certified, if necessary.

1714. What rather impressed me was your observation that this was illegal but you could detain under Section 24 such a person in the workhouse indefinitely?—No, because that would be inconsistent with the reception order.

1715. *Earl Russell*: Your legal difficulty would be got over by calling some part of the workhouse an asylum, would it not?—Yes.

1716. It is only a technical difficulty, is it not?—It is a mere technical difficulty from our point of view as relieving officers but not from the patient's point of view. The primary difficulty we have in London is that we cannot proceed as required by Statute. We have to go to the asylums committee and ask where the patient can be received. That must be done before the justice sees the case, because he must direct the order to a particular asylum. Now as the duty of adjudication is upon the justice, we cannot tell until he sees the alleged lunatic that a vacancy will be required, and, strictly, unless we know where the patient is going at that time, he cannot make his order. Now that is inconsistent with the Act, which presumes that a vacancy will always be available and leaves the justice to make his order on that assumption. We have to resort

21 October, 1924.]

MR. ERNEST JAMES LIDBETTER.

[Continued.]

to various methods to avoid this difficulty; for instance, we may guess to what asylum the patient may be allocated. If it is a Jewish patient I should take the order on Colney Hatch; if the patient had been away before, on the same asylum as before—or the order must be drawn, contrary to Statute, without the name of the asylum being put in. If the vacancy duly comes along we can get the patient away, but if the vacancy is different from the asylum named in the order, a fresh certificate must be taken.

1717. Of course one serious difficulty may arise here because the asylum may have no accommodation?—That is so, and that leads to urgent difficulty sometimes. For instance, I remember a case not so long ago of a woman who was brought in suffering from depressional insanity, who had refused her food, who was under the impression that it was tampered with; the woman had been fasting some time before we received her and she continued to fast in the workhouse. Now we could not get a vacancy for her and we had to resort to forcible feeding. She resisted and a gradual decline set in. Then you get your vacancy when the patient's condition is greatly reduced, and upon that you remove the patient.

1718. *Chairman*: To the obvious prejudice of the health of the patient?—Yes, that is my point.

1719. On the other hand, you cannot create the accommodation if it is not there, and what do you suggest? Do you suggest any means of increasing the accommodation in the different asylums?—Yes. The Lunacy Act is passed on the assumption that there will be the accommodation. The justice is called in and he says "Where is the nearest asylum?" and directs his order. That is the assumption of the Lunacy Act.

1720. The accommodation, in short, has not kept pace with the growth of insanity, unfortunately?—The accommodation has not kept pace with the growth of insanity, and of course the effect of Section 207 was directed to the elimination of private accommodation; but in proportion as the private accommodation was reduced there should have been a corresponding increase in the public accommodation.

1721. We have heard from other witnesses about the shortage of accommodation and I see how it bears on your functions.—Then we have had complaints from various parts of the country of the difficulty of getting justices. They say that there are not sufficient justices, that the justices act reluctantly, and in some cases both methods hamper their movements, but we have not that difficulty to such an extent in London. In London our great difficulty is that we cannot get hold of justices at the week ends.

1722. Quite. It seems important from the duties which these justices have to discharge that they should be responsible people?—Yes. There are times when we feel the want of a justice.

1723. *Earl Russell*: I suppose there are times when the Stipendiary can act?—Yes, but it is undesirable to take people into Court to a Stipendiary.

1724. Of course, but at a real pinch you could do so?—Yes, we could at a real pinch, but I doubt whether you could get a Stipendiary to come and visit.

1725. *Chairman*: As a matter of fact a County Court Judge and a Police Court Magistrate in London can function as a judicial authority?—Yes.

1726. But you do not resort to that, do you?—No, we never do. In London, as a matter of fact, there is also a very high proportion of the justices who are also judicial authorities and we have no difficulty. Then, Sir, the main general recommendations we want to put before you are these: First, that there should be no difference in the process of certification between the pauper and the non-pauper. Secondly, except in very rare cases juveniles should not be certified as insane nor should cases of senile dementia. The provisions of the Mental Deficiency Act, 1913, Section 30, Sub-sections 1 and 2, should be amended to enable juvenile pauper cases to be dealt with under that Act.

1727. *Earl Russell*: What do you mean by juveniles—at what age?—Anyone below the age of 16 years. One may separate the two classes of cases. Taking the case of a juvenile, the Mental Deficiency Act, Section 30, provides that the local authorities shall have no responsibility under that Act in any case where the person can be dealt with under the Lunacy Act, and then it further proceeds to say they shall have no duty to perform with regard to any person who is chargeable to the Poor Law except in such cases where a certificate is given by the Board of Control with the sanction of the Ministry of Health. The effect of those provisions is that the guardians certify these young imbeciles and idiots under the Lunacy Act, and the relieving officers feel that is a duty they would rather not have to do, and it should be done under the Mental Deficiency Act.

1728. *Chairman*: Are these cases not really cases of dementia?—No; more cases of congenital idiots.

1729. Arrested development cases, I suppose?—Yes. It is much easier for the Board of Guardians to secure the certification of these cases under the Lunacy Act than it is to approach the Ministry and pass them through under the Mental Deficiency Act, and therefore the Lunacy Act is resorted to.

1730. *Earl Russell*: But surely the Mental Deficiency Act was one which provides a means as far as possible of alleviating these conditions?—Are you speaking from the patients' point of view?

1731. Yes.—I think the general impression one gets from the Mental Deficiency Act is that it deals more with a permanent class of case than with the lunatic, because in some cases the lunatic may recover.

1732. *Chairman*: Personally I have felt great difficulty in following the classification as between the two Acts. It seems to me that many persons might fall under both Acts, and they might be certifiable as lunatics, or equally they might be placed for proper treatment under the Mental Deficiency Act. Who is to determine whether a person is to be dealt with as a lunatic under one Act or is to be dealt with as a mental defective under the other Act? It is a problem of great difficulty?—It is a problem of great difficulty, and it might be got over by the proposal we suggest of a reception house for all cases.

1733. You mean the period of observation might be utilised; and, without any determining order, the case so watched might ultimately be certified or not; and also classified in regard to the kind of institution and category of mental defect?—Quite.

1734. All these things would be considered during the period of observation, with the result that you might very materially improve the system?—Quite.

1735. It would all be incidental to the period of observation?—Yes. You will notice that these lunacy cases are dealt with under Section 20 as they are brought to us voluntarily by the parents, and very often they go into the institutions for considerable periods before they are certified.

1736. Of course, in a workhouse there must be a number of people of more or less degenerate intellect?—Yes; they gravitate there.

1737. And the time at which they step from a state of sanity to insanity is indeterminate, I should think?—Yes.

As regards the senile cases mentioned, this proof was prepared before the Metropolitan Asylums Board had power to receive them without certificates, so that the problem does not arise now. It was necessary, before that arrangement was made, to certify these cases, and that was a duty which the relieving officers performed very reluctantly.

1738. These are voluntary cases you are speaking of?—No; they are cases where the condition is such that they are neither voluntary nor compulsory.

1739. They are not certified?—Not now, but when this evidence was being prepared they were certified—it is under an Order of the Ministry of Health. The Metropolitan Asylums Board may now receive these cases without certificate, but in the country outside London where the M.A.B. is not in operation such cases may arise.

21 October, 1924.]

MR. ERNEST JAMES LIDBETTER.

[Continued.]

1740. Is there anything else you wish to say?—Then we respectfully submit that the Board of Control or some other authority or Commission should be endowed with powers to determine under proper safeguards ambiguities under the Statutes and points of law involved.

1741. I think you are there taking us a little beyond the scope of our inquiry?—Except that I have already called your attention to some of the ambiguities under the Lunacy Acts.

1742. But this is a question of how they are to be solved if the Statutes remain unaltered, and I do not think we need be detained over that?—Then comes the major proposal we have to make, that the workhouse should no longer be regarded as the place of safety for alleged lunatics; that asylum committees should be required to provide sufficient reception houses in all urban areas.

1743. This is for the person who is ultimately going to find his way to the asylum, and your suggestion is that the workhouse is not a suitable intermediate place for him to be housed?—Yes; but may I say we are more impressed by the possibilities of his case under a properly organised system than we are by the disadvantages of the workhouse. It is not a question of the place or the kind of institution so much as of organisation. What we want to see, in other words, is a wider system through which a patient will pass in all his stages, until he finally gets to the place for prolonged detention.

1744. He might from the reception house go either to the public asylum or to the workhouse?—Yes.

1745. There again this proposal of the reception house is connected with your proposal as to observation?—Yes.

1746. And you suggest that that should not be done in the workhouse?—Yes; because there is no Poor Law area at present which has a workhouse which would provide a sufficient number of cases to do it in the systematic way in which it should be done.

1747. All that of course would involve considerable expense?—It may, but it depends on the extent to which you are prepared to utilise existing organisations. For instance, there are two large institutions in East London at present unoccupied, and I am quite sure by a re-arrangement of patients in other parts you could get possession in London of four or five or six Poor Law institutions.

1748. The point is that such premises should be specially applicable for such purposes?—We want to specialise the justice, we want to specialise the doctors and the institution, not merely by the provision of special accommodation but by the building up, if possible, of a system of information. We think, for instance, if you could cross-index all the lunatics passing through the London asylums and all the alleged lunatics passing through our institutions you would have a great family history that would be enormously helpful in certifications. At present that is not possible, because the parochial boundaries intervene and make it impossible.

1749. Again that would be an improved system of records?—It would be an improved system of records, but then again there is this question—in a great number of workhouses at present where the patient is received, you have no resident medical officer; he is only a visiting officer. Then every justice can call in any doctor he pleases, who may never have seen a lunatic pauper before, and we conceive that medical service should be immediately and constantly available, and that there should be a specialised service in that respect.

1750. Of course, to some extent even in these matters, however anxious we may be to provide all that is best, we have to cut our coat to suit our cloth?—Let me be frank on this point. Some of our branches have said that they would not recommend these things on the ground of the expense involved.

1751. Quite, but we see the importance of your suggestions.—In the first place we say in a centre such as is suggested there would be a sufficient number of cases to justify and require a rota of

justices visiting daily, holding a daily session for the disposal of cases. The effect of that would be that the preliminary period of detention at the relieving officer's instance need be only until the next meeting of the justices—probably twenty-four hours, except at weekends. The preliminary detention on the authority of the relieving officer would be until the next meeting of the justices only, and thereafter as the justices might direct. Such daily centres would be more formal and would conduct the investigations of cases in a more judicial atmosphere than is possible in the wards of the workhouse. The witnesses would appear in less casual conditions than is now possible, their evidence would be more strictly taken—on oath where necessary. There would be a resident medical officer for purposes of both treatment and observation. As time goes on these men would tend to become specialised in this class of work and better able to advise and decide than is at present the case. The justice of the peace would also tend to become specialised. For the purpose of these enquiries the reception houses would maintain a system of case papers with suitable index, and in the course of time family and personal history would be available in a way which is not possible at the present time. It should be possible to arrange a system of observation under detention for shorter and more graduated periods, possible without an actual certificate of insanity, until the patient is discharged or finally certified. During this period of probation a system of observation and classification would be going on, and the patient would finally pass out of the reception home to a place of more prolonged detention on the basis of this system, and would not be allocated to an institution as at present on the casual circumstance that a vacancy has occurred. The reception house should also serve the purposes of a clinic providing advice and treatment to out-patients in proper circumstances. On the recommendation for the discharge of a patient from an institution for lunatics, the staff of the reception homes should enquire and report as to the conditions into which it is proposed to release the patient, and on release make some provision for after care. The reasons for recommending such a system are that it would lead to a much more exact and satisfactory administration. It would be in the best interest of all suffering from mental disorders of any kind. It would do much to prevent the large number of recurrent allegations of insanity, by bringing under control and treatment at the first or second attack many persons who are at present under observation at intervals not always in the same area,—and often not certified, or, as often is the case, not until after many periods of arrest and preliminary detention. It would tend to reduce the number of suicides and other domestic tragedies that sometimes occur in these lucid intervals.

1752. I want to draw attention under Section 13, Sub-section (3), to a point which has been brought to my notice, which is rather important. You have told us about the case where one medical man of two called in by the justice might see his way to certify and the other one might not, and that the justice then might resort to calling in another medical man, and the question arose as to the position then. Apparently the justice who is dealing with the matter may make such other and further inquiry as he thinks necessary apart from the certificates of the medical practitioners, so that he may satisfy himself either upon the certificates of the medical men called in or upon such other and further inquiry?—Yes.

1753. So that he is not apparently tied down to the medical certificates as being the conclusive factor in making up his mind?—That turns, Sir, on the interpretation, does it not?

1754. Yes, it does, no doubt, but my attention was drawn to it. The justice need not proceed on the medical certificates, or a medical certificate only, but on further or other inquiry?—Yes, but the Act requires, for the purpose of this Section, that he must have two positive medical certificates.

21 October 1924.]

Mr. ERNEST JAMES LIDBETTER.

[Continued.]

1755. Yes, I think he must have them before him.

1756. *Earl Russell*: In Sections 13 and 14 you have the words "person deemed to be a lunatic" which seems to convey some doubt. Do you satisfy yourself in that case?—No, the relieving officer does not. It is rather an elastic term.

1757. Have you affirmed or sworn information under Section 14?—No, it need not be in writing.

1758. Section 14, Sub-section (3) says that the justice shall require the relieving officer to bring the alleged lunatic before him, and in your evidence you said you brought the justice to the lunatic?—Yes.

1759. Which is the most common thing to do?—To bring the justice to the lunatic. But may I remind you that I said it was not an absolute rule. In the rural areas the outdoor practice is the common rule and Section 20 is not employed.

1760. Do you mean that the lunatic is brought before the justice?—Yes, it may be loosely done but it is done.

1761. And not the justice brought to the lunatic?—No. I think in the rural districts the lunatic is brought before the justice.

1762. You will find that out?—Yes. I shall be able to find that out.

1763. In Section 15 the words "wandering at large" I suppose would apply to a person who had a home and did not go there?—Yes, that is so.

1764. That is to say, you would apply it to anybody wandering at large in fact?—But I think it has been held that a person who is not under proper care and control is wandering at large—wandering aimlessly.

1765. *Sir David Drummond*: What assistance do you get, say, in the removal of a suicidal case or a very difficult case?—The relieving officer has powers to call to his aid anybody he thinks can help him, and each man is allocated to a district.

1766. You said that a relieving officer deals with a case on the three days system independent of the medical opinion?—Yes.

1767. Do you think that people all over this country or out of this country would not be under a panel

doctor?—I have no knowledge of what happens abroad.

1768. My impression is that it is generally the panel doctor who receives the patient first?—You see it has been held that a medical certificate given, while a valuable expression of opinion is not in law a certificate.

1769. The point is that the doctor does not see the patient before removal to a workhouse?—That is so.

1770. And I think that obtains throughout the country?—The relieving officer is not entitled as a matter of right to a medical opinion first. The district medical officer is only employed by the guardians under contract for other purposes, and he is not available to help the relieving officer to make up his mind under the Lunacy Act.

1771. But he is a panel doctor probably?—Yes, but if the relieving officer took the panel doctor's certificate and acted on it, it would not relieve him of the consequences either way.

1772. *Chairman*: You have advocated the desirability of a system of observation in the shape of a reception-house, an intermediate position between the original detention of the patient and his ultimate reception. Have you any views as to the desirability of placing such reception-houses under the Board of Control or keeping them independent?—We have not gone into that matter at all. What we feel is that the system of control is not so large or so extended as it ought to be.

1773. Relieving officers do not seem to me to be brought into direct contact with the Board of Control?—No. The only way in which we are if our certificates are incorrect they are sent back.

1774. I mean you do not offer any views as to the efficiency of the Board of Control?—No. Of course, Sir, you will understand there is nothing in what we suggest which we expect will have the effect of reducing the number of certifiable persons—in fact it will be the other way.

1775. I desire to thank you on behalf of the Commission for the very clear evidence you have given us.

(The Witness withdrew.)

(Adjourned to to-morrow at 10.30.)

5, OLD PALACE YARD,
WESTMINSTER, S.W.1.

FOURTH DAY.

Wednesday, 22nd October, 1924.

MEMBERS PRESENT:

THE RT. HON. H. P. MACMILLAN, K.C. (*in the Chair*).

THE EARL RUSSELL.

SIR HUMPHRY ROLLESTON, BART., K.C.B., M.D.

SIR THOMAS HUTCHISON, BART.

SIR ERNEST HILEY, K.B.E.

SIR DAVID DRUMMOND, C.B.E., M.D.

MRS. C. J. MATHEW.

MR. P. BARTER (*Secretary*).

MR. W. FAIRLEY (*Assistant Secretary*).

Brigadier-General Sir JOHN BARNSLEY, D.L., V.D., J.P., called and examined.

1776. *Chairman*: Sir John, you are a Deputy-Lieutenant, a Justice of the Peace, and Deputy-Chairman of the Birmingham Justices?—Yes.

1777. I think you reside at Earlsfield, Westfield Road, Edgbaston, in the City of Birmingham?—Yes.

22 October, 1924.]

Brigadier-General Sir JOHN BARNESLEY, D.L., V.D., J.P.

[Continued.]

1778. I think that your Justices, yourself and your colleagues, on observing the appointment of this Royal Commission, convened a meeting on the 24th July of the Judicial Authority and the Visitors under the Lunacy and Mental Deficiency Acts for your City?—Yes.

1779. You had a good attendance, I believe, and after consideration of the terms of reference of the Royal Commission, you and your colleagues decided to bring to the notice of the Commission a number of suggestions and recommendations which you thought might be useful to us?—Yes.

1780. Now perhaps before we address ourselves to those suggestions, Sir John, you might give us, from your large experience, some information as to the duties which the judicial authority performs in connection with the administration of the Lunacy Laws. We are very anxious to understand the practical work that is done by justices in this sphere of their activities; and it would certainly help us if you could give us some idea of the role that is played by the justices in this very important department of administration. Have you yourself personally acted as judicial authority?—Not as judicial authority.

1781. Then probably we shall hear from some other witness of the actual functions discharged?—My colleague, Mr. Lord, will deal with that aspect of it.

1782. But have you acted as a justice of the peace under the provisions of the statutes where a justice of the peace other than a judicial authority intervenes?—Yes.

1783. You have frequently done that, I suppose?—Yes.

1784. How are you, as a justice of the peace, first brought in contact with a case?—The Judicial Authority of Birmingham is composed of 28 selected members from our whole Bench of 150, having regard largely to their places of residence, so that the convenience of the City generally in the various districts may be met as far as possible, and that there shall be a member of the Judicial Authority living within each area, in order that when a case does arise, whether it comes from the relieving officer or whether it comes from private sources, the judicial authority for that particular neighbourhood should be available quite easily.

1785. Of course, the judicial authority being himself a justice of the peace can act in the other capacity of a justice of the peace, if necessary?—Yes.

1786. In your own experience, acting as a justice of the peace, how do cases actually come under your cognisance—how do they reach you?—As a member who is not a judicial authority, they are brought to me by the relieving officer of the guardians. It is pauper cases that we take very largely. We who do not act as a judicial authority; and they are brought to us by the relieving officer. We are asked sometimes to call, or at times the patients are brought to us at our houses or places of business, whichever is more convenient.

1787. Then the relieving officer probably rings you up on the telephone or makes an appointment, and arrives with the patient?—Yes, with the patient, with all the documents, and the doctor's report. Then, of course, under the statutes, we are obliged to see the patient.

1788. I was just coming to that. In the exercise of your jurisdiction you must actually see the patient?—Yes.

1789. Is the patient generally brought to you, or do you go to some place where the patient is?—He is generally brought to me.

1790. What do you do when a patient is brought before you?—We have the report of the doctor, which tells us any particular direction in which mental weakness has appeared, and then we ask questions of the patient. We ask him what his trouble is and go into all the details we can. Of course, we have a clue. Before we see the patient we have an idea as to what evidences of insanity he has evinced.

1791. You will have read the medical certificate by this time?—Yes, exactly.

1792. And I suppose that some of the cases that come before you are really cases of persons incapable of answering you rationally?—In some cases quite hopeless.

1793. But you do your best to elicit from them their trouble?—Yes.

1794. Do you find in some cases that they are able to talk to you about their difficulties?—Yes; and in some cases at intervals the patients are apparently quite rational, and then they go off at a tangent on their particular weakness.

1795. Do you think they realise that you are a judicial person investigating their case?—I should think it is very doubtful in many cases.

1796. Do you find difficulty in making up your mind in particular instances?—Not as a rule. Personally, I have never met a case where I have had any doubt, but at our meeting it was suggested by some of the justices, members of the Judicial Authority and others, that they had occasionally found difficulty in making up their minds. Of course, in the case of the pauper lunatics we can remand them if we wish; we can make a 14-day order and send them to the workhouse to be put under observation, but that cannot be done with private patients.

1797. But it occurs to one that in border-line cases you must find it difficult to determine from your interview with the patient whether the case is on one side or the other. Have you not experienced that difficulty?—Yes; but I think that the pauper cases do not show quite as many instances of that kind as the other type of cases—the private cases.

1798. You mean that a case is probably not brought before you by the relieving officer until the symptoms are pretty well manifest?—Yes.

1799. And in your own experience you have not had difficulty in making up your mind?—No, not very much. I have never had a case in which I have had to make a 14-day order and send the patient to the workhouse to be put under observation.

1800. Of course you realise that it is a very important and responsible duty that is confided to you?—Quite.

1801. On the one hand, you have the interest of the patient to consider, and, on the other hand, you have, of course, the protection of the public to consider?—Quite.

1802. Do you think the provision that you can send the patient on what you have described as a remand—a period of delay of 14 days—is a useful provision?—I do.

1803. I think you said that you had not yourself had occasion to resort to that expedient?—No, I have never had to do it.

1804. In this case, as we know, you proceed upon the certificate of a single medical practitioner?—In the pauper cases, yes.

1805. Is the medical practitioner present when you are interviewing the patient?—Not as a rule.

1806. Do you ever find occasion to send for him?—No, I think not; his report is generally very full.

1807. Do you think it would be desirable to have the single medical opinion which is before you fortified by a second certificate, as in the case of a private patient?—I do, yes.

1808. We have been rather struck in the course of our Inquiry with the difference in the procedure adopted in the two classes of cases, and have been rather at a loss to understand why the procedure should be different in the one case from the other, the topic of investigation being the same, namely, the state of mind of a particular citizen?—Yes.

1809. Two certificates are required in the case of an application relating to a private patient, but in that case there is no obligation to see the patient on the part of the person making the order?—That is so.

1810. But in your case it is one certificate and an obligatory interview?—Yes.

22 October, 1924.]

Brigadier-General Sir JOHN BARNESLEY, D.L., V.D., J.P.

[Continued.]

1811. Would you regard it as satisfactory from your point of view that a second doctor should deal with the case?—I think it would be an advantage.

1812. Would it give you more confidence in exercising your jurisdiction?—Yes.

1813. In addition to this power to place the alleged lunatic in a workhouse for fourteen days for a period of observation, I think you have also power to direct the permanent detention of a lunatic in a workhouse under Section 24 of the Act of 1890?—Yes, I think we have.

1814. Section 24, you will remember, is the one which is expressed negatively—"no person shall be allowed to remain in a workhouse as a lunatic unless the medical officer of the workhouse certifies in writing" certain things; and then a certificate under that section is to be sufficient authority for detaining a lunatic for fourteen days; then "No lunatic shall be detained against his will or allowed to remain in a workhouse for more than fourteen days from the date of a certificate under this section without an order under the hand of a justice having jurisdiction in the place where the workhouse is situate." So that you have power to pronounce an order which will enable a lunatic to be detained in a workhouse on a permanent basis?—Yes.

1815. Have you had to exercise that power at all?—No, I have never done it.

1816. Of course, under Section 24 it is necessary to have two medical certificates in the case of a permanent detention order in a workhouse?—I have never had to do that.

1817. You have never personally had to deal with that?—No.

1818. In addition to the functions discharged by the justices of the peace at what I may call the initial stages, that is to say, the stage at which the desirability of detention is considered and orders are made, there are also provisions for the visitation of institutions by justices, are there not?—Yes, under the Mental Deficiency Act we have a body of visitors appointed.

1819. Yes; but we are rather concerned with the Lunacy Laws as distinct from the Mental Deficiency Act. Under Section 177 of the Lunacy Act of 1890 there is provision made, you will remember, for the justices annually appointing three or more justices and a medical practitioner to act as visitors of licensed houses?—Yes.

1820. Have you any licensed houses in Birmingham?—No, we have no licensed houses in our area at all.

1821. I think you have to appoint such visitors whether there is a licensed house within the area or not?—Yes.

1822. Do you make such appointments in Birmingham?—Yes, we appoint eight.

1823. Have you yourself been one of those visitors?—No, I have not been a visitor.

1824. Then may I take it that you have not had experience of visiting?—No, I have had no experience at all.

1825. Then in the matters which you desire to bring before us you are really voicing the general feeling of the justices rather than speaking from personal experience in certain of the matters?—Yes; I felt responsible for calling them together, and my evidence is really the opinion of the meeting.

1826. On some of the matters you have had personal experience, and on others you are voicing the feelings of those who have had the experience?—Yes.

1827. Now, in the first place, I think that you and your colleagues regard it as important that the justice or the judicial authority, as the case may be, before pronouncing any order or warrant for detention, should actually see the patient personally?—Yes, we feel that very strongly.

1828. There you are speaking from your personal experience, too?—Yes.

1829. Do you find that it is satisfactory both from the point of view of the justice who has this duty

to perform and also from the point of view of the person who is about to be detained?—Yes.

1830. Is full opportunity given to the person who is brought before you by a relieving officer to say anything he or she may want to say?—Yes.

1831. And you therefore attach importance to this?—Yes.

1832. The next matter is one upon which we have heard something in this room: the desirability of what one may call a provisional detention; a period of detention during which the patient, before certification, is under observation?—Yes, in cases where there is any doubt.

1833. Yes. At present the only provision apparently for this transitional or provisional observation is a workhouse?—Exactly.

1834. Now have you any views as to the place where the patient should be under observation?—I think it should not be a workhouse and it should not be an asylum; it should be a separate institution of some kind; and preferably, I think we generally felt, it should not only be used for this purpose, but that there should be some sort of institution at which there should be treatment for people before it comes to a question of certification—a sort of mental hospital.

1835. A clinic?—Yes, a clinic that should be available for anybody who required treatment.

1836. Then you contemplate a reception house to which persons might be sent for a period of observation and treatment?—Exactly.

1837. The result of which might be that the treatment might effect a cure, in which case no order would be pronounced?—Exactly.

1838. On the other hand, the symptoms could be studied there and further information obtained for the judicial authority or justice of the peace to proceed upon?—Yes.

1839. *Earl Russell*: Or to which they might resort voluntarily?—Yes; that is a very important point; we wanted rather to emphasise that.

1840. *Chairman*: That would involve the provision of separate premises?—I think it would, and I think the local authority would have to do it, because this is not a thing that we could put on the same basis as a voluntary hospital.

1841. It would be a place to which you would have a right to send persons of any social position, whether they could pay or not pay?—Exactly.

1842. Of course, that would involve additional expenditure, obviously.—Yes.

1843. Do you think that the expenditure might be remunerative in this way, that it might obviate the necessity to send a number of cases on to asylums?—I think it would, in all probability; and I think charges might be made for treatment by people who could afford to pay for it. There are lots of patients who could afford to pay for a fortnight or three weeks' treatment.

1844. And what they paid might, on the principle we are familiar with in asylum administration, be made available towards making up the loss on the other cases?—Yes.

1845. At present there is no power to provide such places?—No, none.

1846. Would it be for yourselves as justices a comfort to feel that in cases upon which it was difficult to come to a conclusive judgment, there was this opportunity for experiment or trial?—It would, very distinctly.

1847. At the moment there is statutory power for allowing patients out on trial after they have been in an asylum, as we know?—Yes.

1848. Do you favour the view that there should be also a period of trial or experiment before certification?—Yes.

1849. Would you contemplate that all the cases would go there, or only those as to which there was some doubt?—I think only those about which there was doubt.

1850. Would you leave it discretionary to the justice to direct the patient to be sent to such a

22 October, 1924.]

Brigadier-General Sir JOHN BARNESLEY, D.L., V.D., J.P.

[Continued.]

place or not?—I would leave it to his discretion. I quote in my précis one particular instance, you will notice, in which a very serious thing happened through the present procedure.

1851. I was struck with that. I wish you would give us that instance, because it is very striking. That was a case, I think, in which a justice who had difficulty with regard to a case thought he ought not to sign?—Yes, and did not sign.

1852. What was the consequence?—The consequence was that within 48 hours the patient had killed his wife and two children.

1853. *Sir David Drummond*: Was there a doctor's certificate in that case?—Yes, certainly.

1854. That is to say, the magistrate and the doctor differed?—Yes.

1855. *Chairman*: The magistrate had interviewed the patient, with the medical certificate stating that the man ought to be detained, and, after the interview, thought the case was not made out, so to speak?—Yes. May I hand you particulars of that case? I do not want to mention the name of the justice, but if you knew what it was and why it was, you would see at once that it was rather important.

1856. You can hand it in afterwards. I am rather anxious to have this case brought out, for this reason; it seems to me to illustrate very painfully the difficulty which a justice has; on the one hand, he is the representative of the law who is bound to protect the liberty of the subject; on the other hand, if favouring the liberty of the subject, shall we say, he does not pronounce an order in a particular case, then he has to take the risk of allowing such a person to be at large, the consequences of which may be very serious?—Yes.

1857. Therefore, one can see how onerous is the responsibility on the justice?—Yes.

Sir Humphry Rolleston: Would you, if you think fit, ask Sir John whether a distinction ought not to be drawn between the outdoor clinics, which it is proposed should be held for people who are in an early stage of mental instability, and those cases which are sufficiently marked to draw the attention of the relieving officer to them? It seems to me that the two conditions are rather different. If a person is sufficiently deranged to draw the attention of the relieving officer to him and is brought with a medical certificate to a justice, those are cases which may very likely require to be put under control in these reception homes; and a distinction ought to be drawn between an outdoor clinic and a reception house, in the case in which probably some detention corresponding to the fourteen days' remand in the workhouse infirmary would become necessary.

1858. *Chairman (to the Witness)*: You follow what Sir Humphry has said?—Yes.

1859. Of course, people who were attending a clinic for the purpose of getting assistance and advice there, are in rather a different position from those whose condition is so manifest that the relieving officer has had to bring them before the justice. That is Sir Humphry's point?—Yes.

Sir Humphry Rolleston: We are only dealing with the latter class for the moment.

1860. *Chairman*: Yes. (*To the Witness*): You say that in your own large experience you have never had a case which gave you any difficulty?—That is so.

1861. Would your experience lead you to this, that in the cases brought before you by the relieving officer the insanity was so obvious that the period of observation would be superfluous?—Well, I think the fact that it was brought to our notice at the meeting we held by several justices rather proved probably that my experience was not the experience of others—that they had had doubtful cases; and what we want to do is to obviate the possibility of a single case not being properly dealt with.

1862. *Earl Russell*: You have been fortunate in not having doubtful cases?—Yes.

1863. *Chairman*: The experience probably of your colleagues would have embraced cases of private patients where you say there may be less obvious evidences of insanity?—Yes.

Sir David Drummond: In evidence yesterday we heard of some eight patients admitted to the workhouse and discharged in three days.

1864. *Chairman*: Yes. Just following up that point, there might be cases brought before you by the relieving officer in which at the moment the symptoms were very marked, obviously justifying immediate detention?—Yes.

1865. But that case might be one of merely transitory insanity and the recovery might take place in a few days, even although at the moment the mental disturbance was obvious; but possibly detention for a short time in such a clinic as you figure might produce a complete cure, so that there would be no necessity at all for certification?—Yes.

1866. That is another advantage that the observation house might afford, not merely to deal with border-line cases where the justice was in doubt, but where a case was one of insanity of probably short duration?—Yes.

1867. Merely some upsetting of the balance for the time being?—Yes. I am quite free to say this: that this matter was really specially urged by one of the justices who himself, in his own family, had had a case in which he thought it would have been a great advantage if a clinic of this kind had been in existence; he spoke from personal experience.

1868. Of course, it does seem desirable that if there is to be such an institution it should not be either the workhouse or the asylum because of the association of such places?—Exactly.

1869. Persons, I suppose, who are mentally upset or deranged may be very sensitive to the associations of the place to which they are conveyed?—Yes.

1870. You would contemplate, would you not, that such persons under observation must be under some order of detention?—Yes, I think so.

1871. Otherwise, the purpose which you have just explained would not be served—the protection of the public. In the tragic case to which you have alluded the patient was simply discharged to the public, whereas under such a régime as you contemplate that person, although possibly ultimately found to be on the right side of the border-line, would be compulsorily detained, but for a limited period?—Yes.

1872. At the end of the period of observation would you recommend that the patient be brought back before the justice who had originally pronounced the temporary order?—Yes.

1873. Suppose during the period of observation the patient recovers in the opinion of the medical officer in charge of this reception house or place of observation, would you suggest that the patient be brought at once before the justice?—During the period, certainly, yes.

1874. Obviously it would not do to enforce an order for detention for a month in the case of a patient who after two or three days made a complete recovery; such a person would be set free at once?—Yes.

1875. Then you would contemplate that the patient would be under observation during the limited period, but if during that period the medical officer in charge was satisfied that recovery had been effected, he would come to the justice of the peace with his patient and obtain an order of discharge?—Yes.

1876. Then as to the voluntary aspect to which you alluded a moment ago, do you think that this place might serve also the purpose of a place for giving advice and assistance to what we may call outdoor cases?—Yes.

1877. A person might be brought there by a relative and get good advice?—Yes.

1878. Would you contemplate that persons might also enter this institution voluntarily for a period?—For treatment, yes.

1879. Without any detention order?—Yes.

22 October, 1924.]

Brigadier-General Sir JOHN BARNESLEY, D.L., V.D., J.P.

[Continued.]

1880. Of course, if these voluntary cases were cases where there might be dangerous tendencies, you would almost be bound to have some form of compulsory detention, would you not?—Yes; of course, if there were dangerous tendencies, they might have been manifest before they went in, and such patients would have to be treated as compulsory cases.

1881. Yes, that is clear. The third topic to which you refer, I see, is the question of visitation of persons who are detained. Would you be good enough to give us your views on that—the views of yourself and of your colleagues?—With regard to the annual visitation, we rather felt, though we realised that it was a very big undertaking, that something was wanted in the nature of what exists under the Mental Deficiency Act: that all persons should be visited, first of all, after one year, then after the second year, and subsequently every five years; that is what we do in the case of mental deficiency cases. We felt that it would be a great advantage if the inmates of ordinary asylums were visited in the same way, because we so arrange our rota of visitation for our mental deficiency cases that one magistrate sees the same patients each year, and he can therefore tell the progress that is being made. I have got an interesting report here which was presented at our Quarterly Meeting of the Justices last week, the year's report of the visitations under the Mental Deficiency Act; that embodies about 713 cases. (*Handing in a document.*) If we did the same kind of work with the ordinary asylums, it would mean in Birmingham we should have about 2,000 cases. It would be a big job, but we do feel the importance of it; we should have to enlarge our Judicial Authority and increase the number of visitors to enable us to cope with the work; but I think we should be willing to undertake it.

1882. Of course, you are aware of the existing law with regard to the visits paid by the Commissioners and the visiting committees and the guardians of the poor?—But the guardians of the poor, as I understand, do not examine patients so much as look after the administration of these places.

1883. Probably the emphasis is rather on that aspect of it, but they do go to the places where their paupers are being detained and satisfy themselves that the conditions are satisfactory, and so on?—Yes.

1884. But the visitation you contemplate is an individual visitation of each case?—Yes, that each patient should be seen by somebody once a year.

1885. And that person a justice of the peace?—And that person a justice of the peace.

1886. Do you think that justices of the peace would be able to undertake and overtake that duty?—I think so. We should have to enlarge the number of our visitors; we can make it as large as we like.

1887. Do you find any reluctance on the part of the justices of the peace to undertake this duty?—No; it is done quite cheerfully.

1888. Of course, there would necessarily be many cases in which the visit would really be more or less a formality, would it not? I am taking the case of a chronic pauper lunatic?—Yes, quite. There are lots of cases where the thing is obvious on the face of it, and you need waste no time over it.

1889. You seem rather to contemplate the allocation of so many patients possibly by name to particular justices, so that the same justice would see the same people at recurrent intervals?—Yes, under that Mental Deficiency scheme we keep a very close record of every case; they mostly come under the Stipendiary, because he happens to be at the Victoria Courts all the time; most of those sort of cases come before him, and we keep a very accurate record of cases; they are traced from year to year by the visitors, and the same people see the same cases by arrangement of the rota, and they are quite able to follow the rota.

1890. There would need, of course, to be some elasticity about that, because you could not get the same justice year after year and so on; but what do

you consider would be the value of that visit—what purpose would it serve?—Obviously, that nobody was detained in a place of detention who ought not to be there.

1891. Then it would be in order to ascertain whether a person was or was not being properly detained?—Yes.

1892. But you would also consider that it should have regard to the care the patient was receiving?—Yes.

1893. That an opportunity should be afforded of making complaints about the conditions under which the patient was living or the treatment, or possibly the ill-treatment, the patient was undergoing?—Yes.

1894. Now, on the question of detention, that involves, of course, consideration of the medical aspect of the case, does it not?—Yes.

1895. When you first consider the case brought before you, you have the advantage of the doctor's certificate to aid your mind?—Yes.

1896. On the occasion of a visit of this sort by a justice to the patient, suppose the patient complains, "I am being unlawfully detained here; I am quite sane," and discusses his case with you in an apparently rational fashion, do you think the visitor could really make up his mind whether the case was one of improper detention or not, without medical assistance?—I think so; I think I could; personally I have been over a good many lunatic asylums, and I have no great difficulty in picking out such cases. Where the visitor found a doubtful case, he could order another medical examination; of course there is a medical officer at the institution itself.

1897. Yes, but I want to follow this a little closely, because I see its implications. The visit is for the purpose of interviewing the patient, who, presumably, thinks that he is being unlawfully detained. I have some difficulty in seeing how the visitor could decide, unaided, that the case was one that ought to be liberated, because the layman, without medical assistance, might not be able to detect the pathological condition of the patient. I think you will agree with that?—Yes, I quite see that.

1898. You do not suggest, do you, that the visitor should have the power to do anything more than to report?—Quite.

1899. That is a different thing. The visitor, applying his knowledge as a man of the world and experience, would report to whom?—I should think he would report to the Commissioners.

1900. That he had visited the case and, in his opinion, for what it was worth as a layman's opinion, the case appeared to be one where the patient might be safely discharged?—Yes.

1901. But you would not contemplate such a person being discharged directly by that visitor?—No.

1902. That, of course, would afford a safeguard, but it would be of great value, would it, from this point of view, that it would be an independent person interested in the case who had formed an instructed layman's view upon the case and thought fit to draw the attention of the appropriate authority to it, who would then, with medical assistance, investigate it?—Yes.

1903. And, just to complete the picture, you would contemplate that you would then get a report from the Commissioners disposing of your suggestions?—Yes.

1904. That is to say, either accepting your view, or giving reasons why your view could not be given effect to?—Yes.

1905. Do you think that by this means the aspirations of certain sections of the public for some form of independent inquiry might be satisfied?—I do.

1906. Of course, one has to recognise that the justices of the peace are a very large body of men?—Yes.

1907. And I suppose, like large bodies of men everywhere, they include people of varying competence and varying wisdom?—Yes.

22 October, 1924.]

Brigadier-General Sir JOHN BARNESLEY, D.L., V.D., J.P.

[Continued.]

1908. Would you contemplate that these special visitors would be selected from among your justices?—Oh, yes; we do carefully select the judicial authority and also the visitors under the Mental Deficiency Act.

1909. And they might, in course of time, acquire a considerable amount of experience?—Yes.

1910. At what intervals would you suggest that such visits might be made?—I should follow the procedure that we now have under the Mental Deficiency Act—once a year; after 12 months; then after another 12 months; then subsequently, where a case looks like being chronic, every five years.

1911. Putting it broadly, your suggestion is that the scheme of the Mental Deficiency Act might well be applied to Lunacy administration in the matter of visitation?—Yes, quite.

1912. I notice that you use the services of the Stipendiary Magistrate in Birmingham.—Yes, for certain cases; for the Mental Deficiency cases chiefly; he is always there, that is the reason; he is there every day, and he hears them in his private room.

1913. But you do not use his services in the case of the certification of lunatics?—No, not very much.

1914. You do occasionally, do you?—I should think not, because he does not live in the area, and frequently they have to be dealt with on the spot quickly; he lives a considerable distance away from Birmingham; he only comes in the morning, and goes away in the afternoon.

1915. Now, I think you have just two general observations with which to favour us. First, regarding the place where the pauper cases are seen, some question has been raised as to their being interviewed by the justice in the police premises. Is that the case at Birmingham?—Sometimes we see them in a private room at the Victoria Courts; never in the Police Court itself.

1916. Where are most of the cases seen?—I think most of them are brought to us by the relieving officer, to our private residences; mine are chiefly, either to my private residence or to my place of business; they are frequently brought to my place of business.

1917. I should have thought that must be rather a painful aspect of your duty, to have persons suffering in this way brought to your private house?—It is, but it does not very often happen; I mean, I do not get more than one case a month, or something of that sort, brought to me.

1918. Would these cases, in the event of a reception house or observation place being established, not be more appropriately taken there?—Yes, I think they might be.

1919. And would you not have a rota of justices to attend there, who would deal with the cases at what we could call a hospital as distinguished from an asylum or workhouse?—Yes.

1920. Would not that have the advantage of the place being known; some central place known to the relieving officer and to the public as the place where mental cases were dealt with?—Yes.

1921. It does seem rather an objectionable feature that a relieving officer should have to bring patients to private residences, possibly cases of a distressing character, or to business premises?—Yes.

1921a. But, under the present practice, patients must be taken either to the private residence or the business premises of the justice?—Yes, or the justice must go to his house.

1922. Or, in some instances, as you have said, the justice's room; I suppose it would be at the Victoria Courts?—Yes.

1923. It occurs to one that this reception house might be made a place where the justice saw the patient under the best circumstances?—Yes.

1924. That is another use to which these premises might be put, is it not?—Yes.

1925. Then I think your other observation is one that we have anticipated, that you have very little experience in Birmingham of the fourteen day order?—Yes, very little.

1926. *Earl Russell*: On the last point about the place where the patient is seen, we had evidence from a relieving officer yesterday which related to Bethnal Green, and he told us that there his practice was to take these patients at once on his own responsibility to the workhouse which, as you know, he may do, for three days, and that the justice then generally saw them at the workhouse. That would obviate the inconvenience of taking them to a private house or a place of business?—It would, but that is not done with us; our relieving officer does not do that as a rule.

1927. Is the reason for that that you desire to avoid bringing the workhouse into it, if possible?—Yes, I think so. Of course, if a case is violent and dangerous, it has to be treated in that way, because they cannot get them about very well.

1928. But it is a method by which they can be detained in a safe place for a day or two, until a justice can be brought to see them?—Yes.

1929. But in Birmingham you do not use either that method, or the fourteen day order?—No, very little.

1930. You said something just now on this question of visiting the patients that rather startled me. I do not know whether you wish it to go on the note as your considered opinion, but I understand you to say that, having visited an asylum and having had a conversation with the patient there, you could make up your mind as to whether the patient was sane and fit to be discharged?—Not fit to be discharged; only fit to be reported upon.

1931. But to be reported upon in the sense of reporting that in your opinion he was a safe and proper subject for discharge?—Yes.

1932. Do you really wish to tell us that you could make up your own mind on that, without any medical assistance?—I think I could make it up sufficiently to say that it was a case which ought to be investigated.

1933. And without looking at the case books or asking the asylum doctor?—But you would have all the case books before you; you would have the whole of the patient's record.

1934. You did not say that. You would of course have gone into the record and you would have spoken to the superintendent or medical officer of the asylum?—Yes.

1935. So that you have that much assistance before you come to your conclusion?—Quite.

1936. Then, on the question of extra visits, I want to call your attention again to the number of visits that are made already. You know that the friends and relatives of the patient can visit him?—Yes.

1937. You know what the provisions are as to the visiting committee. Section 188: "At least two members of the visiting committee shall together, once at least in every two months" (that is six times a year) "inspect every part of the asylum, and see every patient therein, so as to give everyone, as far as possible, full opportunity of complaint"?—Yes.

1938. Then, in addition to that, I think I am right in saying that the Lunacy Commissioners visit at least once a year and see every patient?—Yes.

1939. In view of that number of visits and by those public people, do you really think that these extra visits by the justices would serve any useful purpose?—I think they would be very useful.

1940. As an additional safeguard?—Yes; it is only once a year.

1941. Was that the general opinion of your meeting?—That was the opinion of the meeting, yes.

1942. Then I want to go back to the question you were first asked about—certification. You said that in your opinion the certificate of a second doctor would always be desirable?—Yes.

1943. Can you tell us, roughly, what is the cost of certifying a pauper lunatic?—No, I am afraid I cannot.

1944. Of course, a second doctor would cost more, would it not?—Of course it would.

22 October, 1924.]

Brigadier-General Sir JOHN BARNESLEY, D.L., V.D., J.P.

[Continued.]

1945. And in all the cases that have come before you, you have had no difficulty in making up your mind on seeing the patient and on the opinion of one doctor?—No.

1946. Having regard to the fact that this cost has to come out of the rates, do you think that in actual practice any real additional safeguard would be obtained by having a second doctor?—It would be an additional safeguard, undoubtedly.

1947. But how many cases have there been in which you or your colleagues have had so much doubt that you have remanded the case for fourteen days' observation—very few, I understand?—Very few.

1948. Where you have remanded for observation you can then, if you think fit, order a second doctor's report to be obtained?—Yes.

1949. In view of all that, do you really think it necessary in the cases where there is no doubt, which, I gather are the largest number, to incur the expense of a second doctor's certificate?—No, I should think perhaps not.

1950. Because we must have regard, of course, to the expense?—Of course you must.

1951. You are acquainted no doubt with the Mental Treatment Bill which Lord Onslow introduced and which dealt with the subject of voluntary boarders?—Yes.

1952. You may know that I introduced a similar Bill about 10 years ago?—Yes.

1953. And I think I am right in saying that it passed the House of Lords twice, but it got no further. That provided what you were suggesting this clinic should do: give an opportunity to a person to enter an institution of this sort, in the hope that certification might not become necessary, and to avoid the penalties which a doctor or anybody else would now concur, who kept a certifiable lunatic for profit without having him certified. Your view is that an institution of that sort would go a long way to deal with cases that would actually have in the end to be certified?—Yes.

1954. And in the case of short, violent insanity, say alcoholic insanity, the patient might probably recover without ever having to be certified at all?—Yes.

1955. Were all your colleagues also of opinion that this would serve a useful purpose?—Yes.

1956. And in the same establishment you would have some persons under restraint under a justice's order for observation when necessary?—Yes.

1957. And if you had such an institution, I suppose you would exercise much more freely your power of remanding a case where you felt the slightest doubt?—Yes, I think so.

1958. You do not yourself apprehend what it is known the public rather apprehends, namely, that this would be an undue infringement of their liberty—the voluntary boarder, I mean?—No, I do not think so.

1959. You are aware, no doubt, that there is a feeling that this Mental Treatment Bill is a fresh infringement of the public liberty?—Yes.

1960. But you regard it really as being entirely in the interest of the patient himself?—Quite.

1961. *Mrs. Mathew*: I was rather anxious to know about this further enquiry. If in the discretion of the justice he thought a case ought to be looked at again by a doctor, would he refer it to the same doctor who had perhaps certified him?—No; I think it should be another doctor, the second time.

1962. Do the visitors see all the patients privately?—You mean the visitors under the Mental Deficiency Act?

1963. Yes?—I do not quite know. I am not a visitor myself; but I imagine they do; I mean they have the same opportunities as when you visit a prisoner; every prisoner has the opportunity of seeing a visiting justice privately if he wishes, and surely the patients must have the same opportunities as prisoners have.

1964. *Sir Humphry Rolleston*: With regard to the question of two medical certificates: suppose that they do not agree, what action would you take?—Well, I do not know; the justice would have to get a third certificate, I think.

1965. What is the practice in Birmingham? That is not in your own experience, because you say you have not much to do with private patients. What would happen supposing two certificates did not agree; is the case discharged?—I certainly think the justice would not make an order. My colleague, Mr. Lord, may know more about it, because he has had cases of that kind.

1966. There is one matter I should like to return to. You thought it might be advantageous to combine the reception house, where people would either be sent by you for observation for a period of fourteen days, or where they would go in voluntarily for residence, giving up their liberty for a time, on the one hand with the outdoor clinic on the other, which I should have thought would have been very much better separated from it and attached to a general hospital; so that people who felt that they were becoming unsettled in their mind could go to a general hospital, and would not attract the same attention as they would if they were seen going to a place where it was known that people of the other type were being taken. Why do you think it would be advantageous to combine them?—I rather think that it points in the direction of the establishment of a mental hospital. I do not think we could undertake either with the Queen's or the General in Birmingham to deal to any large extent with mental cases.

1967. They do not have an out-patient department?—We have an out-patient department, but if a person is suspected of being insane, he is not dealt with there.

1968. These are people who suspect themselves of being insane, feel that they are not all right; and there are a certain number of hospitals, like St. Thomas's, where persons would go very much more readily than they would to a place where they knew other people had been taken, would they not?—They might.

1969. *Sir David Drummond*: You have no licensed houses in Birmingham, have you?—No, none.

1970. What provision have you for private patients—acute cases?—We have two very large asylums.

1971. Private asylums?—No; public asylums.

1972. That is to say, your private patient is brought to the public asylum?—Yes; there is no alternative; we have no private asylums in the city.

1973. Does the relieving officer never bring a patient to you without a medical certificate?—No; he always has the report with him.

1974. The doctor has always seen the patient before you see him?—Yes.

1975. *Sir Ernest Hiley*: Could you tell me how many cases are certified by the justices in a year?—No; I cannot tell you the exact number; but we have about 2,000 lunatics.

1976. Every year? Have you any idea—does it run into hundreds?—Yes, I should think so; I cannot give you any idea really.

1977. Could you tell me this then: what proportion would you say of the cases are such that you would send to this reception home for further observation?—I could not say.

1978. Have you formed any idea, or have the Birmingham Justices formed any idea as to the size of this suggested institution?—No, I do not think we have.

1979. Then just one other question. Have you in your own experience, or have you heard from any of the justices, of a case where they have had to send for a third doctor on account of a disagreement of the two?—No, I have never had a case.

1980. *Sir David Drummond*: May I ask if there is special accommodation for private patients in the public asylums, or are the patients treated just on the lines of the paupers?—There are private rooms, and that kind of thing.

22 October, 1924.]

BRIGADIER-GENERAL SIR JOHN BARNSELEY, D.L., V.D., J.P.

[Continued.]

1981. Special arrangements?—Yes.

1982. *Chairman*: I was just going to bring that point out. You have in your jurisdiction two public asylums?—Yes.

1983. And in those public asylums you have accommodation for private paying patients?—Yes; they do pay.

1984. Can you tell me this? Is the accommodation in those asylums over-taxed at present?—Yes, very much; we are overflowing to the adjoining county.

1985. Where you have to pronounce an order, the order must designate the institution to which the patient is to be sent?—Yes.

1986. Do you find any embarrassment arising from the fact that the asylums are overcrowded, or, at any rate, that their capacity is fully taxed, in designating the place to which the patient is to be sent?—No; it is generally ascertained before they come to us where they can be taken in.

1987. Does the relieving officer inform himself of that?—Yes.

1988. But what happens, suppose both the public asylums in your area are full?—Well, we have three, as a matter of fact; we have one in the City at Winson Green, where all urgent cases go to at once; then we have two in the country—Rubery and Hollymoor. When those three institutions are full, which happens to be the case at the present time, I think, as a matter of fact, we have an arrangement with the Worcester County Council, and the cases are treated at the Barnsley Hall Asylum, which is a county asylum, on payment, of course, from the Birmingham authority.

1989. Then the Birmingham authority has a contract with the County authority for the reception of Birmingham cases?—Yes. I do not know the details of it, but I know it exists.

1990. So that you have not had a case before you for which you could designate no asylum?—No, never.

1991. You spoke of the medical certificate being brought to you by the relieving officer along with the case?—Yes.

1992. I was rather struck with the language of Section 16 of the Act, which seems to contemplate that the justice should himself call in a medical practitioner. May I just remind you of the language of that section? "The justice before whom a pauper alleged to be a lunatic or an alleged lunatic wandering at large"—it is that case—"is brought under this Act shall call in a medical practitioner, and shall examine the alleged lunatic." Have you ever had occasion yourself to call in a medical practitioner or have you always proceeded upon the certificate already furnished?—I have always proceeded upon the certificate already furnished.

1993. In the case of reception orders applicable to private patients, I notice that in the proceedings the alleged lunatic is, of course, a person who may be present, and also any one person appointed by the alleged lunatic for that purpose, that is to say, a friend or a relative may be asked by the lunatic to be present during the proceedings. There is no comparable provision, is there, in the case of the pauper patient, whereby he might have with him some friend or person whom he desires to assist him?—No, I do not think there is such a provision, but as a matter of fact they always do; they usually have a friend with them.

1994. Do you think it is desirable that a person coming before you should have the assistance, if desired, of a friend or a relative, or representative of some sort?—I think it is an advantage.

1995. I suppose the proceedings are informal; they are not conducted with forensic procedure?—No; they are quite informal.

1996. You say that in practice there is generally somebody else present as well?—Usually.

1997. For example, who?—I mean a relative—husband, wife, father or mother.

1998. Comes with the relieving officer?—Comes with the relieving officer and the patient.

1999. Do you discuss the case with the relative?—Frequently, yes.

2000. Are the proceedings in private?—Yes.

2001. Would you think it desirable that the person whose case you are considering should be legally represented before you; that is to say, should be represented by a solicitor?—No, I do not think so.

2002. Have you ever had a case in which the relative has protested against the relieving officer's conduct in bringing his relation before you?—The patient himself?

2003. No; the relative?—No, never.

2004. Have you ever had a case in which the person alleged to be insane has himself protested against an order being pronounced?—No, I have never had that.

2005. Do you tell the person who is before you what are the grounds upon which the medical certificate proceeds—I mean what are said to be his mental defects?—No, I do not think I do.

2006. Do you direct your questions to what is before you?—Yes.

2007. You have the facts upon which the medical certificate has proceeded?—I have the report of the doctor, and I know exactly what the patient's weakness is and the evidence of insanity, and my questions are usually directed to bring that out.

2008. But do you think it would be expedient as a step in the proceedings to read to the person the report upon his case?—No, I do not; I think it might be very detrimental.

2009. The report, I suppose, might say that the case was a hopeless one, or other words to that effect?—Yes.

2010. It might be undesirable to read that to a patient?—Yes.

2011. Do you think that justices in practice see that the topics upon which the medical certificate proceeds are properly explored in their examination of the person before them?—Yes, I think they are as a rule.

2012. Are the grounds upon which the case is brought before you disclosed to the relative who, as you say, accompanies the case?—Yes, I think so; there is no secrecy about it.

2013. If any relative who came with a case before you said, "I should like to see the medical certificate which you have," would you show it to him?—Oh, certainly.

2014. And, equally, if the patient was entitled to be accompanied by a third party, as a private patient is, would you think that third party ought to see the grounds?—I think so, certainly.

2015. But, following what you said, probably with an injunction not to show them to the patient?—Yes.

Chairman: Thank you, Sir John. We are much obliged to you for coming here.

(The Witness withdrew.)

Sir ROBERT WALDEN, C.B.E., J.P., called and examined.

2016. *Chairman*: Sir Robert, you are Chairman of the Visiting Magistrates of Institutions for Defectives for the County of London?—Yes.

2017. You are also Chairman of the Bench of Magistrates, Hanover Square Division, in the County of London?—Yes.

2018. And you have acted as Chairman of the Metropolitan Asylums Board, for the period 1913 to 1919?—Yes, I have.

2019. You are also ex-Chairman of the City of Westminster Board of Guardians, and an ex-member

22 October, 1924.]

SIR ROBERT WALDEN, C.B.E., J.P.

[Continued.]

of the London County Council Mental Deficiency Committee?—Yes.

2020. We therefore have before us a gentleman of large experience. I understand that you desire to put before us views derived by you from that experience on one or two of the main topics of our reference?—Yes.

2021. First of all I gather that the question of the personal examination of a case by a magistrate is a matter to which you attach importance?—I do attach considerable importance to it. I think that in every case where a magistrate adjudicates, he should see the person and ask questions, and of course hear what the alleged lunatic has to say; it is a very great advantage to know the personal conduct of the person. For instance, under an urgency order I believe that a patient may be seen by one medical man; he is removed to some institution and then within seven days he is seen by a second medical man, and the documents can be placed before a magistrate, who can sign that instrument. I think that in that case and in all cases, the magistrate should satisfy himself by his personal observation and contact with the case.

2022. If one may just put it broadly, you think that a justice who has this responsible duty to perform, should not proceed merely upon paper information?—That is so; that is putting precisely what I think.

2023. You think that he should have a personal contact with the case?—Quite.

2024. Under the existing regime, in the case of a pauper there is an obligatory personal interview, is there not?—There is, yes.

2025. In the case of a private patient if there is no personal interview there is a right on the part of the patient to demand an interview with a justice within seven days after reception?—Yes.

2026. One sees that your criticism comes in at this point, that in the case of a private patient who does not resort to that right, an order is pronounced where there has been no personal interview at all?—The patient of course may not know his right, and under the circumstances he may not ask for an interview, but it is necessary, I think, before the magistrate signs the document, that he should see the person.

2027. That is a question of general principle?—Of general principle I think in every case.

2028. Have you yourself had to deal with many cases?—Not a great many; my work has been chiefly administrative, but I have in past years seen a good many cases altogether, and I have recently, of course, seen a few.

2029. It would be interesting if you would just tell us, in the light of the actual experience you have had of dealing with cases—have you had difficulty in saying of a particular person brought before you, "Well, I think this case is one that ought to be dealt with by order" or not?—I have had difficulty sometimes. I have asked for cases to be put back and further observation to be made. I mean it is so very important, I consider, that one should be fully convinced in one's own mind, independently almost of medical evidence, that the patient is mentally disordered. You may converse with a person for ten or fifteen minutes, or even longer than that, and you do not find anything wrong at all, and then something happens, something is mentioned, and the patient goes off wrong altogether. Then there is no doubt about it; very often it takes you days to find out the condition of the patient's mentality.

2030. Are you speaking just now of private patient cases, or of pauper cases?—Pauper cases chiefly.

2031. In the pauper case the provision of the statute is that the justice is directed to call in a medical practitioner. Was it your practice to call in a medical practitioner, or did you find that the relieving officer was already armed with a certificate?—No, in every case there is a medical practitioner present, and there is the relieving officer with his

certificate. Do you wish me to tell you the procedure?

2032. I would like to know how you have done it yourself. Stage the matter for us, so that we can visualise it.—What really happens is that the case paper is put before me, and I read it over carefully. Then, if anything occurs to me, I ask the medical man or relieving officer for an explanation. Then the patient is brought in.

2033. *Earl Russell*: Is it before or after the patient is brought in that you ask the medical man to explain?—If on going through the case paper I find that there is anything obscure that I want elucidated, I ask that question before the patient is brought in. Then the patient is brought in, and I talk to him in as pleasant a way as possible, put him at his ease, and then ask him various questions. Very often, in most cases, the relatives have been informed, and they are there, they also come in. Then you ask the man various questions which you think will not do any harm to the patient; you take him quietly. You commence at first, of course, by general conversation. Then he will generally answer your questions, and you can soon get an idea as to whether there is anything the matter with the man. Very often the people who come with the man will give you some very valuable hints, or information.

2034. *Chairman*: Do you direct your conversation, after the first informal observations, to the matters to which attention has been drawn in the medical certificate?—Yes.

2035. *Sir David Drummond*: Are these cases that have already been brought to the workhouse by the relieving officer?—They may have been brought to the workhouse by the relieving officer or by a policeman; very often they are brought by a policeman. A man is found wandering in the street; there is a crowd there. He comes in in the middle of the night very often, and the policeman is there and tells you how the case occurred.

2036. But they have nearly all been to the workhouse?—All these pauper cases we are talking about now have been taken to the receiving ward of the workhouse.

2037. *Sir Humphry Rolleston*: And they have had a medical examination?—Yes, a medical examination. The doctor then reports to the magistrate his view of the case, which is done, of course, before the alleged lunatic. My idea is to make it as plain as possible, not to hide anything, but let the lunatic know as far as he can. Very often he takes a very intelligent view of the case.

2038. *Chairman*: You say you have a medical certificate before you?—Yes.

2039. When and where has that medical certificate come into being?—It is a form that has been filled in by the relieving officer, I suppose; and the medical man, of course, studies it and gives you his view of the case.

2040. But the medical man is apparently the medical officer of the workhouse?—He may be any one; but the guardians have a medical superintendent who is a very experienced man in these cases. We could call in any medical man, but it is better, I think, to have a man experienced in lunacy. The man I am thinking of has had over 20 years' experience, quite an expert.

2041. But the statute rather suggests to my mind that the selection of the medical practitioner who is to assist you shall be in your hands?—Quite.

2042. But in point of fact you find that a medical gentleman has already intervened?—He is there on the spot; it may be a bad case and a difficult case, and he is consulted. The magistrate does not appear until the day afterwards, perhaps; that is to say in pauper cases, of course.

2043. Have you ever found yourself at variance with the medical man?—I will not say at variance, but I have differed from him, and I have said, "I think this case ought to be put back for further observation; I am not prepared to sign an order."

22 October, 1924.]

SIR ROBERT WALDEN, C.B.E., J.P.

[Continued.]

2044. Has that happened often?—No, not often, but now and then.

2045. What sort of means of resolving the difficulty is there if the justice sitting in his judicial capacity and the medical man differ as to what should be done with the case?—If they differ materially after observation, I think you should have another magistrate and a sort of medical board, consisting of an expert and two or three others that you could call in.

2046. There is no existing machinery provided for that purpose?—No.

2047. And the case has not arisen in your own experience?—No, not to that extent.

2048. I see nothing to prevent you calling in any medical practitioner you liked, and you could select an alienist for the purpose.—I dare say. If it is a very difficult case I would rather have an expert to advise me.

2049. *Earl Russell*: If the doctor who had signed the certificate said to you: "It is no good; I am quite certain the man is mad," you probably would not take the responsibility of discharging him without consulting a second medical man?—No. I should like to be able to call upon somebody who has an expert knowledge. An ordinary doctor has not had the experience; he has not had the training. You want to be sure before you do this if there is a doubt.

2050. *Chairman*: Do you in your practice tell the person who is before you what are the grounds upon which he is alleged to be insane?—Yes; I give him as much knowledge as I think desirable. I go through the case paper and give him the information, whatever it is. I think he ought to have it.

2051. Do you do it by directing your questions to the matters which have been emphasised in the report, or do you actually read to him what is said of him?—I read part of it or make a comment and explain it. He might not get a grip of the thing unless you explained matters.

2052. I can conceive that there may be things in the medical certificate that it might be detrimental to tell the patient?—Yes; I should be careful about that as a matter of fact. You want to use a certain amount of tact in these matters.

2053. But in discussing with him his case, do you specially direct the conversation to the subjects emphasised in the medical report?—I say, "Now tell me all about it. What has happened?" and get his reply to it. He understands part of it generally.

2054. It is always better to be concrete rather than abstract. Supposing the report said, "This man suffers from a delusion that he is Napoleon," would you tell him that?—I should certainly tell him that.

2055. Would you say, "You are said to be Napoleon. Do you think you are Napoleon?"—Yes, I should say that, certainly.

2056. If he said, "Thou hast spoken," you know where you are?—Yes.

2057. On the other hand, if he said, "I never knew anything so preposterous in my life," you would naturally proceed to probe the matter?—Yes.

2058. I suppose you regard it as important that you should have some discretion as to the extent to which you will put before the alleged lunatic the information you have?—Yes; you must trust someone in the matter. Magistrates are chosen men, but some of them dislike the work. I think it would be better to have a panel. In London there are about 316 judicial authorities and they are not all equal in that respect; they do not take the same amount of interest in it. Some of them cannot do it. I have known a man say, "Oh, no, I cannot do that work; I would rather be excused."

2059. As a matter of temperament one can understand that the duty would be much more painful to some people than to others?—Yes. If you are of robust mind you can stand it, otherwise it is painful to you.

2060. If any relative said "I would like to see the medical certificate which is before you," would you

show it to him?—Certainly; I should give them all the information I possibly could, the relatives, the wife, or the father, or whoever it might be.

2061. Any responsible person who is there with the patient?—Yes.

2062. *Earl Russell*: In fact you would give any sane person the fullest opportunity of fighting the case?—Yes; I should hide nothing; I should satisfy them as far as I possibly could. You have nothing to hide; you are acting in the interests of these poor creatures.

2063. *Chairman*: I suppose you endeavour to prevent the proceedings having the aspect of a Court as much as possible?—Yes, quite.

2064. You do not want to import a forensic aspect into the transaction?—No, I do not think it is necessary really.

2065. Now it follows upon what you have been telling us about the possible doubtful case, or the case where there might be variance between the medical man and the justice, that you are in favour of there being some arrangement for the provisional or experimental treatment of cases?—Yes, I am quite in favour of that.

2066. Such institutions have been variously described as clinics or reception houses, or by other terms. Do you think that there should be interposed before the actual certification of any case such an intermediate stage?—I think in a great many cases it would be advisable that provision should be made for observation. I think that this place, whatever you call it, I venture to call it hostel—I do not like the word altogether, but that is subject to consideration—should be under the management of an expert neurologist, and he should have trained people under him, trained nurses, both male and female, having medico-psychological and other certificates, and they should be able to report on the case after a time. I think that would be better than the present system. A person, for instance, may be taken up out in the street. They lose their memory in the middle of the night and they may be taken into a workhouse and put into a ward where there are screaming and violent people. It would upset me, and there might be very little the matter with me. I might have had some domestic trouble—I will not say I might have had too much drink, but in such circumstances a man might be taken there. There this man or woman, nicely dressed, educated and so on, is suddenly plunged as it were, into this undesirable place. There should be a means of classification, I do not mean as to whether a man is rich or poor, but as to his mentality. He may be a poor lunatic, nothing very harmful about him. On the other hand, he may be very violent and do a great deal of harm, ready to commit a murder, or something of that kind. It is very hard to place that sort of person with others in one observation ward in a workhouse. I do not say it in any way disparagingly of the workhouse, but the people who are attendants there have not any expert knowledge; and the surroundings are not suitable for observation. I think at the beginning you want to be very careful how you treat the alleged lunatic. It is the beginning and the end that are important.

2067. That is very important. And another point is this: We have all been a little struck with it in certain instances at least. Cases have to be designated as pauper, possibly quite undeservedly. Now the provision of an observation period such as you figure, would have this advantage, that the cases could be sorted out, not merely according to their ailments, but also according to their ability to furnish the means of their own treatment?—I quite agree.

2068. Another disadvantage to which you allude, I see, is this, that at present the workhouse is the place to which alone you can remand?—Yes, exactly.

2069. That is a place which by the nature of things cannot have the same facilities or equipment?—The same surroundings, no.

2070. Either for treatment or for diagnosis?—Quite.

2071. Do you contemplate that this transitional period might have the result in many cases of a cure

22 October, 1924.]

SIR ROBERT WALDEN, C.B.E., J.P.

[Continued.]

being effected, so that you would hear no more of these cases?—Certainly in some cases.

2072. You would hear no more about them except possibly to write a formal discharge?—That is right.

2073. Is it desirable to eliminate both the workhouse idea and the asylum idea from this stage?—I think that it should be cut off from both the workhouse and the asylum. If you could send these cases to such a place as I have mentioned already, it would be very desirable in the interests of the patients. You would give the patient a better chance of recovery. Some people are very sensitive, and the idea of being sent to a workhouse or an asylum would have a very detrimental effect upon the mind, I think.

2074. Let us consider those people in this observation institution, and what might befall them. At the end of the period of trial it might be found that cases were obviously cases for certification. Then they would pass to the public asylum, or to the workhouse, if they were harmless cases which might be housed there, or they might possibly be the subject of an application for a reception order to go to a licensed house, or any of the other methods of treatment of private patients?—Quite.

2075. On the other hand, it might be found as the result of the trial that a person was not a certifiable person, and ought to return to his friends?—Yes; often it might be so.

2076. Or during the period of provisional detention, the case benefiting by the quiet and treatment might effect a complete cure?—Yes, in about 10 per cent. of the cases, I should think.

2077. It might be a mere transitory attack and due to some brain storm, as a layman would say?—Yes.

2078. Then the case would no doubt be brought back to you at once by the medical officer of the institution, and a discharge pronounced?—Yes. There should be a rota of magistrates, and they could visit an institution of that kind frequently. Then there is the emergency case which required to be dealt with at once. A man has recovered; the medical expert is quite satisfied and the magistrate is quite satisfied; he reports to his friends and there is an end of it.

2079. Do you contemplate that during this period of observation the justice should visit?—If you had an institution of the kind I have mentioned, there would be many cases, and no doubt you would have day to day work to do in that direction.

2080. Do you think that that proposed place would be a suitable place for the patients to be brought to the justice for certification?—That is what I mean; get away from the workhouse altogether. The relieving officer or the policeman would take the patient to this hostel, or whatever you call it, and the patient would be examined there and would not go to the workhouse at all.

2081. It would also obviate bringing the patient to the justice's private residence or to his place of business?—Yes, that is undesirable, of course.

2082. Do you contemplate that use might be made of such a place for what one might call out-patients?—Yes, it would be desirable, I think. Of course it is a matter of money, but I think when you consider health and the liberty of the subject, the money is well spent on these cases.

2083. You are a gentleman of large experience of local administration. How do you look at this from the point of view of the expense of providing such a scheme?—I look at it in this way. Of course, the lunacy accommodation in this country is overcharged at present, and you will have to make provision for it, and that will be expensive. If you provided two such places for London, for instance, one north and one south of the Thames, fairly large places, and spent the money in that way, you would relieve the pressure. There would be a number of people going to these places, and they would relieve the pressure on the asylums. I would suggest that

you should build one or two and make the experiment, and see how you got on with it.

2084. Then you think that empowering legislation would be the appropriate thing at first, rather than directory legislation?—I do not know. I rather think that the Minister of Health by an Order could assist matters in that way. I have not gone into the legal position. It might be necessary to have an Act of Parliament.

2085. Have you found that the limits of accommodation in the Metropolis have been about reached?—The accommodation is inadequate, of course, now, and has been, I believe, for some little time. I was Chairman of a large mental hospital where there were imbeciles, and we also had lunacy cases there, not bad cases; but we cannot find accommodation for them; the authorities are glad to get accommodation anywhere.

2086. Your scheme of observation, of course, assists one there, because we have been struck with this, that there does not seem to be any method of distribution of cases according to their class; that is to say, that a bed in an asylum may be occupied by a chronic case, a hopeless case, which might quite equally and happily be relegated to a workhouse, while in the workhouse there may be a case which would benefit by the special equipment of an asylum?—I would rather have a patient in a mental hospital than a workhouse, because it interferes with the working of classification and that sort of thing. It is rather hard on the poor old people in a workhouse to have even a harmless lunatic near them and associating with them.

2087. Do you think it would be desirable to associate the proceedings for certification with such a hostel as you have described? Might that import an unpleasant element?—I suppose it would. It is difficult, of course; the whole question is very intricate, and it requires consideration.

2088. It has been suggested to me that possibly the certification proceedings within the hospital might be rather prejudicial to its character as a hospital?—Then you would go back to the old workhouse again.

2089. You must, of course, have some place, unless we just carry on with the private residence of the justice or his place of business, which seems rather undesirable?—Yes.

2090. The police court, I think, is surely undesirable?—I think so; I would not go to the police court. It is a question that you will have to think about; it is difficult.

2091. One must bear in mind always that every new facility is expensive?—Exactly.

2092. And we must be satisfied that it is valuable before we could even recommend it?—Sufficiently valuable. You should get a *quid pro quo*, I mean. It is altogether very difficult, but I do think the time has come when some improvement should be made, really.

2093. Have you any view as to whether these places of observation or hostels should be under the jurisdiction of the Board of Control, or independent of the Board of Control?—I should think they ought to be under the Board of Control.

2094. Have you had any experience yourself of the workings of the Board of Control?—From time to time, yes. I have always found them a very reasonable body, always very helpful, and they do the best they can.

2095. You have been brought in contact with them?—Yes; I know the Board of Control very well.

2096. This is quite a general question: Do you regard their position and their powers as affording a public safeguard for these unfortunate people?—Certainly, I think so. They are very careful in what they do, as careful as anybody can be, and you must trust somebody. I do not know what you are to do if you have not somebody of that kind.

2097. Now have you any views to give us on the question of visitation generally?—Well, of course,

22 October, 1924.]

SIR ROBERT WALDEN, C.B.E., J.P.

[Continued.]

they have a different system, I believe, in the country, with which I am not very well acquainted. They have visiting justices, which we do not have in London.

2098. How do you manage in London with regard to your institutions here—what is the system of visitation?—I was Chairman of one institution, and our custom was to go once a month as a visiting committee. They hold a Board meeting in the institution, and they hear what takes place, anything that happens with regard to the nurses or the attendants, or the medical men, or the patients, and every case is carefully gone into. When I was Chairman I used frequently to go. I have even been on Sundays and at different times, when I had not been expected, to see what happened, and I have always found that the institution is well managed. The medical superintendent is a man who has had many years' experience. In every case he is chosen for his special qualities; he has a high position. He is very careful and very jealous that he keeps it. The other medical officers are also under the control of the committee, and they see that everything is perfectly straightforward, and everything as a matter of fact is very carefully done.

2099. But what I would like to know is this: When you visit do you have an opportunity of seeing individual patients and talking with them?—I go amongst them, and they say to me: "Oh, you have not been to see us for a long time; very glad to see you"—all that sort of thing. They know me; they tell me sometimes stories which are not quite true, but it is a relief for them to talk to some one like myself who goes among them and passes a joke, and the time of day, and they appreciate it.

2100. Have any of them grievances?—Very frequently they have grievances, and letters.

2101. If you get a letter do you make a point of seeing the writer?—It all depends upon the letter. It may happen that every time you go the same person has a letter for you; but every complaint that is made by letter I read very carefully, see the patient, the medical man and the case paper, if necessary.

2102. Do you see the patient alone?—Yes, if I think there is anything in the case. I remember going to one institution where a man impressed me very much. I took his name and saw the medical man about it. "Oh," he said, "he is a most dangerous man." That man impressed me that he was absolutely sane. The medical man said, "While he was talking to you we had someone near you." I went into the case paper and found that he was a hopeless man, very violent. I mean, in every case I do that. They have always a great deal to say to you. They let off steam, as it were, and they are satisfied. Another patient will wait and say: "Oh, Sarah, you have had your time; I want to see the gentleman," and then she has a turn.

2103. Do you say that in no case you have found any justification for complaints that have been brought before you?—Yes, there are cases sometimes, minor cases.

2104. We are very much concerned with the question of the safeguards. No doubt the great majority of cases are all right, but one wants to know that there are means whereby if anything goes wrong it can be ascertained and remedied?—That is so. There are minor cases, of course. A nurse perhaps may give a patient a push, or sometimes a woman loses her temper and she gives her a bang, or something of that kind. I have had one or two cases of that kind mentioned to me, and I have gone into them thoroughly with the medical man, and have gone into the record of the nurse or the attendant. There are some cases where there has been a quarrel between patients, and a man has a black eye.

2105. You mean two patients?—Yes. The attendants come and of course separate them, and use a certain amount of force. Of course, the patients are great strong men and they have to

restrain them. They both of them blamed the attendants, but it was not so really. I went into the case with the medical superintendent and found that it was a case of these two patients fighting. All that the male nurses or attendants did was to separate them. In some cases, of course, where we find something wrong has been done to the patient, it is reported to the Board of Control, and we get rid of the attendant at once. To my mind the most serious thing that can happen in that way is violence to a patient.

2106. But does the visit which you make give you an opportunity of personally investigating such matters, and do you afford the patients in the asylum the opportunity of bringing before you anything of which they complain?—I do. I have had telegrams sent to me at my home, "Can you kindly come at once," and I go and hear the case. If I think it is a case to be brought before the Committee I bring it before them; if not, I deal with it as I think best.

2107. As far as you are concerned, representing the local authority, I suppose you have no interest whatever to detain a patient in an institution?—We want to discharge them, of course, if we possibly can; all public institutions do, I believe. They have no interest except the interest of the patient, and they want to make room there; space is always wanted. It is undesirable to keep anyone if you can get rid of them. There are people in an asylum whom you could get out if there were anyone to look after them, but they are so helpless that they would be taken advantage of; they would do silly things in the street, and they are very much better in the asylum; they are very happy there. The ordinary idea is that these poor creatures are in misery all the time, but it is not so; they are quite happy if they are properly treated.

2108. We have heard that many of them labour under the painful feeling that they are being detained although they are quite sane?—Most of them do that.

2109. I should not conceive that that was a state of happiness?—No. What they complain about is that they do not see their friends. These poor people have been in an asylum for years; their mothers and fathers are dead, and sometimes all their relations, and they have no home to go to. The only thing to do would be to send them back to the workhouse, which is done sometimes.

2110. Have you found that as a result of inquiries made it has been frequently necessary to dismiss attendants for ill-treatment?—No, not often. As you know, in all classes you get the wrong sort of people, and you have to get rid of them; but I do not think the percentage is very high, because they know that if they want to keep their jobs they must behave properly and treat the patients properly, and that is always impressed upon them.

2111. Have you ever found in your experience the case of a patient who seemed afraid to tell you of his grievances? It has been suggested, you know, that sometimes a patient may be so much under the domination of a nurse or an attendant that he is frightened to tell the visitors what has happened?—I believe that is so, sometimes.

2112. Have you ever seen people in a cowed state, or in a state of fear?—Not cowed, but they would rather take you into a corner and explain things to you, independently of the surroundings.

2113. Would you always give a patient the opportunity of seeing you privately, away from an attendant?—Yes, always.

2114. What provision is there for private interviews?—You can take them into a private room or into the Board room. If it is a fine day you take them round the airing court and talk to them in that way.

2115. I can see that even so there must be some limit, because a dangerously homicidal patient might say he would like to see you alone, but I can hardly imagine that it would be reciprocated.—No; you have to run that risk, of course. You never know

22 October, 1924.]

SIR ROBERT WALDEN, C.B.E., J.P.

[Continued.]

what risk you run really. As a rule they look upon you as their friend, and that is what you want to encourage. I always say to them, "Do not be afraid of saying anything to me; I will take care it does you no harm. I am here to look after your welfare and do the best I can." They say, "You promised the last time that you would let me out, but I am here still." I mean you cannot help that.

2116. Have you any views as to the desirability of some independent tribunal or independent form of investigation of the mental state of a patient in an asylum?—I think there may be cases, although I have never had one, where a patient is sane—he thinks he is sane, and it is a difficult matter. There is just a border line, and you might want to consult an expert on the matter.

2117. There is at present, as you know, provision for the examination of patients by an independent doctor called in—that can be done.—I do not think so much of an independent doctor in a case of that kind. It all depends who the doctor is. He should be an expert and a trained man, with experience; it is so difficult if there is a doubt between the medical superintendent and another doctor, a private doctor, or a magistrate. They should have the power to call in some experienced man to consult.

2118. Again, you would not consider, would you, that it should be appropriate to make such an investigation on forensic lines?—No; I do not think there would be much good in that. I mean then it becomes a legal question, and so many side issues are brought into it that it really does no good. I am speaking from a medical point of view, of course. You are examining a patient as to his mentality, and that sort of thing, and as to his disease. You do not want to bring a lawyer into it.

2119. I was thinking of what one may call the apparatus of the Law Courts, examination and cross-examination, and so on. Those features do not strike you as suitable for this particular inquiry?—No, and very often the Judge does not know.

2120. He has to proceed on the evidence, of course?—Yes

2121. But by what means short of judicial inquiry do you think there could be provided an independent safeguard?—I should think you might have a Board with a medical expert, the medical superintendent and a magistrate. I should always have the magistrate, because I think people, rightly or wrongly, attach so much importance to that. He is a sort of representative on the part of the public.

2122. He represents the public interest?—Yes; and you could get men to do it; there are men who would do it, of course. They have to be sought out. It is not everybody who would do it; some people do not like it; they cannot do it. Also you want men of experience.

2123. I have difficulty in seeing how you could work this. If, as you tell us, a very large number of rightly certified cases, obvious cases of insanity, labour under the delusion that they are quite sane and are wrongfully detained, would it not be a rather idle ceremony to have Boards sitting upon these cases over and over again?—It would. People do come up who a child could tell were insane. They come round you like a swarm of bees, and they all say they want to go home, but you can see that not one of them is fit to be outside the asylum. There must be precautions against abuse of the procedure.

2124. Have you any suggestion to make to us as to the method of selecting cases on which some independent investigation might be desirable? It seems to me that you get again into the element of discretion.—That is it, in the vast majority of cases. Of course the medical superintendent and the magistrates on the visiting committee do, as far as possible, let them out, and return to their civil life all they possibly can. Those who are detained there are, of course, certifiable and have to remain there. It is only very seldom that you get a border-line case, and it is difficult to determine. It seems to me that

if the person's friends think the person is not insane and ought to be let out, and they can show good cause for it, then you might have a Board of that kind; but otherwise it would be futile and a waste of time.

2125. The initiation of such an inquiry would have to rest either with the patients themselves or with the relatives, or with some person interested in the case?—Yes.

2126. So far as the patient himself is concerned I can see great difficulty in giving him a legal right to initiate proceedings to consider his own case, because, *ex hypothesi*, he is not, or at least may not be, in a state to give any such instructions?—That is so.

2127. The relative, on the other hand, may not bring to the matter an independent judgment?—Very often not.

2128. But may be more desirous of having the person detained in the asylum than released?—Then you would have to go through the report of the case, go into its history and hear what those in charge have to say, the medical superintendent and assistant medical officer, the nurses and everybody. It is a very difficult question, and I think it remains for you to consider the question.

2129. The existing system, under which probationary periods of trial are provided for, of course affords a useful means of dealing with border-line cases?—Yes.

2130. Then we know there is a considerable amount of machinery in the Act dealing with discharge in a great many different ways, but for the moment one was considering whether it was necessary to have some additional method of investigation which might possibly lead to discharge, over and above those which exist in the present code.—I think every possible care is taken at present. There is nothing very much to criticise about it.

2131. Is it your view that so far as possible the medical superintendents in asylums and persons who would have to deal with places of observation should possess specialised qualifications?—Yes; I think they should be fully qualified. A medical superintendent is highly paid. Before he reaches that position and practices he should have every qualification, a diploma in psychological medicine, and all certificates that are obtained. He should be a fully qualified man in every possible way.

2132. Of course, in every profession persons specialise in particular branches; science is now so much divided and so much elaborated. Do you regard it as desirable that medical men, who have to deal with this important branch, should have some special qualification, as distinguished from the ordinary qualifications of the medical practitioner?—Yes, I think they should, and they should go through a course which would lead to these qualifications. They should have considerable practical experience.

2133. As far as I know in the Universities of Scotland a course in insanity is part of the curriculum for a medical degree, but do you regard it as desirable that over and above the general education there should be specialised training?—Yes; that is the point.

2134. *Earl Russell*: On that last question of the safeguards, Section 75 does provide that two of the Commissioners may make an order for the discharge of a lunatic if they think he is improperly detained?—Yes.

2135. And, of course, in a public asylum three of the visitors may make such an order even if the medical superintendent does not agree?—Yes, quite.

2136. I misled you. Section 75 does not apply to a county asylum?—Not a public asylum.

2137. I understand your difficulty was rather not where a doctor improperly stood in the way, but where a doctor and the visiting committee or the justice was honestly in doubt as to whether the man was fit to be discharged or not?—Yes.

2138. And it was in those cases that you thought some tribunal might be useful?—Yes; I threw it out as a suggestion.

22 October, 1924.]

SIR ROBERT WALDEN, C.B.E., J.P.

[Continued.]

2139. But it is always possible, is it not, for the visiting committee themselves to call in an alienist if they like to get his opinion?—There again it all depends upon whom they call in. They can do so, of course, but the ordinary person thinks that if he is a doctor he knows all about lunacy, but he does not. He has not the same experience as an expert.

2140. But, on the other hand, the public think, rightly or wrongly, that an alienist is apt to think everybody certifiable?—Yes, there is that point.

2141. Now, on the question of accommodation, and it also touches this question of the hostel, Section 22 does give the justice who makes an order an opportunity of letting a lunatic be cared for by his friends?—Yes.

2142. So that would, to some extent, relieve the position?—Yes. We find out sometimes that a person has a good home and surroundings and can be taken care of.

2143. What would be your idea as to boarding out, which, as you know, is practised in Scotland, but not very much in this country?—I do not know, I am sure. They get the village idiot, and life is not often very happy. In some cases it might be desirable.

2144. On the other hand, as against that, it is said that they would rather get home surroundings than institutional surroundings?—Yes; it all depends upon the case. I should say in some cases it might be desirable.

2145. Would you yourself feel disposed to recommend extending that practice to England, or introducing it?—Yes. I mean it all depends upon the case.

2146. *Chairman*: Might I put a question at that point?—Take Glasgow, or some of the large industrial places in Scotland; I understand that quite a number of the cases, particularly the juvenile cases, are sent out to country houses, selected foster-parents, so to speak, and there live, as Lord Russell puts it, more in family surroundings; and if the case is a mild one they have rather a pleasanter life and are brought up in healthy surroundings. You would approve of that?—Yes, I would approve of that, but they need to be very carefully selected cases, and also the people you send them to.

2147. *Earl Russell*: There are two difficulties which at once present themselves to me. First of all, the people might take the patient for the sake of profit rather than for the sake of the care of the patient?—Very often.

2148. And, secondly, they would not have the same medical treatment that they would get in the asylum?—You want very carefully to select the cases and the people to whom they are sent. Many of these poor people would take cases like that for profit, and you might get into a serious difficulty.

2149. You also have this difficulty, have you not, that you might possibly get breeding, which is undesirable?—Yes, that is a point; that is why I should carefully select cases, because that is a serious point.

2150. *Mrs. Mathew*: I wanted to ask you, Sir Robert, when you are talking to the lunatic before you commit him, do you go into his previous history at all?—Yes, always; in fact the relieving officer has a note book, and he furnishes you with it, of course; and you hear very often from the relatives, and find out all you possibly can about it, whether he has been certified before, or whether he has been to any other magistrate.

2151. That is not quite what I meant. I wanted to know, do you find it useful to have, or do you ever ask for, the previous medical history—not whether he was certified before or not, but just general observations on the medical history of the case, if any?—Yes.

2152. Do you find that useful?—Yes. I go into the case, and I think magistrates do, as thoroughly as they can.

2153. It sometimes takes a long time?—It does take a long time; you have to remand the case if

you are not satisfied, and go again. It all depends upon the care that is taken and the individuals, the medical men and the magistrate, of course. You want to adopt a sympathetic attitude, and you get full information; they will help you in that way.

2154. Then with regard to seeing the patients in the institutions, is there any record of whom you see when you visit?—Yes, there is a record kept of serious cases.

2155. Even of those patients whom you take away into a corner?—No; as a rule cases of that kind are very few; I mean cases which merit a record being kept, because they are so very often trivial and unsatisfactory.

2156. I only meant the names of the persons who have interviewed you. Is there a record kept of their names?—If it is a serious case, yes, but not in the ordinary way when they come round you like a swarm of bees and want to be liberated.

2157. But I really meant the cases that you take apart and interview in a sort of private way—is there any record kept of such people who interview you?—Not necessarily.

2158. Nobody keeps a record?—As I say, if the cases are worthy of it a record is kept, if it is a serious thing, in every case.

2159. *Sir Humphry Rolleston*: I was much impressed with the stress you laid upon the desirability of specialisation both on behalf of the judicial authorities and of the medical men whom they call in. Would you be of opinion that the justices should be as specialised with regard to the enquiry into diseases of the mind as a coroner is with regard to an investigation into the causes of death?—Of course it would be better, but it would be impossible. You would have to have a paid authority; a man could not give his time. He would have to go through a course of study, and all that sort of thing, and unless you paid a man I do not think you would be able to get him.

2160. Apart from the money, you think it would be desirable?—I think it would be better, anyhow.

2161. And the same with regard to the medical man, that he should be as specialised as a coroner is?—A man cannot have too much knowledge when he is dealing with these cases.

2162. *Sir Ernest Hiley*: Sir Robert, in the case of what are termed trial cases, people who are sent on probation from the institution of which you are Chairman, is there any arrangement for after-care?—No. I think the after-care of these people is a very important point. You should have some arrangement for it. There are private societies, of course, and people who look after these cases, but I think it should be taken up more generally than it is.

2163. At the present time it is left entirely to voluntary agencies?—Quite.

2164. And your institution makes no arrangements whatever for visits in these cases, or to assist them in any way?—No; it is not done.

2165. Do you know whether it is practised anywhere in the country?—I think it is practised more or less all over the country, but it is by private people and private societies. I do not know of any public authorities who take it up in that way; there may be some.

2166. I am not speaking with regard to the juvenile population, the arrangements for whom are carried out in conjunction with the Education Committees, but I mean for the adults?—No, I do not know of any place; there may be some, but I do not know of them.

2167. Do you think that if these reception hostels were pretty generally adopted, something could be linked up with them which would carry out this after-care duty?—Yes, I think it would be a very great advantage if these people could be looked after in that way by an after-care committee; it would assist them materially.

2168. I suppose the vast majority of the cases that come before you present no difficulty with regard to the certificate?—No.

22 October, 1924.]

MR. WILLIAM HENRY LORD.

[Continued.]

2169. You are perfectly safe in sending them to a mental hospital right away?—I always take care that it is so, and I think every magistrate does, too.

2170. Can you give me any idea of what is the proportion of doubtful cases that would have to go to this reception or observation home?—A great many would of course. My idea of it is that it should be a reception home, and that the cases should be remanded there if there is a doubt.

2171. I am asking you what proportion of cases there would be. Can you give me any idea?—I could not really; I have not sufficiently gone into it, but a good proportion of them would go to the reception home.

2172. Of course, as the Chairman pointed out, it would be an expensive matter to construct an institution of that kind, and to equip it?—Yes. Personally I think it would be worth the money, because you would get away from the Poor Law taint and the surroundings of the workhouse, and you would get better people to deal with the patients, expert medical men and people who are trained; the nurses and attendants of those people would be trained also.

2173. Have you appreciated this—that you would almost want one of these reception homes for each district?—My idea of it is that in London you would get one for the north and one for the south of the Thames.

2174. I am speaking more of the country?—I do not know so much about the country. I know it is important, but it is a difficult thing. Connected with the Board of Guardians, where I live, the area is

20 miles one way and 40 miles another, and it is difficult to deal with people there, of course.

2175. I take it that while the patient was in this reception home, he would more or less be under the jurisdiction of the magistrate who sent him there?—Yes, he would.

2176. And it would be necessary for that magistrate to concur at least in his discharge or in his certification?—Yes, quite.

2177. Does not that involve having one of these homes for almost each district?—Yes. That will have to be thought out. I merely make the suggestion. I was thinking chiefly of London, where I think it is very desirable. It may not be workable in the country; I do not know.

2178. But it would be a very expensive matter?—I am sure of that. The question is whether you would get a return for it; I do not know. It all depends upon what is being carried out under the present system.

2179. *Earl Russell*: I want you to qualify one of your answers a little, if you will. You said that you thought a justice who dealt with this matter ought to be highly specialised?—I did not mean to say highly specialised, but I meant a man of experience. I will not go further than that.

2180. You have a considerable knowledge, and you are also a man of affairs, but if it were your sole business to do this, you might lose the confidence of the public?—No, I do not think that.

Chairman: We are much obliged to you, Sir Robert.

(*The Witness withdrew.*)

(*After an Adjournment.*)

Mr. WILLIAM HENRY LORD, called and examined.

2181. *Chairman*: Are you a Justice of the Peace for the City of Birmingham?—Yes.

2182. Have you held office since 1914?—Yes.

2183. I think you live at Northfield in the City of Birmingham?—Yes.

2184. Is your home near Hollymoor and Rubery Asylums?—Yes. It lies between the City and the Asylums.

2185. In consequence of that proximity have you been invoked in a large number of so-called pauper cases?—Yes.

2186. In dealing with pauper cases you act as a justice of the peace and not as a judicial authority?—That is so.

2187. Have you had any experience of acting as a judicial authority as well as a justice of the peace?—No.

2188. You are, however, in point of fact a member of the Birmingham Judicial Authority?—I am.

2189. But you have not had to act in that capacity?—I have not.

2190. May we take it that your duties have been as a justice of the peace dealing with pauper cases?—That is so.

2191. As such, you have a statutory duty to see every case, have you not?—I have.

2192. Do you attach importance to that personal interview?—Very strongly.

2193. What material in practice do you have before you when a case comes up for consideration?—A form filled up by the relieving officer with full particulars as to the patient's family relations, his address, and all the particulars which are necessary, followed in its proper place by one medical certificate as additional corroborative evidence.

2194. Has that certificate been obtained before the patient has been brought into your presence?—Yes.

2195. You are aware, of course, that under Section 16 of the Lunacy Act you are entitled to call in a medical practitioner?—As a matter of fact the medical practitioner is introduced first of all by the relieving officer—not in person.

2196. Does the medical practitioner, whose certificate you have before you, attend when you are considering the case?—He does not attend in person.

2197. Then who is present when you are considering such a case?—The relieving officer, the patient, and one or two assistants of the relieving officer who will act as attendants—one in a mild case, or two if necessary.

2198. Do any of the relatives attend?—They do not. In my case, I do not think a relative or friend has ever attended in my experience.

2199. Where do you conduct the examination of the case?—My house is remote and in a quiet lane; the patient is in a motor-car, and generally I go to the motor-car to see him there and then.

2200. Does the interview take place out of doors?—The interview takes place out of doors. I am always prepared to have them inside, but as a matter of fact I find in taking the examination, that questioning the alleged lunatic is sufficient corroboration of the medical certificates to justify me.

2201. When do you first see the papers in the case?—They are brought to the house with the patient.

2202. A car drives up to your door, and that is the first intimation you have?—No. I get a telephone message first.

2203. You get a telephone message from the relieving officer that he is coming out with a case?—Yes.

2204. Then does the relieving officer come into your house with the papers?—He comes into my house with the papers, and I examine him about the particulars.

2205. Then does your interview with the patient take place in the motor car?—Generally I find it quite sufficient to talk to the patient in the motor car, and there is a real reason for it. If a patient is at all violent, it is inadvisable to disturb him, and they are generally quiet when they arrive. If they have been violent, they have generally settled down when they arrive, and it is better, I find, to have a quiet talk and take them as they are than to disturb them by forcing them out of the car.

22 October, 1924.]

MR. WILLIAM HENRY LORD.

[Continued.]

2206. Do you never take them into your study and talk to them there?—I never have.

2207. *Sir David Drummond*: The examination has not been opened in the workhouse up to this?—No.

2208. *Chairman*: Where has the patient been examined by the doctor then whose certificate you have?—I think it is at home, but of that I am not quite certain. Sometimes it is at the parish offices, but I think usually it is at home.

2209. What about the case of a person who is seized with an attack actually in the street and taken by a police constable? Is such a case brought before you sometimes?—No.

2210. Then the class of cases you are most conversant with are where the relieving officer has been told by relatives or otherwise that there is a case in a particular house requiring certification; and the case is brought out to you?—Yes.

2211. Then may I take it that the cases which reach you are cases as to which there is little doubt?—Very little.

2212. Have you had any experience of cases which I might call border line cases?—No. I had such a case at the asylum to which I was called to certify someone who had to be taken there.

2213. But the cases which come to your door in motor-cars, as you have described, are generally cases in which a brief examination satisfies you?—Quite—it is either a case of deep melancholia or an inclination to violence or strong incoherence.

2214. Then those cases do not involve a degree of dubiety where further consideration might appear desirable?—They do not. My only trouble has been on the medical certificate. I think much depends on the medical certificate, and I have mentioned the matter in my proof.

2215. In the case you allude to was your difficulty this, that the major part of the evidence submitted upon which the medical practitioner proceeded was hearsay evidence, and not evidence which he had himself observed?—Yes, the weighty part of the certificate consisted of hearsay evidence and not arising from his personal observation, and I considered the evidence of his own observation somewhat trivial.

2216. How did you proceed in that case?—I referred it back.

2217. Did you then get a further certificate amended?—Yes, in about three hours' time.

2218. Containing his personal observations?—Containing his personal observations.

2219. Have you had any cases to deal with under Section 13 of the Act of 1890—cases of persons who are not paupers and not wandering at large, but who are not under proper care and control, or who are cruelly treated or neglected?—No, and; especially with regard to cruelty, I am informed that is very rare.

2220. Would you regard it as important that the medical certificate which you have before you should be fortified by a second certificate?—Those certificates which I have had have been from trusted people—medical men whom I have known to be trustworthy, and they have been so decisive that the point has never occurred to me.

2221. The medical practitioners called in in the cases which have come under your notice have been known to the relieving officer, and presumably the relieving officer would resort to the same doctor?—Yes.

2222. And he would be a man of experience?—Yes.

2223. In that way have you come to rely on the opinion of the practitioner?—Yes.

2224. You knew who the doctor was, really?—Yes.

2225. *Sir David Drummond*: Was he the police surgeon?—He was the police surgeon or a Poor Law surgeon, but I am not quite certain—I am not quite certain of the official status.

2226. *Chairman*: In such a case do you find a single certificate, coupled with your own observation, quite sufficient to satisfy you in the discharge of your

very important duty?—It has been, but one feels a very heavy responsibility because you are taking away a man's liberty; and I am rather of opinion, apart from personal feeling, that it would be well to have a second certificate.

2227. Do you think it would be necessary in every case, or are there not cases in which there would be no room for dubiety, and a second opinion might be unnecessarily duplicating the evidence?—That is so, and one knows when the patients are going into a public asylum they will be received by a first-class medical officer who undoubtedly will do his duty.

2228. It seems to be unnecessary for two certificates to certify to the obvious, but, on the other hand, a second opinion might be desirable in border line cases by way of protection?—Yes.

2229. Would it not meet your view if it were possible to have a second opinion in cases where a justice had any doubt?—That would meet any difficulty.

2230. Rather than to incur the expense of two certificates in every case?—Yes; and one must consider not only the responsibility but the possible result of sending a man to the workhouse.

2231. Have you ever had occasion in your capacity as a justice to differ from the certificate which has been before you?—No. I have always found my own observation confirmed by the medical certificate.

2232. I do not think you can assist us as to the procedure by a judicial authority?—No.

2233. You are aware, I think, that in the pronouncement of a reception order by the judicial authority provision is made for patients being attended by a third party?—Yes.

2234. Would you think it desirable that a person who is a pauper coming before you, as a justice of the peace, should have the right to be attended by a friend or relative?—I regard it as of importance for this reason, that if you get a difficult case, the alleged lunatic is, as it were, without any defence and the magistrate has to act as counsel for the defence and, in addition, in a judicial capacity. Now a criminal is brought up in open Court and not in private and in the case of a criminal there is a supposition, if he is charged with an offence against society, that he is innocent until he is proved to be guilty; but in the case of a lunatic I am afraid the supposition is that he is guilty until he is proved innocent. Therefore I think a man should have a friend with him. The wife is not even mentioned in the case of a pauper lunatic.

2235. Of course, there is a notable difference between an ordinary citizen charged with an offence against the criminal law and a person in this unhappy position, in that the criminal is able to instruct someone to defend him and is able to take an intelligent part himself in the proceedings, but in the case we are dealing with the person concerned unhappily is unable to take part in the investigation.—Yes, and the evidence is all on one side—there is no evidence called on the other side.

2236. You have the right, have you not, if you have any doubt, to call in a medical practitioner and say, "I am not satisfied with this case, will you look into it?"—Yes, but if there is nothing to arouse my doubt, I do not exercise the right.

2237. In your case you have not had experience of the difficulty, because the cases before you, having come through the relieving officer, have all been pronounced cases?—Yes, but I have personal cognisance of one case of a man classed as a pauper, a highly-respectable country workman, who had been, I think, a colour-sergeant in the Army, and who was taken without his wife even having had notice of the proceedings. That was not a case of mine.

2238. Where was he at the time?—In the village, and he was fetched with no prior notice of the proceedings, whereas if he had been a private case, the wife would have been the person to present the petition.

22 October, 1924.]

MR. WILLIAM HENRY LORD.

[Continued.]

2239. Then you would attach value to a proposal that in the case of a pauper there should be the right to have a third person present?—I think so.

2240. At the same time, do you consider it undesirable to import the element of a Court into the investigation?—Quite. Of necessity, the proceedings must be private, and they appear to me more a matter of common sense than of argument.

2241. You want the inquiry to be exhaustive and not one-sided only, but at the same time you want to eliminate what I might call the forensic element?—Quite.

2242. Have any of the persons who have come under your cognisance and have come before you in this way protested that they were being taken away against their will quite improperly?—No.

2243. Never?—No.

2244. If a person brought before you by a relieving officer protested that he was quite sane and the whole proceedings were a mistake, what would you do? Of course, you would have the medical certificate telling you the man was really insane, but how would you solve the situation?—I should continue the conversation, and my experience is that in quite a short time the weakness would declare itself.

2245. But if no weakness declared itself, what would you do?—Then one would have to remand the case.

2246. Would you take advantage of the provision that you can retain a doubtful case for 14 days?—Yes, there is one workhouse near Birmingham where such a case could be sent to.

2247. And there the patient would be under observation?—Yes.

2248. I do not think we will detain you at length by going into the question of reception. You have been in the room, I think, while Sir John Barnsley was giving evidence?—Yes.

2249. And it will probably be sufficient for our purpose if you tell us whether you agree with his view as to the desirability of observational treatment, and so on?—Yes.

2250. You concur in his views?—I concur.

2251. Have you any suggestion to make from your own experience?—No. I think the subject has been fairly exhausted by Sir John.

2252. *Earl Russell*: On the question of relations or friends being present, supposing an alleged lunatic is brought before you by the relieving officer, would you inquire from the relieving officer whether a man's wife or a woman's husband or a son, as the case may be, had been told about it?—I have not done so.

2253. And if he were brought with no one belonging to him, would you take any steps to ascertain whether there was anybody related to him concerned?—No, I have not done so.

2254. I suppose if it were a clear case on the certificate and on your judgment, you would feel that there was nothing to be gained by remanding him for the attendance of a relative, but that the case should go at once to the asylum?—Yes.

2255. Of course, you would have power to remand the man and have him up again with his relatives present, but you do not make a practice of inquiring of the relieving officer whether there are any relations, or why they are not there?—No, I have not.

2256. I want to ask a question or two as to the actual words of the Act, which are perfectly clear and which do not seem to us now to be in all these cases observed. Section 16 says that the justice before whom a lunatic is brought (that is you) shall call in a medical practitioner, and then it says after that, if in those cases the medical practitioner who has been called in signs a medical certificate the justice may make an order: in fact, I gather you do not call in a medical practitioner?—In fact, the patient has been seen by the medical officer.

2257. And you do not call him in, in the sense of having him there and saying, "Will you make this certificate?"—you simply take the certificate presented to you?—I simply take the certificate presented to me.

2258. That is not in accordance with the actual words of the section, is it?—It appears not to be.

2259. Then there is another point in Section 18 which says that, "A justice shall not sign an order for the reception of a person as a pauper lunatic into an institution for lunatics or workhouse unless he is satisfied that the alleged pauper is either in receipt of relief or in such circumstances as to require relief for his proper care." In order to fulfil the conditions of that section do you ask the relieving officer whether the man is in fact unable to pay for his treatment?—Into what institution?

2260. The words are, "shall not sign an order for the reception of a person as a pauper lunatic into an institution for lunatics or workhouse."—No, I have never done it. The position is fairly obvious as a general rule.

2261. But your order, in point of fact, is an order that the relieving officer shall take him to a particular asylum as a pauper?—Yes.

2262. And the section says you are not to sign unless you have satisfied yourself?—I have never satisfied myself, but in every case the position is obvious.

2263. I have no doubt the relieving officer satisfies himself, but you have never done so?—No.

2264. Do I understand that this remand to the workhouse is never used in Birmingham?—Hardly ever.

2265. And you send them direct to an institution?—Yes.

2266. And, in spite of overcrowding, you can tell what institution to send them to?—Yes. As a matter of fact, some cases do get sent to the Erdington Union.

2267. If you have any doubt you have a right to call in a second doctor or even a third doctor?—Yes.

2268. As to relatives being present, you said the whole case was being presented only from one side: but if, in fact, you had the immediate relatives present it would not necessarily happen that the case would be only presented from one side, because the husband or the wife or the relative, as the case might be, would tell you all the facts they could, and you would have all the facts that could be given before you?—Quite.

2269. You do not feel that their absence introduces any element of doubt in your mind in dealing with a case?—I do not think it has ever done so in any case I have ever dealt with, but I can conceive that a different complexion might be put upon certain cases by the presence of some near relative, and I cannot understand the position of the relative in a private case and the position of the relative in a pauper case being different.

2270. Let me give you an example of a case of a certificate which came before me as a visitor on one occasion. Practically the only statement indicating insanity in the doctor's certificate was this: "Has delusions that his wife is unfaithful to him." Now you will admit that it was a difficult thing for the doctor to say whether that was a delusion or not?—Yes.

2271. If that case had come before you, would it not have been material to have had the wife before you and that you should have seen her?—Yes.

2272. You would not have accepted a certificate of that sort, would you, without seeing the wife or having some further explanation?—I should not.

2273. I admit that we ourselves were surprised to find that the patient had been brought to the asylum on such a ground as that. But there are cases, are there not, in which relatives would give you any information you desired?—With regard to that, you cannot tell what information a relative might give you, but I have said I think they should be there.

22 October, 1924.]

MR. WILLIAM HENRY LORD.

[Continued.]

2274. Of course, where a statement is made which has to do with a relative, or if one of the statements was that he had tried to kill his small boy, the absence of the wife would be important. But you do not in fact inquire why the relatives are not there?—I do not.

2275. But I take it you think it would be a better practice if they were?—Yes, I do.

2276. *Chairman*: There are many cases, I suppose, where there are no relatives available—for instance, take the case of a person wandering at large?—Quite so.

2277. *Sir Humphry Rolleston*: With regard to the question of having a second or consultative medical opinion in certain cases, have you any view as to what should be the nature of the qualifications of the medical practitioner—should he be a man with a special experience in lunacy, or should he not be an expert?—I have not formed an opinion about that. I think in a case of this kind I should be content with a man of wide general experience, not highly specialised.

2278. Do you think there would be a feeling of prejudice against a man who was always dealing with such a subject?—No, I think not—there might be, but I do not think so.

2279. *Sir David Drummond*: Can you explain to us how it happens that in Birmingham the use of the workhouse is not resorted to?—No.

2280. In some large areas in populous districts the workhouse is nearly always used, is it not, before a patient is sent to an asylum?—No, I have never inquired into the origin of the custom at Birmingham.

2281. Because it strikes me as remarkable that in Birmingham you do not utilise the workhouse generally in that way?—If I may give an opinion, which is not evidence, but only my opinion, it is that it is regarded as better to send a man to a place where he will meet very skilled people rather than to a place where there would be only the workhouse doctor to see to him—I mean a man who has many other duties and has not this one duty in particular to perform.

2282. In the districts which I have in mind it has often been found that a patient might not have to go to an asylum at all, and in 14 days he is discharged, and I do not see how you get over that difficulty at Birmingham, because presumably in a number of cases where a patient has been sent to an asylum he ought to have been discharged?—Yes, I am unable to explain it.

Sir David Drummond: I cannot understand how the practice is so different at Birmingham as compared with places elsewhere.

Chairman: I suppose there is a very considerable variation of practice in different districts, and we have already had examples of that. Some authorities use certain provisions and some authorities use others.

Witness: I would suggest that it is not altogether beyond imagination that very possibly patients are sent to a mental hospital, with a view of giving them a better chance of special treatment straight off.

2283. Would all this difficulty as to the different practice and the 14 days' rule, and so on, be obviated if effect were given to the suggestion that there should be a probationary institution, to which all cases should in the first instance be relegated for observation and treatment before certification?—Yes, very largely.

Sir David Drummond: But I take it, according to Mr. Lord's evidence, that he has not seen any cases which are at all doubtful.

2284. *Chairman*: I think that is the accident of his experience. (*To the Witness*): There must be obviously difficult cases?—Yes. May I say that I happen to be in a very convenient place for approaching Hollymoor or Rubery, and most of my cases are urgent, and I should say that the cases sent to me are such that the officials have to take them to Hollymoor. They must take them in, and they would

rather take them in certified than uncertified, and the most rapid way is to call at my house on the way.

2285. Have your colleagues, the justices in Birmingham, to deal with many other cases?—Oh, yes, a great many.

2286. Have you had any opportunity of conferring with them?—They have never expressed any opinion to me. I am quite sure what I say is right, because the call to me is always, "Can you see them within a short time?" In all those cases they go to Hollymoor or Rubery, so that I think the custom has grown up from the idea that the proper place for a mental case is a mental hospital, and not a workhouse infirmary.

2287. *Sir David Drummond*: It is a question of rapid diagnosis, is it not?—Quite.

2288. *Sir Ernest Hiley*: Could you obtain for us and send to the Secretary the average number of cases per annum you have sent to the workhouse for temporary detention?—Yes, I could get those figures* for you; I think they are almost certain to be available, but I will get any figures I can which you want.

2289. If you had in Birmingham one of these observation homes, would you make any more use of it than you do of the workhouse at the moment for temporary accommodation?—Obviously, because you would have a highly-skilled staff who would be keen on determining the proper treatment of the patients who went in, so that they would be certainly sent there to start with. It would mean this—that you would send them to an institution where you would get a highly-skilled staff.

2290. *Chairman*: I notice that under the Lunacy Act certain forms are prescribed in the case of pauper lunatics, and the order form has appended to it a statement of particulars which you must have often seen, no doubt?—Yes.

2291. And in that statement of particulars information must be given as to whether the person is married, single, or widowed, and also information as to relatives who may have been afflicted with insanity, the Christian name and address of the nearest known relative, and the degree of relationship, if known. So that apparently there is before you information as to the relatives of the person you are examining, and if you wished you could ask to see any such person?—Yes.

2292. I mean, you have to be supplied with that information before you pronounce your order?—Yes.

2293. But you have never found it necessary in your experience to ask to see any such relative?—I have not.

2294. Have you had any experience of a patient after you have certified the case and it has been received into an asylum—have you ever been a visitor?—No.

2295. You have nothing to do with visiting?—No.

2296. Then your evidence is simply confined to your experience in connection with the admission of patients?—Yes.

2297. Have you had any relations with the Board of Control at any time?—No.

2298. Or any experience of their action?—No.

2299. And you have never at any time had any responsibility with regard to the treatment of patients on their detention after certification?—No.

2300. Then your experience is solely confined to the one step you have spoken about?—Yes.

2301. Can you give us any figure as to the cost to the public of the certification of a pauper lunatic—can you tell us what it costs?—No, I cannot. Do you mean the proceedings on the one day they are certified?

2302. There is the expense of the medical man who certifies; there is the expense of the transport, the vehicle or motor which brings the man to you?—Yes, and the proportion of the salary of the relieving officer and his man, or what not. I cannot tell you that, but I think I could ascertain it for you.

* See Appendix VIII.

22 October, 1924.]

MR. WILLIAM HENRY LORD.

[Continued.]

2303. *Earl Russell*: You might ask the Guardians to let us know what the average cost per head of getting a lunatic into an asylum is?—Yes, you want to know what are the out-of-pockets.

2304. *Chairman*: Yes, apart from the percentage of any salaries of the officers concerned?—I will try and get that for you.*

Chairman: Thank you, Mr. Lord.

(*The Witness withdrew.*)

Councillor C. F. SANDERS, called and examined.

2305. *Chairman*: You are a Justice of the Peace in the City of Cardiff?—Yes.

2306. Were you appointed a Justice of the Peace in 1906?—That is so.

2307. Have you in that capacity from time to time signed orders for the detention of persons of unsound mind?—I have.

2308. I think at first your Bench appointed a limited number of justices as the judicial authority?—That was so.

2309. But latterly you have changed some of the arrangements which formerly existed, as they were found inconvenient because justices were not always available; and for some years past the custom has been adopted of annually appointing all the justices to act as the judicial authority?—That is so.

2310. In point of practice, however, the function of the judicial authority falls, does it not, largely on certain of the magistrates?—On a very few, who happen to be conveniently near.

2311. Have you personally been one who has had a large share of the work?—Yes, a very large share during the last couple of years.

2312. You actually daily pass the workhouse, I think?—That is so. I pass it several times a day.

2313. So that you are pretty nearly always at hand?—I am.

2314. In the course of the past two years have you had something like 300 cases through your hands?—Up to date the number is 333.

2315. Of those 300 odd cases which have come under your cognisance, how many of them were discharged without certification?—Of the 333 cases 58 were discharged without being certified as of unsound mind; but two medical certificates are obtained in each case that the patient may safely be discharged.

2316. I am not sure that "discharged" is the correct word. At any rate, nothing further was done in those cases, and no certificate of insanity was granted?—Quite.

2317. It would be interesting to know on what grounds the proceedings were stopped in the case of those 58 people?—Of course they would not all be for the same reason, but I should say a large proportion of them would be cases of men and sometimes women brought in suffering from the influence of drink—delirium tremens cases, or sometimes the taking of methylated spirits—but there were other cases of severe depression coming on suddenly, and after a little rest in a peaceful place all the evidence passed away.

2318. Will you tell us of the 300 odd cases you have mentioned how many were pauper cases?—A great many of them would not be pauper cases in the ordinary sense of the word; that is to say, they would not be persons who had been paupers.

2319. But in a legal sense were they paupers?—They were paupers in the legal sense, because they would become paupers directly they had been brought within the walls of the workhouse, but they were not certificated as paupers.

2320. But you know pauper patients are treated differently from non-pauper patients?—Yes.

2321. And in the one case you have an application made to you as judicial authority, while in the other you function as a justice of the peace?—Yes, but I have had very little experience of private cases.

2322. Then the cases you have told us about must have been cases in which you were acting as a justice of the peace and not as a judicial authority?—Well, I do not know quite the distinction. The procedure is this, that persons finding a relative suffering mentally, either through their own medical man or by themselves, draw the attention of the relieving officer, charged with that special duty, to the case.

2323. If those cases come to you through the relieving officer we know what class you mean?—They do. I find them in the wards of the workhouse which have been set apart for the purpose entirely.

2324. You first come into contact with a case, do you, by the relieving officer bringing it to your notice?—That is so.

2325. And you have to see the person in question?—I do.

2326. Is the person brought to your house?—No, I go to the receiving wards and usually I find some three or four persons, sometimes half a dozen.

2327. Have these persons been taken by the relieving officer to the ward in the workhouse?—Yes.

2328. And you are asked to come there and see them?—Yes.

2329. By that time, has any medical man seen them?—Sometimes, but not always.

2330. Do you yourself call in a medical practitioner?—I do not, frankly, in each case. I have inquired what is the usual practice and I find what is done is that generally the family medical man gives one of the certificates, the relieving officer chooses sometimes the resident medical officer of the workhouse, sometimes he calls in a medical practitioner who happens to be conveniently near. I have discussed with him the principles on which they have proceeded and I sanction the procedure, so that in a sense I may be said to have chosen the method by which the thing should be done.

2331. When you arrive at the ward does the medical practitioner attend you?—Not usually. I frequently see the resident medical officer of the workhouse, and I have sometimes seen others.

2332. Has any medical man left a certificate for your consideration?—Not always before I see the patient, but I always see the certificate before I sign the order.

2333. If the doctor is not there when you arrive and there is no certificate, you cannot very well go on, can you?—I make my own observations and await the production of the certificate.

2334. Do you see any of the relatives of the person before you?—Occasionally, but not usually. Making a rough guess, I should say in 19 cases out of 20 a signed statement of a relative is put before me.

2335. But that is not obligatory, is it?—I do not understand it to be obligatory, but that is one of the methods by which information can come, and it is surely a very obvious method.

2336. In Cardiff do you make use of Section 13 of the Act of 1890?—Yes, I think, very largely.

2337. It has a curious feature, has it not, in that a person dealt with under Section 13 becomes technically a pauper?—Yes, I presume that is so.

2338. Although Section 13 relates to persons who are not paupers, the result of the utilisation of Section 13 is to convert them for the time being into legal paupers?—I understand it has technically that effect, but I do not think anything turns on that in our practice in Cardiff.

* See Appendix IX.

22 October, 1924.]

COUNCILLOR C. F. SANDERS.

[Continued.]

2339. Still the person would be taken to a workhouse?—Yes. A great many of these become paupers afterwards, when they reach the asylum and become chargeable to the Union.

2340. And they become chargeable in consequence of their detention?—Yes.

2341. But they have not been previously persons chargeable to the rates?—Quite so.

2342. Do you think it is desirable that the workhouse should be utilised as the clearing house for these cases?—I cannot think of a better way. It is technically part of the workhouse. But the building itself is quite separate from the rest of the buildings, and except that you go in at the front gate there is no association with the workhouse at all.

2343. What provision have you in the workhouse for mental cases?—In each of the wards there are six or eight beds for females in the one building and males in the other; there are padded rooms in connection with them and there are specially appointed attendants night and day, male and female, and I think the whole thing is worked as reasonably and as effectively as possible.

2344. Have you patients there who are being permanently detained in the workhouse?—Who have previously been permanently detained—yes—a proportion of them come in in that way. They are usually senile cases.

2345. If one visited such wards, would one find a few cases waiting your visit for certification?—I am not quite certain whether we are on the same point exactly.

2346. What I want to know really is whom should we find in the ward in the mental department?—In the special receiving wards you would find only cases which have been brought in for observation, whether they were brought some of them from other parts of the workhouse or from outside. They are not detained there beyond three or four days.

2347. They are there under the three days' rule or possibly under the 14 days' rule?—Possibly, but I should think very rarely are they detained beyond three days.

2348. This accommodation is distinct, is it, from the accommodation which you have in the workhouse for chronic cases which are intended to be detained permanently?—The chronic cases are dealt with at another workhouse two miles distant.

2349. Then these temporary wards are really utilised by you as reception and observation premises? Nothing else.

2350. And also as a place where the justices attend for the purpose of certifying?—That is so.

2351. Do you often in practice, in the cases brought before you, find that any large number of the people are discharged by you at once when you see them?—The figure I have given shows the number that have been discharged.

2352. Does that number of 58 relate to persons who, having been brought in, have within the three days recovered or shown that they ought no longer to be detained?—Yes, that is so—the doctors are satisfied.

2353. And you are accordingly not asked to make an order in those cases?—That is so.

2354. You do not intervene in those cases, do you?—I form my own opinion, and I hear also what the doctor says, and I have mentioned in my précis one instance where I did hesitate to discharge a patient on the advice of the doctors.

2355. You find three or four cases brought before you and in one case a doctor said, "He has pretty well recovered," but you have to deal with the case yourself?—Quite, only I could not do anything without the certificate of the medical man; I could not make an order. But in the one case to which I allude it had been brought to my notice that the patient had shown a suicidal tendency and a disposition to do harm to other people, and I was very

reluctant to say that that man might go. The medical certificates were put before me, one by the family doctor, and I said, "It is quite clear the family want him to be discharged, but I do not think it is quite good enough to say that this medical certificate shows that the patient with such tendencies should be allowed to go out in the care of his relatives." I questioned the other medical man and he said there was a little doubt; he was not prepared to certify and would like the case to be put under observation a little longer; and I said to the relieving officer, "I do not think I could take the responsibility of allowing this man to go; would you like to call in another justice?" He said "No," and I said, "Very well, I want the opinions of two other medical men," and I named two other medical men who I knew would give an opinion, and I was relieved to find that all the four medical men took the same view; and thought that the man, who had been in a dangerous condition arising from delirium tremens, was likely to recover, and he did recover from that condition and he was discharged ultimately.

2356. I quite see from that that yours is a very responsible duty?—It is.

2357. And that was a typical case where you in your judicial capacity were puzzled by the facts, but you had no difficulty in getting the necessary skilled assistance to enable you to make up your mind?—Quite so.

2358. Of course, if anything had gone wrong in that case, after you had disagreed and you had discharged the man, you would have felt a certain amount of responsibility?—Yes. I asked the relieving officer if those certificates would be filed so that they could be produced at any time.

2359. But in this large experience you have had, have you found that there are many cases which give you any difficulty?—Practically none, but in saying that, I should like to add at the same time that I do not think a justice of the peace could make up his mind on his own observation as to whether a patient should be detained or not. I am bound to rely on the certificate of the medical men. Usually as the patients lie in bed, three or four of them might be very quiet; they will show signs of depression sometimes and stubbornness sometimes, and one cannot get an observation from them at all; so that it is very difficult indeed to form a judgment on what one sees, and I should imagine the medical officer has to take means which I should not like to adopt in order to draw from the patient evidence of the condition of his mind.

2360. Do you try to engage them in conversation?—I do frequently, but a doctor can concentrate on certain points and when he has discovered the point on which they are insane, he can deal with them better.

2361. What have you in mind when you talk about the medical man adopting methods that you would not like to adopt?—Well, I presume they will have to be prompted by information supplied to them and examine the patient on certain questions.

2362. You mean they would have to resort to other sources of information?—I mean that I should not like to have to put the patient to the trouble of extracting from him, or her, the information which would be necessary to enable me to form an independent judgment, even if a layman could form such a judgment.

2363. When you talk to them do you direct your attention particularly to the matters which are referred to in the medical certificate?—I do not usually.

2364. How do you set about your task?—I do not understand it to be my task—I may be wrong—but I have never understood it to be my task to examine a patient and satisfy myself from my own observation as to whether he is sane or insane. I think it is more my duty to rely on the certificate of the medical officer and the other information which is brought to me.

22 October, 1924.]

COUNCILLOR C. F. SANDERS.

[Continued.]

2265. But are not you reducing the value of the personal interview very much in that way? We have been told that the personal interview is a very great safeguard?—It may be slightly reducing its value, but I should say, judging from my own experience, that there is very little danger on any such ground as that, and I should be very much surprised indeed to find that any person had been committed to our Mental Hospital at Cardiff without due cause.

2266. You are speaking, of course, always of what we call the pauper case?—I am speaking of the cases that come under my observation—technically pauper cases—and, of course, very largely persons brought from poor homes.

2267. Who become paupers in the sense you have indicated?—Yes.

2268. Is the absence of doubt in your experience due to the fact that the cases you have had to deal with are all more or less obvious cases?—Most of them.

2269. You do not seem to have had any experience of border line cases, except the one you have told us about?—Quite. I think I have had other border line cases, as is evidenced by the fact that 58 people have been allowed to go.

2270. But they might not be border line cases. The cases, I mean, are cases which have been brought in for detention as distinct from cases arising from a bout of drinking?—I should not think any cases have come under my observation otherwise than as cases suitable for temporary detention.

2271. Have you sufficient accommodation in Cardiff to deal with all your cases?—Oh, yes.

2272. And you have accordingly no difficulty in designating the asylum to which any particular case is to be sent?—No, no difficulty at all.

2273. When the patient has been certified and removed to a public asylum at Cardiff, have you personally taken part in the visiting?—Yes, some years ago. Before I became a magistrate I was a member of the board of guardians, and as such I made visits.

2274. And you visited in your capacity as a guardian?—Yes, and for four or five years I was Deputy-Chairman of the Mental Hospital Committee and I visited in that capacity.

2275. Is there any difference between the visit of a guardian and the visit of the visiting committee—you have done both, I understand?—Yes. I could not say that there is as to the visitation; but, of course, the duties of the committee are wider than those of the visiting guardians.

2276. What is the concern of the guardians when they visit a hospital?—To see that the hospital is in all respects satisfactory, that the patients are being well-treated and well-fed, to hear any complaints of patients who wish to make complaints, and to form their own conclusions upon such complaints, and to report such to the superintendent medical officer.

2277. That is a description which might almost equally well fit the functions of the visiting committee?—Quite.

2278. But has not the visiting committee a more responsible part to play; theirs is a more responsible visit, is it not?—Well, they deal with a great number of details as to which the guardians would not be responsible.

2279. Are not the guardians more concerned with the persons who administer the Poor Law and see that everything is going on all right in the institution to which their paupers are sent?—That is so.

2280. Have they any individual responsibility with regard to the detention of the persons there?—No.

2281. Of course, the fewer the people chargeable the better from the guardians' point of view?—Quite, but I do not think that affects them in their action at all.

2282. As a member of the visiting committee, on the other hand, have you seen individual patients and gone into their cases with them?—Only when

some individual has stepped forward and wished to make a complaint or a suggestion (which has happened to me on numerous occasions) that they were all right, that the other people should be kept there but that there is no reason why they should be. I do not think I have visited the hospital without somebody saying something of that kind, and on my mentioning the matter to the superintendent medical officer, I was very speedily satisfied either that the case was under observation with a view to discharge, or that there were very good reasons for the detention.

2283. In such a case would you have a private conversation with the patient who was complaining?—Yes.

2284. What sort of opportunity would you give to a patient of discussing his case with you?—I always allowed him to say what he wished to say. It never took very long, because what they had to say usually was very simple: "I am all right; I understand everything."

2285. Would you have such a conversation in private, or would it be in the ward as you were passing through?—It would be in the ward, but not in any sense interfered with by other persons.

2286. Have you ever been asked by a patient for a private interview?—No, never.

2287. In the frequent instances where a patient has said he is quite sane and ought not to be there, what steps have you taken to inquire into his treatment?—I have usually immediately mentioned the matter to the medical officer, and I remember one case particularly which I mentioned to the doctor, and he said, "Oh, yes, that man is all right, and there is only one question on which he is not right; I will ask him now," and he asked him, "Who is the King of England?" and the patient replied, "I am," and that was the one point on which he was wrong.

2288. In your experience in more than one capacity, as a certifying justice, as a guardian, as a member of the visiting committee, of which you were Deputy-Chairman, you have been brought into contact in Cardiff with the administration of the Lunacy law in relation to paupers?—Yes, and in some other places.

2289. Have you any suggestions to make to us as to the necessity for further safeguards with regard to the personal liberty of the subject?—No, I do not think anything arising out of my experience points in that direction.

2290. Are you satisfied with the powers you possess at the present moment, as enabling you to protect the public and protect afflicted persons against undue detention?—I have never seen anything which would suggest to me that further protection is necessary.

2291. We may take it, however, that your evidence does not relate to the private patient, and consequently has no relation to licensed houses and other institutions where paupers are not received?—I have only one experience of a licensed house at all, and that was unfortunately when I had to take a friend of my own there, and he died within a few days, so that my experience is practically nothing.

2292. So you have no experience with regard to the private patient?—None, except as to certifying in a very few cases.

2293. Then you have no experience of cases where it might be to the pecuniary interest of persons to have patients detained?—No.

2294. And has the only consideration before you in the cases you have dealt with been the question of what was the best to be done for the unhappy person?—Yes.

2295. Have you found the same spirit animating the other persons concerned with you in the discharge of these duties?—I have. I have never seen any variation from that spirit at all.

2296. *Earl Russell*: I understood you to say that when you interview an alleged lunatic whom the relieving officer has brought to your notice, you con-

22 October, 1924.]

COUNCILLOR C. F. SANDERS.

[Continued.]

sider it is not your task to form an independent judgment as to his sanity or insanity?—Not exactly that; I do all I can to form an independent judgment, but I have not conceived it to be my duty, so to speak, to probe the wound, to stir up anything that is latent at the moment.

2397. I can quite understand the perfectly natural feeling that you would not have the capacity or the knowledge of the medical man to investigate that particular question, but you do feel, as the justice who stands between him and the law and his liberty, that you have to satisfy yourself that he is a proper case?—Quite.

2398. And you do that to some extent, do you not, by making up your mind that the person is not sane?—I do that by satisfying myself that there is nothing I can see that is at all out of harmony with the certificate or certificates of the medical man or men which have been produced to me.

2399. But you have no conversation with the person, I understood you to say, on the subject of the delusions, or his obsessions, it may be?—That is not universally true, but usually so. Frequently it is obvious, without my making any endeavour at all, and the evidence is forthcoming.

2400. Apart from those cases where you say nothing beyond a few conventional words, and the lunatic says nothing, do you have any cases in which something more might be gained by the interview; or does it amount to this—that you sign the papers without practically seeing him?—Yes, I see the depression or moroseness, frequently, which seems to me to corroborate the medical testimony and the statements of friends.

2401. It really amounts to this, does it not, that although you do not try to confirm the medical judgment you really do try to satisfy yourself that the man is a proper case for detention?—Certainly.

2402. And to that extent you apply an open mind to the matter, apart from the certificate?—Yes.

2403. Did you hear the evidence given by Mr. Lord?—Only partly.

2404. You see nearly all your patients, I understand, in the reception wards of the workhouse?—That is so.

2405. The practice, we were told, adopted by Mr. Lord, was that the alleged lunatic was brought by the relieving officer to the justice, and was generally seen by him in a cab?—Well, I have had no such experience at all.

2406. And that in Birmingham, apparently, they do not use the workhouse as a place for detention, or a place in which the justice can visit the patient, while in Cardiff you almost invariably do?—Always, practically.

2407. Then there is another difference between you—you have told us that in 19 cases out of 20 you have a written statement from relatives or friends as to what they know about the patient?—Yes.

2408. In Birmingham we understand inquiry is not very often made as to whether there are any relatives or friends at all?—I have not had occasion to make inquiry, because the facts are put before me in the forms to which the Chairman alluded in his examination; and they are always produced, giving full particulars, and those come under my observation.

2409. Then, in fact, there is a different practice with different relieving officers—one takes statements from relatives and friends, and the other, whether he takes them or not, does not put them before the justices. Do you think it desirable that the immediate relatives of a patient should know that he is likely to be certified before such a thing happens?—I think they always do.

2410. But do you think it is right they should know?—I think they should know of the proceedings, and I have no doubt they do.

2411. So that they might have an opportunity of objecting?—Yes, quite, but I think as a rule the proceedings are taken at the desire of the relatives, and often they are taken very reluctantly. There is

one point on which I have not said what I wanted to say, and that is I am afraid that in a large number of cases these proceedings are delayed too long. I had a case only a fortnight ago of a woman, where the information from the relatives was that there had been a change in her condition for the past nine months, and it seemed to me to be a case in which earlier treatment would have been desirable. I have an impression, too, that earlier treatment of persons might take place at a stage before certification, and that in certain cases treatment might be remedial; and I am glad to know that some such work is being done in our Royal Infirmary at Cardiff, where Lieut.-Colonel Goodall, the Medical Superintendent of our hospital at Whitchurch, is attending, I think, weekly, a clinic, quite apart from his other duties, seeing cases of nervous breakdown and that kind of thing, with the object of remedial measures being taken.

2412. In uncertified cases?—Yes.

2413. I do not think the Commission differs from you at all in the opinion that probably in the majority of those cases relatives and friends feel that treatment is necessary, but what we feel anxious about is the possible case in which a patient ought not to be certified and an opportunity ought to be given to the relatives to say so—that is what we have in mind, and that something might be done in that direction. Do you think it desirable that the relatives should know what is going on?—Yes, and I have no doubt that they do.

2414. *Chairman*: If there are any relatives; but there must be many cases where a lunatic is found wandering at large?—Yes, there are a few cases where there are no relatives at all, and where the antecedents of the patient cannot be discovered.

2415. *Earl Russell*: I suppose in a seaport particularly you have cases where no relatives are discoverable?—Quite, but they are rather rare.

2416. If a relative desired to be present when you are seeing a patient, or to see you at the same time, would there be any difficulty about that?—None whatever. They have free access, and I do sometimes see them.

2417. I was rather struck by one thing you said, that you found patients lying in bed—are these people always in bed when you see them?—Practically always, unless they are so violent that they are in a padded room.

2418. That is, of course, very different from the cases we have heard of which were seen in a cab?—I can only speak, of course, of Cardiff, and our experience there. I have understood from our relieving officers that in outside parishes a different course has to be adopted altogether, and in the country a patient has to be taken to a justice of the peace, but in Cardiff our workhouse is fairly centrally situated and there is no difficulty whatever of access.

2419. Can you tell us a little more about the clinic which you mentioned?—It has been opened within the last two or three years, I think. I made some inquiry about it from the Secretary of the Infirmary, and he gave me the number of cases, I think it was 56, which had been treated there within the last 12 months.

2420. It is a voluntary charitable institution, I suppose?—That is so.

2421. It is not rate-aided, I mean?—Well, Cardiff does make a contribution to it out of the rates, but it is supported by voluntary contributions. I think it would very greatly help the Commission, if I might suggest it, that if Lieut.-Colonel Goodall has not already given evidence he should be invited to do so.

2422. *Chairman*: I have just been told by our Secretary that Colonel Goodall is coming to give evidence, so that we shall have the advantage of his views?—I think he would be a valuable witness.

2423. *Earl Russell*: Your workhouse at Cardiff, I understand, is very well fitted up for the purpose of a temporary observation ward and a reception

22 October, 1924.]

COUNCILLOR C. F. SANDERS.

[Continued.]

ward for these cases?—Rooms have been built on purpose.

2424. Would you think it an advantage to have anything like a sort of clearing-house, as has been mentioned—a place which was not exactly a workhouse and not an asylum, where patients could be confined, say, for a month or two months?—The idea came to me first when I heard the question asked just now. I asked myself then whether it was desirable, and I can quite believe that there are some cases in which it would be desirable, but I should not say, arising out of my experience, that anything would suggest itself to me as showing that it would be worth while, dealing with cases as we do in Cardiff, to set up a new and separate institution for that purpose.

2425. You do not think you would be able to get rid of a sufficient number of cases without certification at all?—I do not think so; I think a considerable number of such cases are now sent by us to the workhouse at Ely, a place two miles away, and they can easily be discharged from there. It is regarded as a sort of auxiliary institution for cases which are not discharged and not likely to recover, and they are mostly cases of aged people.

2426. You have, in fact, succeeded in getting rid of 58 people out of 333 without certification?—Yes. I am not adopting your language, "getting rid," but I mean to say they have been brought there for observation, and the observation has resulted in their discharge.

2427. So that those 58 people have never been certified?—Quite.

2428. That is a successful percentage?—Well, I think it shows the desirability of that process.

2429. And as carried on at Cardiff it seems to work well?—It does.

2430. *Sir Thomas Hutchison*: How long do these patients remain in the reception house?—I should say rarely more than three days.

2431. But a few remain more than three days?—Well, it is hardly right to say a few, because they are very rare.

2432. Is there a resident medical officer attached to that building?—Yes.

2433. Whose sole duty it is to attend to that work?—No, not to that work only; he has to attend to the whole building.

2434. How far are the buildings apart from each other?—They are quite adjacent—very near.

2435. So that the medical officer who looks after the workhouse generally can quite well keep an eye on the place?—Perfectly well.

2436. *Mrs. Mathew*: Can you tell us the cost of these observation cases?—No.

2437. I was wondering whether the cost would be any more than the cost in the case of pauper lunatics?—I do not think there would be any special cost, except that of the day and night attendants in each of the wards, male and female. The wages of those persons, I should think, would be the only extra cost.

2438. There would be no different food?—No, I do not think there is any special treatment of that kind,

unless the doctor ordered something. I should think more usually the patients would refuse food.

2439. Then special food is given, though often they refuse food. Were the 56 cases you refer to at the clinic discharged cases, or recurring cases?—As far as I understand they are cases of nervous breakdown, where the friends have some reason to fear that things may tend in the direction of mental instability. But I think as you are going to have Colonel Goodall here he might perhaps deal with that better than I can.

2440. *Sir Humphry Rolleston*: With regard to the 58 cases which were discharged out of the 300 odd, can you tell me what proportion of those cases were cases of delirium tremens?—I am not able to give you an answer now, but I might ascertain, if it is desired; I should think a large number would be cases, not exactly of delirium tremens, but something bordering upon it—cases of excessive drinking.

2441. There are cases of alcoholic insanity, but would you be inclined to include under that class cases of delirium tremens?—No, I think the action which has been taken at Cardiff shows that we do not include it.

2442. *Chairman*: Can you help us by getting us that figure?—I will ascertain from the relieving officer and send to the Secretary under the various headings exactly what takes place.

2443. *Sir David Drummond*: Are private patients sent to the same institution, the workhouse, which you have spoken about?—No, not the strictly private patients. What happens in Cardiff would be this: they are allowed to go through this place and then they are treated as private patients.

2444. They go for three days to the institution you have described, do you mean that?—Yes, probably—I mean persons who are quite willing to pay for the treatment of their friends will allow them to go through that process, and when they arrive at the mental hospital they ask that they shall be treated as private patients. There is very little difference in the treatment, except that they pay.

2445. When you refer to the mental hospital, are you speaking of the workhouse?—No, I am speaking of the asylum, but we always call it the mental hospital.

2446. *Chairman*: The point one wants to be satisfied on is this: In the case of those patients who ultimately become paying patients in the asylum, do their people resent their reaching the asylum through the avenue of a workhouse?—Probably in some cases they do, and they have them sent to another institution; but, as I say, there are some people who are quite willing to allow them to go through the same process.

2447. Because there is something in sentiment, and what one knows as workhouse taint?—I think that that kind of feeling is dying out at Cardiff, because we have a large workhouse hospital, and people are coming to the conclusion that it is better to allow their friends to be put there.

2448. Thank you very much.

(The Witness withdrew.)

(Adjourned to Tuesday, 4th November, at 10.30 o'clock.)

5, OLD PALACE YARD,
WESTMINSTER.

FIFTH DAY.

Tuesday, 4th November, 1924.

MEMBERS PRESENT :

THE RT. HON. H. P. MACMILLAN, K.C. (*in the Chair*).

THE EARL RUSSELL.

LORD EUSTACE PERCY, M.P.

SIR HUMPHRY ROLLESTON, BART., K.C.B., M.D.

SIR THOMAS HUTCHISON, BART.

SIR ERNEST HILEY, K.B.E.

SIR DAVID DRUMMOND, C.B.E., M.D.

MR. W. A. JOWETT, K.C.

MR. H. SNELL, M.P.

MRS. C. J. MATHEW.

MISS MADELEINE SYMONS.

MR. P. BARTER (*Secretary*).

MR. W. FAIRLEY (*Assistant Secretary*).

Dr. A. L. BALY, M.R.C.S., L.R.C.P., Medical Superintendent of Lambeth Infirmary, called and examined.

2449. *Chairman*: Dr. Baly, are you the medical superintendent of the Lambeth Infirmary?—I am.

2450. I think you have appreciated that, under the terms of our remit, we desire to have the advantage of your evidence on the particular aspect of lunacy administration which falls within your province?—Yes.

2451. You have been good enough to place before us in the form of a *précis* your experience and your suggestions?—Yes.

2452. Now do I understand that the hospital under your charge is a Poor Law institution?—Yes.

2453. Is the institution entirely devoted to dealing with rate-aided patients?—Yes.

2454. And is it an institution devoted entirely to persons who are suffering from ailments?—Yes.

2455. From mental ailments or from all sorts of ailments?—All sorts of ailments.

2456. Then it is not an institution associated with a workhouse as the ordinary person understands it?—No, the workhouse has been abolished.

2457. So that it is a specialised institution for dealing with the destitute who are also afflicted?—Yes, the sick and infirm.

2458. Is there no workhouse accommodation at all associated with it?—There is none in Lambeth; all the workhouse inmates are boarded out.

2459. Your work is concerned not merely with the insane destitute, but with the destitute who are suffering from any form of ailment or disability?—Yes.

2460. Before we come to the detail of your evidence will you first give us a description of your institution?—There are about 1,500 beds altogether; 1,000 of them are for sick patients and the remainder for the infirm.

2461. How many wards have you?—Somewhere about 30, I think.

2462. What is the character of the building; are you in detached blocks?—There are two buildings; there was the original infirmary which had to deal with the sick and the institution which was called an infirm workhouse. The infirmity of those in the

infirm workhouse has been steadily rising so that the guardians have decided to amalgamate the two buildings. Our reason for the amalgamation was that there was not sufficient room for the sick; the sick part of the institution was very much overcrowded, and in order to get more room for the sick they amalgamated the adjoining building and made one so-called hospital.

2463. Then putting aside for a moment the special case of the insane rate-aided patient, do the patients come into your infirmary from the various workhouses throughout the City?—No; they are supposed all to come in from Lambeth; but, of course, we have to take in patients if they are urgently in need of treatment wherever they come from, if they come to our doors.

2464. But primarily you treat people from your own parish of Lambeth?—Yes.

2465. Are they brought to you from their houses?—Yes.

2466. And in some instances are they brought from the workhouse properly, so-called?—Yes, they may be.

2467. Then is the infirmary under your charge the place to which are brought all persons who are supposed to be insane and are dealt with under Section 20 of the Lunacy Act?—Yes.

2468. Have you special accommodation set apart for this class of case?—Yes.

2469. Will you tell us what is the nature of the accommodation?—The accommodation prior to the amalgamation was very bad; it consisted of two wards, one for men and one for women; there were 11 beds for men and 17 for women. Subsequent to the amalgamation, I have succeeded in getting four wards for women, so that they can be classified, containing 50 beds; but at present I have not got any better accommodation for men, I have only got the one ward with 11 beds in it.

2470. One ward with 11 beds for men and four wards with 50 beds for women?—Yes.

2471. As far as the men are concerned the accommodation seems to be very limited?—It is very bad

4 November, 1924.]

DR. A. L. BALY, M.R.C.S., L.R.C.P.

[Continued.]

indeed, but I am hoping to get that put right this year possibly, or certainly early next year.

2472. It seems to be limited in extent and does not enable you to effect any classification of the patients?—None at all.

2473. Now will you tell us next the procedure under which patients come into these male and female wards under your charge?—The majority are admitted on orders issued by a relieving officer in lunacy whose sole duty is to deal with mental cases.

2474. So they come before you really through the medium of the relieving officer?—Yes; they are also brought there through the medium of the police.

2475. Cases off the streets, I suppose?—Yes; and a certain number are transferred from the ordinary wards of the hospital to the observation ward.

2476. So that really your first contact in the mental wards arises either through the relieving officer bringing in the patient or through the police bringing in the patient from the streets, some emergency case, or through patients being transferred from the sick wards to the mental wards?—Yes.

2477. Does that exhaust the methods by which they reach you?—Yes.

2478. Now will you tell us how you yourself personally first come in contact with a patient who is brought to your institution?—I see the case myself, the morning after admission.

2479. What happens to the patient when he is brought in?—He is taken to the receiving ward and examined by one of my assistants.

2480. That is a separate ward from the four female and one male wards?—Yes.

2481. Is the receiving ward for male patients only?—All patients come to that ward.

2482. What happens to him there?—He is examined by one of my assistants, purely from the physical point of view, and also to make notes which are required by the Board of Control as to whether the patient has been damaged or has received injuries before admission.

2483. We are familiar with that examination. Then having been subjected to that medical examination by one of your assistants, what happens to him next?—He is transferred to one of the observation wards.

2484. What are the observation wards?—The observation wards are the ones I have mentioned.

2485. If the case is violent, what happens?—If the case is very violent, the patient would probably have to be confined to a padded room; that is the usual form of restraint used; we very rarely use a straight jacket now; but that of course cannot be done without a special order of the medical officer.

2486. So that a violent case is dealt with specially?—Yes.

2487. In the normal case the patient is put to bed simply in one of the wards you have described?—Yes.

2488. And then next morning you see him or her for the first time?—Yes.

2489. Now what do you do next? We are anxious to get a practical description of this system?—I examine the patient; if it is obvious that the patient is suffering from some serious mental disorder, I take steps myself to endeavour to have the patient removed from the observation ward to a mental hospital at the earliest possible moment, especially in the case of the male patients, because the accommodation is so bad.

2490. I suppose that the cases that come under your observation will range through practically every degree of intensity?—Yes.

2491. From slight cases to the gravest cases?—Yes.

2492. Then do you find that some cases present no difficulty at all—I mean that they are obvious cases of insanity?—Quite obvious some of them; I do not think they are in the majority; it is a comparatively small number in which it is obvious at first sight that they are suffering from some serious degree of mental disorder.

2493. I suppose experience such as you possess enables you to diagnose the situation rapidly?—Generally, yes.

2494. Now suppose, on the other hand, the case is not so obvious a one what is your next step?—It depends on when the magistrate visits. In Lambeth there are so many cases to be dealt with that most of the magistrates who attend prefer to come on fixed days of the week.

2495. That will lead us to the point at which you are brought into contact with the legal side of the matter. You make your examination first of all, and make up your mind as to the class of case you have to deal with?—Yes.

2496. Then is the next thing the intervention of the magistrate?—Yes.

2497. In Lambeth I think the duties of relieving officer have been specially delegated to one man?—Yes.

2498. As we know under the Statute that can be done. You will accordingly be quite familiar with the officer who brings the patients to you?—Yes.

2499. Is he a person of experience?—The present holder of the office has been there I should think quite 10 years, or more than 10 years.

2500. Have you confidence in his discretion?—Yes, I think he is very careful.

2501. We have heard in the course of the evidence before us here that the relieving officer seems to have a considerable amount of what one might call the initial responsibility, when he is called on to judge whether the case is one that he should bring to you or not?—Yes, I know that our relieving officer always tries if he can to get a medical certificate even before he will move; I know he does not like removing a patient from a home unless he can get some kind of medical certificate to the effect that the patient should be admitted.

2502. I think he is as it happens a married man?—Yes.

2503. And his wife has the duty of assisting him?—Yes.

2504. Of course in his case he operates under Section 20 of the Act, does he not?—Yes, in nearly every case—not always.

2505. As we know, his duty is to communicate with the magistrate within three days, apprising him of the case and setting in motion the machinery for dealing with it?—Yes.

2506. But do you find that in Lambeth it is desirable to arrange for regular visits from the magistrates?—Yes, I find it is very much more convenient if a magistrate will do that.

2507. When do they attend?—They attend on two days a week—their own choice.

2508. Do the same magistrates attend?—They change monthly; they are on a rota of a month each.

2509. Of course these justices are not “judicial authorities” under the Act. They come under the words “any justice of the peace having jurisdiction in the district may act”?—I think there is a special list of magistrates who are entitled to act in this capacity; I do not think it is “any magistrate,” because I know I am supplied with a list.

Lord Eustace Percy: It is Sub-section (1) of Section 13.

2510. *Chairman*: Thank you. What I am really concerned in is that these justices who co-operate with you do not require to be a “judicial authority” within the meaning of the Statute, do they?—I do not think so; but I do not think any justice of the peace can be called. I think I am right. I know I have a list; and a list is provided annually of the justices who can be called.

2511. Under Section 13 of the Act to which Lord Eustace Percy has drawn attention cases brought in would have to be dealt with by a judicial authority, but you are dealing for the moment with Section 20?—Yes; I was not aware of that fact.

2512. And there I think any magistrate who has jurisdiction within your territory can operate. Of course, it is for the justices to make arrangements

4 November, 1924.]

DR. A. L. BALY, M.R.C.S., L.R.C.P.

[Continued.]

between themselves as they please, and with you they have a system of monthly attendance?—Yes, they have a rota which is settled annually.

2513. And how many justices attend at one time?—One justice.

2514. Two days a week?—Yes, and at other times, if necessary. If I have an urgent case I ask the relieving officer to get a magistrate at once.

2515. *Earl Russell*: That is chiefly to enable you to clear your ward?—Yes, to remove the dangerous people from the ward as soon as possible, because it is so bad for the other patients that they should remain.

2516. *Chairman*: Now before we go further into that, it might be useful to know the extent of your work. Take the year to the 31st of March, 1924, for which you have statistics. How many persons were brought before the magistrates in your mental department during that year?—615.

2517. And we might just get on the note the history of those 615 cases. Of those how many were admitted on orders under Section 20 of the Act?—453.

2518. And of those were 363 brought to you by the relieving officer and 90 by the police?—Yes.

2519. Then as regards the balance of cases were 74 transferred to the mental department from the general wards of the infirmary?—Yes.

2520. And then 88, I think, were dealt with under Section 24?—Yes.

2521. Section 24 is the section under which patients may remain for a longer period in the Poor Law infirmary?—Yes.

2522. I understand that under the administration at present in operation, in some cases there are lunatics in workhouses?—Yes.

2523. But in London I understand a discrimination is made and you have wards set apart for the insane?—Yes. There are none in my infirmary. All those dealt with under Section 24 are transferred to Tooting Bec, a special institution which, I believe, is technically a workhouse; it is for harmless mental cases.

2524. But we must be clear about your position. You simply have an infirmary for dealing with afflicted persons, and one department of that is what we may call the mental department?—Yes.

2525. And the patients from your parish reach you in the way you have described. We know how you are first brought into contact with them, and we have brought ourselves up to the point where the magistrate intervenes, and we have paused there to see how many people there are who come under your cognisance. It is 615 in all; that means to say there are nearly two a day—not quite so many?—Yes, nearly.

2526. Then as regards those who reach you under Section 20 through the relieving officer or the police, how are they disposed of; that is to say, we have 453 to account for. How did you dispose of them in that year?—193 of them were transferred to mental hospitals.

2527. That would be after due process?—Yes.

2528. Then in how many cases were orders obtained but allowed to lapse?—In 111 cases.

2529. Then lastly was the balance of 149 discharged or transferred to the general wards?—Yes.

2530. Now with regard to the 111 patients, I am not quite sure I understand what is meant by a person being certified but the order being allowed to lapse?—There is no means under the Act of remanding a case; so, if the magistrate comes and I am not in a position to give a definite opinion as to whether they are fit persons to be transferred to a mental hospital or not, the only means by which I can keep them is to say that the patient is of unsound mind, which is probably quite correct, and ask the magistrate to suspend his order of removal. That means to say that he has to give me an order to transfer the patient to a mental hospital; he suspends the order under Section 21. I think it is.

2531. We will explore with you a little later if we may the drawbacks of the present rigidity of the

system which you are going to tell us about. You find a certain embarrassment in the statutory time table in dealing with the patient; certain things have to be done within a certain time, but you do not find that your cases accommodate themselves to that calendar. We will certainly get some evidence from you upon that a little later on. Meantime we may reserve that, in order to get the figures further analysed. With regard to the cases transferred to the mental hospitals, can you give us an account of them?—There were 74 who were transferred from the general wards of the infirmary through the observation wards and then sent on to mental hospitals.

2532. That is to say, 74 were people already in your hands as sick patients, passed through the mental department, were certified, and reached ultimately the public asylum?—Yes.

2533. Then next with regard to 88 of those cases?—They were transferred to Tooting Bec. I must make it clear that there is a duplication there. Some of those 88 patients may originally have been admitted under Section 20, either certified and the order allowed to lapse, and then re-certified for Tooting Bec, so that some of those people have been counted twice really.

2534. And a small number were transferred to private mental hospitals?—Yes, there were five.

2535. That gives us a total of 193—is that right?—Yes.

2536. When did you first receive your appointment, Dr. Baly?—In 1911.

2537. So that you have had 13 years' experience?—Yes.

2538. Have the cases increased in number during your period of office?—Yes, they have increased very considerably.

2539. I think when you first started the average annually dealt with was 434?—Yes.

2540. That is excluding the cases dealt with under Section 24?—Yes.

2541. Whilst last year the figure had risen to 527?—Yes.

2542. What inference do you draw from that increase?—I think it is due to the more rigid rule that patients should not be brought into the infirmary against their will. At the time when I was appointed, it was not at all an uncommon practice to bring patients into the infirmary against their will without invoking the Lunacy Acts, which is quite illegal to my mind; so that by more rigid instructions to the officials, these patients could not be brought in without invoking the Lunacy Acts.

2543. Take the figure 434 for 1911. Do you mean that at that time there may have been cases which strictly ought to have been dealt with as mental cases under proper procedure, but simply went to swell the statistics of your ordinary hospital?—Yes. To give the best example I can, old people who are very unwilling to leave their homes remained in their homes until the neighbours complained of their neglecting themselves, and then the relieving officer was called in, a doctor went and saw the patient and had the patient removed to the infirmary, and the patient was removed to the infirmary whether he liked it or whether he did not; whereas now, if the friends want the patient removed and the private doctor wants the patient removed, but the patient objects, then, unless they can get the relieving officer to act, the patient ought not to be removed if he wishes to stay at home.

2544. That class of case would formerly have been dealt with simply as a sick case?—Yes.

2545. Now that class of case is dealt with by being brought within the provisions of the Lunacy Acts?—Yes, a very considerable number of those as soon as they are in the infirmary are quite satisfied. They do not like leaving their homes, but once they are in the infirmary they are quite content to remain. Therefore they are brought before the magistrate, having been brought in against their will, and released—sent to an ordinary ward and treated as a sick patient.

4 November, 1924.]

DR. A. L. BALY, M.R.C.S., L.R.C.P.

[Continued.]

2546. *Earl Russell*: Would that be part of your "order allowed to lapse"?—It may be either an order allowed to lapse or else never made.

2547. *Chairman*: But you desire to have some legal sanction for the removal of these people?—Yes.

2548. Formerly you simply removed them without any legal sanction?—Exactly.

2549. Of course one is familiar with another department where cases of infectious disease are removed, I suppose, *volens volens*, to an infectious diseases hospital?—I do not think they can be.

2550. *Sir David Drummond*: It depends upon whether there is sufficient accommodation?—Yes, if they are not removed, I think they might be prosecuted under certain circumstances.

2551. *Chairman*: Of course there has been in the period in question an increase in population?—Yes.

2552. And that might account, might it not, for a certain number of additional cases?—Yes, it might. I think the bulk of the increase is due to the more rigid enforcement of the Act.

2553. Is one of the difficulties that you have experienced in practice that there are cases, such as you have described, of aged persons who ought to be removed from their homes because of the circumstances in which they are placed, and that there is no existing machinery for doing that unless you invoke the Lunacy Acts?—Yes.

2554. On the other hand, are some of those cases cases which you could not certify as lunatics?—Yes, quite rational.

2555. Does it not seem rather a curious procedure to utilise statutes intended for one purpose in order to achieve another purpose?—Yes; I mean they are rational when I see them. I do not know whether you would consider it rational for a patient to remain in a home when she is too feeble to look after herself and becomes verminous and filthy. As district medical officer, I have been into these homes and have seen the most unutterable filth and the patient refuses to move—yet she is quite incapable of looking after herself. If you see them before they come in they are not behaving rationally, but after they have come in and have been cleaned and have settled down they are perfectly normal.

2556. It may be, however, that that case should be dealt with by special legislation, because the Lunacy Acts are intended to deal with the actually insane person, as you are aware?—Yes, quite.

2557. But you have found in practice that the only way to deal with the cases, which you say you would not medically regard as insane although they may be abnormal or almost pathological, is to invoke the machinery of the Lunacy Acts and then to discard it when you have got them into your hands?—Yes, that is exactly what we do.

2558. I think we need to consider that aspect of the case. Do you find that is a frequent experience?—It is not at all infrequent.

2559. Of course you may have persons who are incapable of looking after themselves or of looking after their affairs who are not technically insane, may you not?—Yes.

2560. Does that occur most commonly in cases of senility?—Yes.

2561. In the case of some person living alone in squalid circumstances?—Yes.

2562. But who declines to enter your infirmary?—Yes. Of course a considerable number of them are cases of senile dementia.

2563. Certifiable cases?—Yes.

2564. On the other hand some of them are not?—Some of them are not.

2565. With regard to those who are not certifiable but who are manifestly their own worst enemies in the circumstances, you find it expedient to utilise this compulsory procedure?—Yes.

2566. Do you think it would be desirable to have some legislative or administrative provisions to deal with such cases which are technically short of lunacy, but nevertheless in a position where the person may be suffering and would be the better for being

brought into your hands?—I am not sure that the patient or anybody else suffers by the Lunacy Acts being invoked and then discarded. It does not affect anybody. The patient simply is brought in against his will by the only means we have got; it seems a very effectual means.

2567. It is a little shocking to the legal mind to find that you should utilise, with the best intentions of course, a code of law designed for one purpose to achieve another no doubt equally beneficent purpose?—The Act might be made to include that.

2568. We are here to get suggestions as to improvements, and I gather that you have been driven to this expedient through the absence of any existing machinery to meet this particular class of case?—That is so.

2569. Is it a class of case which in its own interest you think ought to be dealt with?—Yes, it certainly ought.

2570. Will you next tell us in connection with the patients who reach you under one head or another to what extent you are brought into contact with the relatives?—The relatives, the next of kin, or the nearest friend, sometimes only a landlady, attend at my office the morning after admission. The relieving officer always gives instructions that they must attend; I ask him to point out to them that it is necessary if they want their friends put under restraint for them to attend, and the next morning at nine o'clock I see them.

2571. Do these relatives or friends see you before you make your medical examination of the patient?—Yes, usually they do.

2572. Do you ask them questions about the case?—Yes.

2573. And do you endeavour to get as far as possible a history of the case from them?—Yes.

2574. What has been your experience as to the attitude of the relatives whom you have met?—Well, very frequently the attitude of the relative is that they want the patient detained in the infirmary, they do not want the patient sent to a mental hospital.

2575. They want the patient cared for and protected, but they have an aversion from the idea of the asylum?—A very strong aversion.

2576. To what do you think that aversion is due?—Well, I do not know; partly I think it is due to the fact that they think their friends will become worse if they are placed with other mental cases.

2577. Are they afraid of the effects of association?—Yes, and they also think that something terrible has occurred if insanity can be said to be in the family.

2578. We are familiar of course with the general reluctance of relatives to have any member of their family certified?—Yes.

2579. Apparently in your experience there is quite a strong desire on the part of relatives to obtain treatment, but if possible to avoid certification?—Yes.

2580. And apparently to obtain treatment without association with obviously insane cases?—Yes.

2581. That is a topic we want to explore a little further. After you have had a conversation with the relatives, where do you see the patient?—In the observation ward; I see the patient apart from the other patients whenever possible. There is a small room attached to both wards where I can have the patient alone.

2582. Are the patients in bed?—Yes, they are usually in bed; at least they are always in bed the first morning when I see them, but I can have them out into the room in a dressing gown if I want to.

2583. Do you make your examination in the presence of any other parties?—There is usually an attendant or a nurse there; the nurse, as a matter of fact, is standing by.

2584. Perhaps you would tell us about the staff you have in your mental department?—On the male side there are always two male attendants in the ward, and they are in charge of a sister—a nurse.

2585. Two male attendants in the male ward—with anybody else?—And a nurse in charge; the nurse is

4 November, 1924.]

DR. A. L. BALY, M.R.C.S., L.R.C.P.

[Continued.]

not necessarily in the ward all the time, but she is in charge of them. In the four female wards there is a sister; there are two nurses always in that section of the ward which is set apart for the troublesome patients, and there is one in each of the other wards always present.

2586. On your medical staff have you any assistant whose special province is the mental department?—There are assistants in charge from the physical point of view of both the male and female wards, but I do entirely the mental examination. I have an assistant who goes over the patient to see whether there is any other illness which wants treatment and to treat them.

2587. Have you had any special qualification in the treatment of insanity?—Not in the treatment of it, no.

2588. In so far as your academic course is concerned you would naturally take an ordinary course in insanity?—Yes; all my experience was at Lambeth before I was appointed.

2589. Before you took up your post you had not any specialised training in mental disease?—No, other than being the assistant of Lambeth; I was the senior assistant there.

2590. You were at Lambeth before 1911?—Yes, I went to Lambeth in 1907.

2591. Before that had you been in practice?—No, I came practically straight to Lambeth from one or two hospital appointments I had.

2592. So that you had never been in general practice?—No. In Lambeth we are also responsible for the districts outside. I am the District Medical Officer as well as Medical Superintendent, so that I have had experience in general work and in the homes of these particular people.

2593. But as regards the treatment of mental disease you have acquired your experience in the service, if one may so put it?—Yes, and even there I do not get experience really in the treatment of mental cases. If they want treatment from a mental point of view they all go to a mental hospital.

2594. We shall want to know what facilities, if any, you have for treating cases in your wards, but we will come to that later. Will you tell us about your actual examination of the case? How do you proceed to set about your task? The patient is in bed, we understand, and you have the nurse there? Are the relatives there at this stage?—No.

2595. You have seen them and got from them the necessary history of the case? You are now going to carry out your examination?—I have found from my experience that the easiest way from my point of view is to get the patient to talk if I can, and from his conversation I can judge very clearly as to his mental condition, better than by asking him questions.

2596. You try to put the patient at his ease?—I put the patient at his ease, and get him to talk. That is my method of determining as to his mental condition.

2597. Do you find much difficulty after you have had a conversation and with your knowledge of the history of the case in making your diagnosis?—No, I do not. The difficulty which I experience generally is in connection with the second part of the certificate—not saying whether a patient is of unsound mind or not, but in deciding whether a patient is a proper person to be placed in a mental hospital—I think that is the most difficult part of it.

2598. I do not quite follow that. If the person is to your mind manifestly insane?—If he is manifestly insane there is no difficulty at all; but there are a large number of cases which you can say are of unsound mind, but you have also to sign a certificate to say they are proper persons to be placed in a mental hospital. It does not necessarily follow that, because a person is of unsound mind, it is necessary for him to be sent to an asylum, because the second part, I consider, depends more upon the surroundings and the home conditions of the patient.

2599. When you speak of unsoundness of mind, you merely mean that the patient is in a pathological condition to this extent, that he or she is not normal?—Yes.

2600. But you are not quite satisfied that the abnormality goes the length of justifying detention. Is that the practical difficulty that you feel?—Yes.

2601. And of course you cannot certify unless there are present both unsoundness of mind plus the desirability of detention?—No; that is my reading of it.

2602. So you generally find, do you, indications of mental unsoundness, but your difficulty is whether the unsoundness is such as to justify you in recommending detention?—Yes.

2603. That is where your difficulty seems to reside?—Yes, especially so when one realises that if you certify you are inflicting a stigma on the patient. If that can be removed, then I should not have any doubt in many cases.

2604. Is it a reluctance upon your part, and one which is shared by the relatives, to impose upon the person the stigma of certification, when it may be in doubt as to whether the case is really so bad?—Yes.

2605. We have had a good deal of evidence before from witnesses who have preceded you as to the desirability of some provisional period of trial. Such a scheme would obviate a great deal of your difficulty?—Yes, in the right form.

2606. Again, upon that, we shall want you to expatiate a little later on. Now I suppose one may take it that in the general course, patients who are brought to you, coming as they do through the relieving officer or the police, in the great majority of cases will be *prima facie* cases of mental unsoundness?—Yes, the majority of them.

2607. I am distinguishing between the case of the private patient as to whom there may be doubt. There is no particular desire on the part of the relieving officer, I suppose, to bring patients to you unless there is a *prima facie* case of insanity?—That is so, but I find a very considerable number of cases appear to be more in the nature of domestic trouble than of insanity. Quarrels existing between husband and wife are quite common cases, and when you get the patients away from their surroundings at home they are quite normal. I have had one or two cases where a husband and wife have alternately sent one another in as insane—that is not at all uncommon.

2608. You mean domestic controversy may attain such a height as to reach insanity?—I have not infrequently recommended that they should make some arrangement and live apart, and if they do so I am quite confident they would be all right. There are quite a number of such cases.

2609. A temporary over-balancing of the reason due to exasperation, shall we say?—Due to incompatibility of temper, I think.

2610. But, quite seriously, you do find that people become, shall we say, hysterical or upset in consequence of domestic trouble?—Yes.

2611. Of course, apart from the instance you have taken of strife between husband and wife, I suppose affliction of one sort or another, the effect of a great sorrow or tragedy in a home, or any calamity may produce a temporary state of hysteria or mental upset?—Yes.

2612. The symptoms of which disappear when the patient is brought into a calmer region and removed from the immediate seat of the trouble?—Yes, they form quite a large percentage of the cases.

2613. You would not characterise those as cases of insanity, would you?—No. They are the most difficult cases to deal with—when a husband accuses a wife of trying to put him away.

2614. Or *vice versa*?—Yes, when there is domestic trouble.

2615. I can imagine that your task must call for the exercise of a great deal of tact, doctor?—I think it does.

2616. Do you record your results of the examination of the patient?—Yes.

4 November, 1924.]

DR. A. L. BALY, M.R.C.S., L.R.C.P.

[Continued.]

2617. Is that with a view to the compilation of your certificate?—Yes.

2618. In the cases when you are satisfied that the patient ought to be sent to a public mental hospital or asylum do you then proceed to prepare your certificate?—Yes, I do.

2619. That is the statutory form, is it not?—Yes.

2620. In this case is only one certificate required?—Yes.

2621. If you are not satisfied that the case is one that should be sent to a public mental hospital, what do you do?—If I am uncertain, if I can get any grounds for supposing a person to be of unsound mind, I record all the possible grounds, and I do in practice certify. It is the only existing method under the law that I can see by which you can detain a patient for longer than the three days.

2622. Your examination is taking place the morning after admission?—Yes.

2623. When does the magistrate intervene?—He must come within three days, and I always bring every patient who has been admitted since the magistrate's last visit before him, whether I have really decided or not, because otherwise he would have to come again in the intervening days.

2624. When you have completed your medical examination and have the history of the case before you, are there some cases which you recognise at once as not being certifiable cases?—Yes, there are some you can recognise as not being certifiable definitely, and of course there are others that you can recognise as being certifiable definitely.

2625. What about the cases which are clearly not certifiable cases?—I advise the magistrate on his arrival that the patient is not certifiable.

2626. If there is no medical certificate before the magistrate, he has really no function to discharge, has he; he cannot commit the patient without a medical certificate?—No, he must release the patient.

2627. So that in these cases a certain number will be discharged at once as not being mental cases properly so-called?—Yes.

2628. They remain in your wards until the magistrate comes?—Yes.

2629. And after the magistrate comes, a certain number of cases will be eliminated at once?—Yes, they are released; they can do what they like; they can either remain in the infirmary as patients or they can take their discharge.

2630. Some of them may have medical ailments and would be sent to the general wards; others may have recovered from the temporary upset and are just discharged?—Yes.

2631. Now with regard to the cases which are clearly certifiable, you have prepared your certificate in advance of the magistrate's arrival?—Yes.

2632. In the intermediate category, that is to say, cases as to which you are not quite certain, what do you do?—I prepare a certificate.

2633. Do you sign it?—Yes.

2634. In an intermediate case?—Yes, it is the only way I can keep the patient. It does nobody any harm because nobody knows the certificate has been signed if they recover. It is the only legal way I can see.

2635. I do not know that it is a legal way. The certificate requires you to affirm the two propositions that you have just told us about?—Yes.

2636. Do you tell us that you prepare such a certificate and sign it in advance of the arrival of the magistrate?—I forget the wording of that certificate at the moment. It is "a fit and proper person to be detained" I think. I certainly consider the patient as a fit and proper person to be detained in my observation ward. I think you can get over it by the wording of the section.

2637. Is it what is called Form 8?—"A proper person to be taken charge of and detained under care and treatment?—Yes. In my opinion a person is a proper person to be taken charge of for the time being, but I do not say that it is necessary to transfer him to a mental hospital.

2638. The form, however, asks you first of all this question: "Have you come to the conclusion that he is a lunatic, an idiot or a person of unsound mind?" In that case you would select probably the expression "person of unsound mind"?—Yes.

Lord Eustace Percy: Just to clear up this point: I suppose, Doctor Baly has the option in such a case to sign a certificate under Section 21 or a certificate under Section 24 which merely states in Form 10 that he is a proper person to be allowed to remain in the workhouse as a lunatic?

Witness: Yes, but that requires another doctor as well as myself.

2639. *Chairman:* Yes. Under Sub-section 4 of Section 24 I think you require a medical certificate under the hand of a medical practitioner not being an officer of the workhouse?—Yes, I cannot use Section 24.

2640. So you avail yourself of Form 8 in this case, because you are satisfied that the person is of unsound mind and is a proper person to be taken charge of and detained under care and treatment, although you have by no means made up your mind that he is a proper person to be sent to an asylum?—That is what it comes to.

2641. Then the magistrate supervenes, and what passes between you and the magistrate?—I take the magistrate down to see the patient.

2642. Let us visualise actually what happens. Do you put before the magistrate the papers relating to the cases for that day?—I generally take the papers with me to the ward.

2643. You and he go in company to the actual ward. You have the record of the day's cases in your hand?—Yes, and I hand him the certificate and the case paper.

2644. Of each case as he comes to deal with it?—Yes.

2645. Does the justice go into the ward and find the patient in bed?—Yes.

2646. And he is handed the papers relating to the case?—Yes.

2647. What does he do then?—It depends upon the magistrate. Some magistrates read the paper and ask a few questions of the patient and then pass on to the next case.

2648. They pass judgment upon each case as they deal with it?—Some pass judgment in a way in their own minds; others merely look at the papers and the patient.

2649. And are satisfied without engaging the patient in conversation?—Without engaging the patient in conversation.

2650. Do the justices see the relatives?—Not in every case.

2651. Do they in some cases?—They do in some cases.

2652. Do they ask to see them?—No. If a patient's relatives are very averse and very insistent that there is no necessity to send the patient to a mental hospital, I always tell them they had better see the magistrate themselves. I think the presence of the magistrate will satisfy them better than I can.

2653. If any relatives have come with a patient or are there the next morning and wish in the interests of the patient to see the magistrates themselves, can they always do so?—Yes.

2654. And do they in practice do so?—Not very often.

2655. *Earl Russell:* Do they always know on what day the magistrate is coming?—I do not think they could know.

2656. Then of course they could not be there?—No, that is true.

2657. *Chairman:* It would rest with the relieving officer to tell the relatives that the magistrate would be in attendance?—Yes. What actually happens in practice is that I always tell the relatives. If the patient is in the observation ward, and if it is necessary for the patient to be removed to a mental hospital, they will be informed at once.

2658. If the relatives are there, you no doubt tell them what you propose to do; but how do you know that the relatives have been made aware at all of

4 November, 1924.]

DR. A. L. BALY, M.R.C.S., L.R.C.P.

[Continued.]

what is happening to their unfortunate relation? The relieving officer brings the patient to you; how do you know that the relieving officer has taken any steps to apprise the relatives of the condition of their relation and what may befall him?—I think the relatives are fully aware that their action will lead to a certification if the patient is removed.

2659. I can figure a case where I think that would not happen. Supposing you had an old woman living alone, which not infrequently happens; she has reached a stage when the relieving officer sees that something must be done and has her removed to one of your wards. She may have relations living in another part of the town; some old people insist upon living alone by themselves. Would the relatives in such a case be communicated with?—Yes, always. The relieving officer always informs the next-of-kin if he can find them. If the case is brought in by the police, the police endeavour to find the next-of-kin, and if the police fail, we try; the police always produce the next-of-kin the next morning if they can.

2660. That is all done, although there is no statutory obligation of communication with the relatives?—No, I do not think there is.

2661. Do you regard it as valuable to have information from the relatives?—I always try and get the relatives, before I bring the case to the magistrate.

2662. And do you also regard it as important to ascertain if possible the wishes of the relatives?—Yes.

2663. Would you think it desirable that some machinery should be provided whereby intimation should be given in every case to the relatives of a patient?—Yes. I certainly think so. Of course the relieving officer invariably tries to find the relatives for another purpose; for the purpose of chargeability.

2664. That gives him a motive and a duty?—Yes, but I always expect him to produce the relatives to me.

2665. And I see that you attach importance from two points of view to the presence of the relatives: firstly, that they may inform you of the history of the case, and, secondly, that they may also express to you their wishes and desires with regard to the future of the patient?—Yes.

2666. Those are very important matters?—Yes, very important, especially in the case of old people living by themselves and whose relatives may wish to take them home.

2667. You are aware that in the case of a private patient, the patient is entitled to have at the proceedings before the magistrate the attendance of a third party. There is nothing comparable with that in the case of the pauper patient, is there?—No.

2668. Then in cases where relatives are not to be found or where relatives are callous or negligent, the patient is dealt with by you and the magistrate although no relative may be there at all?—Yes, that is not very frequent, but it does occur, especially in cases brought in by the police, who are sometimes unable to obtain the name of the patient, let alone the whereabouts of his friends.

2669. Do you try to find out from the patient, if the patient is in a mental condition to give it to you, information as to whether he or she has any relatives to be communicated with?—Yes.

2670. If you get that information, do you communicate with the relatives?—We communicate because a notice is sent out from the infirmary, in the case of every patient who comes in whether mental or not, the next day. There is a special notice for the mental cases sent to the next-of-kin, if we know them. If we do not know the next-of-kin, we send the notice to the landlady where the patient lives.

2671. All that is done by you over and above your strict statutory duty, if I may say so?—Yes.

2672. Have you a form for sending out these notices?—Yes.

2673. Is that form one which has been devised in your own infirmary?—Yes.

2674. Is it a printed form?—Yes.

2675. And does that printed form advise the relatives of the time when the magistrate is to attend?—No, it does not, because that is uncertain.

2676. It would be interesting if you could let us have a copy of the form that you use?—I have not one with me but I will get one for you. There are two forms; one is issued by myself and the other by the relieving officer; one is issued by the relieving officer to apprise the relatives of their duty to attend at my office, and my form sets out the regulations governing the observation ward.

2677. If you will let us have copies of those forms, they will be very useful?—Yes, I will let you have them.

2678. Now the justice has gone round the beds with you and has seen the case papers. What happens next that morning?—He returns to my office and discusses the cases with me.

2679. Not in the presence of the patient?—No.

2680. Is each case taken up individually?—Yes.

2681. Do you express to the justice any difficulties you have in your mind with regard to particular cases?—Yes. In those cases where I am doubtful whether it is necessary for the patient to be sent to a mental hospital, I ask him to suspend his order.

2682. That is to say, putting it in more colloquial language, you want more time to make up your mind?—Yes.

2683. A certain number of cases I have no doubt would be immediately certifiable?—Yes.

2684. Are these dealt with by the magistrate upon your certificate and upon the information you have given and upon his own personal visit to the patient?—Yes.

2685. Have you any difficulty as to the destination of the patient? A magistrate must specify where the patient is to be sent to?—Yes.

2686. Do you find in your experience any difficulty in selecting the public mental hospital?—The vacancy is applied for by the relieving officer and I have no choice.

2687. He ascertains where the patient can be accommodated?—Yes.

2688. Have you had any experience of difficulty in getting accommodation for patients?—Yes, on occasions.

2689. Is that owing to the crowded state of the public asylums?—I presume so, yes.

2690. What is done if there is no place for the patient immediately available?—If there is no place immediately available, some magistrates—I do not know whether they are legally entitled to or not—sign the order.

2691. *Earl Russell*: Blank?—I think it is practically blank—to a London County Hospital, or something like that, without specifying. Others initial the order and wait for the vacancy to occur and then when the name of the asylum can be entered they sign it, but I do not know that that part of it is my responsibility. Some of them are actually left blank.

2692. *Chairman*: One wants to know the difficulties that arise in practice?—You do not get your vacancy immediately unless you specially ask for it.

2693. It is really the relieving officer's duty to find out where the patient can be sent?—Yes.

2694. And you find in practice sometimes he has difficulty in getting a vacancy for a particular patient?—Yes, especially if there are a number of patients. They generally remove an urgent case very quickly.

2695. I suppose patients do not come to you with uniformity—I mean you may some days have a pressure of work and on other days slackness?—They vary enormously; sometimes you go for a week with very little to do and then you have a very large number.

2696. In practice, owing to the crowded state of the asylums, there is some difficulty in obtaining the requisite number of vacancies at once?—Yes.

2697. In such a case is the ultimate destination of the patient sometimes left over until it can be ascertained whether there is a vacancy?—Yes.

4 November, 1924.]

DR. A. L. BALY, M.R.C.S., L.R.C.P.

[Continued.]

2698. Now with regard to the cases which are not clear, you have told us that you adopt an expedient for getting a little more time. With regard to some of the cases, on the other hand, although you have granted a certificate meantime, does the justice discharge right away?—Those that are clearly rational are discharged right away.

2699. Do you explain to the justice that although your certificate states that the patient is of unsound mind and suitable for detention, he is nevertheless not, in your opinion, a case suitable for treatment in an asylum?—Those cases are not discharged. The only cases he discharges right away are those in which I am quite clear the patient is rational. I write a certificate to say that the person is not a person of unsound mind.

2700. *Earl Russell*: Which is not a certificate under the Act?—No.

2701. *Chairman*: In that case you and the magistrate are fully satisfied and the patient is released at once?—Yes.

2702. The class of case we are interested in is the difficult case. With regard to the difficult case, you say you get an order from the magistrate but you get him to suspend it?—Yes.

2703. That is rather a novelty to us. What do you mean exactly by that?—It is a suspended order under Section 21, I think it is, which empowers me to detain the patient for 14 days.

2704. We will just look at the terms of that Section: "An order under this Section shall not authorise the detention of a lunatic in a workhouse for more than 14 days." This is a case where a summary reception order has not in fact been made but may be made. And in that case you ask for an order for 14 days' detention really in order that you may have the patient under observation?—Yes. The unfortunate thing is that I have got to certify that the person is of unsound mind in order to do that.

2705. Is that clear?—Yes, I think so.

Earl Russell: I think it is clear because it has to be made in any case where a summary reception order might be made, and he could not make it unless he had the medical certificate.

Chairman: That is quite true. You see, there is another provision (I do not know whether you have it in mind) in Section 19 of the Act, that the justice may make a summary reception order, but may suspend its execution for 14 days.

Witness: That is what I was always under the impression was the procedure.

2706. You referred us to Section 21, but if you look at Section 19, you will see provision is made for suspending the order?—Yes, that is the one I had in mind.

Earl Russell: There is this difference, if I may point it out, that in Section 19 he has actually to make the order and to suspend its execution, and in Section 21 he need not make the order.

2707. *Chairman*: Section 21 covers a case eligible for an order, but where an order has not been made. It would seem really that there are two ways in which a period of 14 days may be secured; one after the pronouncement of a summary reception order and one without the pronouncement of a summary reception order. Which of these two do you resort to? Have you a summary reception order or not?—Yes, I do get it.

2708. Then it is really Section 19 under which you proceed?—Yes.

2709. You get an order, but ask the justice to suspend it?—Yes.

2710. *Earl Russell*: Then the patient has had the stigma of lunacy inflicted upon him?—But nobody is aware of it except the magistrate and myself.

2711. And the patient's relatives?—No. If the patient is not removed to a mental hospital, nobody is aware of it except the magistrate and myself. It gives me the legal authority.

2712. *Chairman*: But still he is a person with regard to whom a magistrate has pronounced a summary reception order, which order he could not pro-

nounce competently unless he was satisfied that the person was of unsound mind, ought to be detained, and was therefore certifiable?—Yes, but I still maintain that the patient cannot suffer the stigma as a result of that order being signed.

2713. *Earl Russell*: He could not bring an action for slander against anybody who said he was a certified lunatic afterwards?—Nobody would know it.

Lord Eustace Percy: I am a little puzzled about this. If you will look at Section 24, Dr. Baly can himself detain a lunatic for 14 days in the workhouse by merely certifying that he is a lunatic and he is a proper person to be detained in the workhouse, if the accommodation in the workhouse is sufficient.

Witness: Yes, that does not apply to a patient brought in under the Lunacy Act. If a patient is brought in under the Lunacy Act by a relieving officer, he has got to be brought before a magistrate, and I do not think I can apply that Section, can I?

Chairman: But Section 24 also has this feature, that there must be an order.

Lord Eustace Percy: Only after 14 days.

Chairman: An order if you are to detain for more than 14 days. I suggest the 14 days are provided for either under Section 21 or Section 24 (1)), and if you wish to detain beyond the 14 days you would have to resort to Section 24 (3).

Lord Eustace Percy: Sub-section (2) of Section 21 is: "In any case where a summary reception order has been made, an order under this section may be made to provide for the detention of the lunatic until he can be removed. (3) An order under this section shall not authorise the detention of a lunatic in a workhouse for more than 14 days."

2714. *Sir Thomas Hutchison*: This does not apply to a patient residing in a workhouse for some other reason?—Yes. I was always under the impression that I could not apply Section 24 to these cases.

Chairman: Look at the marginal note; it is called "Lunatics in workhouses." We have hitherto, I think, been led to believe that this is the class of case where you have a person actually in a workhouse who becomes insane, and then you deal with him in this way.

2715. *Sir Thomas Hutchison*: Brought into the workhouse, perhaps, for some other reason?—Yes, I have always understood that.

2716. *Chairman*: I am afraid we have heard a great many different views on the interpretation of some of these sections from the various witnesses; they are by no means clear?—They are not at all clear. When I first started this work I thought I understood my position, but the more inquiry I have made from those in authority the less clear I am about it.

2717. The programme of action, if I may so call it, is not very well defined?—No.

2718. However, we do not want to trouble you with questions of legal interpretation. We are anxious to know how you proceed to interpret as best you can the statutory duties imposed upon you, and we are interested in the class of case in which you have some difficulty. You get an order actually pronounced by the magistrate following upon your certificate and his visit to the patient; but you say to him: "This is a case which I should like to have more time to consider; will you suspend the carrying out of your order for a period of 14 days?"—Yes.

2719. And you get an order suspending for 14 days?—Yes.

2720. The result of that is that the patient is not immediately taken away to an institution but is left under your charge?—Yes.

2721. Does he or she remain in one of your wards under observation?—Yes.

2722. Now is the period of 14 days used merely for observation or is it to any extent used for treatment as well?—It is used for treatment in the case of the sick patients.

2723. Medically sick?—Quite a percentage of these cases are medically sick. Some of them are actually

4 November, 1924.]

DR. A. L. BALY, M.R.C.S., L.R.C.P.

[Continued.]

removed from the general hospitals under Section 20 because they are delirious. If a patient becomes troublesome in a general hospital, I not infrequently have him sent down to me under Section 20—sick patients.

2724. Are these people dealt with by all this machinery of certification and the rest of it?—Yes, they are certified. Here again the only person who knows they are certified is myself.

2725. But nevertheless the existence of a certificate is serious. Take the case of a patient who merely has a symptom of an ordinary disease; I understand there are many forms of ordinary ailments, for example, pneumonia or typhoid where you may have a transitory state of delirium; a patient may be violent and try to get out of bed, and so on. Are such cases sent down to you?—They are sent down.

2726. *Earl Russell*: Delirium is not at all infrequent in ordinary ailments?—Quite a considerable number are sent down.

2727. But it is not insanity?—No, it is not.

2728. *Chairman*: I am rather alarmed to hear that these cases are put through the mill of the machinery for lunacy?—They are put through the mill if it is necessary to use restraint and the patient is demanding to go out. It seems to me quite illegal—I do not know whether it is—to use a padded room in a hospital.

2729. *Earl Russell*: You would not hesitate to apply force to a patient in high fever who wanted to go out and catch his death of cold, certified or not certified?—No, but those persons sent down to me from the hospital under Section 20 are cases you may class as delirious; they are very restless, very troublesome, very noisy; they could not be kept in any other ward but my observation ward. I think the commonest disease in that class of case is uræmia.

Sir Humphry Rolleston: Dr. Baly gave me the impression that he grouped with insanity cases of delirium tremens. I should like to know whether those cases are treated for the time being as cases of insanity.

2730. *Chairman*: We will ask that. (*To the Witness*): But let us first take a case in your general hospital. You have a patient suffering from a well-known ailment who develops symptoms of delirium and becomes delirious. It is not an uncommon phase as we know of many ailments that a patient may have to be held down in bed to prevent him getting up. You do not suggest that you require the machinery of the Lunacy Laws to enable a doctor to restrain a person in moments of delirium, do you?—No, I do not think it is necessary.

2731. But in point of fact are patients suffering from some well-defined ailment actually removed from the general ward to the mental ward, merely because in the course of that ailment they become delirious?—A certain percentage are. If they are violent it is the only ward where I can look after them, but they are not put through the machinery of the Lunacy Laws as a matter of fact.

2732. These people are not brought before justices, are they?—No, but they have to be brought before a justice if they are brought in under Section 20 from another hospital.

2733. Do you have cases actually transferred from another hospital in a state of delirium consequent upon the onset of some other illness?—I do not think it is quite fair to say delirium in the ordinary sense of the term. They become very restless and they can better be described as mental.

2734. *Earl Russell*: Toxic?—I have one at the present moment sent from a hospital suffering from uræmia—chronic Bright's disease. The delirium resulting from that condition is the class of case for which this machinery is invoked.

2735. *Chairman*: If such a case had been transferred from one of your general wards to your mental department, it would only have been because of the greater convenience of dealing with the case there,

not in order to use the machinery of the Lunacy Acts?—No.

2736. On the other hand, if a case is transferred to you from another infirmary altogether, do you say that you have, in order to detain that case in your mental ward, to invoke the Lunacy Acts?—The Lunacy Act has been invoked to bring the patient there.

2737. To secure the transfer?—To secure the transfer. It has already been invoked, and in the majority of those cases I ask the magistrate to discharge; and if the patient is still restless, he remains in the observation ward, and as soon as he has settled down he is transferred to an ordinary ward. There are some cases where I do actually sign a certificate, but I cannot see that any harm has been done because nobody except myself knows that a certificate has been signed.

2738. But I think one must be a little cautious about that, because when you sign a certificate, that is a matter of record in your infirmary; and, as Lord Russell put it, if any person said afterwards of this patient of yours that he was once certified, they could obtain an order for the discovery of the records of the infirmary, and there it would appear that a responsible medical man had in fact certified under the Act. There would exist a record, although not disclosed by you at the time, that this person had been certified?—Quite.

2739. You are not the only witness we have had who has found it necessary to have recourse to procedure in the interest of patients, as to the legality of which there might be some doubt. All that may well point in the direction of giving you a better system?—We certainly ought to have some legal right. There ought to be some legal authority for interfering with an individual's liberty, and you have to interfere with the liberty of a patient.

Earl Russell: But not in ordinary cases of sickness.

2740. *Chairman*: Almost everybody has had a severe illness at one time or another and may quite well have become wandering in his mind, as we say, or as you put it, restless, wanting to get up and so on. The kindly medical attendant who is looking after him tries to soothe the patient and may have to hold him down in bed for a bit. That is not a case which has any relation to the Lunacy Laws?—I do not think it ought to have. It has a relation at present, in that patients are transferred from hospitals under Section 20.

2741. Once a patient becomes certifiable we know that any question of restraint is a matter under the Act, but we are dealing with a patient who receives medical treatment and requires some measure of restraint in his own home. Such a person would not be a certifiable person, surely?—He should not be.

2742. *Sir David Drummond*: Is it not the fact that in your infirmary you have not sufficient accommodation to treat such a case as uræmia, and so on, in the ordinary wards?—In certain cases that is so. I do not want it to be thought that all cases of delirium are moved to the observation wards; it is only very exceptionally, but a certain number brought in under Section 20 are placed in the observation wards and subsequently transferred to the ordinary wards.

Chairman: I could understand you saying of one case "This is a mental case"; but of another case you would say: "This is a case of Bright's disease but temporarily the patient is upset and, 'off his balance' and requires special precautions." But the two things are quite different. I am again speaking purely as a layman. One would not characterise a patient suffering from Bright's disease as a lunatic.

2743. *Earl Russell*: Is it not one of the commonest incidents of malaria for the patient to be off his head?—I believe it is. Personally I feel that there should not be this distinction. I look upon a person suffering from a mental affliction as sick in the same way as anybody else and I think you ought to remove that distinction.

2744. *Chairman*: Of course the trouble is that you have to get power of detention in some cases, and that

4 November, 1924.]

DR. A. L. BALY, M.R.C.S., L.R.C.P.

[Continued.]

power of detention against the wish of the patient has to be very carefully safeguarded?—Quite.

2745. It is the old story of the difficulty of accommodating legal principles with medical science. In medicine one understands that there is no difference between the extreme case and the slight case, that is to say, they are all symptoms of a pathological condition; but in some cases it is necessary to interfere with the liberty of the subject and there the law steps in and requires certification. That is the problem, is it not?—Yes.

2746. Just tell us also with regard to the case that Sir Humphry Rolleston referred to, the case of alcoholism—I am afraid you must have a number of cases of that sort?—We do. They are mostly brought in under orders under Section 20.

2747. By a relieving officer or the police?—By a relieving officer or the police. It seems to be a question of luck in many cases whether a patient is taken to a Police Court or brought to me as a lunatic. I had only this week-end a patient brought in as a lunatic and the next morning his condition was perfectly clear—the patient was perfectly sober. The magistrate came and the patient was released the next morning.

2748. But may not a case of extreme alcoholism possibly have the good fortune of being taken to an ordinary general hospital? Supposing a person has reached the stage of alcoholic coma in the street, he may be taken off to St. George's Hospital or any of the other hospitals?—Yes, or he might be brought to me as a sick patient.

2749. Or to your ward by the relieving officer?—Yes, or by the police, or he might be taken to the police station.

2750. He reaches you in a state of either alcoholic excitement or coma, stays the night under your roof, is examined by you next morning and is stated to be a case of alcoholism. It is generally easily diagnosed, is it not?—Generally—not always.

2751. The man has "slept it off," I suppose, putting it colloquially?—Yes.

2752. In such a case what would you do?—It may be important that the man should be released at once; a man may lose his work or suffer very seriously through being detained; it is not my business to punish a patient. I arrange for him to see a magistrate that day; but I not infrequently arrange, if the magistrate is not coming, for the relieving officer in such a case to take the patient to the magistrate. I do not think it is justifiable to call a magistrate just for one person who has got drunk, so I send the patient to the magistrate and he is released.

2753. *Sir Thomas Hutchison*: Does such a case arrive at your ward with a certificate?—He arrives with a police order.

2754. But how is that police order obtained?

2755. *Chairman*: He is taken to a police office and I suppose the officer in charge there will give some order?—Yes, he gives the order.

2756. *Mr. Snell*: Not the police medical officer?—No.

2757. *Chairman*: The police officer in charge of the charge room; he simply writes out an order and the constable will then take this man to you?—Yes.

2758. He might equally have been taken to the workhouse infirmary, not the mental side?—Yes. Of course if he were refusing to stay or were obstreperous I should have absolutely no power to keep him.

2759. The police would have?—Yes, they would. Of course if they bring a patient into the hospital who is merely drunk, my medical officer diagnoses drunkenness or tells the police to take him away; but there are cases of varying degree where a patient may be temporarily insane from drink, and I think it is quite justifiable that that patient should be put into an observation ward where you have a padded room rather than keep him in a police cell.

2760. It seems to me that this is largely apart from the ordinary lunacy administration altogether?—As far as I am aware it is the only means by which a drunken man in his home can be put under restraint. A man may be breaking up his home; he may be

damaging other people; you cannot take him out of his home; the only way you can remove him from his home is by deeming him to be a lunatic.

2760A. *Earl Russell*: As soon as he is injuring other people.

Chairman: Then you can call in the police.

Witness: But the police cannot arrest him.

2761. If he is screaming and shouting in his room?—I have always understood that they could not arrest—not in his own home.

2762. Although he is doing damage to property?—His own property in his own home.

2763. Would not he include his wife among his own property?—His wife would have to charge him, under those circumstances.

2764. It rather shocks one, I confess?—I have always understood that it is the only means of removing a man from his own home.

2765. To invoke the Lunacy Act?—Yes, I think so.

2766. If that is so, I think we must see that it is put right?—I think it is so. I had patients before the war who used to be brought in once or twice a year under Section 20, and one man I remember particularly well; in the end he died in his own wreckage.

2767. An alcoholic case—recurrent bouts of alcoholism?—Yes.

2768. Of course, it is perfectly true that alcoholism is associated with insanity, and you must have a certain number of cases that must come under the Lunacy Acts?—If it could be done with a clear conscience, it would be the best thing to do, but you do not get those cases until they have got to a very advanced degree of alcoholism.

2769. *Earl Russell*: You do not get them until they are really useless?—That is so.

2770. *Chairman*: However, you tell us that you have cases of alcoholism brought to you, which are relegated largely as a matter of chance to your mental department, and when seen by you are diagnosed as alcoholics, and you take steps to get the person released as soon as possible?—Yes.

2771. But they have to this extent been subject to the Lunacy Acts; that having been brought into your mental ward through the machinery of the police or the relieving officer, you cannot by your hand release them without bringing them before a magistrate?—No.

2772. An ordinary person brought to your sick department is entirely at your discretion as to when you shall advise him to go?—Yes.

2773. But such a person brought to you under the circumstances you have described is detained by you until the magistrate grants release?—Yes, and the same thing applies to attempted suicides.

2774. Will you tell us about that class of case?—They are brought to me, in many instances, under Section 20 by the police. Personally, I myself prefer that the Act should be invoked because a good many of these attempted suicides are certifiably insane. I think it is better that the patient should be put under the Lunacy Act by an independent authority—not myself.

2775. We are here rather trenching upon a different region, because there are people who hold that attempted suicide itself is practically a form of insanity?—Yes. After all, if a patient succeeds in committing suicide, he is generally deemed to be temporarily insane, and I think it is more satisfactory that they should all be brought to me under Section 20 rather than be brought to me as ordinary patients.

2776. Of course, one can see here that you are dealing with a very grave and delicate class of case. Suppose an unhappy woman is caught in the act of trying to throw herself over Westminster Bridge, for example: do you have cases of that sort brought in?—Yes. We have cases of people who have actually succeeded in throwing themselves in the river.

2777. *Sir David Drummond*: Then it is an accident, whether they are brought to Dr. Baly or St. Thomas's or any other hospital?—Yes.

4 November, 1924.]

DR. A. L. BALY, M.R.C.S., L.R.C.P.

[Continued.]

2778. They are not certified. They are brought up before a magistrate afterwards?—Yes.

2779. *Chairman*: Such a person recovered from the Thames might be taken to St. George's Hospital, for example, put to bed there, might recover all right with good food and with rest, and then simply walk out of the hospital; but if they reach your infirmary, by way of contrast they then find themselves involved to this extent in the Lunacy Acts that they cannot walk out, even although they may have recovered, until a magistrate has passed judgment upon them?—Yes. It is not the invariable practice to issue an order. What decides the police in issuing the order I do not quite know. A cut-throat, for instance, will be brought in to me as an ordinary patient, put into an ordinary ward and treated. I do not think I can ever remember a cut-throat being brought in under Section 20, but cases of attempted gas poisoning and attempted jumping into the river and drowning are frequently brought in under Section 20.

2780. They are *hors de combat* for the moment?—Yes, they cannot go out; you have got to detain the patients.

2781. *Lord Eustace Percy*: But every case of attempted suicide is subject to arrest.

Chairman: It is a crime, of course.

Witness: Yes, but I think they have ceased charging.

Earl Russell: Because it is so awkward for magistrates to know what to do with them.

2782. *Chairman*: One is rather struck by your evidence so far. It seems as if, through the absence of machinery to deal with difficult cases such as you have described, resort has been had to the machinery of the Lunacy Acts in order to get the necessary power to detain such persons in their own interest, to protect themselves and to protect the public against them, although they are not cases that anybody would regard as certifiable cases. Is that a fair representation of the position?—Yes. Supposing an insane person is brought in, having attempted suicide, and I have not got a Section 20 order, how am I to proceed with the case? Arrest him myself in the infirmary?

2783. I am wondering what happens if the patient has been taken to St. George's Hospital or to St. Thomas's?—He may be sent on to me under Section 20 from St. Thomas's.

2784. The patient might be taken there where he would remain a free agent and be treated, but suppose he said "I am going away," and the doctor said "Well you cannot possibly be allowed out just now in view of your state," what would happen to him then?—They have got no right to detain him, have they?

2785. *Sir David Drummond*: But he is in the hands of the police in nine cases out of ten?—Except that the police do not charge.

Sir Thomas Hutchison: But they have got to look after them.

Lord Eustace Percy: You have only to call the policeman at the corner.

Witness: In which case the police would probably bring him on to me under Section 20.

Chairman: You seem to be the ultimate destination.

Lord Eustace Percy: I wonder whether you could ask Dr. Baly if he could let us have an actual list of the cases which he has received from general hospitals like St. Thomas's, say, within the last six months—I do not mean the names of course—so that we might judge how far they were cases of delirium in the sense of persistent delusion.

2786. *Chairman (to the Witness)*: You have, of course, your case records?—Yes.

2787. It would be interesting to have some notion of the class of cases you have had to deal with. We do not want to put too heavy a burden upon you. Would six months be too much to ask you to take up for us?—No, I do not think there would be any difficulty in tracing the cases* removed from the

hospitals during the last six months; they are not a very large number.

2788. We should rather like to have that?—Yes, and their ultimate destination.

2789. *Sir David Drummond*: I think it would be a useful thing if we could have the duration of the illness before they were sent from the hospitals to you?—I might be able to obtain that; I am not sure.

2790. *Chairman*: Now let us revert to cases more strictly under the Act. You have disposed, with the magistrate's assistance, of the clear cases on either side; those who manifestly must go to an asylum, and those who must manifestly be released at once. You have obtained with regard to the remaining cases a 14 days' moratorium, owing to the order having been pronounced but the justice having suspended it for 14 days. During that time those cases are under your observation. Are they always kept in bed during that time?—Not necessarily.

2791. What do you mean by having them under observation; what is actually done?—They are detained in the observation ward. They are seen by myself and my assistant every day, and of course I have the reports of the sister in charge as to their behaviour; they are always particularly examined by myself on each occasion before the magistrate is coming, so that if I can dispose of the cases within the fortnight I do.

2792. What has been your experience with regard to the number of cases dealt with in this way; how many have ultimately had to be sent to asylums, and how many have been found to be cured so that the order, in your phrase, has been allowed to lapse?—A considerable number. I think I have given the number. There were 111 in one year in which the orders were allowed to lapse, but, of course, a certain number of those would be recertified under Section 24.

2793. Let us follow that a little. A summary reception order has been made by the justice; it has been suspended; the patient has been in your hands for a maximum of 14 days; during that time you have observed the case and come to certain conclusions upon it, and if you are satisfied that the case is not one for permanent detention what do you do?—In that case the order lapses.

2794. You do not take any procedure; you just let the 14 days elapse and then out walks the patient?—Yes; or with the magistrate's consent I release the patient before that time. Sometimes the patient is transferred to an ordinary ward, being a case of sickness, or allowed to take discharge.

2795. And passes out of the purview of the Lunacy Acts altogether?—Yes.

2796. Therefore, within the 14 days you may be satisfied that the patient is not a certifiable case although you have certified him?—Certifiable, but not a proper person to be sent to a mental hospital.

2797. A proper person to be released from the operation of the Lunacy Acts?—Yes.

2798. In such a case you can do it with the help of the magistrate, or take the other course; the time lapses and the patient is free to go?—Yes.

2799. Is that in 111 cases in the year?—In 111 cases the orders were allowed to lapse. A certain number of these patients may have been of the harmless type, although desirable that they should be kept in an institution; and, therefore, in the meantime I have applied for a vacancy at Tooting Bec, with a view to getting them to Tooting Bec rather than to the county mental hospital, and when a vacancy arises the patient is recertified under Section 24.

Sir Ernest Hiley: 75 per cent. of the total.

2800. *Chairman*: Yes, a very large percentage. But apparently they are not all cases which in your opinion ought to be detained?—They are proper persons to be detained, but not persons to be sent to the county mental hospital; rather proper persons to be detained as harmless persons in a workhouse.

2801. But still a person who is a certifiable case?—Yes.

* See Appendix X.

4 November, 1924.]

DR. A. L. BALY, M.R.C.S., L.R.C.P.

[Continued.]

2802. I am rather interested to know how many of these persons during the period of 14 days' observation are found by you to be persons who ought not to be dealt with any further under the Lunacy Acts at all; that is to say, persons who ought to pass out of their operation?—It is difficult to give the figure; I can only give an approximation which I think is fairly accurate.

2803. I regard the person who is transferred to your sick ward as equally passing out of the operation of the Lunacy Acts altogether; but, on the other hand, the person dealt with under Section 24 is still under the Lunacy Acts; he is merely transferred from the operation of the one section to another. Therefore, he is not the class of person about whom you have been satisfied during the interregnum that he ought to be outside the Lunacy Acts?—I should think about 75 per cent. of those are absolutely released; 75 per cent. of the 111, and the remaining 25 per cent. of them are recertified under Section 24 as harmless.

2804. Let us just bring this to a focus. It is obvious then that if there intervened between the time when the patient is first brought under medical care and the time when the certificate is made, a period of observation, a very considerable number of persons would never be certified at all, because during the period of observation it would be discovered that the symptoms had passed, and that the person was not a person who ought to be certified at all?—Quite.

2805. Does that lead you to favour the view that some machinery should be provided whereby patients may be provisionally dealt with, in order to ascertain whether the case ought to be finally certified or not?—Yes, certainly. If there is an objection to the patient being certified in this manner, without any knowledge to anybody—if there is an objection to that, I certainly think you would have to have some other machinery for keeping the patient under observation.

2806. I think you may take it that there is a general dislike to a certificate even coming into existence with reference to any patient which certifies that the person is of unsound mind, even although you may take every precaution to prevent it becoming public?—Yes, but you would have to have a certificate of some kind.

2807. That may be, but we have been considerably impressed with the desirability of some period of probation or trial intervening between the case first coming under the cognisance of the authorities and the pronouncement of what I may call the sentence upon the case?—Quite.

2808. If such a period were available to you without any certification, but under some proper safeguards, it would look as if quite a large number of cases reaching you would never be certified at all?—Quite a large number.

2809. *Sir David Drummond*: What proportion of the 75 per cent. were acute cases that had to be removed from the home—that is to say, they could not be left?—That is difficult to say.

2810. That is an important question?—It is an important question, but I am afraid I cannot give the figure.

2811. A considerable proportion of these people were people who could not be kept at home?—I think the original removal was perfectly justified.

2812. Acute cases?—Yes.

2813. *Lord Eustace Percy*: So that from your point of view, the scheme for a probationary period would be no good unless it was possible during that time to keep the patient as much under detention by force, as he is now kept if he is certified?—I think it would certainly be necessary to have power of detention during that period—very necessary.

(*The Earl Russell at this point took the Chair.*)

2830. *Earl Russell*: There are only one or two things that have occurred to me on what you have said already. The first was as to the legal position.

2814. *Chairman*: I suppose you may have very acute cases, but cases as transitory as they are acute, and during the acute period obviously forcible detention may be necessary?—Yes. I had a case only this week-end where the patient was certainly in a condition of acute mania, a puerperal case, and the patient had to be in the observation ward and in a straight jacket, and was in fact certified.

2815. Is that a transitory phase?—Yes, it had passed within two days. I always suspend those cases in the hope that they are going to recover within 14 days.

2816. If you had, on the one hand, some means of detaining such a case in its own interest, pending ultimate certification, then it seems to me you could protect the interest of the patient physically and at the same time socially prevent the stigma of certification?—Yes.

2817. That would be desirable, would it not?—Very desirable.

2818. And you have in point of fact tried your best under the existing regime to accomplish the same result?—Exactly, thinking in my innocence that I did no harm in certifying a patient when nobody knew it but myself; but I had no other method of doing it.

2819. Then you find there are deficiencies in the existing code, when you endeavour to deal as you would wish to deal with quite a large number of cases that reach you?—Yes.

2820. *Lord Eustace Percy*: Might I ask whether you have any views as to the length of time for this probation. Are these 14 days really sufficient for proper observation?—Not in all cases. There is one view of it; if you prolong their probationary period beyond the 14 days, we should certainly have to have what I consider most desirable, namely, proper means of treating mental cases in the infirmary—proper means and proper staff.

2821. *Chairman*: You have alluded to the fact that observation in your case is not accompanied by treatment in the medical sense?—I have not the means or the staff.

2822. Therefore no doubt, although you will alleviate as far as you can by nursing and attention, you would not describe yourself as treating the cases from a medical point of view?—That is so. Of course the guardians would say that they ought not to come to me.

2823. Therefore if they are to be kept there for a longer period than 14 days you would really be converting yourself into a temporary asylum where you ought to have means of treatment as well?—Yes.

2824. Even during the 14 days? Take this very case you have spoken of, puerperal mania. Surely the case requires some treatment during the 48 hours of the acute mania?—It is a question of the restraint which is used. Of course that is treatment; but if we were going to treat patients beyond 14 days I should require a special staff anyhow to advise on the treatment, if not actually to treat.

2825. For one thing you would have more cases to deal with?—I should want bigger accommodation and I should want specialists attached to my staff.

2826. Does the justice in your experience ever call for further medical assistance beyond your own certificate?—During the last year there were only two cases where I asked the justice to call in a specialist.

2827. Did the suggestion emanate from you?—The suggestion emanated from me.

2828. But you have never had a case of a justice saying "Well now, Dr. Baly, I would like to have a further opinion upon this case"?—I cannot remember one.

2829. *Lord Eustace Percy*: Have you ever had a case where a justice refused to make an order?—A justice has asked me to bring the case before him again before the patient is moved. I have had that.

Legally you are a workhouse, are you not, or a workhouse infirmary?—Yes.

4 November, 1924.]

DR. A. L. BALY, M.R.C.S., L.R.C.P.

[Continued.]

2831. And therefore you get all the powers under Section 20?—Yes.

2832. And technically you are a medical officer of the union, I suppose?—Yes.

2833. So that gives you the power?—Yes.

2834. Then there is the question of the senile dementeds you spoke of. Of course it is the case sometimes, is it not, that without being insane, and still more without being certifiably insane, some people prefer to live in a state of filth and squalor that others would find intolerable?—That is true.

2835. You could not, of course, certify them on those grounds?—No; but I do look upon a person who is in a state of extreme neglect as being essentially of unsound mind; I mean cases which are almost incredible.

2836. Would it be better to deal with them by compulsory powers of cleansing under the Public Health Act, if they are not certifiable?—That class I think is certifiable. When I put on a certificate that a person is admitted in a state of extreme self-neglect I look upon that as being a condition of unsound mind.

2837. There are cases one has seen in the newspaper occasionally in which a woman has kept innumerable cats and kept her house in a state of filth. I have seen no suggestion in those cases that the person was insane; it was merely that their habits were offensive to their neighbours?—It is a question of degree.

2838. Those cases would be better dealt with under the Public Health Act rather than under the Lunacy Acts?—Yes.

2839. You might take compulsory powers of disinfection and of cleansing in extreme cases?—Yes.

2840. Of course it is an interference with the privacy of the home, even if an undesirable privacy?—Yes.

2841. I notice in your *précis* you say something about the cost of a second certificate. We had a witness before us who suggested that in all these pauper cases a second certificate would be desirable, and I tried to get from him some figures as to what the cost of a second certificate would be; he could not tell us. Can you tell us what it would be?—It varies; the fees paid vary in different parishes. The minimum fee paid is half a guinea; probably quite a common fee would be a guinea.

2842. So that a second medical opinion would add from half a guinea or a guinea to the cost of every certification?—Yes.

2843. The same witness told us that on the one certificate he had never had any difficulty in making up his mind. Is it your own experience that a second certificate would be useful in many of these cases?—I do not think so. In very few cases I think a second certificate necessary.

2844. There have been only two cases in the year in which you have thought it desirable to ask for it?—Those were cases in which I did not feel justified in certifying, but the friends wanted certification. I really called in a second opinion, not so much for my own satisfaction, but to protect my guardians in the event of the friends being right and the patient possibly committing murder after leaving the infirmary.

2845. And when the second opinion was called in, it confirmed yours, did it?—It confirmed mine.

2846. I just want to turn to Form 8. You have to certify that the patient is "a person of unsound mind and a proper person to be taken charge of and detained under care and treatment." You do not have much difficulty with the second part of the certificate if you are satisfied as to the first part, do you?—No; that is why I say it is quite right to certify and suspend the order. My difficulty is in deciding whether it is necessary for the patient to be sent to a mental hospital.

2847. But you still think he ought to be detained under care and treatment?—Yes, I think I am right in certifying him.

2848. You are not saying very much more than you would say about any sick person, that the

patient would be better for care under detention and treatment?—Quite.

2849. I did want to ask you about a part of your evidence which rather struck me, and that was as to the presence of relations at the examination before the justice. We have had two classes of evidence before us. One was from a relieving officer, who said that in all cases he did everything he could to have the relations present when the justice saw the patient. The other was from a justice, who said that in the cases he was acquainted with they practically never had the relations present. I understand you have given us two reasons why you think the relations should be present?—Yes.

2850. One reason is to give the history of the case, and the other is to express any wish as to the disposal of the patient?—Yes.

2851. Do not you think it desirable that some relations or some friends of the patient should attend at the hearing before the magistrate?—I do not see the necessity for it. I adopt the attitude that it is my duty to do what I consider best for the patient; the patient's interests are mine; and therefore, having found out the wishes and the abilities of the friends to look after a patient or not, it seems to be sufficient to give my advice to the magistrate.

2852. I have no doubt you are discharging the whole of your duty, but the magistrate is interposed for the express purpose of representing the public; and not the patient's medical interest, but the public's interests and personal liberty. Do not you think it would be desirable that when the magistrate is in effect signing an order which deprives a person of his liberty, some relative or friend of the patient should if possible be present to urge anything, if there is anything to be urged, against that order?—I am not sure that I see the necessity for it, assuming that I am acting myself *bonâ fide* in the patient's interest.

2853. Of course, I quite agree it makes a great deal of difference if you yourself have seen the relatives, but suppose no relative has been seen, and the first thing they hear of it is that the patient has been certified. You would not approve of that?—No; I certainly think the relatives should be apprised, and when their presence can be obtained it should be obtained.

2854. Surely there would be many things they might say to the magistrate in order to enable him to make up his mind?—Of course, the information received from the friends is on my certificate.

2855. But they might give further information, or the magistrate might ask them questions on your certificate, and develop it, or they may give information of another kind, that the patient is perfectly quiet, and that they are willing to look after him at home?—I have never understood quite clearly in my mind what is the function of the magistrate. Is it the magistrate's duty to say that the patient is of unsound mind or not, or is it his duty to see that everything is in order? In the case of a private patient I do not think he sees the patient.

2856. He does not have to do it before the reception order is signed, but that fact has to be stated, and the patient has a right to demand to go before a judicial authority if he chooses?—Quite. I did raise that point in my *précis* by saying that I thought the position of the magistrate might be more clearly defined.

2857. The magistrate is there, and of course he is in a difficult position; he is not there to contest a medical certificate; he is there partly to see that everything is properly done, and to decide, after the medical certificate, whether the person should be deprived of his liberty or not?—Yes.

2858. Miss Madeleine Symons: You say, I think, in paragraph 22 of your *précis* that you often try to get an order suspended where the patient is suffering from physical infirmity as well. Then you go further, and say that you are of opinion that any treatment of patients in a specialised mental institution is a bad thing. I was wondering whether you would care to develop that point?—My point of view

4 November, 1924.]

DR. A. L. BALY, M.R.C.S., L.R.C.P.

[Continued.]

there is that I think all special institutions are undesirable, that you will get your patients of all kinds much better treated, if they are in a general institution capable of dealing with all forms of sickness, and that is especially so in the case of mental patients. They are sent to special institutions for mental diseases; I take it that the staff are all specialists; the patients must require treatment for other conditions besides their mental condition. I am also of opinion that if mental cases were treated in a general institution, with general physicians on the staff, we are likely to obtain more knowledge of mental disorder than we are if the patients are sent to a special institution; I feel that very strongly; besides, there is the tremendous advantage, from my point of view, of removing the stigma of the certificate. From what I can judge from the attitude of friends, that is very real, and if you cannot remove that stigma, no reform is likely to meet the desire of the public, as I see the public—the friends of the patients.

2859. *Mr. Snell*: You said there were only 11 beds available for men. What happens to the men patients who require treatment, if there is inadequate provision for them? There are 11 beds for men, and 40 for women, which leads one to suppose that there are some men who cannot get proper treatment because of the lack of accommodation in the ward?—That male ward of mine is, in fact, generally overcrowded.

2860. Is there any difficulty in getting accommodation of the right kind, for such patients as you want to dispose of, in other institutions?—No, I do not think there is any difficulty in sending them to mental hospitals. As a result of my lack of accommodation a greater proportion of men are transferred to mental hospitals from my institution than women.

2861. Is the social status of a patient considered in the selection of a mental hospital?—There is only one differentiation I know of as regards social status, and that is that at one of the London hospitals they have what they call a private side, and any patient who is likely to be suitable for the private side of that mental hospital is sent to that particular one, even if they have not got a vacancy.

2862. Would you say that the quality of the treatment is satisfactory—whether a patient is poor or

well off, he gets adequate medical treatment?—I am not in a position to express an opinion on the treatment in mental hospitals at all.

2863. Then you said that the relieving officer had a good deal of initial responsibility for admitting or confining patients. I would like to know whether patients are in any way prejudiced by the fact that the relieving officer has actually detained them; does that count, do you suppose, against them?—I do not think it does to any extent, although I do have it given to me in the history that the patient has been detained in other observation wards in other parts of London; that may prejudice the patient to a slight degree.

2864. I would like to know whether, on the next morning, when the patient is seen by you, he is assisted at all by the presence of friends or relatives who might speak for him?—No. I see the relatives first, and then I see the patient away from the relatives afterwards.

2865. Would it not be likely that excitement or fear of a patient would show him at his worst when being medically examined? I have been medically examined myself, and I think it does make some difference to your pulse-beats, for example. Is that natural nervousness allowed for?—Yes, we certainly discount that.

2866. I have not a doctor's knowledge of diagnosis, naturally, but as a layman I was a little alarmed to find that a part of your decision was based upon what the man said. You said: "I get the patient to talk, and put him at his ease, and this is my main method." Is that quite satisfactory? If people's sanity were to be judged by what they say, I wonder how many of us would be at large. A man in a state of excitement, or after some sort of mental storm, might be irrational in his speech without being permanently so?—I quite agree, but what I meant by that was this: If you ask the patient questions you very often get unsatisfactory answers; whereas if you can put the patient at his ease so as to reduce that excitement, and assure the patient that you are acting on his behalf, that he is your patient—if you get him to talk, you very often find that the delusions will be discussed by him, whereas if you simply put a question to him to answer, you would get nothing out of him at all.

(After an adjournment.)

(*Mr. Macmillan in the Chair.*)

2867. *Mr. Snell*: I want to ask you, Dr. Baly, how many of your staff are trained in mental nursing?—There are six male attendants.

2868. Who are trained?—Yes.

2869. In regard to one point of your evidence, you say cases are quite frequently due to domestic trouble. Is a part of this domestic trouble due, say, to overcrowding or to unemployment or social conditions?—It is certainly due to unemployment, I am sure.

2870. That would induce a mental condition which would be a temporary condition, assuming the social conditions were better?—Yes, I am sure about that.

2871. Then you said, I think, that you always tried to get the opinions of relatives before seeing a magistrate. Do you think sometimes relatives, because of the special conditions with regard to a patient, might not be anxious for him to be detained, and is not that a thing which ought to be watched?—Yes, that is so. Relatives, however, very often want patients to be detained, and where relatives and a patient contradict one another, I try to get from the patient the name of someone who is independent.

2872. Often, you said, physical trouble might arise out of their condition. Are those patients treated medically and restored to physical health before their mental condition is decided upon?—That is not always possible. Time is too short in many cases.

2873. Supposing a person, for example, has a high temperature, and may be irrational and violent, is

the judgment as to his mind taken under average conditions or on the fever conditions?—No. If I diagnosed correctly, the mental condition is due to physical illness, and I try my utmost to keep the patient in an infirmary. It is possible under Form 8 to certify the patient unfit for removal.

2874. Would a person found by the police in the street suffering from chronic alcoholism run the risk of being certified as a lunatic?—A certain number do become certified. There is a recognised condition, I think, of alcoholic insanity.

2875. But the insanity is a secondary symptom, is it not?—It is a secondary symptom to the alcoholism.

2876. Suppose by some legislative or other means, a man could be kept sober, the condition of insanity would not arise?—I am afraid I do not follow you.

2877. *Chairman*: There could not be any alcoholic insanity if there was no alcohol?—No.

2878. *Mrs. Mathew*: Is yours a very overcrowded district?—Yes, in the neighbourhood of the infirmary it is.

2879. Do you think insanity is a result of increased overcrowding?—I cannot say I have any proof that insanity is on the increase, but I do think a number of cases of mental disorder are the result of overcrowding, but chiefly unemployment.

2880. Would you consider 14 days sufficient, or would a longer period of observation be desirable?—I think it is desirable that we should have power to

4 November, 1924.]

DR. A. L. BALY, M.R.C.S., L.R.C.P.

[Continued.]

detain mental cases in the infirmary for a longer period.

2881. *Sir Humphry Rolleston*: If, when brought to a receiving home by either the relieving officer or by the police, the individual appears to be absolutely normal, your assistant medical officer is, I suppose, according to the existing state of the law, unable to discharge the patient straight off; so that if some mistake occurs on the part of the police or the relieving officer, the patient has to stay there three days?—Yes. The patient has to be admitted to the observation ward. In the case of a woman, it is possible for a medical officer to classify the case, and I have power to detain a case for three days, but there are cases when I have caused a release the next morning.

2882. In the case of a patient obviously suffering from alcoholism when admitted in the evening, would he go to a ward other than an observation ward or a ward specially set apart for treatment of alcoholic patients?—I have a part of the receiving ward set apart for the purpose of taking in a single patient of that kind.

2883. Would it not be an advantage if the assistant medical officer particularly who might be in charge of an observation ward were, so to speak, seconded to some mental hospital for a period so that he might have more experience? Would that be a difficult matter to arrange?—It would certainly be desirable if we are going to have power to retain patients for a long time; we should then have more experienced medical officers.

2884. In your evidence you suggested, and gave reasons, that it might be advantageous both from the point of view of the physical health of the insane and also for their reputation after their release, that the distinctions in the treatment of the insane should be abolished, and that is looking at it with anxiety for the future of present insane patients. But have you considered the practical difficulties there would be on the one hand of taking such a step as that, and, on the other hand, the disadvantage to the ordinary patient in a hospital? For instance, do you suggest you would have an entire block labelled "insane," or would you have the patients mixed up? Have you balanced the interests of the insane with the interests of the people under your charge?—Yes, I think I have. My view is this, that a very large number of those who under existing circumstances have to be certified and, furthermore, have to be sent to an institution labelled as mental could quite well be treated in the ordinary ward of a hospital with or without certification. A certificate of some kind would only be necessary when you are detaining the patients against their will. Secondly, there is another class of patients whom it might be desirable to put into a separate ward or a separate portion of the ward, provided they were of a class which would not injure the other patients by their proximity; and you would only have to separate those who are actually dangerous, just as we have to separate patients who are infectious. There are many advantages in my view in treating a mental case in a general hospital. First of all, the mental condition may be dependent upon some physical disease, and it seems to me the staff of the general hospital would be much more likely to detect that physical disease and treat it than could be expected from a specialist on mental disease. Secondly, the mental condition may be complicated by physical disease, and here again the staff of the general hospital would much better look after that patient than the staff of a special hospital. Then if patients could be taken to a general institution on account of their condition, I think they would be treated earlier. The fact that they have to go to a special institution deters them from seeking treatment, and I can imagine a patient in the earlier stages of the disease coming willingly into a general hospital, whereas, if they were told that they were to go to a hospital for nerves or mental disease, they would be afraid. That is my point.

2885. Many of us entirely agree that it is a great advantage for people in the early stages to go to a hospital which is not labelled mental hospital, but to go to a general hospital. I however want you to deal with the question in relation to all institutions. The great advantage of letting people be treated in the earlier stages is of course apparent?—That I recognise as an ideal which is probably impracticable at the present time.

2886. You have thought it out?—Yes. There are 1,300 persons chargeable to the guardians on account of illness or sickness, and there are 1,300 suffering from mental disorders.

2887. *Sir David Drummond*: You referred to a special case where a poor woman was admitted to hospital and you were advised to put her under restraint in a straight jacket. May I take it that is exceptional treatment?—A straight jacket is very rarely used, and is not used in an ordinary manner. It is used by my staff as an aid to restrain the patient, and the patient is not tied down in it. There is less physical exertion to the patient to have a straight jacket in the manner we use it than without.

2888. It occurred to me that perhaps your staff were not quite sufficient in numbers; that is to say, if you had abundant help you would not require such aid?—That is so to an extent, that we are always short of a nursing staff, but in the cases we use it for, as a matter of fact it is less injurious and harmful to the patient in the manner adopted.

2889. You referred to a special examination in the case of people who were violent. What exactly were you referring to?—I was referring to the examination of every case brought in under the Lunacy Act with a view to noting every injury received before treatment. We are bound to examine the patient on admission to mark every sign of injury, and again on transfer to a mental hospital, the patient has to be examined and the injuries noted, so that when a patient is admitted severely bruised, they can trace whether the injury was caused before or after admission and fix the responsibility.

2890. But practically the same examination applies to all?—Yes.

2891. With reference to your practice of certifying people who are suffering from mental symptoms arising from general disorders, do you really think that is the only way you can retain them. You know it is not the common practice throughout the country, do you not, to certify cases of that kind, but they are put into wards and treated. I take it you have not the accommodation for the purpose?—We have very poor facilities for isolation accommodation, which is one of the details which my Board propose to overcome by means of amalgamation. We have no isolation wards attached to the place at all.

2892. To my mind, it is rather an alarming statement to make that people suffering from chronic disease of the heart and so on have to be certified?—It is not every case which has to be certified; it is only a small percentage.

2893. I am referring to mental cases?—They are all mental cases, but from the point of view of certification, if their insanity is due to some known physical condition, I always do my utmost to retain the patient in the infirmary and not transfer him to a mental hospital whether the insanity is due to a mental condition only or not.

2894. *Sir Ernest Hiley*: Referring to the 111 cases in your table "certified and the order allowed to lapse," that is in round figures, 25 per cent. of the total number of patients certified in the year?—Yes, that is so.

2895. And those certificates were allowed to lapse at the outside at the end of 14 days?—Yes, there were a few, a small percentage of cases, where it is necessary to re-certify in order to retain the patient longer in the infirmary. If, for instance, an insane patient is brought into the infirmary, but his physical condition would not justify his travelling as far as the mental hospital, I certify the patient insane, but unfit to travel.

4 November, 1924.]

DR. A. L. BAILY, M.R.C.S., L.R.C.P.

[Continued.]

2896. Notwithstanding that, in 25 per cent. of the cases, you say the patient was discharged certainly as regards his mental condition in about 14 days?—Yes.

2897. And in those cases where he was not absolutely discharged you keep him in the infirmary for medical treatment?—Yes.

2898. In every one of those cases you made a certificate?—In the 111 cases.

2899. Had you communicated that certificate to the patients' relatives, or was it one of those you filed in the office?—I would communicate it to no one except the magistrate.

2900. Have you ever thought what your position is in making a certificate of that sort?—I have always viewed it in this light—if at any time in future that patient or his friends brought an action against me for wrongful detention, I was covered.

2901. Notwithstanding the fact that you would not communicate it to anybody and in 25 per cent. of the cases the man was able to be discharged within 14 days at the outside?—Quite.

2902. You have never been advised, have you, as to your position in making a certificate of that sort?—Yes, I have. I have asked advice, and in my previous evidence I said I thought I knew more under the Lunacy Act than I do now. But I have been advised I was all right as far as that was concerned.

2903. And that you would be protected?—Yes, I imagine so, because it is quite easy to see a patient is temporarily insane.

2904. Supposing you were not an officer of a public institution, but a private practitioner, would you still be protected in giving a certificate of that sort?—I imagine so.

Mr. Jowitt: Why do you think you would be protected under the Public Authorities Protection Act?

2905. Chairman: Surely it must be a mistake. It is not the Public Authorities Protection Act; that Act limits the time within which action may be brought against public authorities?—I imagined, at any rate, I was protected.

2906. Chairman: Yes, but protected by the provisions as to immunity which this Act contains?—Yes.

2907. Sir Ernest Hiley: Because you were acting as an officer of a public authority?—No, I think under the Lunacy Act I am protected as a medical man.

2908. Are not you referring to Section 330 of the Lunacy Act, which protects people who are supposed to be acting in good faith and with reasonable care? The second sub-section deals with it, but of course your point would arise in this way, that this protection is only given to persons acting in pursuance of the Act, but persons acting without the Act would not be protected. However, you have been advised about that?—Yes, I have been advised, but as to the quality of my advice I am not certain.

2909. Do your Board of Guardians know that this is your practice?—I do not know that they do.

2910. Sir David Drummond: Is the fact that 75 per cent of these persons are discharged within 14 days any reflection on your diagnosis?—I do not think patients are brought to the infirmary without some reasonable cause.

2911. But it seems to be a very large number, does it not?—Yes.

2912. Sir Ernest Hiley: I see by your *précis*, paragraph 19, you say: "I am of opinion that any medical practitioner giving a certificate of any kind ought to be protected as is an expert witness giving evidence on oath." What protection are you referring to there?—I believe I am right in saying that an expert witness giving evidence on oath is protected in an action. I am certain of this, that as far as my own neighbourhood is concerned, there is scarcely a private practitioner who is willing to have anything to do with the Lunacy Acts if he can get out of it.

2913. Chairman: Why is that—is it because of the complication of the Act or the responsibility under

the Act?—I think it is because of the actions which have been brought against doctors.

2914. Do they show a reluctance to participate in its administration?—Very strong.

2915. Because of the apprehension that they may get into legal trouble?—Yes. I had a case not very long ago of a patient who was removed at the instance of a private practitioner, who gave a certificate to remove the patient to the observation wards, and I saw the patient. Meanwhile, the officer got into touch with the friends, and it was found out that the patient had means, and therefore should have been put into a private institution. I referred the friends to the general practitioner who had been in charge of the patient, who refused to certify—he refused to sign a certificate under the Lunacy Act.

2916. Why?—Because he said he could not certify that she was insane.

2917. Sir Ernest Hiley: I see you point out the position of the medical practitioner in dealing with Poor Law cases, and you say it should be more clearly defined "further that it ought to be sufficient protection for the public if steps are taken as far as possible to see that the medical practitioners giving certificates under the Lunacy Acts act *bonâ-fide* and impartially." Have you ever had any doubt on that point at all?—As to what?

2918. As to the protection under the Act?—I have never had any threatened action against myself.

2919. I want to know what inspired you to write this?—What inspired me is that I do find medical practitioners, whose patients I have sent to the infirmary, are unwilling to take any part in the certifying of the patient; they would much rather send them to me and leave them in my hands than they would certify themselves.

2920. Lord Eustace Percy: I see that of your cases about 20 per cent. come in through the police?—Yes, 90 out of 450.

2921. I think you also say you make a point so far as possible of making both the relieving officer and the police in such cases act on a certificate of the medical practitioner?—It is not my responsibility, but the relieving officer in Lambeth does endeavour to get a medical certificate. But in the case of a police officer he does not have a certificate—the police surgeon I think, is not called in. But that is not my responsibility.

2922. You do not happen to know whether the person detained is usually taken to the police station first?—I suppose he is?—Yes, he is generally taken to the police station first.

2923. Can you tell us whether you have noticed any ill effects in the process of taking people who may be mentally unsound to a police station, and examining him or her there?—I cannot say I have noticed it, but I should have thought on general grounds that it is unfortunate that a mental case should have to be taken to a police station, my view being that a mental case is a sick case.

2924. But you have no definite evidence?—We have no definite evidence.

2925. If the 111 and the 149 cases are taken, it appears that a good deal over 50 per cent. of the cases brought to you under Section 20 should not have been brought, from the point of view of the lunatic—they have been erroneously brought to you in fact?—I agree it would be advisable if there was some other means of bringing those patients to the institution, but there are no means.

2926. In relation to that, in the latter part of your evidence, you mention the Mental Deficiency Act which is rather outside our reference, and you rather indicate that under Sections 36 and 37 it would be possible for you, if you liked to do it, to get over some of the gaps, so to speak, in the Lunacy Acts by using the machinery of the Mental Deficiency Act?—Yes, I have at the moment a patient from prison sent to me whom I have referred to the Mental Deficiency authorities. In the meantime, he is in fact certified.

4 November, 1924.]

DR. A. L. BALY, M.R.C.S., L.R.C.P.

[Continued.]

2927. May I frame my question in this way. You say you yourself have tried to have as little as possible to do with Mental Deficiency cases?—Yes.

2928. But do you know whether generally speaking in workhouses and infirmaries the machinery of the Mental Deficiency Act is in fact used to fill up the gaps in the Lunacy Acts?—It is in fact used. Whether it fills up the gaps it is difficult to say.

2929. Is it possible under the Mental Deficiency Act in practice to certify a case which is uncertifiable under the Lunacy Act, and to reach your end by that means?—Yes, I believe it is possible to certify a patient under the Mental Deficiency Act who could not be certified under the Lunacy Acts, if that is what you mean.

2930. *Chairman*: I am interested in the general suggestion you made in answer to Sir Humphry—you thought that there should be no distinction, you said, between hospitals for one kind of ailment and hospitals for another kind of ailment, and that mental illness was simply one manifestation of sickness. But has it not been found in practice desirable to have specialised institutions to deal with particular forms of illness. We know of cancer hospitals and epileptic hospitals. Do not you think the concomitants of mental disease are such as to make it desirable to have special treatment?—My own view is that a special institution of any kind is much better as a department of a general institution than as an isolated unit.

2931. Is that on the ground of the stigma which may be associated with the special institution?—No, not on that ground only—on the ground of general treatment, I think it is better for a patient to be under the staff of a general institution than a specialist.

2932. You are aware that there is a strong view that mental illness is such that it would be desirable to have practitioners in this work specially trained. Do you think it desirable that people suffering from a particular class of mental ailment should be treated along with all the other patients in a general hospital by a staff which has no special knowledge?—Yes, provided they have the assistance of a specialist consultant.

2933. Then you would invoke the consultant who would be a person not constantly in the institution, to come and give advice to the staff who had merely ordinary qualifications in the matter?—Yes, because there is nothing to prevent some members of the resident staff having special training.

2934. Is it not the case that it is an incident of mental disease that you must have special forms of treatment—for example, the curative effects of open-air treatment and farming are found to be very great. You could hardly have a farm associated with a city general hospital, could you?—No, but we have convalescent homes for our city hospitals, and there is no reason why you should not have a general home to which patients could go. In fact, in many cases brought to me, probably a convalescent home would meet the case.

2935. In the case of an ordinary patient who comes to a hospital because of some injury he has received, or some disease from which he suffers, the whole purpose of his residence in the hospital is curative, and the great bulk of the cases pass out after perhaps a couple of weeks; but is it not a feature of mental disease that unhappily in many cases the condition is a permanent one, and the person has to be resident in the institution. Now what will you do with all the people who will have to make their future life, such as it is, in a hospital—they could not be in a general hospital, could they?—I, in my institution, have to have permanent cases of all kinds, not necessarily mental. The addition of mental cases would not make a serious difference, though I am prepared to admit it would be desirable to have a mental case more in the country.

2936. I am rather exploring what seemed to me to be the difficulties of your view. I think you will have the assent of us all in this, that one wants to

diminish the difference between mental and other illness. Brain disease is like any other disease, but it has the feature of disturbing the responsibility of the citizen. To go a little further, do not you think again the symptoms in many cases of mental illness are such as to render it undesirable to associate them with the ordinary rational patients of the surgical or medical class which enter the hospital?—Not necessarily all of them. I think you could divide mental cases into three classes; and quite a considerable number, including the patients as to whom I allow the orders to lapse, could be treated in a general ward without harming others at all. There would be a section to be separately treated in a separate ward, and there would be still another section of incurable cases who might be treated in a separate block or if necessary in a separate institution. But you never remove the stigma if you put them into a special institution, and I think you could do a great deal towards that if you keep them in a general institution.

2937. But some form of warrant would be necessary, because these people would be retained against their will in the hospital. If it is the character of the place of residence which gives the stigma, the asylum taint, as it is called, would not the hospital attract that in turn?—Surely if the certification is an official document, it is not so likely to cause a stigma. Take for example what is being done at the time. In the case of the aged, at the present time there is at Tooting Bec a very large number of people certified as insane, and you cannot get there unless you are certified. They are shortly going to admit the old patients uncertified into a home for the aged. Now supposing that home for the aged has got certified and uncertified patients mixed, no one will know who is certified and who is not.

2938. Then it looks to me that your point is, you object to the segregation of mental cases and treatment apart—you would have them lumped with all other cases?—Yes; I think that is the only way of overcoming the stigma.

2939. Your motive is to get rid of the idea of the stigma?—Yes, and also, I think, their treatment would be better. I know nothing about the treatment in mental cases at the present time, but it seems to me to stand to reason that patients who have got a general staff in charge of them must receive better treatment than patients who have a special staff only—because, after all, surgical conditions may arise in the insane, and if they are under the care of a general staff, surely it must be better.

2940. They may get better treatment if they have surgical or medical ailments, but much worse treatment if there are mental disabilities which they are there for?—No, because if you had a general hospital equipped to deal with mental cases as well as others, there would be a mental specialist attached to the hospital to treat the patients, and I think with the conjunction of a general man and a specialist we are likely to find out more about a case of mental disorder than the specialist himself.

2941. We will hear what the specialists say about that; but I suggest for your consideration, if we are able to devise some method of eliminating the element of stigma from asylum residence, these specialised institutions afford the best means of treating this class of case, and that your point about the general health of the patients might well be met by arranging for the specialised staff calling in the aid of surgeons or physicians from the general hospitals in the district to treat patients who require such treatment. That is done, as we know, in cases where a patient develops appendicitis, and the medical attendant, who may not have performed the operation for years, invokes the assistance of another surgeon?—But surely the invoking of the assistance may come very much later when the diagnosis has to be made by a specialist.

2942. I suggest it is the other way, that in a general hospital the surgeon or physician may be so much interested in the case that he may entirely fail

4 November, 1924.]

DR. A. L. Baly, M.R.C.S., L.R.C.P.

[Continued.]

to detect what a mental specialist would put down at once as a case of insanity?—Of course, there are a large number of cases in general hospitals who are uncertified, and if there were a mental specialist attached to the hospital, there would be more persons certified.

2943. May I suggest your experience has been confined almost to a floating population, that you are having a constant stream of people through your wards, and you are not dealing with them for a long period?—No, and that is why I say that if power were given to detain cases for a longer period, I should have to ask, and would ask, for proper accommodation and special consultants.

2944. But for the moment it seems to me the people you meet with in your mental wards are in your hands, either for three days or for three days plus fourteen days, or an additional period if you have them re-certified, but in any event are they there for any prolonged period?—No.

2945. So that you are really a sort of clearing-house through which the cases pass; you do not profess to provide any treatment?—No.

2946. Nor do you profess to have experience of dealing with cases over a long period of observation?—No.

2947. With regard to what you call re-certifying, I am a little puzzled to know what is the reason for that. You have an order justifying detention for 14 days, which you obtain quite correctly. When that expires, do you ask the justices to give you another order?—Yes, I have done so in a few cases.

2948. Can you suggest to me any authority there is for a series of orders of that sort?—I do not know whether I could name the authority, but surely if the patient has been certified, and the order has been suspended and has not been acted upon, the patient would become a free agent, and if it is necessary to take that freedom away, the procedure would be to repeat what has been already done.

2949. You see it would repeat 14 days' orders *ad infinitum*?—Yes, you could do so.

2950. I doubt very much if that was contemplated. I suggest that the 14 days' suspension is intended to enable a decision to be reached as to whether the case should be discharged into the world or sent to permanent detention?—The cases in which I have used it are cases which are unfit for removal. Therefore, the order having expired, I must make another.

2951. By unfit you mean physically unfit. But in that case the patient ought to be removed, ought he not, to the general wards?—Not if he is insane.

2952. But that begs the question. If he is discovered to be insane during the time, then you would have a certificate; but you would not require to go to the justices again. There is provision made for keeping him until you can send him on, is there not?—Is there?

2953. In Section 19, Sub-section (2) of the Act of 1890 it says: "If a medical practitioner who examines a lunatic as to whom a summary reception order has been made, certifies in writing that the lunatic is not in a fit state to be removed, the removal shall be suspended until the same or some other medical practitioner certifies in writing that the lunatic is fit to be removed."—Then I have acted on the safe side in bringing the matter periodically before a magistrate. I did not know I could obtain an order under which I could keep a patient for an indefinite period.

Earl Russell: You can keep him until you certify that he is fit to be removed.

2954. *Chairman*: Have you any special association of doctors in charge of workhouse infirmaries?—Yes.

2955. Because you speak of having received some legal advice. Does your association obtain legal advice as to your powers and duties?—No. I can always get legal advice from the Medical Defence Union, but the advice I have obtained has been from various Lunacy Commissioners.

2956. With regard to your nursing staff, have you an adequate staff to cope with the cases which come

to you at present?—I do not think any institution has an adequate staff of nurses at the present time.

2957. That is a sweeping statement. You do not find yourselves efficiently staffed?—You cannot get them. I cannot get the number of nurses we are entitled to have.

2958. When you say that you cannot get them, do you mean that the financial resources of your institution will not run to them, or that the class from whom they are drawn provides inadequate recruits?—I do not think the nursing profession is attracting a sufficient number of nurses.

2959. Then it is not a question of financial stringency?—No, except that I suppose if you pay enough you would draw them.

2960. No doubt, if you offered attractive terms you would bring more people into the profession. But what I mean is, if you have felt the want of additional staff, have you approached your authority in order to get additional nurses?—Yes.

2961. And have you obtained their sanction to do so?—We obtained sanction to increase the number of the staff quite recently, but so far we have not filled the vacancies.

2962. Why not?—Because we cannot get the staff.

2963. On the terms you can offer?—And recently the terms have been improved.

2964. So that it is not a case of the administrative body starving you of nurses, but the difficulty of getting nurses on the terms you are able to offer?—I think if I were to ask for all the nurses I thought I would require, the administrative authority would object.

2965. One can believe that, because everyone wants to be perfect in his own sphere; but your demands have been acceded to, and your difficulty has been to get the personnel?—Yes.

2966. Do you think that is due to the terms which are offered?—I think it is due to the remuneration of the nursing profession when they are trained. I think they are inadequately paid throughout, and it does not attract sufficient numbers.

2967. You speak of it as a profession. What sort of applicants present themselves to you to be taken on as nurses?—They are very variable; a good many may come from the provinces.

2968. But what have they been doing before—what qualifications have they for taking on this work?—I do not know that they have any particular qualification.

2969. Do they start as probationers?—They start as probationers.

2970. And they are placed under responsible nurses who have been with you?—Yes.

2971. Just as when nurses are taken on in a hospital?—Yes, exactly the same.

2972. Will you tell us the scale of remuneration, dealing only with your Poor Law infirmary?—Yes. The untrained probationers who are coming to learn their profession are paid £105 spread over three years. That is for women.

2973. *Mr. Jowitt*: How do you mean, spread over three years?—It is £30, £35 and £40, paid in three years.

2974. And their keep?—And their keep.

2975. *Chairman*: At what age do they come?—21. When they have got their certificates, the trained sisters receive from £70 rising to £90; that is the sister in charge of a ward.

2976. *Sir Thomas Hutchison*: With uniform?—Yes, everything found.

Mr. Snell: How are the men recruits obtained?—The present men were partly recruited from the R.A.M.C. in the war.

2977. *Lord Eustace Percy*: Does not service in your infirmary qualify for a certificate?—Yes.

2978. And they are entitled to be registered?—Yes, and they can, if they like to stay on, get their Central Midwives' Board certificate, and a few get the Incorporated Society of Massage certificate.

2979. *Miss Symons*: Would they, once they had obtained a certificate in your infirmary, be eligible

4 November, 1924.]

DR. A. L. BALY, M.R.C.S., L.R.C.P.

[Continued.]

for nursing anyone?—Yes, they are trained nurses, and are registered as such.

2980. *Chairman*: There is another aspect of their life I should like to ask about. What amenities of life have they? Have they social rooms or anything of that kind?—Yes, there is a nurses' home.

2981. In the building?—Yes, in the building, with the usual recreation room and smoking room.

2982. For the ladies?—Yes.

2983. One has to cater for new developments nowadays?—Yes, and they have a tennis court, not a very good one.

2984. And the hours of labour?—The hours of labour are 55 a week, I think.

2985. And what vacations?—Three weeks when they are probationers, and the trained staff have three weeks too, but if they have been with us five years they get a month.

2986. *Earl Russell*: Are these pensionable appointments?—Yes, they have an option when they first come whether they will go on the pension scheme.

2987. *Chairman*: Is it a contributory scheme?—Yes.

2988. Will you tell us exactly what you feel about your own staff—I am not asking about individuals, but are you satisfied generally with the efficiency of the staff?—I am satisfied with the general efficiency of the female staff. As to the male staff, I have found them a great deal better since I put them in charge of a sister. I put a sister in charge of the male observation ward, with male attendants to assist her. I feel more secure with her in charge than I did when there was a man in charge.

2989. How have you reached that conviction?—I do not know how I reached that conviction exactly, but I never felt, when I had a man in charge of that ward, quite secure that they treated the patients as they should always treat them.

2990. Do you think women are better as nurses of the insane?—I have no experience of the treatment, but I feel more satisfied with my ward with a woman in charge of it than when I had a man.

2991. Is it because you can place more reliance on her?—Yes.

2992. She has a greater sense of responsibility?—Yes.

2993. Is it a case of the individual woman, or is it your general observation?—I think it is a general observation. I have had several women now who have taken their turn. Of course the sister cannot always be in my observation ward, especially as I have only one on the male side, so she is in charge of the receiving ward on the same floor.

2994. You prefer to delegate your responsibility to a woman rather than a man?—Yes, I do.

2995. In your own experience?—In my own experience.

2996. Is there no liability to friction on that account?—I have had none at all.

2997. Is the scale of pay different for the men and women?—Yes, it is. The men are non-resident to begin with, and so they are paid accordingly.

2998. What do the men get?—I am not quite sure. I think the juniors get about £3 5s. a week, and the seniors somewhere about £4 a week.

2998A. And they get their meals, I suppose, while in the institution, and live out otherwise?—They live out otherwise.

2999. Do they get uniforms?—They get uniforms.

3000. I want to ask you what are the subjects which are obligatory for the purpose of examination for L.R.C.P. and M.R.C.S. in matters dealing with mental diseases? You have been through the usual medical curriculum?—I have.

3001. Where did you graduate?—The University College Hospital, London, and did part of my work at Cambridge.

3002. In your curriculum, what lectures did you attend in connection with mental disorders?—I attended a course of lectures at a mental hospital, given by a mental specialist.

3003. Was that obligatory for the purpose of your degree?—Yes.

3004. Was it a half course?—I forget how many I attended, but I had to sign up as having attended a course of lectures on insanity by a specialist.

3005. Apart from the lectures which you attended, had you any clinical work?—No; the lectures were given at a mental hospital, and we were shown patients.

3006. *Mr. Jowitt*: There was no examination?—No, there was no examination in my time.

3007. *Chairman*: On the subject of examination, had you to pass in insanity among other subjects?—I think questions were asked on the subject.

3008. But there was no separate paper?—There was no separate paper.

3009. It was not one of the examinations?—I remember certain questions about the certification of lunatics.

Sir David Drummond: May I suggest that this is a general question with regard to the qualifications of medical men, and you are questioning the witness with regard to the examination of the two Royal Colleges. Would it not be possible to consider the qualifications of medical men as a whole, and have the subject gone into by a witness who can speak for all the bodies. In asking these questions we are only inquiring into the witness's qualifications?

Chairman: We are to have a witness who can tell us about the curricula of all the examining bodies.

These questions were put with a view of ascertaining the medical qualifications of a person who could sign a medical certificate.

But we shall have a witness later on who will tell us the extent of training which each graduate undergoes before he begins to practise.

Thank you very much, Dr. Baly.

(*The Witness withdrew.*)

DR. J. DUDGEON GILES, O.B.E., M.D., called and examined.

3010. *Chairman*: You are a Doctor of Medicine of Edinburgh?—Yes.

3011. Are you Medical Superintendent of Salford Union Infirmary?—Yes.

3012. Is that a Poor Law Infirmary?—Yes, it is a Poor Law Infirmary.

3013. Is it an institution distinct from the work-house of Salford?—It is separated from the work-house.

3014. By separation do you mean locally?—It is under a separate Poor Law Order, and is separated by distance—it is a separate institution.

3015. In that institution do you deal with all cases of infirmity and sickness of pauper patients?—We do.

3016. To what extent have you opportunities of dealing with mental cases?—We have about 180 beds.

3017. How many wards?—Three wards.

3018. Which of them are male and which female?—There is one male ward with about 70 beds in it, and for females there are two, one with 70 and another with 30 beds.

3019. Are these three wards under the same roof with the rest of your wards?—Yes, they are part of the hospital.

3020. In addition to the wards, have you any accommodation, or do you include under wards, rooms where patients have to be confined alone—a padded room or anything of the sort?—They are close to the ward in each case.

3021. How long have you been at this institution?—Nine years.

3022. As medical superintendent?—Yes.

3023. Were you there before in any other capacity?—No.

4 November, 1924.]

DR. J. DUDGEON GILES.

[Continued.]

3024. When you first went there, had you any special experience of dealing with insanity?—No. What I had was learnt in Poor Law—three resident Poor Law appointments.

3025. Had you had some experience as a general practitioner before?—I had not.

3026. You had always been in the employment of some Poor Law authority?—I was always doing hospital work.

3027. And when you came to be medical superintendent of this infirmary you found there was a mental side to it?—Yes, as there had been in places I had been in before. I had been chief medical officer of two such before I came to Salford.

3028. How many patients altogether have you in Salford?—Just under 900.

3029. And how many of these would one find in the mental ward?—We have about 180 beds, but some of them are vacant. Perhaps 150 we average altogether.

3030. Will you tell us, as shortly as you can, how you work out the provisions of the Lunacy Act in the administration of your infirmary on the mental side?—By far the majority of the patients come in on a three days' certificate or relieving officer's order. We practically never have a justice's 14 days' order case at Salford, as it happens. Again, the majority of these cases so admitted are subjected to a further 14 days' order for observation. A considerable number are also admitted direct on the 14 days' order of the medical officer or sent up from another ward in the hospital where they have developed mental symptoms.

3031. Transferred cases?—Yes. At the end of the 14 days' under Section 24, Form 10, we make it a practice in all cases which are not fit for discharge, that is to say, discharge from the Lunacy Act altogether and from the mental wards, of putting them under permanent detention, unless they are suitable for an asylum.

3032. We have heard from Dr. Baly that he resorts frequently to the suspension of the summary reception order in order to give him the 14 days required for observation. In some cases of dubiety do you resort to that?—No, we do not.

3033. You go direct to Section 21, and get a 14 days' order under it?—Direct to the permanent detention order.

3034. Then you go direct to Section 24?—Yes.

3035. This is really a section expressed negatively, that no one is to be allowed to remain in a work-house unless certain facts are certified by the medical officer?—Yes.

3036. You have got the patient in your infirmary on the mental side for three days; before the three days expire you certify in the terms of Section 24, and then, that being done, you may detain for 14 days?—Yes.

3037. And you must not detain for more than 14 days without getting a special order?—We get the special order during the 14 days, or at the expiration of that 14 days, and put them on a detention order, unless they are certifiable for removal to an asylum.

3038. Do you find that of the people brought in on the three days' order many need detention under Section 24 for a further period of 14 days for observation?—Yes; 55 per cent. of the patients admitted in that way are detained for 14 days.

3039. Will you state your percentage of results?—Eighty per cent. of the patients coming in come in under Section 20.

3040. These are three days' order people?—Yes, three days' order people. Then 55 per cent. of the patients thus admitted are placed under a further detention for 14 days.

3041. That looks as if 40 per cent. of all your patients came under a Section 24 order?—Yes.

3042. Are some of the patients discharged within the currency of the three days?—Yes. I find about 1.7 per cent. are discharged within the three days.

3043. Rather less than two out of 100?—Yes.

3044. On what grounds are those people released?—I take it these are cases which Dr. Baly was talking about—delirious, or with a slight mental confusion which is cleared up quickly, or where the physical disability is greater, and where one transfers them to an ordinary ward for treatment.

3045. Would there be alcoholic cases included?—There might be, but not many.

3046. Then those cases leave your mental wards without any certification at all?—Yes.

3047. Do you take them before a magistrate before disposing of them?—No.

3048. In that you differ from Dr. Baly; you regard yourselves as entitled to discharge them within the three days without bringing them before a magistrate?—Yes.

3049. Then they pass out of your hands?—Yes.

3050. Then you are left with a residue of 98 per cent. to dispose of, and of those you tell us a substantial number are detained for 14 days. What about the others, in whose cases you do not get a Section 24 order. You say 80 per cent. come under Section 20; 55 per cent. of that 80 per cent. are further detained for 14 days under Section 24. How do you dispose of the others?—I am afraid I have not worked that out very clearly.

3051. I confess I had a little difficulty in arriving at the disposal of the patients. You have provided us with a table at the end of your proof?—Some of the 35 per cent. left would be certified and transferred to mental hospitals straight away. Some would come under that heading. I do not think any would come under the permanent detention—they would probably all be detained for a 14 days' observation, and there would be a very few who had died.

3052. And some, of course, have been discharged, as you have explained?—Yes, that is a very small percentage.

3053. *Earl Russell*: Is this correct—358 out of 2,180 die? That is one in seven. Do they die in the 14 days?—No, that is spread over the whole five years.

3054. *Lord Eustace Percy*: Is the last figure for 1923 accurate, that there were 475 cases, and 218 discharged within 17 days?—Yes.

3055. That is roughly half of the admissions?—Yes.

3056. *Chairman*: I observe they are discharged in the care of relatives?—We always discharge them in the care of relatives.

3057. Does that mean that they may be certified cases, but cases in which relatives are able to take charge of them?—No; it means they are fit to go out.

3058. Because one knows provision is made for actually certified cases being handed over to relatives, where the relatives are able to look after them?—That does not apply to those cases.

3059. When you say discharged, you mean discharged because they are no longer appropriate to be dealt with under the Lunacy Acts?—Yes.

3060. *Earl Russell*: Do you mean this figure 63 "died" in 1923 to be out of 475?—Yes.

3061. It is a very large number, is it not?—The percentage works out at 15 per cent. of admissions during the five years—15 per cent. die during the time they are under detention.

3062. *Chairman*: The table is rather difficult to follow. There must be some overlapping, surely?—Yes, I quite admit that; it was done while I was away by my clerk, and I have not had an opportunity of making it quite logical since I have been back.

3063. What I would like to see would be a table showing the cases reaching you in the course of a year, and what happens to those cases, and how they were dealt with and disposed of. Some within three days would leave altogether, and you hear no more of them?—Yes.

3064. Some again would go to asylums, there again passing out of your province?—Yes.

3065. Some would be detained under 14 days' orders and for observation by you during that period, and in consequence of that observation they

4 November, 1924.]

DR. J. DUDGEON GILES.

[Continued.]

would be discharged or sent to an asylum. One would like the analyses made out in that way?—I admit this is not a clear statistical statement. I have not had time to go over it properly and make it as I would like to. I sent it as a rough idea of what happens.

3066. Perhaps in the meantime you will give us what is of value—your own experience which you can speak to. Do you ever have such re-certification as has been referred to by Dr. Baly?—No, practically not. If one order lapses without any definite step being possible, we discharge the patient altogether, and try him for a day or two. If the symptoms are still definite, then we take the matter up *de novo*, probably by issuing a medical officer's certificate for 14 days' observation in the lunacy wards.

3067. So that you do not have a continuous series of orders such as seem to be resorted to by Dr. Baly?—No. The only case I have known where an order has been suspended is where a patient has been certified for removal to an asylum, and where for physical reasons the order has had to be suspended, pending the recovery of the patient or otherwise from some physical ailment.

3068. In your case the population in your mental wards is constantly changing?—Yes, that is so.

3069. You will have nobody in your wards who has been there longer than the maximum of 17 days?—No, we have a considerable number who have been there many years, who have been there on permanent detention. There is a background of chronic cases all the time, and a series of floating populations always passing through.

3070. So that of those who come in, some pass into the class of those who are permanently detained, as they may be in a workhouse infirmary under Section 24 of the Act?—Yes.

3071. That requires, does it not, an outside medical certificate?—Yes.

3072. And you get that in these cases?—Yes, and I should add here that none of the staff of my hospital do any certification beyond the 14 days. All the further certification for further detention or removal is done by an outside medical man in addition to our own medical officer's certificate.

3073. Then that is one of the ways in which the cases coming into your hands are disposed of—by permanent detention?—Yes.

3074. And therefore you have always a background of these cases?—Yes.

3075. What influences you in deciding that the case is one for permanent detention?—They are mostly senile cases, or cases of mild chronic dementia which are not likely to give us any trouble, and are fairly well in health.

3076. Is not there another feature one should bear in mind too—are there not cases in which the prognosis is more or less hopeless—that is to say, it is the class of case which you regard as chronic, which would be probably as well dealt with in your mental wards as they would be in an asylum?—Yes.

3077. Have you any facilities for the treatment of mental cases in your establishment?—Not very much. For ordinary observation we have, but not for anything beyond that.

3078. Are those cases which you relegate for permanent detention cases which do not require treatment in a medical sense?—I think one may safely say they are.

3079. Then as regards the passing through population, are those all persons who are awaiting disposal in one or other of the methods provided?—Yes.

3080. We are interested to know the extent to which that interval of time results in persons leaving your wards without certification at all—that period of observation must result, I take it, in a number of cases never reaching certification at all?—Yes; there are a good number who never reach the stage of permanent certification.

3081. They reach you on a three days' order, and after that, to justify detention for the 14 days, there has to be, has there not, a certificate?—Yes.

3082. Is that your certificate?—Yes, that is the medical officer's 14 days' certificate.

3083. That is a certificate of insanity, is it not?—Yes, I take it that it is a certificate of insanity.

3084. Is the person described as a certified person? You see, the terms of the certificate are that he is a lunatic?—Yes.

3085. Before you can obtain this 14 days' observation period, you have first of all to make up your mind apparently that a case is one of insanity?—Yes, and that there are sufficient symptoms to justify detention for further observation.

3086. A little further than that, is it not?—Yes.

3087. Does it not seem putting the cart before the horse—first of all certifying that a man is a lunatic, and then putting him under observation to see whether he is or not?—Yes.

3088. You have experienced, as others who have preceded you in the witness chair have experienced, embarrassment owing to the way in which the programme of events is set out in the statute?—Yes, that is so.

3089. Then I take it you would be an advocate of a system which allowed you a period of observation before certification?—Yes, undoubtedly.

3090. Would it be necessary, having regard to the character of the case we are dealing with, that some power of restraint would have to be possessed by you during that interval of time?—Yes, I think that would be necessary, both on account of the patient's own efforts and also of the efforts of the relative. One has to say often: "You cannot take this man out; he is under the Lunacy Act, and he is not like a man where you can say, 'I will take him out.'" We have the power to say that patients may be detained for observation.

3091. And at present you arm yourself with an authority to detain, by granting a certificate that a person is insane and ought to be detained?—That is so.

3092. At the same time you recognise the desirability of having an opportunity of studying the case, and making up your mind whether it really is a case for which there should be a permanent order or not?—Yes.

3093. You tell us that a number of the cases subject to a 14 days' order actually recover in your hands, and are sent away?—Yes.

3094. And those persons have had the misfortune to be certified by you as lunatics, even though the fit has passed off within a week, say?—Quite so.

3095. Have you thought out yourself as to how some system of provisional detention might work in dealing with the rate-aided patients who come under your care?—I do not know that there is anything more necessary than an alteration of the wording as you suggest, so that the certificate is not so worded that you certify them actually as lunatics, but really only that you want them to be under observation for a period.

3096. Would you be in favour of what I have called the programme—that is to say, the series of steps which the statute lays down, being simplified and unified?—I certainly should.

3097. Have you found embarrassment in reconciling the different sections of the Act dealing with pauper patients?—Yes; it is a difficult Act to understand, and what one has done is to take the apparently easy and simple way of relying on practically what I have suggested.

3098. Then I take it you would welcome a simplification of the code which would give you a more uniform method of dealing with cases?—Yes.

3099. And you would regard it as essential that any amendment of the code should provide for some provisional method of detention, preferably without certification?—Quite.

3100. Lord Eustace Percy: Taking these 218 cases which were discharged, were many of them well enough to consent to coming into the infirmary and staying there?—At the beginning, do you mean, of the period?

4 November, 1924.]

Dr. J. DUDGEON GILES.

[Continued.]

3101. Yes.—That is rather a difficult question to answer from memory. I should think a pretty big proportion of them would be able to give their own voluntary consent to come in for observation.

3102. Do you find the person who is brought in in that kind of state objects very often to staying?—No, not a large proportion of them object.

3103. I am asking, of course, because there always will be a tremendous difficulty in providing for compulsory detention, and I am wondering how far the compulsory power is really necessary?—I think it is. One finds a good deal of difficulty with the relatives especially in the lower class of society; the less educated they are the more difficult it is to deal with them. I dare say perhaps I was wrong in saying the bulk of the patients are in a proper state to ask them for their consent or otherwise. However quickly they may clear up, probably on the day they come in they are very excited, and cannot be properly examined.

3104. Does that condition, do you think, arise from the method in which they have been brought to you by the relieving officer?—No, I do not think so to any extent.

3105. *Chairman*: I suppose that is one of the difficulties in dealing with this class of malady; and it is very difficult to value the consent of a patient?—Yes. As the patients come to us now we get a certain number of cases of neurasthenia or nervous breakdown, and at that stage a patient is not in a state to give a proper valid consent to being put under observation or treatment, with a view to definite mental symptoms coming on.

3106. If there is no power to control or retain, the consent which has been given you may equally be withdrawn at any moment?—That is so. You may have a patient whose symptoms you are just beginning to find out who decides to go off, and you know that will involve in the near future another and worse breakdown, whereas a week or two of observation will clear them up definitely.

3107. They wish to go away peremptorily, and so destroy the benefit they have received?—Yes.

3108. Although you might be able to get consent from a number of patients, you wish to have the power retained because a patient might withdraw his consent at any moment?—Yes, and the first consent should be a consent for a definite period of time—limited but definite—and during that period a patient should be at the disposal of the medical officer.

3109. It always must be a matter of the value of that consent, and the difficulty is to place any value on the consent of such a patient at all?—I was thinking at the time rather of the pre-mental conditions. When cases come in and are mental at the time of coming in, the consent is valueless, but I am thinking of what might happen in the future, where you could get the consent from a patient before the actual mental condition had arisen.

3110. Then you are looking forward to this: If provisions were made for treatment without certification of cases, it would encourage many cases being brought forward for treatment at a much earlier stage?—That is so.

3111. Do people delay bringing in cases for treatment or detention because of the present bogey of certification to which the patient would be subject?—Yes, I think perhaps some people are influenced in that way. There is a general feeling of dislike at having anything to do with an asylum or with the Lunacy Act.

3112. *Sir David Drummond*: How would you classify the majority of people who are discharged within 14 days?—From memory I find that question a little difficult to answer, but I should think they would be mostly cases of mild melancholia, and some of them senile cases—cases which sometimes clear up and the patient can be sent to an ordinary ward, and then there are a few puerperal cases which clear up within a week or so.

3113. There are no alcoholic cases?—No, not a great many.

3114. *Chairman*: I should like to ask whether you yourself have felt in administering the law that there are any difficulties as to the existing arrangements to which you would like to draw our attention; because we want to understand the practical conditions. Have you any observations to make for our assistance on that matter?—I do not think so. I think I have put down in my proof everything I wish to say, and I do not think there is very much to add.

3115. Apart from the Act of Parliament, have you found in your administration that you have been able to do good work to your own satisfaction and unhampered?—Yes. I think we have worked under the existing system pretty well.

3116. But what you would like, I take it, is that we should simplify the system for your legal guidance?—Yes.

3117. And also improve the system by providing for observational treatment without certification?—Yes.

3118. If the system were simplified and new provisions were made, would you think yourself adequately equipped to deal with the situation?—Yes, I think so.

3119. *Mr. Jowitt*: Will you turn to the table at the end of your proof and take the year 1923. There you give a figure of 475 new cases admitted, 153 permanent detention cases under Section 24, 156 certified and transferred to mental hospitals, 63 died, 64 were transferred to ordinary wards, 25 were discharged within three days to the care of relatives, and 218 were discharged within 17 days. You will let us have an elaboration with regard to those figures as you promised?—Yes.

3120. 218 cases, you say, were discharged within 17 days. I take it that is 218 cases out of the 475 new cases admitted, which is a percentage of, roughly, 50—do you follow that?—Yes.

3121. Have you formed any opinion from your long experience that in certain cases relatives are anxious to put on one side people belonging to them?—I have found that kind of thing very little, and there are very few cases where I have even suspected any inclination to put people on one side.

3122. But have you come across cases where that has occurred?—Yes, I have, but very occasionally.

3123. Can you give us any percentage figure at all?—No.

3124. Would it be something like half-a-dozen times in the course of your experience?—I should think only half-a-dozen times within the last five years.

3125. That is your impression?—That is my impression, out of the 2,180 cases given in the table.

3126. It is quite negligible?—Yes, I think so.

3127. Do you find among the poorer classes that there is a great horror and a feeling of stigma attaching to a case of mental disease?—Yes, and that is one argument in favour of having an observation ward attached to a general hospital; but they willingly consent to come to our place, the Hope Hospital, although they are much opposed to the idea if you say they must be certified and sent on to an asylum.

3128. Do you know why it is that the poorer classes regard this mental disease with a greater horror than they do an ordinary physical disease?—No. I do not.

3129. But it is the fact?—It is the fact, and it is not confined to the poorer classes, because we get a good many of the lower middle class and the middle class people with whom it is just as strong.

3130. And that, you think, would be alleviated by treatment in a ward of a general hospital?—Yes. As far as my observation goes, I do not find myself in accord with Dr. Baly further than that.

3131. The practical difficulty in combining the two things together is that you think it would be undesirable?—Yes. In fact, I should like to see the permanent detention cases taken out of hospital once they have become definitely mental cases, and I would

4 November, 1924.]

DR. J. DUDGEON GILES.

[Continued.]

rather they were not detained in a general hospital at all. In saying that I do not wish to include the senile cases, because many of them are just as well off, if not better off, in our hospitals than they would be in an asylum.

3132. *Chairman*: One was rather struck with the statement that the asylums are very fully populated at present, and they are, of course, specialised institutions where curative means are, or ought to be, available. Do you not apprehend that if you have a large number of these chronic cases occupying beds in these highly specialised asylums, they might further aggravate the shortage of accommodation and make it difficult to get treatment for the cases which are more hopeful?—Quite. Of course there are difficulties whichever way you look at it.

3133. *Mr. Jowitt*: And if you have people suffering from mental diseases in the general wards of the hospitals?—We could not do that administratively.

3134. Do you suffer from the same difficulty with regard to assistants as Dr. Baly?—No. We have been pretty successful in getting female nurses, and for the last couple of years we have had a very satisfactory male staff as well. We have a male staff and a female staff and the idea of putting a sister in charge of the male staff has not been thought of at all at our hospital.

3135. And your staff is as large as you can afford?—It is quite adequate, I think. On the male side we have a head attendant and three charge attendants who are all trained men, and the others we have trained ourselves.

3136. What medical staff have you got under you?—There are four resident doctors in addition to myself.

3137. Have you special facilities, if you so desire, for getting any outside assistance you may want?—Yes, the guardians would make no difficulty about that.

3138. And do you in fact?—No, not in relation to mental cases, because there the specialist is at a mental hospital, and it is not easy to get the staff of another hospital to help him.

3139. *Mr. Snell*: If the period of observation were increased, would the numbers of curable cases be possibly increased also in your opinion?—I think on my figures it probably would be the case because, as I was saying, after the 14 days under the medical officer's certificate we immediately put a patient on permanent detention, but many of these cases are not detained for more than two, three, or four weeks. A great many are brought before the Committee formally, and are discharged within a few weeks of their being put on permanent detention.

3140. Is it right to assume that, while a proportion of the cases may be accurately diagnosed in the 14 days, there is a proportion of cases that ought to have a longer period assigned to them?—Yes, I think there is no doubt about it.

3141. Have you in your mind any period of extension of the observation stage as being desirable?—I think 28 days would be desirable, though perhaps not in every case, but the period may be laid down as not exceeding a month, so that you could have a month during which you would have provisional control.

3142. During the period they are under observation, of whatever kind it may be, do the patients receive any treatment in the event of their being out of physical condition?—Oh, yes; they would be treated medically all the time.

3143. Supposing a case of acute neurasthenia, would treatment for 14 days help the patient?—It might help him, but a month would be better.

3144. You think the patient might respond sufficiently to treatment?—Yes, and there is one recommendation which I put forward in my *précis*, that it should be made compulsory on the authorities and institutions receiving patients under Section 20 to make the accommodation for these short-term cases quite separate from the wards allocated for the treatment of permanent detention cases. At present we

have to treat the short-term observation cases in the same ward in which are confined the permanent detention cases.

3145. *Chairman*: That is an undesirable state of things, I should think, because you bring the mild cases which may be cured altogether into contact with the depressing surroundings of the chronic cases?—Yes, that is so. The Commissioners might ask, why have you not asked the guardians to do this, but I think if one had the authority of a recommendation of the Commission behind one in making such a request to the guardians, it would be done. It could be done, although like most poor law hospitals, we are short of room. If pressure were brought to bear and representations were made, I think it would be done.

3146. Of course one sees this difficulty, that if you have only one male ward available to you, in which your chronic male cases are confined and into which is being introduced a very different class of case, those other cases of acute mania might develop into melancholia, or something of that sort, so that it would be somewhat unfortunate if they should all have to be in the same ward?—Yes, and that is why I recommend that provision should be made for separating them.

3147. But to put the chronic cases amongst those which are not chronic you think is not desirable?—Yes, but here I suggest that we should be in consultation on the spot with the local mental hospital, so that we can work out a system of better dealing with the observation cases as well as the permanent detention cases.

3148. Of course it is quite impossible for you in the poor law infirmary to have special wards for special cases?—Quite, but more could be done than is being done if the job were tackled, I am sure.

3149. *Mr. Snell*: Is it at all likely that any system could be devised for caring for those people who have been under observation, or would it be possible to reduce the number of certified cases?—Yes, I think it might be.

3150. How far is the objection to treatment in a mental hospital due to general antipathy to Poor Law institutions, do you think? You said that your experience was that the antipathy existed equally among middle-class people as among the poor people. Is there a decided antipathy to Poor Law institutions because it is associated with the Poor Law?—I think that that feeling is dying out, and what I said was that, though they willingly come into our place for observation, they are much opposed to being sent to the asylum. It is a Poor Law question, but the prejudice is dying out in localities.

3151. *Mrs. Mathew*: I want to know what you meant by the phrase "trying them out" which you used some little time ago. Do you mean letting them out on trial, or what do you mean?—We have no authority for that, really, under the Lunacy Act, but I do not quite remember what the context of that remark was.

3152. I think you were talking about the 1-7 per cent., and you used the words "trying them out"?—Very often within the three days a case is transferred from the mental ward to another ward in our own hospital in order to test a patient's condition before actually deciding.

3153. *Chairman*: And that occurs within the three days?—Yes, sometimes it does.

3154. *Sir David Drummond*: Did you hear Dr. Baly say that at Lambeth the only means they had of detaining some of these cases of general disorder for mental treatment was by certifying them?—Yes.

3155. That is not the case with you?—We do not find that difficulty. In cases of delirium which are sent from the general local hospital, as far as we possibly can if the patients are at all manageable, we treat them in the ordinary wards. Occasionally we do have to send them up to the mental wards if they become violent.

3156. If you had the staff you desire, you could treat them in the ordinary way?—No, it is not a

4 November, 1924.]

DR. J. DUDGEON GILES.

[Continued.]

question of staff. We could put on special nurses if necessary, but some cases are such that you cannot manage them in an ordinary ward, and I have always gone on the principle that you cannot put a man into the mental ward at all without certifying him in some form or other. It is very rare, but occasionally we do get a case where a man is mentally afflicted to such an extent that you have to treat the mental symptoms as predominating for the time being.

3157. *Lord Eustace Percy*: With regard to poor law treatment, you said you have a certain number of neurasthenia cases coming into the general wards. I suppose those cases which come in voluntarily are really indistinguishable from cases which come into your mental wards?—Yes, they often are.

3158. Do you find that these neurasthenic cases which come to you voluntarily are willing to stay for the full time which you think necessary to keep them under observation, or do you find any reluctance on the part of the patients to stay?—I think it rather depends on the nearness of the neurasthenia to actual breakdown.

3159. In reply to questions put to you, you stated that the reason why people were so reluctant to have mental treatment was not because of the stigma of the Poor Law and you said that the feeling was dying out, but do not you find some reluctance especially on the part of the poor to mental examination?—No, I do not think so.

3160. On the whole, do you find, unless the mind is very near the border line, that a patient is prepared to remain in the institution?—You can usually persuade him without using any formal method of detention, but at the same time our hands would be very much strengthened if there was some simple form of power to detain without certifying.

3161. Granted that a sort of clearing house and a place of observation is necessary in connection with a patient's general mental condition and arrangements for treating that mental condition, do you think that a Poor Law infirmary is the best agency for it?—That depends very much on the locality and the local reputation of the Poor Law hospital, does it not? In some localities I think it is true to say that Poor Law hospitals have such a reputation amongst the people that they will go there willingly. I know it is so in Salford, and any other branch services like a mental observation branch attached

to Hope Hospital would be welcomed amongst the general population of Salford.

3162. I know the reputation of the hospital, but I was rather having regard to the mental side. Do you regard it as being sufficiently equipped on the mental side as to become a sort of clearing house?—No, it is not at present. If we were going to do that, real pressure would have to be brought on the guardians to provide for staffing a ward for the purpose of carrying out different things.

3163. But you do act as a clearing house now?—We do, but the conditions are not satisfactory.

3164. I notice on your 1923 figures you have only 170 beds and 153 permanent detention cases. Do you only have 17 beds to do all your clearing house work?—No, those figures are deceptive, but we have not many more than that number.

3165. In that case your process of distinguishing between cases for permanent detention and cases going out must have been very defective, must it not?—No, I cannot admit that. There is not, however, enough room and there is no segregation there which there should be between the two classes of cases.

3166. *Chairman*: I think one can see why you wish to get rid of the chronic part of the population; you wish to have more room for dealing with the other cases?—Yes.

3167. You do not have Poor Law mental wards provided for the curative treatment of your cases, do you?—No. Medical treatment we can deal with, but we have no definite system of mental treatment.

3168. All you can give is a bed in which the patient can lie quiet and warm?—Yes, but not always quiet.

3169. But you could at least give a patient shelter, warmth, and a bed and a certain number of remedies, hypnotics and so on, to quieten him, but beyond that you are not able to do anything to cure him, are you?—Practically not.

3170. Would the number of cases which recover without certification be largely increased if this period of observation were accompanied by all the facilities and appliances for some curative treatment?—Yes.

3171. And if the period were 28 days instead of 14 days?—Yes.

3172. And you think that there might be a still larger number of persons who might escape certification altogether?—Yes, I think so.

3173. We are much obliged to you

(*The Witness withdrew.*)

(*Adjourned to to-morrow at half-past 10 o'clock.*)

5, OLD PALACE YARD,
WESTMINSTER.

SIXTH DAY.

Wednesday, 5th November. 1924.

MEMBERS PRESENT :

THE RT. HON. H. P. MACMILLAN, K.C. (*Chairman*).

THE EARL RUSSELL.

LORD EUSTACE PERCY, M.P.

SIR HUMPHRY ROLLESTON, BART., K.C.B., M.D.

SIR THOMAS HUTCHISON, BART.

SIR ERNEST HILEY, K.B.E.

SIR DAVID DRUMMOND, C.B.E., M.D.

MR. H. SNELL, M.P.

MRS. C. J. MATHEW.

MISS MADELEINE SYMONS.

MR. P. BARTER (*Secretary*).

MR. W. FAIRLEY (*Assistant Secretary*).

Mr. HAROLD SENIOR and Mr. GEORGE USHER, called and examined.

3174. *Chairman*: Mr. Senior, you are President of the National Association of Masters and Matrons of Poor Law Institutions?—(*Mr. Senior*): Yes.

3175. And, Mr. Usher, are you Honorary Secretary of the same body?—(*Mr. Usher*): Yes.

3176. I think, Mr. Senior, you are Master of the Southampton Poor Law Institution?—(*Mr. Senior*): Yes.

3177. While you, Mr. Usher, are Master of the Hartlepool Poor Law Institution?—(*Mr. Usher*): That is so.

3178. And are you here this morning both as representing your Association and also to give us the benefit of your own experience as Masters of Poor Law Institutions?—Yes.

3179. I think before we discuss any questions of general policy it might be helpful, Mr. Senior, if you were to tell us a little about your own institution. We are anxious to know the character of the class of institution with which you deal, and the arrangements that are made in it, before we come to general questions. You are the Master of the Southampton Poor Law Institution?—(*Mr. Senior*): Yes.

3180. Will you tell us what is the character of your institution, and what organisation you have there; first generally, and then how you deal with mental cases?—The institution will accommodate 630 people—that is the whole institution. The component parts are the able-bodied and the infirm—both men and women. We have a nursery in connection with the institution for 50 children; and then there are the mental cases. We have accommodation for 150 mental cases.

3181. Are your inmates drawn from the parish?—They are drawn from the Southampton Union.

3182. What area geographically does that represent?—About 80,000 acres.

3183. Then we are specially interested, of course, in your provision for mental cases. Are the mental cases under your charge segregated from the other cases?—Quite.

3184. And accommodated in separate quarters?—In separate quarters; a separate block entirely. We have one block entirely for the accommodation of mental cases, men and women; but for the daily

accommodation we have to encroach upon a block that is partly used for other people.

3185. Are the mental cases under your charge permanent residents with you, or are they what we may call a floating population passing through your hands?—They are chiefly permanent residents under detention.

3186. Will you tell us generally what class of mental case you have as permanent residents?—The permanent cases are, of course, under detention orders issued under Section 24.

3187. I was thinking of them from the point of view of their disabilities. Are they chronic cases?—Yes, chronic cases chiefly; you might reckon that 90 per cent. of them are chronic cases.

3188. Probably cases of senility?—No, chiefly the imbecile class and moral perverts; there is a certain section of those. We have certain senile dementia cases, but the majority are idiots, perverts and imbeciles.

3189. Generally, I suppose, a class of patients who, while suffering from mental disability, are not troublesome in their conduct?—That is so; they are not at all troublesome. They are all quiet cases, and their mental condition is such that they do not improve.

3190. They are not cases which could hope to benefit from treatment?—No. Whenever there is a case that could hope to improve under treatment, we try and get that treatment by sending to another institution.

3191. Then in the case of these unhappy persons your function really is to make their lives as comfortable and as happy as you can?—Yes, that is the chief point.

3192. A certain proportion of your cases, on the other hand, are cases that have come to you from the relieving officer and pass through your hands?—Yes, we get a good many, of course, which are very transitory, from the ships—from the immigration authorities.

3193. With regard to those who are under permanent detention, we understand, from what you have told us, how you are situated, but with regard to those new cases that come in to you through the

5 November, 1924.]

MR. HAROLD SENIOR and MR. GEORGE USHER.

[Continued.]

relieving officer, either from the ships or from the police, as the case may be, how do you deal with them? What provision have you to deal with them, because they will be all classes of cases, and not merely chronic cases?—Of course they come in under the three days' order as a rule, and occasionally under a justice's 14 days' order. They are put under observation in the ordinary way, put in bed, and we have just one receiving ward.

3194. For both sexes?—No; I mean one for male and one for female cases, but we do not segregate any of the classes until they have been with us for several days. All the males are put into one ward.

3195. Is the observation ward distinct from the wards in which your chronic permanent residents are?—In the same block, but a distinct ward.

3196. So that you have provision for treating those cases that come in to you, apart from your general lunatic population?—Yes, quite apart. You can consider that the men in the receiving ward are there merely for a short time.

3197. They are under the transitory orders?—Yes.

3198. Then they are brought, I suppose, before a magistrate, and disposed of?—Yes, either by discharge, or a permanent order, or to the mental hospital.

3199. Do you find that of the cases which are brought in to you in that fashion a large number are discharged without any order for their permanent detention?—Yes, quite a good number.

3200. What is the maximum period of observation which you apply?—17 days.

3201. That is the 3 plus 14 days?—Yes.

3202. And within that period of 17 days do you find that a substantial proportion of the cases either recover or are found to be such that they can be safely discharged?—Yes, a fair number. There is a difficulty with regard to that. It appears to me that the period should be extended. We have found a case where the doctor has not come to any decision; the patient has made some improvement, but not sufficient to discharge him, and yet he feels that by a longer observation the patient might completely recover; yet he has to deal with him in those 17 days.

3203. Then you would be well disposed to a prolongation of that transitional period?—Yes; say from 14 to 28 days.

3204. Do you think that in the course of a month the magistrate and you would be able to come to a definite decision on most cases?—Yes, I do, and probably it would prevent certain of the cases having to go under a permanent order.

3205. And such cases would avoid certification altogether?—Yes.

3206. In your observation ward are you able to do more than house the patients, and keep them in quiet and comfortable surroundings; have you any provision for treatment?—Not for special treatment; it is merely an observation ward.

3207. Do you find it necessary to restrain some of the violent patients who come in?—Occasionally; very little; we do it as little as possible. It is done under the instructions of the medical officer.

3208. You would be able to give them medicine, I suppose?—Yes, under the doctor's instructions.

3209. Is he a resident doctor?—No; he visits twice a day.

3210. But beyond providing them with the shelter of this ward, and the attention of the doctor, and some medical treatment, you have not any provision in your wards for treating these patients during this transitional period of 17 days?—No; that is the ordinary treatment.

3211. What we have in mind is this: Whether even a larger proportion might not escape certification if the provisional period were always available for treatment as well as merely for temporary detention. You have not the facilities for that, of course?—No, we have no facilities for that at all. We do the best we can with our rather limited accommodation.

3212. Do you find that your accommodation is adequate for the present system?—Personally, I feel that we should have more classification; just another room for classification.

3213. I suppose that these cases that come into your observation ward will be of all classes of mental disturbance?—Yes.

3214. You may have violent cases, or you may have depressed cases?—Yes, that is my point. I feel that there are cases of violence that might go into the observation ward we have, but there are cases of neurasthenia, and of men who are of a quieter type, who might be put in a separate ward to their benefit.

3215. Do you think that the association of all the different classes of cases in one compartment in your institution may be detrimental?—I think so, yes. I am only the Master; I am not, of course, a medical man.

3216. Your practical experience as one conversant with these people is very useful to us. What staff have you for dealing with your mental cases?—We have an average of 65 male cases, and I have a staff of 11 attendants. We have a similar number of female cases, and a similar staff, 11 female attendants.

3217. Do you find that your staff is adequate to cope with the work?—Quite.

3218. And quite satisfactory?—Quite satisfactory. With regard to the attendants, one would wish that they could have had some kind of training; I think that would be an advantage.

3219. Are some of your attendants really probationers learning their work?—Yes; certain of them are trained attendants, and the remainder are men who come in from any other kind of work. If they are not suitable they are dismissed; if they are suitable, it takes them a year to get into the job, but if they had proper training they would be able to give better attention to the patients.

3220. Of course, one recognises, as in nursing generally, that experience can only be obtained in such institutions themselves?—Yes.

3221. Therefore I suppose you must have always a class of probationers who are learning their duties?—Yes, that is so; one must have that.

3222. I should just like to conclude the account of your institution by asking you about the remuneration that your staff receive?—The chief male attendant is paid to-day £3 8s. 6d. a week; the assistant attendant £3 3s. a week, with uniform; they work 56 hours a week, and live entirely off the premises.

3223. Do they get their meals during the day on your premises?—Yes, I arrange that during their period of duty they get half an hour allowed for one meal.

3224. Do they mess, so to speak, in your institution?—They bring their own food. We give them accommodation to get the food; but they live entirely off the premises, and no food is provided for them by the guardians. The female attendants are under a different principle. Three of the attendants do live entirely on the premises, but owing to the lack of accommodation the remainder have to live out. They are paid at the rate of £50 per annum, with an allowance of £21 for accommodation. The three who live in get £50 a year and very excellent food, and all found. In the case of the women who are off duty we give them a limited ration, because they are away for a certain time, and we allow them 1s. a day in lieu of part rations.

3225. With regard to the diet which the patients receive, both those who are permanently with you and those who are passing through your hands, how do you deal with them? Have you a satisfactory diet?—We have an excellent diet.

3226. Have you ever had complaints about it?—No, never. If a person requires extra diet—milk, or fish or any special food—he gets it.

3227. You have no trouble with your Guardians in making such provision?—Not at all; they will give anything that is required.

5 November, 1924.]

MR. HAROLD SENIOR and MR. GEORGE USHER.

[Continued.]

3228. Can you give us perhaps a little more detail with regard to the diet? What does it work out at per head?—The cost per head throughout the institution is about 4s. 6d. a week; that is for the patients' dietary. You must understand that is entirely uncooked food at a contract price. They have meat, of course, every day; a hot dinner every day, with pudding four or five times a week. For breakfast it is very plain food; a good margarine, and bread, coffee or tea, and in winter I give them three or four times a week a little porridge and milk to start with, in addition to their ordinary diet.

3229. Can you tell us what is the cost of maintaining an inmate per week?—I believe the exact cost is 16s. 8d. per week, including the whole of the overhead charges; we have no loans, of course. That is, food, clothing, lighting, heating, staff, drugs, and so on.

3230. *Earl Russell*: And what per week does the asylum charge if you send patients to the asylum?—I believe the present charge is about 22s. at Basingstoke.

3231. *Chairman*: Then I think, Mr. Usher, you might be good enough to tell us generally about your institution, on the same lines as Mr. Senior has told us?—(*Mr. Usher*): Yesterday we had 640 inmates all told; that includes a hospital with 360 beds; there were 310 patients in the hospital, which included the lunatics. We have two separate wards; I mean the lunatic wards are a part of the hospital, and under the superintendent nurse. It is a big institution, and I am charged with the whole institution, the hospital as well as the lunatic wards and the remainder of the place. There are about 140 in the house, mainly infirm people, male and female. Then we have the school buildings loaned to the Northern Counties Feeble-Minded Committee, and I think there are about 200 mental defectives in the school buildings. I am the superintendent of the mental deficiency blocks.

3232. Then do you have, as Mr. Senior has, a considerable resident population of mental cases?—Yes.

3233. Do you also have the experience of a number of people coming to you through the relieving officer who have to be disposed of under the Statute?—Yes.

3234. Do you agree with the view expressed by Mr. Senior that a longer period of observation might be desirable?—Yes, I think it is very desirable.

3235. Has it been your experience also that after a short time in your observation section a number of the patients recover, or are seen to be unsuitable for detention?—Yes, I should think quite 50 per cent. of the cases.

3236. As high as that?—50 per cent. of the people who come in under temporary orders are cured.

3237. Therefore, if the period were prolonged, do you think that the percentage might be even higher of those whom it would be found unnecessary to certify?—Yes, slightly higher. I mean it would obviate the necessity of some of them going to an asylum.

3238. Of course, on the other hand, I suppose one should take this into account, that you will not have facilities for treatment any more than any of the other Poor Law institutions, and that some cases, by being delayed longer in the observation ward, may be deprived of the advantage of treatment which they would get by a speedier transfer to an asylum?—We are urging that in small houses where there is no suitable accommodation, the temporary cases be sent to an institution allocated for the purpose in the district.

3239. We will deal with the others a little later, but I am anxious to get your own actual experience with regard to your own institution. Can you give us figures to correspond with Mr. Senior's figures as to the wages, cost per patient, and cost of diet?—We have probably 40 certified under Section 24—20 males and 20 females. We have only four attendants to the male side; we have three attendants at the female side, but they get considerable assistance from

the probationary nurses. It has always been argued that it is very essential that nurses should have experience in dealing with mental cases, therefore we have always made a point of using the probationary nurses in the mental wards.

3240. Do you find the staff adequate for your purpose?—Yes, considering the kind of patients we have; I mean they are mainly imbeciles.

3241. Does the same staff deal with the observation cases that are brought in under a three days' order?—Yes.

3242. Those cases, of course, will exhibit every type of mental derangement?—That is so.

3243. Do the same nurses deal with those cases as deal with the chronic cases?—Yes.

3244. Have you an observation ward in which these cases, brought in under a three days' order, are dealt with apart from the inmates generally, or from the chronic cases?—We have a side ward, but all the cases are not put in there for observation; it depends upon the kind of case, and how bad they are. If a man is suffering from acute mania he is put in the side ward.

3245. Do you find that you have to accommodate in this side ward cases of very varying degrees of insanity?—Yes, but in the main acute.

3246. Do you exercise your discretion as to whether you set apart a particular case for this ward, or allow the case to be among the others?—The doctor does. You asked about the salaries. I think my colleague's officials get a trifle better pay at the male side. I think our head attendant gets £3 7s. 6d. a week, and the other attendants £3, but we beat him at the female side. The two charge nurses at the female side—they work alternate day and night duty—get £70, and the juniors £60.

3247. Do they live in or live out?—They live in, and all found.

3248. Including uniform?—They have £6 allowed for uniform; they buy their own.

3249. Then what about the dietary?—Are you speaking of the officers' dietary?

3250. No; first of all, the patients'?—They are all dieted by the doctor. None of them has able-bodied diet. An ordinary imbecile has infirm diet. Then we have a resident doctor and three visiting doctors, so that the patients get daily attention, and they are dieted many of them individually.

3251. Have you an overhead figure of cost per day or per week of the food?—I am afraid I have not, but our institution, I think, is rather on the low side, for food and other things too.

3252. You have not taken out any statistics to show us the amount expended?—No: I am afraid I did not anticipate the question.

3253. We are just taking advantage of your presence here to-day to get some information. Do you think the diet is satisfactory?—Yes.

3254. Have you had complaints about it?—Never.

3255. Can you tell us the cost of the maintenance of an inmate, per week?—Complete maintenance, under 13s.

3256. *Mr. Snell*: Including overhead charges?—Yes, I think that includes everything but loan charges.

3257. *Chairman*: Do you know what the asylum charge is?—24s.

3258. The asylum to which you send on your cases?—I think at present it is 24s.

3259. We are much obliged for these details about your own institutions, and we now pass to more general considerations. I think you represent your Association here this morning, and your Association has 1,200 members?—Yes.

3260. Which represents 96 per cent. of the masters and matrons in England and Wales?—Yes.

3261. Is there a considerable diversity in the Poor Law establishments throughout the country in accommodation?—Yes.

3262. I suppose they will vary with the districts?—Yes.

3263. Are some of the institutions quite small?—That is so.

5 November, 1924.]

Mr. HAROLD SENIOR and Mr. GEORGE USHER.

[Continued.]

3264. Then the variation will be from quite small, possibly rural, institutions, up to fully equipped urban institutions?—From six inmates to 3,000.

3265. That gives us a good idea of the range. But do mental cases find their way to all those institutions?—No, not to all of them, but to most of them. I have now in mind two Unions, where in one case practically all the temporary cases go to the workhouse or the Poor Law institution. In the very next Union none of them goes; they send them direct to an asylum. To my mind that is to be deprecated, because quite a number of cases improve or get better, and there is no need to send them to an asylum.

3266. Do you mean that in some Unions a case under a three days' order does not pass through your hands at all?—That is so.

3267. Does the relieving officer get the case consigned direct to an asylum?—Yes.

3268. On a magistrate's order?—Yes.

3269. In such a case the relieving officer must necessarily have made arrangements with the asylum beforehand, I should take it?—I do not know that it is necessary. If he get a case signed up, they have sufficient accommodation to take him at any time.

3270. The relieving officer will get knowledge of a case, take the case to a magistrate, or get the magistrate to visit the case, and, having got the order, will present himself with the patient at the institution and ask admission?—Yes, that is right.

3271. What would happen if the patient were violent meantime?—Do you mean in the conveyance to the institution?

3272. *Earl Russell*: No; from the moment he began to think of certifying to the time he is actually conveying him to the asylum, there may be at any rate 12 hours, and possibly 24, and if the man is violent during that interval, how and where is he confined?—That is left to the relieving officer. I have already said it is desirable to send him to an institution, but I take it they have a magistrate pretty well at command and they have all the facilities for getting the case certified quickly.

3273. *Chairman*: The relieving officer would take charge of him, I suppose, until he got him into the asylum. Where he would keep him if there is any delay is a little obscure?—In some places the relieving officer and workhouse officials have assistance from the police. Usually, I think you might say, the police are very helpful.

3274. *Earl Russell*: You mean they would keep him in the cells, if necessary?—No; they go to the house and help with the case.

3275. *Chairman*: If it were a case of a man in his own home who had gone suddenly mad, somebody would be left with him, is that what you mean?—Yes.

3276. Either a constable, while the relieving officer was trying to get the magistrate, or some other responsible person?—I do not wish to commit myself any further than the knowledge I have. I go round and get the information. We get quite a number of these people, and it is absolutely impossible to treat them and cater for them, because we have not trained people to look after them, or the accommodation; but in the very next Union they get none; they send them straight to the asylum.

3277. That is rather a new feature—cases not passing through Poor Law institutions at all, and therefore not coming within your cognisance. That does occur in some instances?—Yes.

3278. I wonder if you could instance a Union in which that practice is observed?—I will give you that information privately. It is a matter of complaint from one master of an institution, and he would not expect me to use it at a public inquiry.

3279. If we desire the information you can give us an instance of such an institution, because we want to inquire about the case. Perhaps you might communicate with the Secretary about this?—Yes, certainly.

3280. As you have told us, the institutions throughout the country vary greatly in size, in equipment and in accommodation, but generally mental cases find their way to those institutions, whatever be their equipment, for a time?—Yes.

3281. In small institutions, what is done with a mental case if there is no special accommodation, no observation ward or other special accommodation, for dealing with such cases?—The patient is taken, say, by a police constable, without an order. The very fact that the police constable takes the case is enough for the master; he admits him. In some cases the master is left there with the patient. He may be an old man, 60 years of age. In some cases the master is the only male officer in the institution and he has to do the best he can with him. I have one case in mind where they get quite a number of three day and 14 day order cases, and only last spring there was a Ministry of Health inquiry because the master and the porter were charged with roughly handling a lunatic, while neither of those people had any special instruction or experience in handling lunatics; both of them were totally unfitted for handling a case of that kind. Fortunately the case was not proved against them, or the master would have lost his post and lost his pension, and certainly it would not have been his fault, because he is not capable of dealing with a man of that kind. You get in very acute cases, or cases suffering from delirium tremens, and they really need skilled men to handle them. To go and land them in a workhouse where there is only a master and a porter is very, very unfair to the patient.

3282. Accordingly, is it your view that some of the Poor Law institutions throughout the country are unsuited for the reception, even temporarily, of mental cases?—All the small country houses. I have no small country house in my mind that is suitable to receive a case under Section 20 and Section 21.

3283. On the other hand, as matters stand at present that is the only institution to which they can be taken in a case of emergency?—That is so.

3284. Do I understand that your Association is in favour of some provision whereby only such Poor Law institutions as are certified by the Board of Control as being fit and proper for the reception of mental patients should be utilised for this purpose?—Yes, we think that is a very urgent need.

3285. But can you help us practically? Such a requirement might rule out a considerable number of the smaller institutions, might it not?—I do not know that it need do so, but if it does, take a step further and allocate one institution in a given district, and use it exclusively for mental cases.

3286. I follow. Otherwise the practical difficulty that was pressing itself upon my mind was this, that if you ruled out a number of small institutions in rural districts, because you could not there have officials capable of handling the cases or suitable accommodation for the reception of the cases, then there would be no place to which such patients could be taken, and they might have to be removed to a considerable distance, which again has drawbacks, as you know, from the point of view of the relatives and others?—Yes, but in these days of quick transport, if you are 60 miles away it is not very much, is it?

3287. Then your practical suggestion is this, that in each district—we do not know what size the district would be—there should be one Poor Law institution which should be selected and equipped for the purpose of dealing with these cases?—Yes.

3288. And that they might all be relegated to that institution?—Yes. Of course, that will be determined by the number of patients who could be removed from the asylum as almost cured, and by the number you had in the district. I mean you could not say, "One institution for a county." The whole thing would have to be thought out.

3289. It is obviously a problem of local administration of some difficulty, but apparently your Association is satisfied that a certain number of the Poor

5 November, 1924.]

MR. HAROLD SENIOR and MR. GEORGE USHER.

[Continued.]

Law institutions in this country, through no fault of their own, are inappropriate for the reception of mental cases, even temporarily?—Yes.

3290. On account either of the smallness of the accommodation, the unsuitability of the accommodation, or the inevitable lack of experience on the part of those in charge?—Yes.

3291. *Lord Eustace Percy*: Might I ask whether there are many institutions in the country outside, say, county boroughs which would be suitable under your proposed arrangement? Do you think the Board of Control would be able to certify many Poor Law institutions in this country outside county borough institutions?—A few; not a lot.

3292. That would make the process of disposing of lunatics very difficult, would it not?—I do not see how it can be tackled without allocating separate institutions.

3293. *Chairman*: I take it you would contemplate that one institution in each area would be selected as the reception house, and that that institution would then, if necessary, be equipped for the purpose, and special accommodation provided in it. I suppose that is your idea?—Yes.

3294. *Earl Russell*: It means a good many consequential amendments of the Poor Law, both financial and otherwise?—Yes; I suppose you are here to consider that. I really cannot understand how this matter has been overlooked for years past. It is a real scandal, these temporary cases being taken to small Poor Law institutions, where people do not know how to handle them; no wonder they do get bruises.

3295. *Chairman*: With regard to cases brought to these small institutions, suppose it was a chronic case, and therefore perhaps a case inappropriate to send on to a mental hospital, a case which might quite suitably remain on in the workhouse; are there in some of these small institutions, of which you have spoken, to be found one or two cases of that sort living with the rest of the inmates?—Yes, and I think it is desirable. When I am speaking of a small Poor Law institution not being suitable for the lunatics, I am only referring to those under Section 20 and Section 21. Under Section 24 a lot of people are very much happier in Poor Law institutions than they would be in any other institution.

3296. We must bear that distinction in mind. In these Poor Law institutions do you think that the chronic cases, that is to say, the old person whose mind has gone, or the imbecile, or cases of that sort, hopeless cases, are quite well looked after?—Yes, excellently.

3297. Your recommendation does not apply to that class of case?—No.

3298. In such small institutions do the chronic mental cases just live with the other inmates?—Some of them; it depends upon the degree of insanity; many of them live in the house, and some of them are very popular, too, and very happy. By living in the house they get more liberty. There has been a great change during the last 10 or 15 years in dealing with this class of patient. A master takes upon himself more risk in letting a male case go out for a few hours, so long as he is quite safe, and not dangerous to himself or anyone else.

3299. I can quite understand that that class of harmless case would probably be happier—supposing it was an agricultural labourer, for instance—in his own district, in the little poor-house of his own area?—Yes.

3300. Where he would be among people whom he knew, and would, as you say, have a certain measure of liberty?—Yes.

3301. You do not condemn, then, the small rural institution as a proper place for that type to remain in?—No.

3302. When you are recommending your reform, it really applies to those cases which reach the poor-house for the purpose of classification and ultimate disposal?—Yes, but there would have to be some give and take, because you would not be able to run

an institution unless you had some permanent cases also. I take it that if you wanted the Lunacy Acts amended to enable this idea being carried out, and you allocated an institution in a district, you would want it on up-to-date lines, with probably a medical officer; you would want to do things properly. I suppose the idea is to improve the lot of the lunatics. I do not suggest that you could keep the institution to wait and receive the cases under Section 20 and Section 21.

3303. May I suggest this to you, because one is anxious to avoid duplication of institutions. Would it meet the case if the asylum properly so-called had a department where uncertified cases were received for the purposes of observation and disposal, without this intermediate institution which you have figured?—I would prefer the other.

3304. Is that because of the unfortunate associations with the asylum?—Yes. People say there is something very, very terrible about the stigma of a Poor Law institution, but I think you will agree with me that the stigma of sending a friend to an asylum is ten times worse; and to avoid that, this kind of intermediate institution, or a home of rest, or give it whatever name you are disposed to give it, I think would be preferable to sending them to a branch of the asylum.

3305. Then you contemplate that this intermediate place might be not only what I may call a clearing house to which the people might be brought in order to have them observed and ultimately disposed of, but also a place of permanent residence?—The asylums are already overcrowded; it is a well-known fact that many of the patients in asylums are harmless, and they would probably be more comfortable in such an institution; at any rate, it would be a convenience to the State to transfer them from the asylum to such an institution as this.

3306. Then we should have chronic harmless cases really housed more or less fortuitously in the three classes of institutions: first, the case you figured, in a little country Poor Law institution; some of them in the intermediate place; and then you would find some of them in the public mental hospitals?—I do not know that there is any reason why they should not be.

3307. You do not favour the idea of this reception house, this intermediate place, being simply a clearing house in which observation of cases might take place with a view to their ultimate disposal; if it were a chronic case, sending it back to its own Poor Law institution, or if it were a case for the asylum, sending it on there?—I do not think it is practicable to have a place allocated exclusively for cases under observation under Section 21, but if you take the cases from the asylum under Section 25, and put them in an institution of this kind, then you could run the place all right.

3308. Would not this institution very rapidly attract to itself very much the same reputation or stigma as the asylum, because it would be known that so-and-so had been taken to this place; it would be a place exclusively dealing with persons mentally disturbed, either temporarily or permanently?—It is an intermediate state, between the Poor Law institution and the asylum, so that it would get that degree of stigma. The stigma would not be so bad as going to a lunatic asylum.

3309. In giving us your views just now, are you expressing the views of your Association?—Absolutely.

3310. *Lord Eustace Percy*: Might I ask whether, in the view of the Association, it is essential that this new sort of intermediate institution should be a public institution, or has the Association contemplated the possibility of having it, for instance, as a department of one of the general hospitals in the district?—No, I think it should be a public institution. I do not see why you should not make some arrangement with the Poor Law authorities, and take one of their institutions in each district. I do not see why it should not still remain under the Poor Law.

5 November, 1924.]

MR. HAROLD SENIOR and MR. GEORGE USHER.

[Continued.]

3311. *Chairman*: I think we quite realise the undesirability of imposing upon a small institution the burden of dealing with these cases where they have neither the equipment nor the experience to deal with them. The problem of how it should be met is, of course, rather more complicated, in view of the existing organisation, but we appreciate your views. Then does your Association also advocate, as Mr. Senior has done, the lengthening of the period of preliminary detention?—Yes.

3312. What is the period which you regard as desirable for the purpose of arriving at a final determination on a case?—28 days.

3313. Have you considered the point I made a little while ago, that so lengthened a detention in a preliminary place, such as the workhouse ward, might deprive the patient of the benefit of the special treatment which he receives in an asylum, and which might hasten his recovery?—It depends very largely upon the kind of institution. If you are dealing with the large institutions, which, of course, if you carried out our recommendation, you would do—take the doctors there; I say they are almost experts; and in our institution we have a very capable doctor who has been dealing with these cases for 40 years; he ought to be an expert now.

3314. Then we must complete your story by adding this: You would contemplate that in such an institution, set apart as an intermediate institution, you would be able to have such equipment as would afford opportunities for curative treatment during that interval, as well as observation?—Yes.

3315. In that way you would obviate the objection I was suggesting, that the patient might be merely observed instead of cured?—Yes.

3316. Have you found yourself a little embarrassed by the existing code of lunacy law as to the programme, that is to say, the periods which are prescribed by the Acts?—Yes.

3317. Do you desire that, if possible, the scheme should be made more precise and clearer?—Yes. If you do not mind, my colleague and I arranged before we came in that I should deal with the first two pages of the *précis*, and that he should deal. I think it was, with the part commencing on page 3 of the *précis*.

3318. Then you would rather that Mr. Senior should give us his views with regard to the purely legal topics?—Yes.

3319. Then, I think, Mr. Senior, if you will be good enough to give us your views with regard to any emendations of the sections under which you work, we should be glad to have them?—(Mr. Senior): In the first place, with regard to Section 20, the three days order, there is some difference of opinion as to what should follow the three days order. If at the end of the three days it is decided to make a summary reception order, and send a man to a hospital, there can be a suspending order made by the magistrate for 14 days. On the other hand, the medical officer of the institution can detain a man for a further 14 days under Section 24. There appears to be, as I say, a difference of opinion as to what should occur. We suggest that there should be a three days' order; to follow that, there should be the magistrate's 14 days order; in every case the magistrate should visit the institution and see the patient; we urge that, for the sake of the protection of the patient, and to cover the medical officer. Instead of having a 14 days order, we suggest a period of 28 days. Then, following that, should be either discharge, of course, or a summary reception order, or a detention order in the institution under Section 24, as at present. We feel that the procedure is not quite clear, or that there are different readings of the order in the various areas.

3320. If one looks at Section 14, in the first place, Mr. Senior, the relieving officer must, within three days of a case coming to his knowledge, give notice to a justice?—That is so.

3321. Then, on notice being given to a justice, the justice must require the patient to be brought

before him within three further days?—That is so. The patient is then visited by the justice; that is done in every case. As a result of that visit the magistrate cannot give a 14 days order; it is not legal for him to do so. That is my reading of the Act at present.

3322. Of course, when the magistrate has had the case brought to his notice by the relieving officer within three days of the relieving officer knowing of it, he must then within three further days dispose of the case, unless advantage is taken of some of the later provisions of the Act?—Yes.

3323. And within the three days he may dispose of the case by making an order right away?—Yes, on the suggestion of the medical officer.

3324. He may call in a medical practitioner, and, having seen the lunatic, may dispose of the case at once?—Yes.

3325. But in your practice do you find that many cases are so disposed of at once, within the three days allowed to the justice?—Very rarely indeed. The usual practice is that after the three days order the man is immediately put on a 14 days order by the medical officer under Section 24. Then comes a period of observation, and before the end of what would be 17 days definite action is taken.

3326. Then no certificate is issued by the justice in such a case? It is a sort of 14 days remand really, without a certificate?—That is so, on the medical officer's signature only.

3327. It does require a certificate from the medical officer, does it not, for his detention for 14 days more, but not an order, I take it, by the justice?—I, as a master, cannot detain a man. After a man is in the institution itself I cannot detain him for 14 days on a justice's order; it is an illegal thing to do. That is the opinion of the Law Officers of the Crown.

3328. Have you contemplated the operation of Section 19, under which the justice who makes the order may suspend its execution for a period not exceeding 14 days?—I know that can be done, but it rarely is done. As a matter of fact, I cannot remember a single occasion when that has been done at Southampton, and we send a large number to the mental hospital.

3329. Suppose the justice made the order, but suspended its execution under Section 19; what authority would you have for continuing to detain the patient in your workhouse?—The justice under those conditions can give an order for detention for 14 days—the suspending order.

3330. He may give directions as to the proper care and control of the lunatic, and those directions would be your authority, I take it?—They would be my authority.

3331. But in practice has it come to this, that you regard the prolongation of this period as so valuable that you resort to the 14 days order in most cases?—In practically all cases, I might say—99 per cent. of the cases.

3332. Why do you do that? What is the object of resorting to this expedient?—That is the medical officer's business, because he can come to no decision within the three days.

3333. It is really to enable the justice to come to a more deliberate opinion, and the medical officer also to come to a more deliberate opinion, upon the case?—That is so.

3334. Then the real upshot of this evidence is that you regard the period of three days, which is the statutory period, as too brief a period to enable a considered judgment to be arrived at on a case?—Usually quite inadequate.

3335. *Earl Russell*: Might I put this point? If the relieving officer has once given notice to the justice under Section 14, is not the justice bound by the mandatory provisions of Sub-section (3) of Section 14 to proceed to action and see the lunatic within three days?—Yes, and he does so in every case.

3336. Then he must make some order?—He makes an order, but that order is not given to me. I do not accept it, because it is not legal. That appears

5 November, 1924.]

MR. HAROLD SENIOR and MR. GEORGE USHER.

[Continued.]

to be a difficulty. Why should not that be legal? According to the opinion of the Law Officers of the Crown it is not legal.

3337. *Chairman*: Then you do get a 14 days' order to detain him?—He is detained by the medical officer, and not by the magistrate.

3338. He is detained under Section 24?—Yes.

3339. The magistrate, as Lord Russell has pointed out, must require a relieving officer or overseer to bring the alleged lunatic before him, and then under Section 16 he has to call in a medical practitioner and examine the lunatic; then by order he has to direct the lunatic to be received and detained in an institution, if he is satisfied. Now how do you, so to speak, accommodate those provisions with your 14 days' order?—It clearly says he must be received into an institution, but he is already in an institution.

3340. Yes, "received and detained in the institution named in the order." We do not want to embarrass you with legal questions, because they are very difficult.—They are very difficult to understand sometimes.

3341. I am rather anxious to bring out the difficulties which the persons who have to administer this Act feel in working it out.—Yes. May I explain very briefly what occurs at Southampton, whether we are right or wrong? A person is received into an institution from a police constable or relieving officer under a three days' order. Notice is at once given to a magistrate by the officer to visit this man. The magistrate in every case does visit, and he signs a certificate saying that he has seen the man, and in that certificate he orders me to detain that man for a period of 14 days.

3342. Then he becomes at that moment a certified lunatic?—Undoubtedly.

3343. There really has been a summary reception order pronounced in such a case?—Yes.

3344. Now just go on. What next?—But that order is not given to me; it is filed by the relieving officer, and my power for detaining that man for a further 14 days is under the signature and the certificate of the medical officer.

3345. Then is your institution not the institution to which the justice of the peace in this certificate has destined the patient?—Yes, it is.

3346. Because, if so, would not the reception order justify your continuing to detain that patient?—But then it is against the opinion of the Law Officers of the Crown. I had this case up many years ago. There was some litigation owing to my detaining a man after he had been previously admitted to the institution on a three days' order, and I wrote for an opinion.

3347. *Earl Russell*: But if the justice has made a summary reception order he must have named in it a place to which the lunatic is to be taken. What place has he named?—The workhouse.

3348. And yet you say you cannot receive him?—Yes.

3349. *Chairman*: Was that opinion taken by your Association? It could not be taken by your Association, because of course the Law Officers' opinion must be obtained by the Government, but was it obtained at your instigation?—A copy was sent to me, but it was obtained before.

3350. It was given in 1901. I think we can study that at leisure. At any rate, you have been advised that after three days you cannot detain, even although a justice has pronounced an order?—That is so.

3351. We will examine the legal aspect of that. What we want to get from you is your practical working. You get a 14 days' order?—From the medical officer. I detain under a 14 days' order, which makes a total detention of 17 days, but before the expiration of that period the medical officer must come to some definite opinion; he must either discharge, send the patient to a mental institution, or detain him in the institution under a permanent order. That is the mode of procedure in most places, I think.

3352. Does the justice intervene again?—Under Section 24 (3). Of course, the patient cannot be detained without his signature.

3353. For that you require a justice's order. But take the case of a patient who, during the currency of the 14 days, is to be sent, as the medical practitioner advises, to a public mental hospital; does the justice intervene again?—Certainly, in every case. Within 17 days the justice would see the man twice; he would see him before the end of the first three days, and he would again see him for the purpose of sending him to a mental hospital.

3354. Does he pronounce another order?—Yes, the summary reception order for the asylum.

3355. *Earl Russell*: With the name of the asylum in it instead of the workhouse?—Yes.

3356. *Chairman*: That is the way you work it?—Yes.

3357. Then almost in every one of your cases there must be really two orders by a justice?—Yes, in practically every case.

3358. First, one order under which the patient is detained in your workhouse for 14 days; then, if the patient is sent to a public institution, a second order designating that asylum as the place for his reception?—Yes. May I say that I do not detain under a justice's order in the first place at all? There is a three days' order given. I may be wrong, but I am taking my own reading, or the opinion that has been given to me. The magistrate within three days visits the patient and signs the order.

3359. What do you call that order?—It is a 14 days' order which is illegal, according to the opinion given here by the Law Officers of the Crown, so I take no notice of it; but the magistrate has done his duty by seeing the patient. Then the doctor signs a 14 days' order in the institution. Then he gives notice, if he wishes the man to go to a mental hospital, to the relieving officer, and the necessary order is made by the doctor's certificate and the magistrate's certificate, and the patient is again seen by the magistrate. (*Mr. Usher*): There is another procedure. A man is brought in by a constable or by a relieving officer on a three days' order under Section 20. The magistrate does not see that man at all necessarily, but he is put on a 14 days' order under Section 24 by the medical officer. That is in accordance with the authority of the Law Officers of the Crown, given on the 30th July, 1901. That is the reason for our Association wishing that you should make this more explicit.

3360. Under Section 20, of course, no one is to be detained for more than three days?—That is right. The custom is that after that three days the medical officer of the institution puts them on a 14 days' order under Section 24.

3361. And neither Section 20 nor Section 24 seems to require the intervention of the magistrate?—According to the Law Officers of the Crown, no, but according to the lay reading of the Act, yes.

3362. Well, I suppose it is for us to compose those differences. At any rate, you have made conspicuous to us the practical difficulties which you have experienced in working the Sections of the Act, and have therefore made your case to us for simplifying, if possible, this part of the code.—(*Mr. Senior*): That is so.

3363. That is really the object of this evidence?—Yes.

3364. It is always well, when you attack an existing code, to tell us what you wish substituted for it.—(*Mr. Usher*): We feel that the method of procedure should be as follows: A three days' order should be made in the usual way, as now; the magistrate would be informed by the relieving officer.

3365. In every case?—In every case he should be informed. The magistrate would visit the case, and, if necessary, I mean if the man were not discharged at the end of the three days, or not sent to a mental hospital within the three days, he would give an order for the man's further detention. We suggest 28 days.

5 November, 1924.]

MR. HAROLD SENIOR and MR. GEORGE USHER.

[Continued.]

3366. Would you suggest a special medical certificate as well, to justify that order for 14 days' further detention?—Certainly; I think that would be wise, for this reason: It is at the instigation of the medical officer that that is done, and he wants to have the man under observation for a further period.

3367. The justice would take the doctor along with him in this matter?—Yes.

3368. Then you would get a much simpler code, if you had first of all the three days' order?—Yes. The three days order is of assistance in bringing in the case of a man who is taken suddenly ill mentally; he can be brought to the institution; it saves time.

3369. But during those three days he should be brought before a magistrate, and a medical certificate should be obtained. A medical examination should take place, and he should then be disposed of by the magistrate, I suppose in one of three ways: he might either be discharged at once, or he might be so manifestly a case for relegating to an asylum that he might be sent direct on the order; or thirdly—and this is the point you are making—the magistrate should be empowered to say, "This is a case which ought to be observed longer by the medical practitioner; I pronounce an order for the further detention of this case for 14 days."?—Yes, that is so. We suggest 28 days.

3370. Then that would bring the legal provisions into conformity with what you seem to have in practice carried out?—Yes.

3371. *Sir Humphry Rolleston*: Might I ask whether it is proposed that 28 days should be substituted for 14 days, or whether it should read, "14 days, or, if there be sufficient need, for 28 days."?—Yes. I should say for 28 days, for this reason: A man can be discharged under Section 81, and that should be made a little more clear and easier to be done. May I just point out that Section 81 says that the guardians may discharge? My association feel that the medical officer on a certificate should be able to act for the guardians in that case, on that question of discharge. If that were so, the man could be discharged at any time within the 28 days by the medical officer.

3372. *Chairman*: When you say you recommend 28 days, it is 28 days as a maximum period of detention, without prejudice to the possibility of the patient being discharged at any time during the currency of that detention order, provided he has recovered and the fact of his recovery is duly certified by the medical officer?—That is our point.

3373. Of course it would never do to detain a person on a 28 days order who, on the third day of his detention, had become perfectly well again?—That is why we suggest that, as the guardians meet only once a month, it is impossible for the guardians to discharge in that case. That is why the medical officer should be able to act in place of the guardians.

3374. I was just going to suggest that that might be met in this way, that in the event of a case subject to a 28 days order recovering during the currency of the period, the medical man might at once give a certificate that the patient ought to be discharged, should present that at once to the justice who had given the order, and the justice then, taking into account the medical certificate, would at once discharge the patient. It would be a 28 days order with liberty to apply, so to speak, as we say in the Courts, during the currency of the order?—Yes; the justice should take some responsibility with the medical officer.

3375. The justice is the proper person to release him from that order, if he is satisfied from the medical certificate that the cause for detention has ceased?—Yes. (*Mr. Senior*): Is not this somewhat unnecessary? When it is a matter of releasing him, who knows better than the medical officer who has been in touch with him daily? There is a difference between an ordinary patient in a Poor Law infirmary and a patient in an asylum. The magistrate would

not come up and see; it is only a matter of form; is it not an unnecessary matter of form? That is the view we take of it.

3376. I am not sure that it is not desirable that it should be brought to the notice of the justice that the person, with regard to whom he has been advised that a further period of detention is desirable, ought now to be released because of his recovery. It rather appears to me to complete the procedure. A justice is always available, I take it?—Not always. Supposing a justice went away for a fortnight, you would keep the man in during that time. My Association do not see the need for it. We think that the doctor's opinion, by reason of his being in touch with the case every day, ought to be enough.

Earl Russell: Of course, in a public asylum the concurrence of two Visitors is a formality, almost invariably, but still it does introduce a public authority.

3377. *Lord Eustace Percy*: May I ask if it would suit the witness if the procedure was similar to that in the case of an asylum? If the order could be signed by two guardians instead of by the Board of Guardians, would not that meet the case?—(*Mr. Usher*): I do not know that that would meet it; we should have to send for the guardians; they may be on rota, as they term it. If we wished to have them we should have to send for them.

3378. *Chairman*: Do you think the medical practitioner would wish to take the responsibility of discharge? He might feel that it was a case that he should bring before the justice?—We cannot speak for the medical faculty, but personally I am quite sure that our medical officer would take the responsibility. He would know very well if there was any doubt as to the man's surroundings.

3379. You have brought your suggestion before us, and we shall note it and consider it, with the arguments you have put before us. Now, *Mr. Senior*, are there any points of procedure to which you wish to direct our attention?—(*Mr. Senior*): With regard to the three days order, we feel that it should be clearly stated that the date upon which the order is made should not count as one of the three legal days. A man may come in at 11 o'clock at night. If that is to be counted a day it makes the period of observation rather short.

3380. What you would suggest is something like this: "Three days to run from midnight on the day of his reception"?—Yes, that is right.

3381. You merely want the compartment of time more precisely defined?—Yes.

3382. Have you any other suggestions?—With regard to Section 24, relating to people under permanent detention orders, we feel it would be for the protection of the patient—we do not wish to say that men are kept in an institution unnecessarily—we feel it would be better if there were some method of revision similar to that under the Mental Deficiency Act.

3383. What provision have you for visitation of the mental cases permanently resident in your institution?—The medical officer has to submit a statement every quarter, and the Visitors sign the book. The medical officer would naturally suggest the discharge of a man if he thought it necessary.

3384. Are the guardians required to visit?—They visit really on their rota; there is no necessity for them to visit—not to discharge, or anything of that kind.

3385. How often do the guardians visit?—They are round the place continually. They are supposed to visit every week. They have a rota on our Board.

3386. Do the guardians see the actual inmates themselves?—Yes, they go round; that is their chief duty, and they pay attention to that, but they are not able to decide, without the medical officer there, whether a man should be discharged.

3387. But they would be open to receive any complaints on the part of the patients?—Yes, they listen to any complaints, and talk to the patients—visit them, and so on.

5 November, 1924.]

MR. HAROLD SENIOR and MR. GEORGE USHER.

[Continued.]

3388. Do the guardians ever draw the attention of your medical officer to the case of any particular patient?—Do you mean for discharge?

3389. Yes.—Never; they never have done so in Southampton.

3390. But they would deal with any other complaints?—Yes, they would deal with them, if it were a question of diet, and so on. I am afraid it is looked upon by the guardians, if a man asks for his discharge, as being part of his delusion, very often. There are men in the institution who are detained, and every day they say, "I want to go out." I do not think it is necessary always to draw the doctor's attention to that fact, because it is part of their delusion, really.

3391. That, of course, is one of the difficulties?—That is one of the difficulties.

3392. Now, on this question of a periodical revision of a case, to whom do you consider that that function should be delegated?—Really, to a rota of justices.

3393. Not the guardians?—No, not the guardians. There should be some outside authority brought in in conjunction with the medical officer. It has been suggested that some of these cases should even be seen by another medical man, as under the Mental Deficiency Act.

3394. *Lord Eustace Percy*: Do you couple with this recommendation any idea that the medical certificate under which a patient is detained at a Poor Law institution should be communicated to the Board of Control, or to some authority, as in the case of an asylum?—That is not part of our suggestion.

3395. At the present moment it is communicated to no one?—To no one at all.

3396. *Chairman*: So that the Board of Control is not apprised of the detention of this particular case?—No. The Commissioner of the Board of Control, when he visits the institution, asks to see the order relating to a particular case, if he wishes; in fact, he sees the whole lot as a rule, just runs through them to see that they are in order.

3397. Does the Board of Control visit your institution?—Yes.

3398. How often?—Not less than once a year.

3399. You see, one must safeguard institutions against spending most of their time in receiving deputations. One has to consider that point of view. At present you have the medical officer, who is constantly there taking charge of the cases?—Yes.

3400. Then you have the guardians, in the course of their ordinary duty, coming to the institution and moving about among the inmates. Then you have the Board of Control's representative at least once a year coming to your institution. Is it your suggestion that there should be yet a further body taking cognisance of the cases?—As the magistrate makes the order, it would appear that he should have some interest in discharging the man.

3401. *Earl Russell*: I should have thought that the guardians, who are there constantly, and know the patients by sight, would have been the natural people to review the cases?—Of course, that is a matter for the Commission; but there is the point that the magistrate makes the order, and it would appear that he would be interested to know what had become of the case.

3402. *Lord Eustace Percy*: Has the guardian on the rota any right to see the certificate?—They have the right, but they rarely bother about that kind of thing. (*Mr. Usher*): It seems to us a terrible thing for a man to be on a permanent detention order, a man incarcerated in a lunatic ward for ever and ever, and we think it is a very desirable thing that he should come systematically before the authorities. I am quite certain that in many institutions guardians do visit periodically, but in many institutions they do not, and the point is to get these people brought before some authority so that it is ascertained whether or not they are fit for discharge.

3403. *Chairman*: Then you do not regard the medical officer's quarterly report upon the case as

a sufficient safeguard?—I should say in large institutions it would be quite all right; I am not here to criticise medical officers. The point is that it should be fixed that periodically these people are examined with a view to their release, if possible.

3404. *Earl Russell*: These people do not get a periodical report to the Board of Control, do they?—The medical officer sends a quarterly list.

Earl Russell: Not a report like the one year and two year cases?

3405. *Chairman*: I think not. (*To the witness*): Then your real contention is that a case which is being permanently detained in a Poor Law institution under a justice's order should, over and above the quarterly reports by the medical officer, be brought up for revision periodically by some quasi judicial authority?—Yes.

3406. Either the justices or possibly the guardians, or at any rate some authority?—Yes, as is done with the mental defectives now.

3407. You wish a reconsideration or revision of the case at stated intervals by some person in conjunction with the medical officer?—That is right.

3408. So that the medical officer might confer with some independent body of that sort at periodical intervals?—If an appointment could be made with the medical officer and the magistrate, that would meet the case.

3409. *Sir David Drummond*: You referred to the Mental Deficiency Act. A medical man accompanies the magistrate in that case?—Yes.

3410. He is there—the medical visitor, you know. Do you suggest that the medical man and an independent medical man should accompany the magistrate?—No, because the cases are very different. Many of your mental defectives are simply moral cases, moral defectives, young girls and boys. They are very much more important than these imbeciles, and the probabilities of improvement and the like are quite different. I do not suggest that an independent doctor is necessary, but I think that a magistrate and the medical officer of the institution should examine the case together; it brings the case to their notice, so that these people are not left without some effort on their behalf.

3411. *Chairman*: It would ensure that such a patient had at stated intervals an opportunity of expressing, so far as he was able, his wishes and his complaints, if he had any, to an authority?—Yes.

3412. It would necessarily bring him into contact with authority?—Yes.

3413. *Lord Eustace Percy*: Is there in your view any difference between the Poor Law institutions and the public asylum such as makes it desirable to have a different kind of visiting authority? You are suggesting something which is neither the guardians nor the visiting committee of the public mental institutions?—It may be an improvement on either.

3414. Why do not you suggest that the mental ward of a Poor Law institution should be visited by the visiting committee of the asylum?—Of the guardians, do you mean?

3415. Yes?—It would be very bad taste on our part, the servants of the guardians, to criticise the way in which they carry out their duties.

3416. I mean the short answer is that you do not think the visiting committee of the asylum is a satisfactory body in all respects?—I do not say so. I am not dealing with asylum cases at all, but with Poor Law cases, and I say that in very large institutions the thing is quite all right, but in some institutions the visitation is not probably what it should be.

3417. The visitation of a Poor Law institution?—Yes; in many institutions the guardians do not systematically visit the people.

3418. That is hardly my point. My point is this: You have in a county a visiting committee which is visiting the public asylum?—Yes.

3419. If you wished to have a review of cases in the Poor Law institution, why do not you suggest that that visiting committee's functions should be

5 November, 1924.]

MR. HAROLD SENIOR and MR. GEORGE USHER.

[Continued.]

extended to visiting the Poor Law institution as well as the asylum?—I do not think that is desirable.

3420. *Chairman*: Why not?—I do not think the guardians would care for it. The guardians may say, "If they come to visit our cases, why do not we go and visit theirs?" It may create some feeling unnecessarily. I do not think it is of that importance, because we are not suggesting that 50 per cent. of these people under Section 24 are going to be released, or something of that kind, but it is in order to give them a feeling that somebody outside is looking after them.

3421. *Earl Russell*: It is rather your point that it should be somebody who is not a guardian?—Our feeling is that it should be a justice of the peace. I certainly would not bring the asylum people into it. A justice of the peace and the medical officer of the institution.

3422. *Chairman*: We have your suggestion, Mr. Usher. Now, Mr. Senior, I think you wish to say something about the case of children?—(*Mr. Senior*): Yes. We receive into our Poor Law institutions quite a number of children; I mean the type of children who are not mentally deficient, but beyond that stage—the idiot class—and they as a rule have to be kept in the same wards as adult patients. We do not consider that that is a good thing.

3423. Are these cases not dealt with under the Mental Deficiency Act?—They are cases that are beyond the stage of that Act. I have a child in the institution now, a little boy of six; we have been trying to get him away for quite a long time; we have tried three separate institutions; they will not take him; we have to keep him at our institution. Of course, he is growing older, and we find that he picks up the habits of the adults. He has enough sense to do things that are probably bad. The children pick up the degrading habits of the older people, and we find that does no good. But to get that child into another institution appears to be almost impossible, and we feel that there should be some special institution set on one side, or a part of some other institution set on one side for the reception of this class of children, and they should be kept separate, not with the adult patients.

3424. *Miss Madeleine Symons*: I suppose the same difficulty arises in your observation wards; I mean presumably you have to admit children or young persons into this single observation ward?—No, we do not. With regard to children I have another ward where they are put. We do not put them with the violent cases that are received in the ordinary way; we try to deal with the children a little bit differently from the adults.

3425. Would that be true of most of the Poor Law institutions?—I should think not, because they have not the accommodation.

3426. You mean there may be cases where they do have to admit them to a general observation ward? Yes, many cases.

3427. *Chairman*: As we know, the Mental Deficiency Act has not been put fully into operation yet in this country?—That is so.

3428. If it were, would not such a child readily find a place within one of those institutions, It seems to me to fall into that category?—Yes. The guardians at Southampton and other guardians have great difficulty in getting such a child into an institution.

3429. Probably because there is not yet complete equipment?—Yes. We ask that some arrangements should be made. This is not a new thing. We have had to send cases to an asylum, and we feel that is not the proper place for them.

3430. That was really the justification for the passing of the Mental Deficiency Act, to provide institutions for such cases, but they have not yet been brought into being through the country, and probably that is the reason why you are experiencing this difficulty.

3431. *Lord Eustace Percy*: Is not the point of the witness that these cases are not suitable for the

mental deficiency colonies that do exist?—That is so; they are too far advanced; they are unimprovable cases.

3432. *Chairman*: I have great difficulty in seeing how they could refuse to receive them as not falling under the category of mentally deficient. Under the Act of 1913 the first class of defective is: "Idiots; that is to say, persons so deeply defective in mind from birth or from an early age as to be unable to guard themselves against common physical dangers."—That is so, but nevertheless the difficulty is still there, that we cannot get this class of case away.

3433. *Sir David Drummond*: Does that apply also to Mr. Usher?—(*Mr. Usher*): No. I think we have to take this view of it. There is limited accommodation for mental defectives, and this grade is naturally the last they will take. You have to bear in mind that the cost of treating these cases must necessarily be higher than the cost of treating other grades of cases, and probably it might be a question for the Government to consider the advisability of giving a bigger grant, or doing something to urge upon mental deficiency committees to cater for these cases.

3434. *Chairman*: Yes, we see your difficulty, but it is a difficulty which at any rate the Act of 1913 was intended to meet. Whether it has yet succeeded in meeting it is another matter.—It is 11 years, and still there are a lot of cases in Poor Law institutions.

3435. Eleven years during which development has necessarily been paralysed by even more vital matters?—Yes.

3436. Now you also advocate, do you not, the desirability of notifying the relatives where any case is to be dealt with by the justice?—(*Mr. Senior*): Yes, just from the point of view of protection, or to give them an opportunity of objecting to the order, or they may have something to say upon the matter.

3437. Assisting in the matter?—Yes.

3438. Then you regard Section 81 of the Act, the discharging Section, as requiring some amendment, I think?—Yes, from the point of view I have already mentioned, that it states that the guardians only can discharge these people from the institution; and, having in view the fact that the guardians only visit once a month, it seems rather a long time to keep a patient under control unnecessarily.

3439. Does this relate to persons who are only temporarily with you, or does it relate to persons who are permanently with you?—Section 24, permanent cases. An opinion has recently been given on that. The Board of Control gave an opinion in July of this year, and this is their last paragraph: "Until the actual moment of discharge a person, whether detained under Section 21 or Section 24, is detained as a lunatic, and the power of discharge is apparently in each instance with the guardians." Those are cases under Section 21.

3440. Now you have suggested as regards those cases that are not being permanently detained that the medical men might discharge?—Yes.

3441. And it has been suggested that possibly in addition it might be necessary for a justice of the peace to intervene, but we will leave that aside. With regard to the permanent cases, do you think that there is the same urgency for discharge, because one would assume that, the case being a case of permanent detention, the exact moment of recovery might be less easily ascertained; it might be a case gradually improving?—(*Mr. Usher*): The difficulty is that all over the country the procedure is different. In some very important institutions the patient, under Section 24, is discharged by the master on the recommendation of the medical officer, and in other institutions the cases have to come before the guardians. It seems to us that to hold a case up is very hard. A man may be put on a 14 days order, and because he is not cured at the end of 14 days, and the doctor has not decided what shall be done with him, he may put him on an order under Section 24. Perhaps in a week he makes up his mind that the

5 November, 1924.]

MR. HAROLD SENIOR and MR. GEORGE USHER.

[Continued.]

man is fit for discharge. It is very hard lines if the man has to be detained for another week, until the guardians meet.

3442. *Earl Russell*: Do they not sometimes act by a committee, who could act in the meantime?—The Act says, "The guardians." We think that the medical officer, who is in touch with the case daily, is quite qualified to judge as to when a case should be discharged.

3443. *Chairman*: Of course, another view might be this, that as the patient finds his way into the institution upon an order of the justice, coupled with the doctor's certificate, so also he might make his exit from the institution on the medical certificate, coupled with an order from the justice?—There is some little difference, because a justice does not in practice see a case that is certified under Section 24, but he does under Section 20 or Section 21. An independent medical man signs the order.

3444. *Earl Russell*: Would "any two of the guardians" meet your point?—We think that the medical officer would meet the point in such a case. (*Mr. Senior*): It would appear that if the medical officer recommended the discharge of a man to the guardians, they would naturally discharge the man.

3445. *Chairman*: Naturally they would act upon the skilled advice they received, but the Legislature seems to have contemplated that it was desirable that this matter of discharge should not repose merely in the hands of the medical officer, but should also, formally at least, be in the hands of some lay authority?—(*Mr. Usher*): Perhaps you will be good enough to consider this point, and bear in mind that we feel very strongly that the medical officer's signature should be enough to effect the man's discharge.

3446. We take it from you that you are anxious to facilitate the means of discharge, and we must consider by what means that can be achieved, if the existing system is not satisfactory. You have expressed your views to us on that?—Yes.

3447. Then you allude to a difficult topic in your *précis*—the case of attempted suicides. What have you to say about that?—(*Mr. Senior*): I am giving my own opinion, because there has not been an opinion expressed by the Association. I take it that there are many different causes of attempted suicide. It may be a case of domestic or business trouble; it may be a case of a mental disorder. Would not an examination by a real mental expert be the best thing to get over the difficulty? The mental expert to be called in, if a man is to be brought to a Poor Law institution, in each case; the man to be examined, and the man should either be detained or discharged as the result of that examination.

3448. Do you think it requires an expert?—I do. (*Mr. Usher*): My point is that we do not know where we are. Some cases are brought in under an order, and some are not; that is the difficulty.

3449. *Earl Russell*: Do you mean: "Here is a suicide: do what you like with him"?—Yes. These people demand to go out, and we have no power to detain them. (*Mr. Senior*): May I cite a case? I have in mind a case that occurred about two years ago. A man came to the institution, having attempted to commit suicide. After about seven days the man was apparently quite rational, and the doctor discharged him. Within an hour and a half that man committed suicide by going on to the railway and a train passing over him. The police do not take action in many of these cases.

3450. *Sir David Drummond*: They do in other parts, you know?—Not to-day, Sir David. I mean if a man is brought to the Poor Law institution because he has attempted to commit suicide, we are informed if the police are going to take action, and we should not discharge under those conditions except to the police.

3451. *Chairman*: Is he brought to the mental department?—All those cases are sent down to our department. We have a separate infirmary four miles away from the main institution. (*Mr. Usher*): In our case, if a cut-throat comes in—we get quite

a number of them—they are put in the general ward, because they want skilled nursing, and a lunatic attendant may not be a skilled nurse.

3452. The question seems to be whether you are automatically to treat a case of attempted suicide brought to you as a case of insanity, and bring it under that code, or whether you are to treat it as a surgical or medical case in the ordinary ward of your infirmary, if you have one. It is very difficult to say. Is the medical officer of your institution not then in a position to classify the case, and say, "This is a case for the mental side," or, "This case will be all right in the general ward"?—(*Mr. Senior*): In a case of attempted suicide there has been some cause for the attempted suicide, and my experience is that they are difficult to read—difficult to get at the cause. If a man is determined to commit suicide he has sufficient sense to keep that to himself. He will hide that fact to get away from the institution to commit suicide, and that is why I think some expert should be brought in to examine such a man most carefully.

3453. Would it not meet the case if all attempted suicides brought to you were dealt with under the Lunacy Act by this period of observation which you propose of 28 days?—It would be an improvement upon the present system, because there is no system at the present time.

3454. Detention for 28 days of an attempted suicide case would enable observation to be made of the case, and deliberate consideration of whether it is a case of insanity or not?—Yes, probably the ordinary medical practitioner could find out in that time. (*Mr. Usher*): I do not think there are any experts in suicidal cases. I rather think, in practice, it would not work out well to wait for experts. You generally find the coroners say that, if they happen to die, they were insane, and they were in the same frame of mind if they happened to recover as when they committed the act. But all we are concerned about is that it should be uniform; they should be treated as lunatics. If these people want to go out when they are so far recovered, and they are not under order, the master has no power to keep them in.

3455. If we see fit to recommend a provisional period of detention of 28 days without certification, then it is not necessary for you to make up your mind whether or not the case is one of insanity, but the case might be detained for that period, with liberty to apply, in the mental department. That would meet your difficulty, would it not?—No, I do not think this Commission should recommend that they should be put in any department. I think that it should be left to the medical officer to deal with the case on its merits, because some lives might be lost if they were left in the mental ward, whereas if they were put into the general ward they might be saved. It is a matter of touch and go all the time.

3456. You want, first of all, to be directed as to which category these cases are to go into?—Yes, for our own safety.

3457. Do you suggest that all attempted suicide cases should be classified as mental cases?—Yes: you might have a special order for them—something intermediate between a lunacy order and an ordinary order. We do not want to brand them as lunatics, but at the same time we do not want to run the risk of litigation.

3458. I think you have already given us your views as to the training of staff. You recommend that we should delete the word "workhouse" where it occurs, and substitute "Poor Law institution"?—Yes, and may we add to that the word "pauper"—a very distasteful word. To my mind "rate-aided" is almost as bad as the word "pauper." If we steer clear of anything in that line it would be an advantage. Either an "assisted" or a "district case" I think would be very preferable, but "pauper" is certainly objectionable.

3459. Then you also have a suggestion that cases of senile dementia should be dealt with by a special certificate?—Yes, that is very desirable, because you never think of putting an old "granny" under a

5 November, 1924.]

MR. HAROLD SENIOR and MR. GEORGE USHER.

[Continued.]

lunacy order. We have nothing now but a lunacy order under Section 24. They are not responsible for their actions; they are in their dotage, and some of them demand to take their discharge, and if they demand to take their discharge we have no power to keep them. That may be very risky indeed; they may go out and something may happen to them because they are not responsible for their actions. There ought to be something less drastic than a lunacy order, so that the medical officer can detain them until he is satisfied that their friends can look after them.

3460. You see, we must take care not to introduce fresh complications in an endeavour to simplify matters, and if you are going to have different grades of orders we may get into difficulties of classification which may embarrass you very much?—We have this actual difficulty.

3461. How do you deal with it in practice?—We have to take risks, and after what has happened we want to obviate that.

3462. Do you mean you let people out?—Here is an old man in his dotage, and he has demanded to take his discharge. The doctor feels he is not really capable of taking care of himself. It is hard lines to put a man like that on a lunacy order, but if we had some other means of detaining him without making a lunatic of him it would be very preferable. We have the fullest sympathy with these old people, and it seems very cruel to make lunatics of them when it is simply senile dementia that they are suffering from. (Mr. Senior): I think we all have that difficulty. I have a case of an old lady of 96. We had an infirm ward in our main institution; we closed it, and sent the people to the infirmary. This old lady did not wish to go; in fact she said, "I will take my discharge." She was not fit to take her discharge, and I had no alternative but to put her into the mental ward, and she is there to-day.

3463. She is not certified?—No. That is rather a difficulty. She does not now wish to go out, because she is down at her old home.

3464. Miss Madeleine Symons: I wonder whether, following on what you have said about the old people, you experience the same difficulty with temporary cases. We heard yesterday that there were some cases, possibly sent from the hospitals, where temporary mental difficulty was due really to physical disease—sometimes cases of pneumonia. Do you find it so difficult that in those cases you sometimes have to certify them in order to keep them?—Yes. I really had a note to mention such cases, but I felt diffident about doing it. There are such cases as you mention; people suffering from physical illness which temporarily creates mental trouble. We are compelled to put them under a lunacy order for a short time, and it would be well if that could be obviated. After all, if a person has been under a short order under the Lunacy Act it has rather a bad effect on him later in life. People know about this thing, and they object to dealing with a man who has been a lunatic. It would be good if some other order could be made to keep a man for a certain time without being under the Lunacy Acts. Quite recently a man came to my place; he had been a soldier in the late war; he said: "I am feeling funny in my head, and I want to be taken care of." I took him in, put him in the mental observation ward without an order, and within a week the man was discharged, quite better. He had had some slight neurasthenic condition in the Army, and he had had some slight mental disorder, and this was a recurrence of it, but he soon recovered in seven days. It would be rather a pity to put such a man under the Lunacy Act if you could avoid it. We try to avoid it by keeping a man under observation without any power to detain.

3465. Then on this question of training, I wonder whether you could give us any idea of the proportion of attendants in the Poor Law institutions in your Association who are trained?—I am afraid I could not give you any figures, except with regard to my own case. Practically in all cases the chief attendant would be a trained, qualified man, but the

assistant attendant, as a rule, has no qualification whatever. Out of 11 men, I have four who are really qualified attendants; the rest have merely got their experience in our own place. After a man has been there two or three years he is equal to the occasion, to meet the situation as far as the Poor Law institution is concerned.

3466. Can they take the mental nursing certificate after they have had a certain experience in your institution?—No, there is no arrangement of that kind. We wish that something of the kind could occur, that a man after a probationary period could undergo some examination, or go for further training in a fully equipped mental hospital, get a certificate, and then return to a Poor Law institution. I think the patients would be better looked after by the trained people.

3467. Earl Russell: Mr. Usher gave us some figures of the percentage of the patients who recovered in the 17 days, and who were able to be discharged without proceeding for an order. Could you give us similar ones for your institution?—(Mr. Senior): Yes. Last year, up to the year ending 30th September, we received into the institution local people, 277 patients. These are people discharged within, say, three days. Shall I go through the figures?

3468. Chairman: Could you make a table* for us and hand it in?—With pleasure.

3469. We will use it as an appendix to your evidence?—Yes. The figures relate entirely to Southampton, of course.

3470. If you would tabulate them for us we should be very glad?—I have a note with regard to the aliens admitted under the deportation law. They were 29 during the year. Only two of those went to the asylum, and the rest were taken away by the shipping companies—taken to their own country.

3471. Earl Russell: I want you to elaborate a little what you say in your *précis* about the importance of the next-of-kin or other known relative being given an opportunity of appearing before the justice. You take a strong view, do you not, that they should always have that opportunity?—Yes.

3472. We had evidence from one justice, who said that he practically never saw the next-of-kin, and did not inquire if there were any, and the medical officer did not tell him. Therefore they had no opportunity to protest. You do not think that is desirable?—I think they should have an opportunity in every case.

3473. Then we had evidence from Dr. Baly, who said that the next-of-kin should be apprised, and when their presence could be obtained it should be obtained, but they were not generally present when the justice was present. Do you think it preferable that they should see the justice and have an opportunity of saying what they want to say?—I do. The usual practice is that we say the patient has been transferred to the mental hospital.

3474. That is after they are certified?—Yes.

3475. I understood you to mean that you thought it desirable that they should be present at the justice's inquiry?—That is the point we make, but I was just quoting the present procedure.

3476. Sir Thomas Hutchison: In answer to the Chairman you told us about the male attendants. What about your female attendants?—The same thing applies. Of our female attendants there are seven of them who have had previous experience.

3477. Trained nurses?—They are trained in that particular work; the other four are local people who have just had their experience in our own institution.

3478. Probably wanting to go on in the nursing service afterwards?—Yes, if they can get patients.

3479. Mr. Snell: I would like to ask Mr. Usher, is the National Association of Masters and Matrons of Poor Law Institutions representative of the whole of the masters and matrons, and can it speak with authority?—(Mr. Usher): Yes.

* See Appendix XII.

5 November, 1924.]

MR. HAROLD SENIOR and MR. GEORGE USHER.

[Continued.]

3480. *Chairman*: You represent 600 institutions, and 96 per cent. of the masters and matrons?—Yes, and may I say that every member of the Association has been written to on the subject and had an opportunity of expressing his views, and after these views had been got together an executive meeting discussed them, and this *précis* is the result.

3481. *Mr. Snell*: Thank you. In your evidence you suggested that what you call small country houses were not suitable for the reception and treatment of mental patients. Have the nurses or attendants in these small country houses had any special training in mental cases?—There are no attendants in some country houses. In some of them there is simply one man—the master of the institution—and in most of them there are only two—the master and the porter. They have their ordinary duties to do during the day, and a case of acute mania or delirium tremens may be taken in, and may be three or four days, very violent, and want attention. Another very strong point there is this: I have seen brought into our institution a man suffering from delirium tremens, and he was dealt with by three big, powerful men. They handled him roughly, but they had no alternative; they did not know how to handle him. As soon as they handed him over to our attendant, who did not weigh more than 10 stone, he could handle the man himself, because he was a trained and skilled man.

3482. So that except for the supervision of the doctor these patients are without any skilled treatment?—That is so.

3483. Is it your belief that if trained attendants and nurses were available it would be an assistance to the recovery of the patient?—Yes.

3484. You suggested, I think, that in order to avoid the stigma of the asylum and to give the right cases the best chance, there should be intermediate places, homes of rest, or some other name, which would be used, I suppose, for patients who might respond to treatment—not necessarily permanent cases?—Yes; I think I said cases sent from the asylum under Section 25; cases that are now in the asylum and quite harmless would be just as well in an institution of this kind, and probably better than in an asylum.

3485. *Earl Russell*: You want a nucleus of chronics?—Yes.

3486. *Mr. Snell*: I think Mr. Senior suggested that all those who are detained should come periodically before a proper authority with a view to release if their condition justified it, and that the certificate of the medical officer immediately concerned would be sufficient. I would like to ask whether in his judgment it is not desirable that there should also be an independent doctor associated with this revision? Is there not a danger, for example, when once a doctor has made up his mind that a case is permanent, he might fail to bring to that case an open mind?—(*Mr. Senior*): I do not think so. I think the institution medical officer is in close touch with the cases. He is not anxious to detain the cases any longer than necessary, and probably has in mind the question of accommodation; but, apart from that, I believe he would take a fair view of the thing, and would not keep a man a day longer than is necessary.

3487. You think there is no danger of a medical officer taking the case of a permanency for granted?—No, I am quite sure of that.

3488. *Mrs. Mathew*: What are the duties of the probationer nurses?—They take the duties of an ordinary assistant attendant. First of all their duties would be in the nursing of the ordinary patients in the institution; they have been trained in little dressings, the general comfort of the patient—proper feeding and so on.

3489. They are not straightway put on cases that are under observation; they are not left in charge of mental cases?—No, never.

3490. How much are the probationers paid?—Our scale commences at £2 15s., rising to £3 3s. per week.

3491. How much are the women probationers paid?—They commence at £40 per annum, and rise quickly to £50, with uniform and everything found. In using the term probationers you mean the people who are not qualified in any way. We do not term them as probationers in the mental ward; they are merely people without experience. In an institution of our kind there is no question of training for a certain period.

3492. What I really wanted to know was whether the probationers are expected to take charge of the wards where the mental cases are, either by night or by day?—In my own case a man or a woman would not be expected to take charge of any ward under, say, six or nine months' experience.

3493. About how old are the women when they come to you to learn?—It is rather a difficult question to answer; they are all between 30 and 40, except the chief attendant, who is rather older there. May I say again they are not probationers; they are assistant attendants, and they are women of about 30 years of age; we do not take them under 25.

3494. Then I wanted to know about their diet. Are they fed like the inmates, or are they fed on a slightly better diet?—A better scale of diet.

3495. Have you calculated the cost per head of that diet?—Yes; to-day it is about 13s. 6d. per head. You are speaking now of the attendant?

3496. Yes?—Yes, I am correct then. The cost of provision for feeding an officer or an assistant attendant, or an attendant of any kind, is about 13s. 6d. per week.

3497. As against 4s. 6d. for the inmate?—Yes, that is the cost.

3498. Do you think for the wages that are paid you would be likely to get skilled or trained attendants, or would you suggest a higher scale of salary?—I think that the scale we pay is rather a low one, but, fortunately, we do get good attendants for our money; we have a very good lot to-day in spite of the fact that the pay is low. My own opinion is that a person with any training at all ought not to commence on such work as this under £50 a year and have everything found.

3499. At what age would you suggest?—About 25. We do not think they are physically fit very often to deal with the situation and their nerve is not equal to it, before that age.

3500. Have you got such a thing as a voluntary service? I mean are the nurses expected to give voluntary service on, say, the seventh day of the week?—No.

3501. Never?—Never. If they do any extra work by taking the case to the mental hospital they are paid extra for it.

3502. Under what order do the attempted suicide cases come into the workhouse?—Very often under no order at all. They are brought in by the police very often; sometimes under a three days' order, but sometimes they are brought to us as being a place of safety for observation, and they bring them under no order, but as a rule they are placed under an order by the medical officer.

3503. *Sir Humphry Rolleston*: When speaking of your own establishment at Southampton you said there were no facilities for treatment. Supposing, as must not uncommonly happen, particularly when an acute case comes in, the patient absolutely refuses food. He must either be forcibly fed or left to drift, or sent to another establishment. I presume that in an emergency like that he would be forcibly fed?—No, they are always sent to another establishment.

3504. I should like to return for a moment to a subject we have discussed a good deal, and that is your recommendation of altering the period of the order from 14 to 28 days. I want to ask you whether there are not some disadvantages as well as the advantages you have shown, in making that change. If you make it 28 days there must be a tendency to a more leisurely procedure, and a more leisurely procedure would entail the disadvantage of further overcrowding of Poor Law institutions. It prolongs the possible period for which a patient is retained

5 November, 1924.]

MR. HAROLD SENIOR and MR. GEORGE USHER.

[Continued.]

in the infirmary, and it is a matter of expense, of course. What I should like to put to you is that one of two alterations should be made to meet your wishes; either that it should be 14 days which can be prolonged if it is absolutely necessary to 28 days, or that there should be some other machinery of prolonging the time after the 14 days have elapsed?—My experience is that the procedure is taken in proper course. I do not feel in recommending this that there is any danger of a person being detained any longer than is necessary by extending the period up to 28 days. For instance, with regard to the question of a man going to a mental hospital, if within five days the doctor said he would have to go, he would go. He would not keep him in the institution for any longer period.

3505. I think you explained that before. But would it not be better to have 14 days, and then to have a power of prolonging that 14 days for another 14 days?—That would meet the situation of course quite well; that is, to preserve the present 14 days and then to have the option of a further 14 days. I think that would meet our recommendation quite well.

3506. Just one other point. Would it not be better if all suicide cases were, so to speak, under the legal authorities unless and until they were referred to the mental division? I mean there are a good many cases of suicide in which there is no real reason to think that the patient is insane?—That is the difficulty.

3507. Should they not be under the control and care of the police until they are referred to the medical officer as possible cases of lunacy?—If I may ask a question, where would they be controlled?

3508. The police would sit by the man's bed?—Where there are trained attendants I do not think that is necessary.

3509. You have got trained attendants?—Certainly. That is one reason why we suggest this centralisation of areas. (*Mr. Usher*): That is for a large institution. We must differentiate between a large place and a small institution. We have said in our *précis* that, until some arrangement can be made to make provision for these people who now come to small institutions, it should be an obligation on the police to render assistance. You can quite see the danger of a lunatic being planted in a place with no able-bodied man to look after him. I have heard of a master having to get a tramp out of the tramp ward to assist him to look after a lunatic. Well, it is a disgraceful state of affairs.

3510. If they were under the legal authorities that would be met?—Yes. (*Mr. Senior*): Of course our point is that a violent case is often lumped on to a small institution and the police leave at once and leave the master, a young or old man, and one or two women about the place. It is not fair to the place or to the officers. That is our point for centralisation.

3511. *Sir David Drummond*: I think you scarcely understood the drift of Miss Symons' question with reference to the certification of people who are delirious. Miss Symons instanced pneumonia, and you said you certify it. Do you really mean that you certify a patient suffering from pneumonia?—We have cases from outside the institution on a three days' order, and it has been found later that they have been suffering from pneumonia, and that pneumonia was the cause of their mental condition. They are at once sent to the hospital then.

3512. If you recognised that pneumonia was the cause of the man's mental condition you would not certify him?—No, certainly not.

3513. Or in the case of chronic heart or kidney disease you would not certify because the man had delirium?—No; our hospital is four miles away. They send a man down to us suffering from mental trouble. It is very often a case of a difference in the medical opinion. We have to deal with the situation as it is.

3514. If you recognised the cause as physical you would not certify that man?—No, and we should get the patient back to the hospital as quickly as possible.

3515. Do you seriously suggest that the opinion of an expert would be of much service to you in deciding whether a man who had attempted suicide would in future recur to it?—Well, Sir, my colleague says no. I have got my own opinion. Some time ago a woman was sent from India, was landed in our mental ward; the friends came along and said they had had trouble with her before, and it was certainly a mental case. Our own medical man could not come to any decision. He called in a doctor in the town who is a retired medical superintendent of our mental hospital, and certainly an expert, and he examined the patient and was with her for three hours and came to the definite conclusion that she was not a mental case. That woman might have been sent to the mental hospital. The woman was erratic in her manner of speaking and behaviour, but the mental expert said she was not a mental case. She was taken away by her friends, and I have heard nothing of the case since.

3516. Was she an attempted suicide case?—No, but in a case of attempted suicide it appears to me it is most difficult to come to any conclusion as to the mental condition of the patient.

3517. *Sir Ernest Hiley*: Do you think it is quite a feasible suggestion to say that one of these homes of rest, or places of observation, should be established in each union?—Not in each union; we do not say that.

3518. Have you thought out a combination of unions?—It is rather difficult to explain an area, but I had in mind, for instance, the Sussex district where there are four Poor Law unions and none of them is equipped to receive mental cases. It would appear that one of those institutions could quite easily be set on one side for the reception of the patients from the whole of that area, which is quite a small area having in mind the transport facilities of to-day.

3519. And you think the relatives would have a proper opportunity in a case of that sort of keeping in touch with the patients?—If you put one institution in the centre of the district it would not be more than 10 or 12 miles away. That is the kind of area we suggest. (*Mr. Usher*): I am afraid in the main there would have to be larger areas than this. I have in mind Hull which would take in four or five unions round there, a matter of 40 miles. I quite appreciate the fact that it is rather a long way for friends to go, but it is better than things are arranged at the present time. I mean it is so absolutely necessary to alter the state of things that obtains to-day; if the friends have to submit to some little inconvenience it is worth it.

3520. You think there would not be any inconvenience in rural places like Devonshire or, we will say, in Settle in Westmorland?—Yes, I think there would. I have been labouring the point of small workhouses, and I had in mind Devonshire and Cornwall; I have been round there this year. May I give you one case? There was a Master in a workhouse. I said, "Where do you put your temporary lunatics?" He replied, "I will show you," and he showed me a small room. I asked, "Where do you put your women?" He said, "Here. Supposing we had a man here under a 14 days' order and a woman brought in under a 14 days' order, we should have to decide which was the worse of the two before putting them in the room." You will see the reason for labouring this point when I tell you how very difficult it is. (*Mr. Senior*): We do not suggest it is easy to combine the areas, but there is the necessity for something being done, and I think that the patient should be thought of rather than the friends; they will have to take the inconveniences with it; there are means of transport to-day which there were not ten years ago.

3521. Really the County asylum is probably more convenient and more available than any other institution?—That may be so in many cases. (*Mr. Usher*):

5 November, 1924.]

MR. HAROLD SENIOR and MR. GEORGE USHER.

[Continued.]

But we want to obviate the need of taking the case to an asylum.

3522. That was your point; you would have some other institution?—Yes.

3523. *Lord Eustace Percy*: Mr. Senior, did I understand you to say that the institution in which your mental wards are is four miles from your infirmary?—That is so.

3524. That is to say, that your mental wards are in the workhouse, as it were?—That is so. We have a general institution so-called and an infirmary which is four miles away.

3525. So that really your mental wards are in the non-medical section of your institution?—That is so; we have no resident medical man; he visits twice a day.

3526. Is that common in Poor Law institutions in England?—Yes, there are a good many places where that occurs; we are probably further away than most cases. The intention was to remove the remainder of the institution some day to the infirmary, but we cannot afford to do it. I do not know of many such cases, except in some of the London places; Marylebone Infirmary is quite at a distance from the institution. I know of that one case. (*Mr. Usher*): I should think there are more mental wards away from the hospital in big institutions than in them. I think ours is an exceptional place, where the mental wards are really part of the hospital.

3527. I suppose you would agree that the separation is very desirable?—Personally I prefer it very near as part of the hospital; it works very well in our union; you are under the eye of the doctor and the superintendent nurse all the time.

3528. If you have a large floating population passing through your mental wards, how does your medical superintendent manage to do his work at the infirmary four miles away and also do his observation work in the mental ward?—(*Mr. Senior*): In our case it is not the same medical man; we have a separate medical officer who visits only and is not resident. It may be necessary for him to come four times a day, but his regular visits are twice a day. If a patient comes in and requires his attention, the patient receives his attention as soon as the doctor can be got at.

3529. In most Poor Law institutions where there is a permanent population in the mental wards that permanent population is relatively small—relatively I mean to the numbers who are passing through for observation?—In the case of Southampton the permanent cases to-day are roughly 58 men and about

60 women, and the total population for the mental wards was, I think, 61 on the male side and 65 or 66 on the female side.

3530. I think you told us you had about 270 a year passing through?—Yes.

3531. Those 270 patients, your temporary population, are practically subject to no inspection from outside at all, because the Board of Control representative only comes about once a year?—Yes.

3532. Practically you have a large temporary population which is never inspected by any outside person whether administrative or medical?—They are inspected by the guardians, of course.

3533. By no one else?—By no outside authority.

3534. Have the guardians any control at all whether a case is passed on to the mental hospital or kept at your institution as a permanent detention case or discharged—have the guardians got anything to say in the matter at all?—With regard to the question of their being sent to an asylum or being detained, not at all. The medical officer acts for them in discharging people under any section in the institution.

3535. So that to put it graphically, the medical officer, with the justice of course, is deciding whether the case shall be sent to the mental hospital, costing the guardians 25s. a week, or whether it shall be kept permanently detained at the institution?—That is true. (*Mr. Senior*): We think those cases should not come into it.

3536. *Chairman*: I have been asked to put this question to you. Have you any view as to whether relatives should be present at this periodical revision of the case that you contemplate by a medical officer?—No, I should suggest not.

3537. Have you any view as to the authority under which such intermediate institutions as you have figured should act—which branch of Local Government?—I think it would still have to come under a joint committee of guardians who would have to pay.

3538. As a Poor Law institution?—Yes.

3539. As part of the Poor Law organisation?—Yes, I think that would be better. (*Mr. Usher*): Before you leave the other point, although we do not suggest that the friends of the patients should be there at the revision, yet we think, as is done under the Mental Deficiency Act, a report should be given of the home surroundings, because that must have a great deal to do with whether the patient is discharged or not. (*Mr. Senior*): That is a case of after-care, of course.

Chairman: Thank you very much for your assistance and the evidence you have given us.

(*The Witnesses withdrew.*)

(*After an adjournment.*)

MR. L. WHITEMORE, J.P., called and examined.

3540. *Chairman*: Are you a Justice of the Peace for the City of London?—For the County of London.

3541. Have you been appointed a Judicial Authority in the County of London under the Lunacy Acts?—Yes.

3542. I understand you have had considerable experience as a judicial authority in dealing with petitions for reception orders in the case of private patients?—Yes. First of all I should like to say—I am only speaking for myself, not for any of my colleagues—I find the greatest trouble we have is the division of the Act into two parts. There is considerable trouble over what is known as the three-day order dealing with Poor Law cases, and it seems to me that Section 20 is on all fours with Section 11. Section 11 is for private cases and for dealing with emergency orders, and Section 20 is the same for the Poor Law cases. Personally, I have always understood the legislature to mean that the same was implied by Section 20 as by Section 11.

A relieving officer goes to see a patient under Section 21, and he has knowledge, and he finds the condition is such that he must bring him in under Section 20, so that precisely the same rules apply. I think Section 21 is applicable to Section 20 as to Section 11; that is to say, he is to give notice to the justice within three days.

3543. Then your point is that there is an unnecessary duplication under the Act?—Yes. I find the Act is divided into two parts, and if it could be so altered so as to make it the same, it would be most desirable. But first of all I should like to say in passing that the justice has to make an order that the patient should be examined.

3544. We are anxious to keep distinct the procedure under the two systems—the pauper system and the private patient system. We have had a good deal of evidence from justices and others as to how they deal with pauper cases. Where I think you can assist us is as to how the justices deal with private

5 November, 1924.]

MR. L. WHITEMORE, J.P.

[Continued.]

cases. We have not had much information on that hitherto, and we should like you to give us your view as to the present system of dealing with private patients. Will you tell us how you are brought into action in the case of a private patient?—I have had to deal with them in three different ways. First of all, a case has gone in as a Poor Law case, and then the friends wish to proceed by petition for the patient to go to a private asylum. Then I have had petitions independently of that in the first instance; and then again I have had to deal with patients already moved under Section 11 for removal to an asylum, and there we have a petition again. In all cases a petition is presented giving the full facts of the case, and in all cases you see the patients, except when they are removed under an emergency order.

3545. There is no obligation to see private patients?—No, that is the point I was making; I think it undesirable that any justice should make an order unless he sees the patient.

3546. Do you yourself in practice ever see the patients?—I always see them. I have never made an order without seeing the patient.

3547. What benefit do you derive from seeing the patient—how does it assist you in your duty?—You have the medical certificate to start with, and then you converse with the patient, and are able to draw some conclusion as to his mental state.

3548. You have two medical certificates before you?—Yes.

3549. And do those certificates suggest to you points which you can follow up?—Yes, and then I like to see the patient alone and have a conversation with him.

3550. Do you find that patients in practice have much to say to you?—Some have and some have not. Some will scarcely speak to you; others, again, are very communicative indeed.

3551. But do you get satisfaction to yourself in discharging your duties from information you obtain from the patients themselves?—Yes.

3552. And you find that of assistance; and you recommend that in all cases the patients should be actually seen by the certifying justice?—Most certainly.

3553. Do you find much advantage taken of the provision that a third party may be present? There may be one person to be appointed by the alleged lunatic to be present with him or her at the inquiry before you?—I have not had a case of that kind.

3554. Have you found that you have the relatives before you?—Oh, yes, but not on all occasions.

3555. But you have had the petitioner, I suppose?—Oh, yes, on petition; and where it has been a case outside the Poor Law, or outside Section 11, I have always gone to their own homes to see them.

3556. Do you think it is of importance that at that stage you should be brought into contact with the relatives of the patients?—That has its advantages and its disadvantages.

3557. No doubt there is a balance of consideration?—Personally, I like to see the relatives, but it all depends upon the condition of things. In some cases it is of no assistance at all. In a chronic drink case, as a rule they are not of very much assistance. There is very often a feeling that they want to get rid of them, in the circumstances. It is not like an ordinary patient. With an ordinary patient it is desirable, I think, to see the relatives and obtain all the information you can; but in a drink case you do not very often get much assistance from them.

3558. I should have thought the relatives of an alcoholic case have just as much interest as in any other class of cases?—They have an interest, but they have a feeling.

3559. You mean, it is rather a feeling that it is a disgrace, and they would rather not take part in the proceedings?—Yes.

3560. When you speak of a disadvantage in the presence of relatives, do you think some relatives find it painful to be present?—That is so, and would rather not be present.

3561. But do not you attach importance to relatives having an opportunity to be present if they so desire?—Personally, I should welcome and desire everyone to be present who could; but we must remember, having in consideration the class of patients with which you are dealing, that privacy is essential.

3562. You do not want it to be converted into a public court?—Of course, I do not mean that.

3563. You see, the person who applies for an order is, of course, entitled to be present, and that person is generally a relative, is it not?—Generally so—in all my cases it has been so.

3564. If there is a relative present, the petitioner, and if a patient is entitled, and knows he is entitled to have somebody else there also, is it desirable to summon any more members of the family to this inquiry?—I do not think it is, unless there is something altogether undesirable to start with, and there is an atmosphere about it.

3565. You mean, if there is an atmosphere of uncertainty or suspicion?—Yes, and in that case you would get all you could from those directly concerned.

3566. But you know you are already empowered to obtain further information before making the order, and if you feel any suspicion about a case, you could send for anyone you wanted?—I have a case in mind, the case of a husband and his wife. She is a chronic drink case, and if she herself makes allegations against him, which is frequently the case when she is in drink, then you get all the information you can.

3567. But I am at the moment on the point as to whether relatives—next-of-kin—should have notice of an inquiry, and I suggest to you that, if there is an atmosphere of suspicion or doubt about the case, the judicial authority already has power to adjourn consideration of the application, and give such notice as he thinks fit, and summon any person to attend before him; so that if you want to clear your mind of any suspicion in the case, you could adjourn it and ask to see, let us say, a son or daughter or other independent relative?—Yes, I could do that.

3568. Do not you think that affords a sufficient safeguard, seeing that the applicant is already present, and the patient is entitled to have a third party?—Yes.

3569. In dealing with applications for an order in the case of private patients, have you felt the presence of that element or atmosphere of suspicion in your mind?—Only in drink cases. What I mean is this—it is rather difficult to explain. You have a woman notified to you under the Lunacy Act; and I have a case in mind. Her husband proceeded by petition. When I saw the woman she made a number of accusations against her husband as being the cause of all the trouble. That is what I mean by an atmosphere of suspicion; and then you want to get all the evidence possible to clear that up. What I feel in those cases is the inadequacy of the Lunacy Acts to deal with those cases. I feel we ought to have some power. A number of these drink cases do not come before the police in the ordinary way; they do not get prosecuted, and under the Inebriates Act of 1898 there have to be three convictions before they can be sent to a home. That is not so under the Lunacy Act. Now when a case of that kind comes before you, you are faced with the evidence that this is solely a drink case, and it will depend on the evidence of the wife or husband; and it should not go to an asylum, but you have no alternative. That is the difficulty, and I feel that in those cases—a case where two medical men certify a drink case, and it is suitable for an inebriates' home, a justice might then make an order to send the person to an inebriates' home.

3570. I was thinking of a different kind of suspicion. In the case of private patients there is prevalent evidently in some quarters an idea that relatives may wish to get the patient put away. Have you found any of the cases you have dealt with invested with any atmosphere of suspicion of that sort?—No, I have not.

5 November, 1924.]

MR. L. WHITEMORE, J.P.

[Continued.]

3571. You have not encountered that?—No.

3572. Would you have any means of judging whether the desire of the petitioner was prompted by the interests of the patient, or his own interests?—Well, if you had a suspicion at all, you would adjourn the consideration of the case.

3573. You have power to do that?—Yes, and we do that.

3574. But how would you judge of the motive of the applicant? You have very little means of doing that, have you?—You would have to be guided by the atmosphere and the general evidence. I had one case in which the petition was brought to my house, and I had certain suspicions in my own mind on those lines, and I went to the house of the patient, and when I got there the suspicions were dispelled; the case was obvious; it could not be misunderstood.

3575. In that case something had aroused your suspicion as to the bona fides, and you went to the house where the patient was, and you found there was no ground for the suspicion, because it was obvious?—In that case the patient would not come to me—would not come to me in the house, and that aroused my suspicions further, and I insisted on seeing the patient where she was, and then it was quite obvious that it was all right.

3576. It was obvious that the case was one that should be detained?—Yes.

3577. In short, that there was no ground for suspicion in consequence of the applicant's conduct?—None at all.

3578. Have you any additional safeguards suggested by your experience to prevent the possible risk of certification in cases where certificates should not be granted?—I feel there ought to be a longer time given.

3579. Your suggestion, then falls into line with that of other witnesses that there should be an intermediate period of observation before a final judgment is pronounced on any case?—Yes; that is one weakness of the present Act; there is no period of observation at all.

3580. How does that apply in the case of a private patient? Do you suggest in the case of a private patient that the patient should be kept under provisional observation for a period, and then that the application be renewed to you with such results as the observational period revealed, and then you might pronounce a final order?—No.

3581. Then how would you set about it?—In the case of a private patient we have two medical certificates to start with; then the justice should see the patient, and if he thinks it a case for a longer period than 14 days, without stating any length of time at all, he should make a recommendation to the Board of Control; but first of all, I think, the medical man should state fully his reasons—all certificates are not full.

3582. Is it a prolonged period of adjournment you are contemplating? Of course, we have heard a great deal about the 14 days in the case of a pauper patient, but in the case of a private patient there is an adjournment. Do you suggest a longer period of adjournment should be allowed?—No, I suggest there should be a longer period of observation. Now a voluntary patient is taken under care by giving consent. That in actual practice is almost useless, because it frequently happens that the person who wants to be under observation most thinks he has the least need of it. I feel in a case of that kind where there is a suspicion, or there is a petition brought, however it may be brought—whether voluntarily or by petition—that the two medical men should give special reasons themselves for putting the man under observation, and that the justice himself should not take the responsibility of taking away the liberty of anyone for the longer period, but should act under the Board of Control.

3583. I take it you are quite in sympathy with the views we have heard that a longer time is desirable before certification, either in the case of a private

or a pauper patient?—If it is a case for a longer period of adjournment than the 14 days, I think the Board of Control should sanction it, as a greater safeguard. I feel a responsibility in taking away the liberty of anyone without certification; the responsibility is too great to rest upon one man. I feel that where you are convinced that a man may benefit by a system of observation and treatment for a long period, it should be done under the Board of Control.

3584. The upshot of it is, you think there should be a longer period, but if there is to be a longer period, there should be an additional safeguard in the shape of an order from the Board of Control?—Yes, that they should sanction it. There are one or two other points that I want to draw attention to. I think there should be greater safeguards in all cases—the relieving officer and everybody else concerned—against what we call frivolous or needless notifications. I have several cases of that kind, and now you are considering the whole Act, I think I ought to mention this. I will give you one or two cases I have in mind. A mother gave information about her son, who was 20, and said he had a gun in his room and would settle her, and she went in fear of her life. The relieving officer went to the house and saw him. He said his mother was continually nagging him, and would give him no peace. There was a rifle in the house belonging to the volunteers. He took the son in; the medical officer certified no sign of insanity; I saw him, and saw no signs of insanity in the least. Now that has occurred three times, and I think where cases of that kind recur there ought to be some way of strengthening the hands of the justices in putting a stop to it. So where a case has occurred two or three times, a justice might be empowered to see the informant and read over Section 317 Sub-section (1) to him or her, and tell them if it was notified again, the case would be brought before the Board of Control.

3585. *Earl Russell*: This was a pauper case?—Yes. I have a case in mind again where an ex-soldier suffering from neurasthenia was continually being notified over and over again. I myself saw him three times, and in that case I was able by reference to the Clerk of the Guardians to stop it; but I do think if something of the kind I suggest were introduced, that might be stopped.

3586. *Chairman*: Is there anything else you wish to draw our attention to?—There is one point I should like to mention, and that is, that I think greater safeguards should be devised now with regard to discharged persons. I have a case in mind, a poor law case, a sewerman sent to an asylum. He came out cured, and his mates refused to work with him, were afraid to work with him, in fact. He attempted suicide, and I am not quite sure what happened; but any way, he is quite sane, and I think you might recommend some machinery whereby a case of that kind might be looked after.

3587. After care?—Yes. Then I think a safeguard should be provided for those taken out under Section 79. I have a case in mind where a woman was in an asylum 13 years—she was 40 years of age, and discharged to the care of a society, and she obtained through these persons a situation; she is there now. She went there without any clothing; the people themselves provided clothing, and now this society come along after she has been there seven months, and want to take her to some other employment. The girl does not want to go, and the matter is causing some trouble and is having a bad effect on the girl's mental health. I think there ought to be some safeguard in a case of that kind.

3588. You mean some precaution ought to be taken that a patient in the hands of a relative or friend should be looked after?—Yes, and I think before being released, the people should prove they are able to look after them.

5 November, 1924.]

MR. L. WHITEMORE, J.P.

[Continued.]

3589. To see that the destination is a safe one?—Yes. I want to say about the Poor Law, there is no power to adjourn. Under Section 21 you send a patient to the workhouse for 14 days. I think there ought to be power, as under Section 6, to adjourn.

Chairman: We are fully alive to that point; we have heard a great deal about it.

3590. *Earl Russell:* How are these petitions brought to your notice? Is it a solicitor or a clerk to the justices, or a medical man who tells you you are to act? Who first speaks to you about it?—I have had the Poor Law authorities come direct to me.

3591. When you say "come direct," how do they do it? Who comes to see you, the doctor or the petitioner?—The petitioner.

3592. With a petition?—Yes.

3593. Then you make your appointment?—Yes. What I do in that case is to go immediately and see the patient straight away.

3594. Do you appoint the doctor who makes the examination?—Not in private cases.

3595. You do not?—No. The petitioner brings the certificate with him.

3596. *Sir Humphry Rolleston:* I want to ask a question about private patients. Do you see a good many of them?—Yes.

3597. Has there been any alteration in the number of cases certified by doctors within the last few months compared with the last few years?—Not as far as my experience goes. I have not had a private case for some time, except under Section 11.

3598. Then you cannot say whether there has been an increase or decrease in the number of private patients?—No.

Sir David Drummond: Do I understand that in the case of a petition accompanied by two doctors' certificates you suggest the magistrate should use his own discretion, and refer it to a Board of Control?

Chairman: I think what the witness meant was this, that he has power at present to adjourn the consideration for 14 days, but if he proposes to exercise the power of adjournment for more than 14 days with a medical certificate before him because he is not satisfied, in that case the Board of Control should have a say in the matter.

Witness: Yes, in every case where the justice came to the conclusion that the patient was not fit to be certified, but should remain under observation, and the two medical men so state in their certificates.

(The Witness withdrew.)

Colonel P. BROOME GILES, C.B., F.R.C.S., J.P., called and examined.

3599. *Chairman:* You are a Companion of the Bath, a Fellow of the Royal College of Surgeons, and you are also a Justice of the Peace?—That is so.

3600. Have you had considerable experience as a magistrate acting under the Lunacy Acts?—Yes.

3601. Have you been a judicial authority?—Yes.

3602. Have you had to deal with petitions in the case of private patients?—Yes.

3603. Have you had many of those to deal with?—Yes, about 7 or 8 a year since the Act came into existence.

3604. For what County or Borough are you a Justice of the Peace?—I am a Justice of the Peace for Herefordshire, where I practised 25 years, and for 21 years in Buckinghamshire, where I did not practise, and for the last few years I have been at Folkestone, where I have had quite a good lot of cases.

3605. Then you have had great experience of administering the Act in rural as well as urban districts?—Yes.

3606. In administering the code as it is now, in the case of private patients, have you any observations to make as to safeguards?—The only one is that it should be a *sine qua non* that the magistrate should visit the patient in his house.

3607. There seems to be unanimity in regard to that. Why do you lay so much stress on that?—Because you have to sign a certificate, and unless you have some personal knowledge of what you are signing I do not think you ought to sign.

3608. In practice did you see the patient yourself?—Yes, always.

3609. And you think the practice should be made obligatory?—Yes, because if you do not, there may be some outside influence existing which otherwise you might be able to check.

3610. When you made your orders in the case of private patients, have you had the petitioner before you?—Always.

3611. And the patient?—Always the patient.

3612. Had you any doctor there?—Not in the room at the time. I would not have the doctor in. I visited the patient and asked this question: "Is there anybody here to represent the patient?"—which I think is a very important thing—I think it is a great thing that everyone should be represented, and whether a person is insane or not, I think it is only fair that he should have a friend or a representative in the room with him.

3613. You are aware that under the Act provision is specially made for the attendance, if so desired, of a third party?—Yes.

3614. Did you find in practice that that was taken advantage of to any extent?—No, very seldom.

3615. Did you in practice tell the patient who was before you that he or she could have a friend there if desired?—Yes. I said, "I am a stranger who has made a call upon you. Is there any friend you would like to join in our conversation?" I always tried to make it appear that I was not there in a judicial position.

3616. But you did not find in point of fact that the patients took advantage of this provision?—No.

3617. In the cases you dealt with, you really proceeded on the medical certificates and the statements in the petition before you in the presence of the petitioning relative?—Yes.

3618. And after seeing the patient for yourself?—Yes.

3619. Did you find yourself able, with that material or experience before you, to deal satisfactorily with all the cases?—Having had a fair amount of experience in lunacy, I always made up my mind whether the person was sane or insane before signing. I never would sign until I thoroughly made up my mind.

3620. Did you find much difficulty in making up your mind?—Yes. The very last case I had, I was over an hour and a half before I was able to make up my mind that the person should be under restraint, and it was one of the most violent homicidal people, which I did not know before, but it took me all that time before I could thoroughly satisfy myself.

3621. You had not in the course of your conversation got on the track?—No, I kept off it. He happened to be a man who had been a fifth wrangler, and a very clever man, but there was no doubt about his being homicidal. I found out a few days afterwards what he had done to his own mother a few days before, but I would never sign until I had satisfied myself.

3622. *Sir David Drummond:* Was not this stated in the certificate of the doctor?—I always see the patient before I see the doctor.

3623. *Chairman:* So that you hold over the doctor's certificate for examination after you see the

5 November, 1924.]

COLONEL P. BROOME GILES, C.B., F.R.C.S., J.P.

[Continued.]

case yourself?—Certainly, because I think if I went into the room, having read the doctor's certificate, I might be influenced.

3624. You are in rather an exceptional position, you see, because you are a qualified doctor, but all justices of the peace have not that advantage?—Then they must use their own judgment, the same as I do.

3625. Some of the witnesses have said they found the facts stated in a medical certificate were a useful clue to them in their own interviews, as giving them an indication of the lines to follow up?—Yes, and if I were not a qualified man, I should certainly place the greatest faith in what the doctors have written, but having the qualification, I judge for myself.

3626. Do you mean that people who have not the qualification must rely more than you do upon the medical certificates; but you have the double qualification, being both doctor and magistrate?—Yes, and in both capacities I might make mistakes.

3627. Taking an ordinary justice of the peace less highly privileged, do not you think he would be assisted in his conversation with an alleged lunatic if he had read through the certificate?—Absolutely; it would be really his chief guidance.

3628. And that is the intention manifestly of the scheme?—Yes.

3629. Have you ever found it necessary to adjourn cases under the power in the Act?—No; unfortunately they have always been rather of a heavy type, and any adjournment, I think, would have been a mistake.

3630. They were cases, in short, as to which you were able to make up your mind?—Yes, there was no doubt about them.

3631. Then may I take it you have had no instances of those difficult border line cases?—As a practitioner I have had them, and I have had a fairly good breaking in with numerous neurasthenia and shell-shock cases in the big camps I have had.

3632. We have had an almost unanimous body of evidence to the effect that, at least in cases where there is any difficulty in diagnosis, there should be a period of intermediate or provisional detention for further observation before certification?—Yes, I am quite in agreement with that; because, for instance, in cases of alcoholism, puerperal mania, mental obliquity from sudden shocks, it would be a cruel thing to put those cases immediately into an asylum, because you know that within a very short time, with no organic disease, those people would be well again.

3633. I cannot but feel that it would be a great comfort for a justice of the peace who had a case before him on which he had genuine doubt to say, "I want to know more about this case; I have two medical certificates; I have seen the man, and I do not feel quite sure, and before I discharge this public duty I should like to know more about the case," and to continue it for some time under some kind of order such as would preserve the safety of the man himself, and also safeguard the public, and afford an opportunity of seeing what the case really is?—I quite agree with that, and I should have an adjournment in a case like that.

3634. Speaking from the magistrate's point of view, I should have thought it rather a comfort to feel that you were not called upon to decide at once—possibly a little more delay would give you more information as to the facts of the case?—I quite agree, and I should do it.

3635. At present there is provision for a 14 days' adjournment. Do you think that should be the full period?—I heard the last witness speak about the Board of Control—I should be rather antagonistic about that. I should have thought that after 14 days, it is certain action should be taken.

3636. The suggestion made by Mr. Whitmore was that if it was to be more than 14 days, the Board of Control should come in, because that involved a considerable interference with the liberty of the subject?—I understand.

Sir David Drummond: What does the witness suggest would occur to a private patient during the 14 days' observation? Where would he be—at home?

3637. *Chairman:* What would happen if a patient is brought to you by the relative and you are not quite sure about it and you say, "Let us adjourn the case for 14 days for consideration"? What is to happen to the person in the meantime? The patient may be for aught you know insane, but for aught you know he may be sane; and if he is insane risks are attached to the position, but if he be sane there are no risks. What do you suggest should be done during the period of remand?—I should have him placed under the charge of nurses; I should have nurses in and a resident medical officer and the man carefully watched; on the other hand, I think it is the duty of the country to provide certain places for such cases.

3638. At present the only place that such a person could be sent to would be the workhouse, is it not?—Yes. I am vice-chairman of our workhouse and I have been for some time, and although the people are treated very well there, I do not think it is the proper place, with its surroundings, for a private patient to go to.

3639. We have heard that quite a number of private cases, as they ultimately turn out to be, have to pass through a pauper stage en route, as it were, to their destination. Have you found that to be a disagreeable feature under the existing law?—It is rather an offensive thing to the relatives, and many relatives strongly object to what they call the taint of pauperism which there is about it; but which I do not think really does exist. In our workhouse, for instance, we have trained nurses and doctors quite as good as in any hospital, and it is only the association of class—that is all.

3640. It is not quite so much class really, is it? I think anybody would rather resent the thought that their father or sister or brother had been sent to the workhouse?—Yes. That is the kind of thing.

3641. *Lord Eustace Percy:* You say you do not think the workhouse infirmary is a proper place with its surroundings for a private case?—Yes, for this simple reason, that you are getting mental cases into an infirmary where general diseases are being treated, and I do not think that is a good thing.

3642. But that applies to the pauper cases as well as to the private cases?—Yes, but the pauper cases are put into separate wards; and if you have sufficient separate wards in a workhouse, apart from the family objection I think you do get persons well taken care of.

3643. *Sir Humphry Rolleston:* When a private case is sent to a workhouse does not the patient go into a separate room?—Yes, but the relatives know that such persons are under the care of the guardians; they are in the guardians' home or the workhouse, or whatever it may be called, and that is the objection.

3644. *Chairman:* But where else is there for them to go?—I know that is the great difficulty; what are you to do? Are you going to build separate houses for these people? We can only send them to the places which exist now, and that is the workhouse, and I say it is not the proper place for them to go to, because of the dislike on the part of the relatives.

3645. Have you thought about this: We know there is a considerable movement in favour of having places where non-certified cases might be treated. Would it not be possible to have a place where a case, the certification of which was open to doubt, could be kept?—Quite possible.

3646. There are some such existing already, but whether they are legal or not is a question. However, one knows that is a possible recommendation of this Commission?—Yes. But then again the question arises, if people are not certified and they commit suicide, or they prove to be homicidal, will there not be a terrible outcry?—that is my difficulty.

5 November, 1924.]

COLONEL P. BROOME GILES, C.B., F.R.C.S., J.P.

[Continued.]

3647. I think it would be inevitable that you would have to provide for some degree of control or compulsory detention during that interval of time; and that was what was suggested with regard to pauper patients, and in cases where there had to be an adjournment, and the magistrate was uncertain as to the safety of the case. Would you suggest that it might be dealt with under a temporary order, provided there was accommodation available for uncertified cases?—Yes. Once the order is obtained and they could be treated without certification, no difficulty would arise whatever.

3648. You have been on a visiting committee, have you not?—Yes. I was on the Visiting Committee in Herefordshire, and at Aylesbury I was Chairman of the House Committee; and we had this rule, that when people went out on probation they came before the whole Committee. Now it is a very trying thing, particularly for a nervous woman, to come before 16 people. Before the war two of us with the medical superintendent used to come in, and the people who were interviewed were asked, "Are you well and happy?" and so on, and everything was done to make them feel comfortable, but to be catechised by 16 people I think is not giving the person on probation fair play.

3649. Of course one wants to avoid any semblance of forensic inquiries or publicity, and I understand you wish to keep the thing as simple and as little formal as possible?—Quite.

3650. I wish you would tell us about your experience as a member of a visiting committee. What institution did you visit?—I used to visit the Herefordshire County Infirmary and I used to visit the Abergavenny Asylum many years ago, and in Buckinghamshire I used to visit the institution at Stowe every fortnight, and I have visited the Chartham County Asylum since I have been living at Folkestone.

3651. How often did you visit these places?—I visited once a month and sometimes once a fortnight in Buckinghamshire and I visit every three or four months now. We have a number of patients from our area in the Chartham Asylum, and I go out there to see how they are getting on and to see if there are any complaints.

3652. Do you think that your visits give the patients a satisfactory opportunity of access to the outside world and an opportunity of making complaints?—There is always the chance of making complaints when I go, and I sometimes get complaints; but when you investigate them you find there is practically nothing in them. Sometimes we get complaints about diet and many times we get complaints like this: "I do not like that woman, she has a red head" or "I do not like the hat she wears" but you hardly ever get a complaint of a tangible nature, because the superintendent of an asylum is so very careful that very seldom can a patient be abused or knocked about.

3653. Do you find that patients complain of being detained against their will?—Yes, that is a very common complaint.

3654. When a patient says to you, "I should be out" or "I should not be here," what do you do?—I generally hear what they have to say, take notes and go to the superintendent and examine into the case. For instance, at the Buckinghamshire Asylum for 16 years a lady worked in the washhouse, and every time I went to visit she used to say to me, "Do not you think I ought to go before the Board to-day?" She was a woman who was very disorderly in her dress, and I used to say, "Had you not better put it off until the next Board?" and that answer always satisfied her. That was before the war, and I know she is in the same asylum now. You want to treat them as charitably and kindly as you can. You may be sure when you get a complaint which is a genuine complaint which can be substantiated, it is always investigated.

3655. If a patient, possibly a patient who was genuinely on the way to recovery, thought he had

reached a time when he should be released and wanted seriously to interview you with regard to it, would you have an opportunity of discussing his case with him alone?—Oh, yes. There has never been in my experience any difficulty put in the way of a patient interviewing the visitor.

3656. Have you had any interviews yourself with patients?—Yes, several. I have always insisted upon it, and I have always said, "If you want to see me come and see me yourself," and I say then, "Let us have your tale. You are no longer a patient and I am no longer a magistrate; we are man to man, let us have your grievance."

3657. But surely in a dangerous case that would not do, because you might find yourself shut up in a room with a homicidal patient?—I won the middle-weight gloves at the United Hospital.

3658. I see—so that you do not flinch from that kind of thing?—If you want to do your duty, you must take risks. I took risks during the war, though perhaps I should not like to take them now.

3659. But you have had the interviews yourself?—Yes, and there has been no opposition raised.

3660. Have you ever found as the result of such interviews that there was really cause for complaint on the part of any patient?—I have found an actual cause of complaint with regard to the treatment by an attendant, and I have gone to the superintendent and said, "Here is a complaint; do you think it is correct? If you do, you must bring the attendant before the Board the next time we come; if you do not think it is correct, let there be a fresh attendant put there so that there shall be no grievance," and I have never had any difficulty there.

3661. Have you found any cases of ill-treatment verified to your own satisfaction?—Yes, in the case of an attendant, and the attendant was discharged.

3662. Was that case brought to your knowledge by the patient?—No. That case was brought to my knowledge by the medical officer, and we had it up before the Board.

3663. Have you ever had any case of ill-treatment brought to your notice by a patient?—Yes, two or three, and in one case, which was sustained, the attendant was removed.

3664. So that that patient, having been ill-treated, had no difficulty in bringing the matter before you as visitor, and you took action, and the defaulting attendant was dismissed?—Yes. There is one thing I would like to say, and it is this: I think people out on probation should have rather more careful after-treatment, because they very often go back to a place where they are not living in a house but in a hovel; and where people who have had every care in an institution go out, they sometimes get badly fed and neglected to a great extent, and I think more supervision should be exercised over those who go out of an institution on probation.

3665. Mr. Snell: You said you always like to see the patient alone. Does that mean in the absence of the doctor?—Certainly.

3666. What is the special advantage of seeing a patient in the absence of the doctor, when the visitor must be guided by the doctor's advice?—He has to be guided to a great extent by the doctor's advice, but he has to form his own opinion. I do think this, that these people when in the presence of other people, who they know will certify against them, are a little bit nervous.

3667. Assuming the case of a visitor without any medical knowledge such as you possess, he must be guided in the end by the doctor?—Yes, in the end, but I think he should see the person.

3668. You said a justice of the peace, you thought, should visit a patient at his own house and also see the petitioner?—Yes.

3669. Is the relative, who is the petitioner, accepted as the representative of a patient?—Yes. I always ask the question: "Have you any friends you would like to be present?" and if there is no one you must take the petitioner.

5 November, 1924.]

COLONEL P. BROOME GILES, C.B., F.R.C.S., J.P.

[Continued.]

3670. Suppose you had a relative who had petitioned to have a patient certified, could you accept him or her as representing the patient?—I should take them simply as the petitioner, and not as an individual who was the patient's friend.

3671. Is it always to be assumed that patients are unwilling to go into an institution?—No, certainly not. There are some people who will tell you at once, "I am very ill; send me away."

3672. What opportunity is there of a patient in a general way having a private conference with the visitor? Is there a special room provided for the purpose?—I have always had them in a separate room.

3673. There is no difficulty about that?—None at all. I mean I should kick up a row if I did not have a private room. I have never had any opposition to it.

3674. *Earl Russell*: One thing you said rather struck me when you were talking about your interviews with patients. You said you got on friendly terms with them, and I want to know if at any time during the interview you conveyed to the patient's mind that you were the person who would be depriving him of his liberty, and if so whether they ever made any kind of appeal to you?—I have been qualified as a medical man for 53 years, and that is the last thing I should contemplate, because there you put the fear of God into the man right off.

3675. If you do not do that, is it not possible that the patient may be certified without knowing that you are the person who is to decide?—That is a question I have never considered.

3676. Do not you think the theory of the Act is that the patient should have some idea that he is before a representative of the public, before being deprived of his liberty?—I have not read the Act in that way.

3677. *Miss Symons*: Might not that account for the fact that they do not very often want other people present?—I cannot tell you what is in the back of their minds. My own opinion is that that feeling has never existed with them.

3678. It only occurred to me that if one thought it was just a friendly interview and nothing depended on it, one naturally would not think of inviting anyone else to represent one. There is that side of the matter, is there not?

3679. *Chairman*: Where do you carry out your examinations?—In a room—it may be a bedroom or a sitting-room.

3680. In the private house?—In the private house.

3681. Then, so far as the patient is concerned, may your visit be indistinguishable from that of a doctor?—Yes. I go as a stranger, and I apologise and say, "I have come to have a little conversation with you," and then we begin.

3682. Of course, I can see the delicacy of saying, "I have come to see if you are insane or not"?—I never say that.

3683. *Earl Russell*: If a patient were only partially insane, he would never know at what stage he could fight the order?—I never ask that and I have never had any difficulty, and we frequently get on quite friendly terms.

3684. *Miss Symons* suggests that it is hardly a friendly visit if you have come to lock them up?—But they do not know that I have come to lock them up. Do not you think it would frighten them more if they knew that this man had the power of sending them away? I can tell you that they are awfully impressionable, and once they get the slightest hint of anything it makes them a great deal worse.

3685. I quite appreciate that, but I wanted to know if you realised that it was a provision of the Act which puts you there as a justice representing the public, before the man is deprived of his liberty and in order to give him an opportunity of protesting?—I never have taken that view, and unless I alter my mind I shall not.

3686. *Sir David Drummond*: Are you aware that in some parts of the country the patient is seen by the magistrate at a police court?—No, I have never known that.

3687. *Chairman*: Not in private cases?—No, nor in pauper cases. I will tell you what I have done in court: When I have seen a man who is not fit to be a criminal, I have sent him away to be examined.

3688. You would not approve of such a thing?—No, certainly not. It would be a most barbarous thing, I think.

3689. *Lord Eustace Percy*: Have you ever refused to sign an order in the case of a petition backed by two medical certificates?—No, because they have always been hopeless cases. As a rule people do not like the word "lunacy" and do not like certification, and I have had many cases where I have been called in as a friend and have recommended a nursing home—cases like alcoholism, puerperal mania, and sudden shocks.

3690. What I was referring to was the extent to which a magistrate was a real check on the medical man?—It can only be by exercising his own judgment and his own views. His is simply an act of administration, and if he finds nothing to the contrary, I take it he is obliged to sign, but if he has any doubt, he can adjourn a case or refuse to sign.

3691. And it is very rare that the magistrate's opinion goes against the medical opinion?—I have only known it twice and in one case it was the class of man who should not have been a magistrate. It was a pauper case and the magistrate refused to certify and within two weeks the wife's throat was badly cut and the man had committed suicide. I do not think any magistrate would act against skilled medical opinion.

3692. I want to ask you a question as to discharge. From your experience of visiting committees have you ever known the procedure for discharge under Section 77 (1) taken; that is, by three visitors without the intervention of medical officers?—No. I have never known anybody's discharge refused if the medical superintendent or the staff certified that they were fit for probation.

3693. Have you ever known of a case of discharge except with the authority of the medical officer?—No, never—and the committee afterwards.

3694. And any two members of the committee?—Yes—we never had two members.

3695. I suppose you have never known of a case under Section 73 of a discharge of a pauper lunatic on the strength of a relative becoming responsible for his maintenance?—No, no superintendent would ever do it.

3696. But under Section 73 the board of guardians, who are responsible for the maintenance of a pauper lunatic, have the right to order a discharge?—I should doubt it.

Earl Russell: That is subject to Section 74.

3697. *Lord Eustace Percy*: So that in practice the only way of discharging is on the certificate of the superintendent?—Yes.

3698. Have you ever known of a case of a patient being discharged on the presentation of a petition?—I have known that but not where I have acted as a magistrate.

3699. *Chairman*: You are of course familiar with Form 8 under which the medical practitioner gives you, first of all, the facts observed by himself and then the facts which have been communicated to him by others?—Yes.

3700. Have you in practice ever taken any steps to verify the facts which the medical practitioner has set forth?—Yes, always.

3701. What I mean is this: the certificate tells you that the certifying doctor has obtained some hearsay evidence, as we lawyers would say; do you take any steps to verify that hearsay evidence?—I always ask one or two people who have given him the evidence if that was their statement.

5 November, 1924.]

COLONEL P. BROOME GILES, C.B., F.R.C.S., J.P.

[Continued.]

3702. Because I can conceive a case like this: the doctor might, among many other facts, state this: "His wife says that he goes about complaining that she is unfaithful to him." Now on the face of it would you in such a case ask to see the wife?—I should ask to see the wife as I always have done. There is often no foundation at all for such an allegation as that.

3703. Then you have seen the people in order to verify the independently ascertained facts which have been communicated to the medical practitioner by others?—Yes, certainly.

3704. Do you think such an investigation ought to be made obligatory on the justice?—Yes. Then you would have a perfect check on what I do not think exists, that is, the possible squaring of the practitioner.

3705. Do you think it is necessary to make that obligatory?—No, I do not.

3706. That is the point I want to make because I can conceive that there might be many idle statements which it would be mere waste of time to follow up; while, on the other hand, there might be some critical statements which it was worth while following up, and I want to know whether you think there should be some discretion allowed on the part of the justice?—Yes, when you have examined a witness sometimes you can tell whether the evidence is good or bad, but I think such a case

so seldom would occur that it would not be much benefit to make it obligatory.

3707. *Sir David Drummond*: Do not you think it might deter a doctor from signing a certificate if he knew there was to be such a compulsory investigation on the part of a magistrate?—I do not know about that.

3708. You know, I suppose, that there is great difficulty in finding a doctor to sign a certificate now?—Is there? I have never found that personally.

3709. *Lord Eustace Percy*: In your experience of three day orders do you think that many three day orders are made by relieving officers and the police in cases where people should not be sent to the mental wards of a workhouse?—Those are the cases I have already spoken about—the cases of alcoholism, and so on. There are many cases of alcoholism where a person is violent and has tried to commit suicide; then what are you to do? You have no other place for them. You cannot keep them in the cells of a police station; therefore it means sending a person to a public gaol and I think sending a man to a public gaol is a far greater stain on him than sending him to a workhouse.

3710. Then is it only in cases of alcoholism that such a thing arises?—That is the only occasion on which I have ever known of it.

3711. Thank you very much.

(*The Witness withdrew.*)

(*Adjourned to Tuesday, 18th inst., at 10.30 o'clock.*)

1, WHITEHALL GARDENS,

WESTMINSTER, S.W.1.

SEVENTH DAY.

Tuesday, 18th November, 1924.

MEMBERS PRESENT:

THE RT. HON. H. P. MACMILLAN, K.C. (*Chairman*).

THE EARL RUSSELL.

SIR HUMPHRY ROLLESTON, BART., K.C.B., M.D.

SIR ERNEST HILEY, K.B.E.

SIR DAVID DRUMMOND, C.B.E.

MR. N. MICKLEM, K.C.

MR. H. SNELL, M.P.

MRS. C. J. MATHEW.

MISS MADELEINE SYMONS.

MR. P. BARTER (*Secretary*).

MR. W. FAIRLEY (*Assistant Secretary*).

Chairman: This morning we have to welcome to our deliberations Mr. Micklem, who has been appointed a member of our Commission, to take the place of Mr. Justice Mackinnon. I am sure we are all very glad to have his assistance. At the same time we have to express our regret that we are losing the services of Lord Eustace Percy, who has been

called to another office. During the time he was with us we recognised what assistance he would have been able to give us, had he remained; but he will be now going to another sphere of usefulness, and I am sure we tender him our congratulations.

Our first witness this morning is Lieutenant-Colonel J. Francis Dixon.

Lieutenant-Colonel J. FRANCIS DIXON, M.A., M.D., called and examined.

3712. *Chairman*: Dr. Dixon, you are Medical Superintendent of the City Mental Hospital, Humberstone, Leicester?—Yes.

3713. When were you appointed to that office?—In November, 1911.

3714. Had you previously had experience in the same line of work?—Yes, I had had about eight years' experience in the Three Counties Asylum, Bedfordshire, and also a year as house physician at Bethlem Royal Hospital.

18 November, 1924.]

Lieutenant-Colonel J. FRANCIS DIXON, M.A., M.D.

[Continued.]

3715. Has your whole career been spent in mental work?—No, not entirely.

3716. Were you engaged in general practice first?—No, I was not engaged in general practice, but I was engaged in the South African War; that is the first thing I did after I qualified; I was about 2½ years there.

3717. Then you obtained your first appointment in Bethlem Royal Hospital, and since then you have been engaged in this particular department of work?—Yes.

3718. It would be interesting to know whether you had any special preparation for this work in the sense of special study or research before you began it?—Before I began, no; but in Bethlem, yes. I took out the certificate which at that time was the only qualification that one could take in this particular branch for medical men.

3719. We have been interested in the question of the qualifications of gentlemen occupying your position—whether it is desirable for them to have special qualifications. In your instance you have acquired your experience really in practice?—Yes; but, of course, I did take the only qualification then obtainable when I was learning the work at Bethlem; that is the teaching hospital for this particular branch.

3720. It might be convenient if you told us first of all about your institution. It is a public mental hospital?—A public mental hospital—the City Mental Hospital.

3721. Where is it situated?—At Humberstone, on the borders of the city of Leicester.

3722. But within the city boundaries?—Partly within the city boundaries and partly outside; part of the estate is one side and part the other.

3723. What accommodation have you?—Roughly, 1,000 beds—just under 1,000. We did accommodate over 1,000 during the war, when we had some overcrowding.

3724. When was the asylum built?—I think it was opened in 1869.

3725. Has it been added to, or modernised, since then?—One can hardly say it has been modernised, but about 25 years ago it had a very large addition for accommodating about 350, and that is now used for the male patients, whereas the old building is entirely devoted to female patients.

3726. Is it one block of buildings, or are there a series of detached buildings?—No, it is practically one block. The old building and the new building are connected by a corridor, but I could not say that the new building was built on modern lines, as we understand the term now.

3727. From what sources are the patients under your charge derived?—From the city of Leicester entirely, with the exception of some London County patients on the female side who are boarded from the London County. They are accommodated with us because we have some spare accommodation on the female side; and we have a very few private patients, who may come from outside the city.

3728. Have you experienced any congestion in your hospital recently?—No, not as is understood by the regulations.

3729. What I am thinking of is this: We have heard that in some districts the relieving officer has been embarrassed in designating an asylum for the reception of a patient, because of the crowded state of the asylum to which he would ordinarily send his patients. Are you always able to take those that are sent to you?—We have been up to the present; we have never had any difficulty in that matter; but of course we have not got very much spare accommodation.

3730. The fact that you are able to take patients from London rather suggests to me that you have a little margin of accommodation?—Yes, we have some margin on the female side, but very little on the male side.

3731. With regard to your private patients, which you tell us are few in number, have you special accommodation for them?—We have separate accommodation on the female side for about 20 private patients of a certain class. We have some other private patients who are not in a suitable mental condition to take advantage of that particular kind of accommodation, and those patients are kept in the general wards. On the male side we have no separate accommodation.

3732. But I suppose these private patients will pay for their accommodation and treatment?—Yes; they do not pay very much more than what are known technically as pauper patients or rate-aided patients.

3733. That is to say you charge them practically what it costs you to keep your other class of patients?—And something more.

3734. And the excess—what one may call the profit on those cases—will go to the general funds of the institution?—Yes, that is so.

3735. I think you have given special study to the working of the lunacy code which you administer?—Yes.

3736. And of course you have had ample opportunities, have you not, of testing its efficiency?—Yes.

3737. In the course of putting the Statute and the Rules under which you act into operation, have you encountered any difficulties?—Not difficulties that were insurmountable.

3738. Have you found, however, that your administration was to some extent encumbered or embarrassed by the terms of the Statute under which you act?—I cannot say that I have found myself embarrassed, but I have heard of instances where other people have felt embarrassed.

3739. We are interested in the question of the smooth working of the code, as to whether difficulties are encountered under the present Acts in carrying on the day-to-day work of institutions such as yours; and we are anxious to have from medical superintendents like yourself any suggestions as to simplification or improvement of the code under which you work. We shall therefore welcome from you any suggestions which you can make for our assistance upon that topic, and we should like you to tell us quite freely what you have experienced yourself in your own practice. There is nothing like hearing a man talk about his own business; he knows the practical difficulties that he encounters. We hope you will assist us by telling us quite frankly what has occurred to you in your experience which might be bettered by a more satisfactory legal system. Have you any such suggestions to make to us?—Speaking generally, of course, if one interprets some of the legal enactments purely by the letter of the law, one can raise difficulties, but on the other hand if you can just go behind the letter of the law and see what is the spirit of the law, I think a good number of those difficulties can be overcome.

3740. That is not a task that should be set to anybody, to have to go behind the letter of the law in order to ascertain its spirit. The letter and the spirit should be one?—There may be a good deal in that, of course, but I will give you an instance. We have what are known as continuation orders. A continuation report is for the purpose of continuing the original reception order, which is the authority on which we detain the patient, and the continuing order by its form necessitates your stating that in your opinion the patient is insane, still insane, and a proper person to be detained under care and treatment. Now as a matter of fact that continuing report may be due to be written and sent to the Commissioners at a time when the patient is not insane, in your opinion. That patient may be convalescent, and may be perfectly sensible and quite reasonable, and may desire to remain until the termination of convalescence.

3741. Yes, I could appreciate that from the medical point of view it is very difficult to say where convalescence has reached the stage of cure?—Yes.

18 November, 1924.]

Lieutenant-Colonel J. FRANCIS DIXON, M.A., M.D.

[Continued.]

3742. Do you find that you have cases which are steadily improving, but as to which it is difficult to say at what precise moment of time they pass from the region of unsound mind into the region of sound mind?—Yes, I think that is the difficulty; and the same thing would apply to people who suffer from recurrent attacks. It is sometimes rather difficult to be able to say in regard to a continuation report that a person at the particular time when you have to write is insane. The patient may not be insane at that time; the patient may remain quite sane for weeks, or even months, and then that patient may have two, or three, or four attacks, lasting a week or ten days, when he is absolutely helpless, and requires a lot of attention, quite incoherent, and unable to look after himself. It becomes rather a difficult matter, if you take the letter of the law, in the intervals between those attacks, to say whether the patient is sane or insane.

3743. You may have to make your continuation report just at a period which we, as laymen, would call a lucid interval?—Yes, quite; but then the question is whether a patient is altogether insane who has only infrequent lucid intervals, or short lucid intervals. Of course you can have recurrent attacks, the lucid intervals of which last a year, we will say. You cannot keep a patient in an asylum for a year when the patient may be perfectly sane, although you know that the likelihood is that the patient may have another attack next year. I have patients who come in six, seven, eight and nine times, and after a time it becomes a question whether it is not better for them to stay in altogether, although for a large part of their time they are quite sane.

3744. When you speak of the continuation report it is a term we have not had as yet. Is that really the periodical report you make upon the cases under your charge?—Yes, I have to make a report at the end of the year, and then at the end of two years, and then at the end of the 4th, 7th and 12th years, and every 5 years thereafter.

3745. To whom do you make that report?—To the Commissioners of the Board of Control.

3746. Does that apply to all your patients?—Yes.

3747. Do you then feel some embarrassment in certain cases, cases of convalescence or cases of recurrence, in giving the certificate of continued insanity which is contemplated?—I think so, yes.

3748. Although at the same time you have no doubt as to the desirability of the continued detention of the patient for a time in your institution?—Yes.

3749. In the interest of the patient himself?—In the interest of the patient himself.

3750. Do you avail yourself extensively of the power of letting out patients on probation or trial?—Yes; a great number of my patients go out frequently for days and week-ends to their friends and relatives, if they have decent homes to go to.

3751. Of course, while they are away from you on that basis they remain certified lunatics?—Yes.

3752. And can therefore be brought back?—Yes: I have power myself to allow a patient 48 hours' leave by the Act. For any more than that I have to get permission from the Committee; but I frequently give them leave.

3753. I should imagine that you would take advantage of that power of allowing your patients out on trial in cases of convalescence?—Yes, a great number of my patients go out for week-ends for a month before they go out for good, to get used to the home surroundings again after a period of detention.

3754. As I appreciate your difficulty, it is this: There are patients in your hands who have reached a stage at which it is still desirable that you should have a power of detention or power of control in their own interests?—Yes.

3755. While at the same time you are unable to say definitely that they are at the moment persons of unsound mind?—Yes, that is so. I have a case in point of a man who goes out practically every week-end, but he is a man of not very much self-confidence. He is a

man who has had frequent breakdowns when he has been discharged on previous occasions, and I have had a long discussion with his people and himself, and told him that I thought the only way for him to remain well was to remain in the institution; but he could go frequently backwards and forwards to his home; he was not able to undertake any work of a serious nature, but he could do a good deal of work if he had his own time and his own opportunity. He would employ himself very well in the institution, but he could not go out and do work for a wage.

3756. One can quite understand that persons who have been under the shelter of institutions, when they are exposed again to the rough and tumble of life outside, may sometimes find the strain too much?—Yes; they can stand a good deal outside if they have the shelter of the institution to fall back upon. It just gives them the moral support that they require.

3757. We have among other things to consider the question of dealing with patients without certification at the initial stage. I wonder what the solution for your difficulty would be; whether it might be in the shape of a modification of the form of report which you have to give, or possibly in a limited measure of control at this convalescent stage?—I do not quite follow the exact meaning of that. You either have a certificate or you do not?

3758. Yes, but it may be that we may have some modified form of certificate or notification for relapse cases?—But the object of a certificate is to relieve you of the responsibility for detention.

3759. Yes; that will need to be safeguarded?—Yes.

3760. But just as suggestions have been made that at the incipient stage it might be desirable to avoid the stigma of certification by some expedient, which we shall have to consider, I was wondering whether your difficulty might be also met at the other end, where your patient has passed in your view out of the region of insanity, but it is still desirable to detain him?—You mean a continuing certificate?

3761. In a modified form—in short, to salve your conscience?—Yes.

3762. Because the difficulty you have presented to us is a serious one. We do not like the idea of a doctor having to certify a case as of unsound mind when he has real doubt as to the sincerity of that statement; although he is perfectly convinced, on the other hand, that it is desirable in the interest of the patient that there should be a further period of detention. You follow my difficulty?—Yes.

3763. One does not like forms which compel people to state things they do not entirely believe?—Quite.

3764. I was wondering whether a solution had occurred to you which would meet that difficulty?—I think it might be that the form we already have might be modified. For instance, what is the necessity of saying that the patient is "still of unsound mind." Why not say, "It is still desirable that the patient should remain under treatment"? We might say the patient desires to remain under treatment.

3765. That raises, of course, the larger question whether it is legally proper to have any persons detained against their will who are not of unsound mind?—Yes, but in nearly all these cases the patients consent; they wish to stay themselves. In cases of that sort perhaps something like that could be done.

3766. *Earl Russell*: The words in the Act are, "certifying that the patient is still of unsound mind, and a proper person to be detained under care and treatment." Would it meet your view if you certified that the patient was not fully recovered, and a proper person to be detained under care and treatment, or is that still too strong?—I think that is still too strong, because that is practically what it was before. If he has not recovered he must be insane, provided he was insane before.

3767. *Chairman*: As long as you have consent, I can see you get over the difficulty, but you may have cases of persons who are in a hurry to get back to

18 November, 1924.]

Lieutenant-Colonel J. FRANCIS DIXON, M.A., M.D.

[Continued.]

ordinary life?—I would not like to say so, but perhaps the fact of their being in a hurry is an indication of their not being of sound mind.

3768. That may be, but you follow what I have in my mind? We may have to devise under the second branch of our remit some form of modified control over persons who are not certifiable, but whom it is desirable to detain temporarily, even against their wishes, in their own interests?—Yes.

3769. Similarly, it occurs to me that at the other end of the process it may be desirable to detain for a time persons who are in a stage of convalescence, but as to whom it is not possible to say definitely that they are still of unsound mind. You follow the idea?—Yes, I do.

3770. I suppose the patient is not infrequently the worst judge of what is best for himself?—Not when he is convalescent; but when he is of unsound mind, of course, he is—that constitutes the unsoundness of his mind.

3771. Then would you regard it as a valuable provision that you should be authorised to have voluntary patients?—I think so. I frequently have patients coming up and asking to be taken in, and I cannot take them in; they have to go away and get certified; and they may only be suffering from what they feel may eventually bowl them over, but which has not bowled them over at the time.

3772. They feel a premonition, I suppose?—Yes, they frequently do; they get run down, their work is worrying them, and that sort of thing. Perhaps they are suffering from loss of sleep. They come in that stage and want a rest.

3773. Do they come and ask for the shelter of your institution in such cases?—Yes.

3774. Without certification?—Yes.

3775. Then do you think it would be desirable that you should be authorised to accommodate such patients?—Certainly.

3776. They would have the benefit of the shelter and the treatment afforded by the institution, and they would also avoid certification, and might be restored within a short time to useful life?—Yes, I think so. Of course, that sort of thing is likely to take place much more frequently in the future, when things are done in a better way than they have been in the past. I think it is possible to arouse the public's confidence in the mental hospitals in the future; it is improving; we are getting the public to have a little more confidence. I think I mentioned in my précis that one of my patients said I was quite at liberty to say anything I liked about her.

3777. There is nothing like a practical instance?—As a matter of fact, I think her case is an extremely informative one for the Commission.

3778. Will you give it to us in some detail?—She wrote an article. By the way, I might mention that I started last year a magazine written entirely by the patients in the institution, not edited or censored or anything of that kind, so that they can express their opinions on things.

3779. Perhaps we might defer for a little the description of what goes on in the day-to-day life of your asylum. We wish to hear that, too. For the moment, however, what was chiefly occupying my mind and the minds of my colleagues was this: We are presented with the legal code; we understand that is the code which you have to work in your day-to-day practice. We are very much concerned to know whether that code is sufficiently clear, simple and workmanlike to enable you to discharge your duties to your own satisfaction. We have to look at the existing law on these subjects of certification, detention and care; and our primary concern, therefore, is this: Examining that law, is it a satisfactory code as it works to-day? You are the kind of person who, working it, would encounter the difficulties?—Yes, from a certain point of view I am working it; I am working it from the inside, not from the outside. I am in the position of receiving the patient

with a receiving order as my authority for taking the patient in.

3780. Therefore certification does not interest you so much, because the patient is brought to you with, if I may so call it, the accompanying warrant, and then you proceed to deal with the detention and care. Therefore you can help us upon those two topics. As to detention, you have just told us one thing that is very useful, that you find some difficulty in continuation certificates, for the reasons that you have explained to us. Now we want to know whether, if I may put it colloquially, there are any other legal snags which you have encountered?—In the certificate and the receiving order there are sometimes inaccuracies, or perhaps deficiencies is a better word. Inaccuracies are usually corrected by me or by my office, but deficiencies are pointed out by the Commissioners. A copy of the certificate goes up; I hold the original as my authority. Now I have not got any option in regard to the body of the certificate, as to taking the patient in. I may think in my mind that there is not sufficient evidence displayed in the medical certificate for me to take the patient in.

3781. In short, if you had been the judicial authority before whom that had been put, you would have said, "I am not satisfied"?—I might have said that. I do know cases in which that is so. Now instead of my disposing of the matter at all, or having any authority in the matter, my authority is not the medical certificate, but the judicial authority's direction; he directs me.

3782. It is a mandatory direction to you?—Yes; and then I send a copy of the certificate up to the Commissioners of the Board of Control; they look through it, and if they are not satisfied with the contents of the medical certificate, they send it back to the medical man who wrote it out. In my case it is mostly one medical man, because they are nearly all rate-aided patients.

3783. *Earl Russell*: Direct, or through you?—They are sent through my clerk and steward, not through me as medical superintendent.

3784. *Chairman*: We have heard about the amendments that are made in these reception orders; but the patient is received by you under an injunction that you must receive the particular patient into your institution, and from that moment the further detention of that patient is a matter primarily for you, who have charge of the patient, and are able to study the condition of the patient; so that your responsibility with regard to detention is manifestly one of very great importance?—Yes, it is.

3785. And after the patients reach you under this mandate from the justice of the peace, when and how do you first come into contact with them yourself?—I see the patients practically very soon afterwards. They are first examined; they are actually received and examined by the medical officer and the matron or assistant matron, as the case may be. The physical examination is made, and as soon as one is able to take an opportunity the mental condition is gone into, but within seven days I have to write a report on that patient, as I find the patient, to the Board of Control.

3786. I should imagine that that is a very important stage?—It is.

3787. Because it is the first time the patient is in the hands of an expert—I mean an expert who is going to have charge of the patient?—Quite.

3788. And you naturally are concerned with the state of the patients placed under your charge?—Yes.

3789. Do you make a full examination of the case with the papers before you?—Yes.

3790. It would be interesting to know whether you have in your large experience encountered any cases in which, on your examination of the patient admitted to your institution, you were satisfied that it was not a proper case for detention. Have you encountered any such cases?—I have encountered cases in which I was unable to confirm the statements that were

18. November, 1924.]

Lieutenant-Colonel J. FRANCIS DIXON, M.A., M.D.

[Continued.]

made on the certificate on which the patient was admitted; but it is rather a serious thing, and what might be said to be rather a delicate matter, to say that a patient probably has none of the symptoms that were assigned to him before he came in, because he may not be showing those now, whereas he may have shown them quite recently.

3791. They may be transitory symptoms, I suppose? Yes. I had a case admitted quite recently, the case of a man who had been a patient about a year or two ago. He gets sudden attacks in the street; at least, the previous one he had was a similar one to the present one. He runs amok and creates a disturbance and gets arrested. He is incoherent and quite off his head; he was not drunk. He remained like that for a few days, but he was sent up to me, and he recovered, and became quite normal in a few days. But the Committee, who are the authority for discharging patients, meet once a month. Having had an attack like that, although he got completely over it and was quite sane in the course of a week, he still remained on as a patient for a fortnight, perhaps, or three weeks afterwards, until the next meeting of the Committee.

3792. In that case it appears to me that the certificate of detention which you received was amply justified, because the symptoms which were stated in it had actually occurred?—Yes, that is quite so, but on the other hand, you see what I mean: when I came to examine him further the man was practically all right, and he did not show any symptoms. He might just as well have been looked after somewhere else. He need not have been certified in the first instance. The fact remains that he is unaccountable for his actions for a short time, and in consequence has to be certified.

3793. That class of case might well be met by expedients which have been suggested by other witnesses, that the permanent detention order should always be preceded by a provisional order of some sort, during which a patient might be under observation, and possibly under treatment; with the result that a cure might be effected, or the symptoms might pass away, and the patient never come under a permanent order of certification at all. That would meet the difficulty you have told us of just now. However, in such a case at the time of your examination the symptoms may have disappeared, but that does not mean that the symptoms were not present at the time of the examination by the certifying doctor?—No. If I have to say that the patient is in my opinion insane, I have not got to say it in that report. I only have to say it in the continuation report. If I did have to say it in the first report, I might find a considerable amount of difficulty.

3794. Just take that case. You really feel that in that instance the person whom you are detaining, and whom you are by law entitled to detain against his will, has really recovered?—As a matter of fact it is not against his will really.

3795. I mean in law it is?—In law it is.

3796. It is a question of the power we are looking at. You have actually in that case a power to detain, and a duty to detain a person who you are satisfied might safely be at liberty?—Yes.

3797. Is that simply due to the circumstance that by the machinery of your administration there is a delay in getting the discharging body into operation?—That is so, yes; but I do not know that it amounts to a hardship. If it did amount to a hardship, it would be easy for me to overcome that. In the ordinary convenient way I leave the discharges until the meeting of the visiting committee, but if there were any urgency in having a discharge I could easily get a couple of the members of the committee to come and examine the patient, and according to the present law the patient could be discharged on the spot.

3798. I can imagine the case of a person who had an onset of mental disturbance quite sufficient to justify certification, but which might pass off in a

few days. Such a person might have important public duties, and he would say, "I really must get back to my work," and you would say, "I am bound to detain you here until I get a discharge." What would happen?—Provided I thought it was a sound thing to do, I could get a couple of the members of the committee to come up and see the patient.

3799. Then machinery does exist?—That is so, but I should like to point out that I do not think power ought to lie with two members of the committee.

3800. That is the question of discharge. We are studying just now with you the question of detention, and you have explained to us the stages in which you proceed. You examine the patient after seven days to verify the continuance of the symptoms. Then I suppose the patient is directed to be treated in an appropriate fashion, and relegated to the appropriate department, subjected to the proper treatment, and supervised by you from time to time?—Yes.

3801. Then you have to give these continuation reports?—Yes.

3802. Then you come to the question of discharge. Apparently you have some criticism to offer us upon the facilities for discharge?—Yes. As far as my experience goes I have not had any difficulty myself in regard to that matter. When any question of discharge comes up, if it requires to be done before the ordinary meeting, I have on occasions had two members of the committee to discharge. My ordinary routine practice is to wait until the visiting committee meets; the patients come before the visiting committee and they are seen. They are recommended in the first instance by me as suitable for discharge, either completely cured or recommended for trial leave for a month or less, and if they continue all right when they are outside (they usually do), a certificate by their own medical man is written to me to say that in his opinion the patient does not any longer require institutional treatment, and on that the discharge takes place, having passed the committee previously.

3803. I understood you to say that you were dissatisfied with the existing system of discharge by a couple of members of the visiting committee?—I said I thought it might possibly be open to abuse, if two members of the committee had the power in opposition to the medical superintendent.

Earl Russell: It has to be three.

3804. Chairman: It must be three if the medical superintendent is not a party to it?—Am I wrong?

3805. I think it is two with the medical superintendent, and three without?—Nothing like that has ever happened to me, but I have heard of it happening elsewhere, and I have heard it complained about.

3806. I take it your view is that the medical superintendent's opinion of the case should at least be the predominant element in the discharge?—Yes, I think so.

3807. One knows that suggestions have been made in various quarters that there should be some outside authority, to which any patient who objected to his detention should be entitled to go, for the purpose of obtaining what one may call an independent verdict on his case?—Do you mean the patient should go, or the independent authority should come?

3808. One way or the other there should be an independent investigation at the instance of a patient or a patient's relatives?—Yes.

3809. Have you in your experience found any indication that such a course would be desirable?—No, I have not, but I should think it would probably be most undesirable; for this reason, that the people who complain most about the asylum, and about everything in it, are usually the most insane people. I do not suggest that because they make complaints therefore they are insane, but so far as I know nearly all these complaints are from quite insane people. There is no question about it.

3810. No doubt the motive for the suggestion that I have put before you is the fear that persons may be detained improperly or illegally?—Yes.

18 November, 1924.]

Lieutenant-Colonel J. FRANCIS DIXON, M.A., M.D.

[Continued.]

3811. There is, as you know, a considerable element of suspicion about these things?—Yes. What I am suggesting is this, that if all the people have that right, there will be a constant flow of people being interviewed. That sort of thing would create a considerable amount of disturbance, I think. These delusional cases would be constantly wanting interviews with people. To the committee themselves and to everybody connected with them it is perfectly obvious that they are deluded and so forth, and I think it would be uncalled for. I am all for opening up the asylums as far as possible for the public to come in and see them. I always take anybody round who wants to see the asylum at any time. I never make any bones about it or put any obstacle in the way of any medical man coming and seeing his own patients at any reasonable time.

3812. Then do you think that sufficient safeguards are provided by the present arrangements for visitation and for access to patients by independent medical men?—I am only telling you what obtains in my own place. I think as a matter of fact there is a tendency rather to object to publicity in asylums. There has been a good deal of it in the past, and I think there is a good deal of it still existing; but not, so far as I am aware, on account of any objection to letting the public see what is going on. I think the principal objection is owing to the feeling that the whole thing is more or less confidential, and that the patients' friends do not like other people to see their relatives there, and they do not like it to get out that they have relatives there, and that sort of thing. That, I think, accounts for a lot of the shrouding or secrecy or hush-hush we have with regard to asylums.

3813. I can quite appreciate that. That is the kind of atmosphere that is liable to engender an element of suspicion?—As a matter of fact, I think it is the basis of a lot of the suspicion that exists.

3814. I can see this also, that from the point of view of treatment it would be very undesirable to have your patients exposed to constant visitations by all and sundry?—Yes, I think so. I rather fancy that there are a number of people who are inclined to be busybodies. I should think you would have a considerable number of people of that type probably wanting to poke about and inquire about things. The patients get regularly visited by members of the committee; monthly visitors go round. I suggest that visiting can be done and yet heaps of things may be passed over. All sorts of things can be passed over, because the public know very little about it, and a large number of the public have rather a horror of the whole thing. A great number of them are afraid, as a matter of fact, to go through the wards. It is not fear of being damaged, or anything of that sort, but they have a feeling of discomfort and are distressed with the whole situation. They do not understand it; it seems foreign to them, and they cannot grasp it. Of all diseases it is the least understood and the least known by the public.

3815. What one is anxious to do is to reconcile every proper desire for privacy, in the interests of the patients and the relatives themselves, with such opportunities for ventilation, if one may say so, of the institutions as will preclude the possibility of abuse?—Personally, I am inclined to believe in ventilation at the expense of privacy, rather than in privacy at the expense of ventilation.

3816. Because the privacy is calculated to engender a suspicion which might be found, if there were more publicity, to be unfounded?—That is my distinct view.

3817. Have you any suggestions as to how there might be more publicity or ventilation in asylum life, so as to dispel suspicions where they are unfounded?—I think part of it rests with the public; the public are afraid to come near these places as a rule; they do not take the same interest in them as they do in other hospitals. I find a great deal of difficulty in

raising people's interest in the welfare of the patients. For instance, it gave me a lot of work and took me a lot of time to get a sufficient number of magazines collected for the patients. The public never thought that lunatics could read, or appreciate anything. People do not understand what lunatics are capable of; they are capable of a great deal more than the public realise. They do take an interest in things; they read the papers; they discuss things; they are discussing this Commission, talking about it and saying all sorts of things. They discuss the various cases that have been in the papers, and they discuss them fairly intelligently.

3818. That is a very interesting aspect of the question. One knows that in an ordinary hospital the public take much interest. I mean, ladies visit, and recreations are provided; there are Christmas trees, concerts, and all sorts of things are done to assist the welfare of the patients. Do you find that mental hospitals do not get the same attention?—They do not get the same attention. Of course, we have some attention, but it is not from the public generally. We have an anniversary, for instance, and as it happens in the summer time the patients go out into the grounds, and the town councillors and their wives and families come up and meet them, and talk to them, and to each other, and so forth; they have a sort of spread on that occasion; they mingle with the people, but they do not mingle with the general public.

3819. Is there not this difficulty, that owing to the very nature of the unfortunate malady from which they suffer many of them are persons who really could not be visited by the ordinary lady visitor of a hospital?—Yes, but not nearly so much as one would imagine. I think that is a very much exaggerated idea. I think the more they mingle the less their deficiencies will appear. It will wear off in the course of time. The mere fact of their being so much isolated makes them still worse.

3820. You think it would probably be a beneficial element in their treatment if they had a little more of that social attention that you speak of?—Yes, I think so. In fact, anything that will humanise them and produce normality is all part of the principle of treatment, I think.

3821. I can imagine, of course, that in certain cases of mental ailment, the mere fact of being exclusively in the society of people suffering from the same malady and seeing only the professional people who have to deal with that malady must in itself be a deterrent in the way of recovery?—Quite. The patient to whom I have referred points that out. She has written an article that she wants me to get published in the "Morning Post." She mentions that very point.

3822. What you are telling us just now is exceedingly interesting. May we take it that quite a large proportion of your institutional population might really benefit by visits from good-hearted people—ladies and gentlemen, who take an interest in the institution?—I have no doubt they would, except this, that I have noticed people, who are not accustomed to them, treat them in such a way that it rather has on the patient the same effect as one can imagine would be produced on a precocious child, if treated as though he were not precocious.

3823. That again just brings up the difficulty that I was alluding to: Where the ailment is a mental ailment, a member of the general public visiting with the best intentions might be very liable to disturb the minds of such persons?—That is so. Of course, it depends upon who visits.

3824. You would have to select your visitors rather carefully?—I can quite understand that some visitors would have an irritating effect upon the patient, whereas others would have just the opposite effect. I do not think, therefore, that anyone should be allowed to go round. That is one of the reasons why I said that I thought it should hardly be the right of any insane patient, or any persons who might think they were not insane, to call in anybody they might

18 November, 1924.]

Lieutenant-Colonel J. FRANCIS DIXON, M.A., M.D.

[Continued.]

fancy. On the other hand, of course, if there is a question about having an experienced medical man, or anybody experienced in insanity, it should be a district commissioner, who might pay more frequent visits than are capable of being paid by the Board of Control.

3825. Yes. I think the public, or at least some portion of the public, seem to desire that there should be an outside check, so to speak, which would obviate the risk of improper detention of persons; but have you found in your own experience any difficulty with regard to your cases; I mean, have you found that you have any discomfort with regard to the continued detention of particular cases, or any doubt as to the propriety of their detention?—I cannot say that I have, but perhaps I ought to have. I mean to say, I do not feel very uncomfortable about having to say that I think this person is still of unsound mind and a proper person to be detained, although I know she is not, and I know she is going out in a couple of months. I am on perfectly friendly terms with that particular individual. I do not take the thing very seriously. It is merely a formality I have to go through; she is perfectly satisfied to be under my treatment; she thinks I am doing her a lot of good.

3826. And she wants to stay with you to complete the process?—Yes. The meaning of that form is that it prevents me keeping people that I ought not to keep; that is what it is intended for.

3827. Is there any motive for your detaining people in the asylum when they are fit to be out?—No; on the contrary, there is every motive for me to send them out before they are properly cured, because the more people I say are cured the better my percentage of recoveries is, and the more I am thought of as an expert in the cure of mental diseases, and all that is to the good.

3828. So far as I have learned, almost the only motive that has been suggested for detaining persons unduly in institutions such as yours is that they are found to be useful to the institution. So much work has to be done by the patients, and if a person proves to be exceptionally efficient and intelligent, there may be a motive from that source for the continued detention of that person. Have you any experience of that?—My experience of that particular point is this. We have so many patients to deal with, and we find that employment and occupation are so essential for their welfare, that it would be a great advantage to get rid of good workers, in order that their places may be taken by other people for whom we cannot find enough employment, owing to the fact that we have other people doing it.

3829. You really have more patients than work?—We have more patients than work, so that that matter in my place would never arise at all. I should be only too pleased to get rid of these people, so as to fill their places by other people for whom at the present time I cannot find proper occupation.

3830. You have spoken of the advantages of a little more association of your patients with outside persons as a curative element. Can you tell us what facilities you have generally for the treatment of cases in your hands?—Do you mean in regard to their going out?

3831. No; generally. There is another matter we have to explore. It is suggested that an asylum is more a place of detention than a place of treatment, and one wants to know to what extent the persons who are detained in the asylum receive treatment. Have you facilities for treating your patients?—Oh yes, we have facilities for treating them up to a certain point.

3832. I am thinking not for the moment of medical treatment; I am thinking of the treatment for their particular malady—mental treatment. What can you do, and what do you do for your patients?—First of all we have to classify them.

3833. Have you facilities for classification?—Yes, up to a certain point. I think the facilities for classification are not by any means adequate. The old building was put up in 1869, and I think the other was opened in 1901. Now that was considered to be modern at that time, presumably, but there was practically no attention given to the necessity for classification in the structure. It was simply a repetition of the same units all along—constant repetition of the same thing. I had to modify the way in which the patients are accommodated very considerably. For instance, at that time a ward unit consisted of one room and one dormitory, with a kitchen off the one room, and that was the whole unit; so that the patients were expected to live and eat constantly in the same room; they moved from the living room into the dormitory, and *vice versa*, and they were served with their food from the kitchen. Of course, there was lavatory accommodation, too. In my opinion that is not a proper unit for the vast majority of the patients. It should consist of another room, and that should be a recreation room or sitting-room. I have been able to modify part of the male side so as to include three parts to each unit, that is to say, a dining-room, a recreation room, and a bedroom. With regard to classification, we classify the patients not according to the mental diseases, but according to the amount of liberty that we can give them, the amount of confidence that we can have in them. Of course, on the two sides, male and female, the conditions are different, because the structure is different. On the male side half of my patients are at liberty to go about the place more or less as they like. The other half are not sufficiently trustworthy, or they are too feeble, or too demented, or they might lose their way; they are not sufficiently intelligent, and for one reason or another they are under confinement. A proportion of the patients on the female side are under the same conditions.

3834. Have you any classification from the very outset, because this has occurred to one as a defect: If you have a number of patients coming into an institution more or less simultaneously within a day or two, let us say, suffering from all kinds of mental disturbance, from a case of simple melancholia to a case of mania, nothing, to the lay mind at least, could be worse for these cases than that they should be—I do not use the word offensively—herded together in one place, even for a few days, before you have time to sort them out. Is not that a difficulty you have?—That is a difficulty; they are more or less herded together. They have to be, because of the structure of the place. Take my female side; I have an infirmary ward to which the sick and infirm are sent, and some of the new admissions are sent there if they happen to be suitable for that ward. It is a ward which consists of 50 beds, and it is more or less a square ward, where there is very little segregation. If they do not go in there they have got to go into the reception ward, which is a very pleasant ward as far as its appearance goes, but it contains about forty patients.

3835. Take a sensitive case?—That is exactly what the patient who has written the article says.

3836. Take the case of a woman rather highly strung, but temporarily unbalanced, who has been accustomed to decent conditions at home, a well-doing person, but for the time unhinged, brought into association with possibly depraved cases, you may say sexual perverts, or maniacs; I could imagine that such an association might well accentuate the symptoms?—It certainly would not tend to cure them, except by the force of example it might tend to pull them up, as a moral shock. I have a case in point of an hysterical girl, who did not seem to be getting on at all. I could not make anything of her. She was very naughty, really like a naughty child, and I remember I told her that if she did not try and pull herself together I should take her over to the other side of the house, amongst the chronics, and she got well in a very short time;

13 November, 1924.]

Lieutenant-Colonel J. FRANCIS DIXON, M.A., M.D.

[Continued.]

it shocked her so much that she really pulled herself together. Of course, on principle, I could not go as far as that. I quite agree with what you say; that is one of the difficulties we have to contend with.

3837. If you had even a rough system of classification at the outset, whereby cases on reception were relegated to separate reception wards or separate compartments, even, of your establishment, would not that get over the difficulty?—I think so. As a matter of fact, I am quite sure that when my committee are contemplating any extensions that will be the first thing they will have in mind. They will build reception wards pure and simple, and with separate arrangements, so as to classify the patients better on admission.

3838. Then you attach importance to classification at the outset?—Undoubtedly.

3839. Now with regard to the treatment of patients after classification, you have explained that the amount of liberty depends upon their ability to look after themselves. What further treatment have you for them, beyond giving them comfortable conditions of life and general medical supervision? Is there any curative treatment available?—In some cases, of course, there is curative treatment—definitely curative treatment. For instance, recently we have introduced the treatment of general paralysis, which was an incurable disease so far as one knew of it up to the last year or so, by the inoculation of the malaria parasite. That is a definite attempt to cure a definite condition. But so many of these conditions are ones which really lend themselves rather to influence, the influence of the medical staff on the patient by personal contact.

3840. Psychological influence?—Yes, it is psychological, no doubt, but at my place we do not go in for any definite psycho-analytic methods, although I did have a medical officer who was very keen on it, and I gave him every facility for carrying it out. I said, "So long as you get results, it is all right," but he did not get any results, so we gave it up. It appears that treatment of that kind is not usually successful with a patient at that particular stage. In the earlier stages it may be useful, but not in the stage at which we get them in mental hospitals. To bring them back to normal depends greatly upon the nature of the defect. We might have a person in an acute state of confusional insanity, restless and sleepless, like a person with an acute fever, probably with some actual fever, getting no sleep, refusing all food, throwing himself about, and all that sort of thing. A case like that would have to be put in a padded room in order to give the patient no opportunity, or as little opportunity as possible, of doing himself damage. They may have to have sedative treatment, or tube feeding; all sorts of things have to be done. A patient of that kind will very often get quite well in the course of two or three months.

3841. These are measures of protection of the patient against himself?—Yes. Then you get cases of melancholia. They are probably of very much longer standing. They take a longer time, but by personal contact with them, trying to occupy them, and trying to get them into a healthy bodily condition, you often improve their mental condition. A lot of these mental conditions arise through bodily ill-health, so that a large amount of the nursing is restoring a regular healthy life with proper food, sleep, and proper attention to the bodily functions.

3842. Do you find that a certain amount of discipline such as your institution affords is bracing to the patients?—Undoubtedly I think so, yes, provided it is discipline of a right type.

3843. I suppose you may have cases where the intelligence is not much more than that, as you put it, of a naughty child?—That is so.

3844. How can you deal with the naughtiness of that type? In the case of a child it is quite simple: you spank the child. But what do you do with the

case of a patient who is grown up, but whose intellectual equipment is very much that of a naughty child, a patient who does mischievous things, and so on?—If I might just ask the question, Do we spank the child in these days?

3845. I hope we do. I am told on the best authority that if you spare the rod you spoil the child.—No doubt the best authority of antiquity, but what about modernism? As a matter of fact, we cannot spank these people, but we use the modern methods which we say we should use with children now, namely, moral suasion, so far as we can.

3846. Do you find yourself assisted by your staff in your efforts in that direction?—Yes, but the amount of assistance we get from the staff I think can be very largely developed in course of time now that more attention is being paid to the proper qualifications of the medical staff, and especially the nursing staff; because, after all, I attach almost as much, if not more, importance to a well-qualified and well-selected nursing staff as to a medical staff.

3847. The staff is in hourly and daily contact with the cases, whereas you can only be there at intervals?—That is so.

3848. Have you any observations to make to us on the question of staffing the asylums?—No, except that I think we are beginning to go on the right lines now. I think in the past we have been very behindhand in a great number of things connected with asylum work and administration. For instance, we have not in the past offered sufficient inducement to the right class of men and women to take up mental nursing.

3849. Inducement has two sides. Inducement may be pecuniary, or it may be the conditions of life—conditions of service. Which have you in mind—is it the conditions of service, or the remuneration, or both?—I think the conditions of service and, to some extent, the remuneration. But in regard to remuneration, I should like to say that I think it is not right in this respect. I think now that we are devoting a lot of time and attention to the training of the probationer nurse, the pay that she is now having is very much greater than she ought to get under the circumstances. I also think that, having selected and having trained and got useful people who are likely to stick to the work, we do not make the career sufficiently attractive for the people to stick to it. In other words, the senior people do not get enough pay, and the junior untrained person gets too much pay proportionately.

3850. You want for the probationer the stimulus of something to look forward to?—Yes, I think so. As to the conditions, of course they are in most of the mental hospitals that I have seen not such as are considered necessary for up-to-date general hospitals. It is all a matter of development and time. We are improving in that direction, and no doubt nursing homes such as they have in general hospitals will come into being in the course of time, but at present I think there is a lot to be done in that direction.

3851. Do you find that it is a career which attracts a good class of men or women?—As far as my own place is concerned, I have been there now about 13 years. When I went there first, there was no training of any kind except a little first aid; it was not encouraged, and educated people were not encouraged to be taken on the staff. It was the policy. That policy was adopted, and I do not think that was the only place where a policy of that nature held good. I understand that the reason for that policy was that uneducated people were more easily satisfied with the conditions as they then existed; they put up with them better; they were not so restless; they did not want so much done for them, and they stayed longer, whereas if you tried to get a better class they would not put up with the conditions. They say it is not good enough, they are restless, they move off, and you cannot get any steady staff.

3852. Perhaps they are less able to withstand the distressing influences of the place?—There may be

18 November, 1924.]

Lieutenant-Colonel J. FRANCIS DIXON, M.A., M.D.

[Continued.]

something in that. Of course I take a different view myself. I take the view that we have to get better people into mental nursing and train them, and do the best we can to keep some of them. My view about mental nursing is that it is a very much higher kind of work, more difficult, and calls for greater qualities than general nursing.

3853. It must also call for special qualities of self-sacrifice I should think, and sympathy?—Yes; all the higher qualities are required in an extreme degree in mental nursing, whereas you get on tolerably well with a smaller degree in general nursing. General nursing is more or less mechanical. In mental nursing there is a good deal of heart and soul required to get at these people.

3854. Then if you are going to have a career which is to attract persons with these higher qualifications, it must be a career that is adequately remunerated and one which has prospects?—Especially prospects. I think the initial remuneration for a career is one which does not affect the better and more farseeing class of people.

3855. But prospects do?—I think so; it is the possibilities.

3856. Would you be in favour of a policy of interchange of staffs between the ordinary hospital and a mental hospital, or must you have a specialist staff?—I think you must have a specialist staff; but now that the Nurses Registration Act has come in, in which the first year is common to all nursing, they go through a common training for one year, and they pass a preliminary examination; the whole of the nurses do that now whatever their ultimate destination may be. I think it is a very good thing for a mental hospital to get some of the spirit of nursing which exists in some of the larger and better conducted general hospitals.

3857. The practice is improving in that respect then?—Yes, undoubtedly, but nothing very much has been done up to the present. I was down seeing Dr. Good in Oxford some time ago, and he has attempted to effect an exchange from time to time between some of the nurses at the Radcliffe Infirmary and some of his nurses from the Littlemore Mental Hospital, but it is only in its infancy. I think something could be done, and it would be an advantage.

3858. One wants to cultivate the idea as much as possible that mental disease is, after all, one of the ills that flesh is heir to, and assimilate the atmosphere that surrounds that malady to the atmosphere that surrounds other maladies, and no doubt in many cases there are physical symptoms which are the concomitant, if not the cause, of mental symptoms, and which would benefit from the treatment by a nurse who has had general experience in an ordinary hospital?—Yes, but it is quite likely that if you take one of our typical qualified mental nurses and put her into a general hospital, she would be very much more at home at her work there than if you took a typical qualified general nurse and put her into an asylum. I am quite sure the mental hospital nurse would be more useful in the other atmosphere than *vice versa*.

3859. In pursuance of your view, do you hold classes or give lectures for your nurses?—Yes, I lecture; both my assistant medical officers lecture; my matron lectures; my head male nurse lectures, and my sister tutor lectures. My matron, who has double qualifications, lectures. When I say that the matron has a double qualification I mean that she is a qualified general nurse and has got the Medico-Psychological Certificate and also the C.M.B. My sister tutor has similar qualifications.

3860. Do the nurses obtain any qualification?—They are going up for the State examination, but it is only just now that the State examination has come into existence. Before that they went up for the Medico-Psychological examination.

3861. Do they now have facilities for preparing themselves for the State examination?—Yes.

3862. I notice in your précis that you rather deprecate the present machinery under which a patient has to go before a magistrate before he reaches you?—Yes.

3863. Have you considered that, after all, we are dealing here with an order of a more or less judicial character which is going to restrain the liberty of the subject?—True.

3864. Do you not think the civil arm in the shape of the law must have some recognition at that stage?—It is really that the patient should be taken before the magistrate that I deprecate, not that the patient should see the magistrate. I frequently find that the fact of going before a magistrate seems to impress itself upon the patient's mind in the then state of his mind; and it seems to create a feeling in the patient that some evil or wrongdoing has been committed, and that he is in the hands of the law rather than in a hospital being treated for a disease. That is the only question in regard to that point of being taken before the magistrate. If it could be avoided I think it would be well—if the magistrate could come to the patient.

3865. We have been told that relieving officers take patients to a Poor Law institution in the first instance, and that there the magistrates come and deal with the cases after they have been put to bed?—Yes, I think that would meet the difficulty, but a great number of cases that have been up to me have been to what they call the municipal buildings, and that impresses them very strongly.

3866. *Earl Russell*: That is the same place as the police court?—Yes; they cannot get it out of their heads that they have done something or other. It has a bad influence, I think.

3867. *Chairman*: Then you really object to the patients in your hospital reaching you *via* a Poor Law institution?—I find as a matter of fact that a great number of them are doing so now, because the medical men are beginning to be rather chary about certifying. There has been a considerable amount of diffidence about certifying recently amongst medical men, and they send them to the workhouse for observation, and they are nearly all certified by the medical superintendent of the infirmary.

3868. Then you think there has been a tendency to increase the number of cases which pass through the pauper stage before certification?—I think so, yes. When you say "pauper stage," of course the mere fact of certification technically constitutes pauperisation.

3869. There is a strong feeling in many quarters that it is unfortunate there should be that element of pauperisation connected with this particular malady, which does not exist in the case of other maladies?—Yes, but how are those patients who have to go to the workhouse infirmary for other diseases, supposing they are not taken into a general hospital, to be dealt with? What are they?

3870. There is just this difficulty, that many well doing people can get treatment in our general hospitals because their ailment is such that it can be treated here. They get treatment, they recover, and they have never had any element of pauperisation about them at all; but, because of the particular nature of the mental malady and the necessity of the detention order, for some reason or other this element of pauperisation seems to come in?—I was bringing up another point, and that was supposing a patient is unable to be admitted to the general hospital for a physical disease, and the patient goes to the Poor Law infirmary—is he not a pauper?

3871. Yes, you are right, he is?—Is it not a parallel case?

3872. The only thing that occurs to me is this, that all the mental cases which reach your asylums, that is to say, all cases of mental malady other than private cases, are designated paupers, but all cases of physical ailments are not. Very, very large numbers of people suffer from physical ailments and are treated

18 November, 1924.]

Lieutenant-Colonel J. FRANCIS DIXON, M.A., M.D.

[Continued.]

in general hospitals and do not suffer this stigma at all; of course those who go to the Poor Law infirmary do suffer that stigma, but still there is an alternative?—You mean there is an alternative for the poorest people, where it is a purely physical ailment?

3873. Exactly, you see the point. Every poor person who suffers from a mental malady seems inevitably to become a pauper, but every poor person who suffers from a physical malady does not become a pauper, because he may go into one of the general hospitals?—Would the public be likely to support hospitals for mental disease?

3874. You ask a difficult question, but we shall have to consider the question of whether this inevitable pauperisation of mental cases is also a desirable feature?—That point is also mentioned by my patient who says she thinks not.

3875. Just tell us about this magazine, because it is evidently one of the amenities of your institution. Can you supply us with a copy?—Yes, I brought a copy up in case you might like to have it.

3876. Yes, I have it. This is the October, 1924, issue of the "Harvest Magazine"?—Yes. I have what I call a spring magazine, a summer magazine, a harvest magazine and a Christmas magazine; it is a quarterly publication.

3877. It is evidently a new literary venture?—Yes, this is the first year of its life.

3878. And is it written entirely by patients?—Entirely by patients, and not censored in any way.

3879. How is it paid for?—It is printed by the patients; the print is set up and they print it themselves. When I say themselves, it is done by one man under the supervision of our asylum printer. We sell it to various people for 6d. a copy, and I pay the contributors out of the money; the contributors get the money. The lady who has written this article has also written some verses in that magazine which are not at all bad, I may say.

3880. Are those the verses on "Buttercups"?—No.

3881. "Disturbing spirits"?—"Disturbing spirits" is the article she wrote, yes, but she has written an article on "Should married women work?" She is quite versatile.

3882. You have handed us, I think, another article by her separately?—That particular article is "Asylums or mental hospitals—which, or both?" I think she is in favour of having two sets of things: one an asylum for the care and treatment of old people, and the other for the treatment of acute cases, which I think is a sound proposition.

3883. She is a certified patient?—She is a certified patient well known to the members of the Board of Control, I think.

3884. Is it the case of a person as to the propriety of whose detention you have no doubt?—I have no doubt about the propriety of her detention, but I think hers is a case in which a great many people might have a doubt up to a certain point; they might be some time in coming to a conclusion that she was a suitable patient to be detained.

3885. Has she ever expressed any views as to the propriety of her detention?—She has constantly.

3886. Does she want to be out, putting it quite plainly?—Yes. She thinks she is being illegally detained and says that when she does get out she will bring an action. She is constantly making efforts to escape, but she has written that article at the same time and written these other things.

3887. One does not want of course to probe the identity of any person to whom you are referring?—She personally wanted to publish that article of hers in the newspapers, and she sent her name and all about it; she does not mind about that at all. At the same time it is not necessary to probe her identity.

3888. No, but what I wanted to know was this. This seems to be a class of case round which a good deal of controversy might arise in the public mind?—I thought it was a very interesting case for that reason.

3889. Have you any doubt of her insanity?—I have no doubt of her insanity.

3890. Would you rather not discuss it?—I think it is quite open to discussion; I have no objection to discussing her case. I told her it was quite possible it would be discussed. She is perfectly sensible in a great number of ways.

3891. What is the type of insanity?—She is what is known as a case of paranoia.

3892. What are the symptoms?—The symptoms are that the patient has ideas that there is a conspiracy against her.

3893. Is that a delusion of persecution?—A delusion of persecution of a certain type—a rather delicate type in a sense. It is not very easy to see what her ideas are, but she is lacking in judgment, and no amount of persuasion on anybody's part would explain that the various things she thinks of are without foundation, and that nobody has any motive for doing the things she thinks are being done. If anybody took the trouble of reading that article, they would be able to discover the elements of insanity in it, but a great deal of what she says is perfectly true; a great deal of the criticisms about asylums are perfectly true so far as they go, but the point is that it is not well-informed, and does not go the whole way. There is a lot of truth in it.

3894. Here is a case evidently of a person with a considerable degree of intelligence who desires to leave your institution. Has she been seen by your visiting committee?—Yes, she has been seen by individual members of the visiting committee on several occasions; she has been seen collectively by the visiting committee on several occasions. I have written reports about her to the Board of Control on several occasions; she has been seen by the Commissioners of the Board of Control.

3895. Has she ever had an opportunity of putting her case to outside people?—She has written to the Lord Chancellor, the Lord Chancellor has written to the Board of Control, and I have sent up further reports; and, in order to give the Lord Chancellor an opportunity of seeing what the case is really like, I enclosed, with the patient's consent, about 100 or so letters she has written to various people.

3896. Has she ever asked for an examination by an independent doctor or by the Board of Control?—I do not know if she has asked for one, but if she did she could have one at once. All these things have been done, and I think everybody is satisfied that she is insane. So far as I know nobody has come to any other conclusion.

3897. *Earl Russell*: Except herself?—Except herself.

3898. *Chairman*: Does she protest that she is sane?—Yes; she gets annoyed with me when I tell her she is insane. I do tell her definitely that she is of unsound mind, and I tell her in what way she is.

3899. Can she grip the idea?—I am beginning to wonder if some sort of a marvellous thing is not going to happen about her. Every now and then I seem to think that there is a sort of gleam or glimmer of her getting an insight into her condition. It is elusive; it goes away, and she is bad as ever again. We do not look upon those cases as at all curable, and if she is by any chance cured, we should be rather pleased about it.

3900. It is quite obvious that you have studied this case very particularly?—I have.

3901. Do you give special attention to those cases where there may be some difficulty, or where the patient is protesting against detention?—Yes, certainly, of course. I mean there are some cases that have no sense at all. You do not want to be a doctor to know that they are insane. Any man in the street can see that certain cases are absolutely and completely off their heads. These others are the difficult cases. These are the cases that want to be studied and are studied.

3902. And may the manifestations be subtle?—Very subtle, and not easily discernible. Many people go round and say, "I do not know what is wrong with that person at all." On the other hand,

18 November, 1924.]

Lieutenant-Colonel J. FRANCIS DIXON, M.A., M.D.

[Continued.]

they might see a person coming in who is very obviously insane, and they might say "That is a hopeless case," and I say "No."

3903. It seems in those cases the public must depend to a large extent upon the medical men who have to deal with the cases?—I think so undoubtedly. I mean to say that a member of the public coming in to examine that case, without the assistance of the expert to point out and to lead him into the region of trouble, might never approach it at all, might never touch on it.

3904. Then we will circulate this article among ourselves if you will be good enough to leave it with us?—By all means.

3905. There is one other matter. Have you any views as to the desirability of removing chronic cases and hopeless cases from your mental hospital to Poor Law institutions?—Yes, I feel rather strongly on that subject. I think that if there is any stigma—and it is acknowledged that there is a stigma—attached to being a patient, remaining a patient under certificate, when other accommodation can be found it should be found for people who are perfectly harmless and do not require the administrative arrangements which have to exist in a mental hospital.

3906. I thought that one of the reasons in your mind was that you would in that way relieve the strain on your accommodation and concentrate the use of your curative appliances and methods upon cases which had more hope of recovery?—That is so.

3907. But the chronic cases for which nothing can be done except to provide shelter and such comforts as you can give, would do as well in a Poor Law institution?—Yes. I refer now to senile cases, cases that are simple-minded and only require to be treated like children. Some of them are bedridden, hopeless bedridden cases that ought to be treated in a general ward of a Poor Law institution; no mind of course, and can be certified as of unsound mind, because their mind is finished, but they do not require asylum treatment at all.

3908. Then have you any views upon the treatment of incipient insanity without certification?—I think it is very desirable that patents should be able to get treatment without necessarily being certified as insane.

3909. You know the difficulty of justifying what may be a necessary element of detention without the intervention of some kind of order?—Yes.

3910. Do you think, looking at it from the practical point of view in your own experience, that many cases might be saved from certification if they were dealt with in some provisional way?—Yes. With regard to certification I cannot quite follow some of the arguments in connection with it. To certify a patient is really to say that a patient requires treatment, and to say that the patient requires treatment for unsoundness of mind. Now really if you are going to treat an unsound mind you must have power over the individual who possesses that unsound mind. The mere fact of unsoundness of mind connotes authority to deal with the individual.

3911. Connotes irresponsibility, and therefore the necessity for control?—Yes. I mean to say you may be ill, and your mind may be affected, but when does it become unsound?—It becomes unsound when your conduct begins to get such that you are not amenable to ordinary society, and you become irresponsible in that way; but you may be suffering from mental disease which perhaps need not necessarily amount to unsoundness of mind.

3912. Yes, but to you, of course, the idea of certification may seem more or less innocuous; it is a matter you are dealing with regularly. There does seem on the part of the public to be a certain abhorrence of stamping any human being with what you may call the hall mark of insanity; it is a blot on the record of that person, which they do not suffer from if they have merely had pneumonia or any other ordinary disease, which, as an incident of their lives, passes away. But for some reason or other a person in

whose case a certificate of unsoundness of mind has been given is regarded as a person against whom there is a definite mark for life?—Do you think that really has to do with the past or with the future? Is it traditional, or is it a fear of a return of the malady?

3913. It is very difficult to say whether it is a thing which may pass away with more enlightenment, but it seems to be very deeply ingrained in the public mind?—Yes, but I think it is more traditional than anything else. It seems to me that it is largely the outcome of former ideas of the nature of insanity.

3914. Yes, probably, but let me put an example to you. Supposing you have a witness giving evidence before a jury, a witness giving quite excellent testimony, and then the question is put in cross-examination "Were you certified as a lunatic six months ago," and the answer is "Yes, I was." Now I am looking at the jury, not at myself at all. To the mind of the jury that would inevitably convey a serious imputation upon the value of that evidence?—It would, but many things presented to the jury have the same effect; they are mentioned for the purpose of affecting the jury, and that would be one.

3915. But a certain solemnity would attach to that observation which might not attach to another. There are many comments made of course upon past records, but just as a previous conviction, so to speak, is a very awkward thing for a criminal, or indeed a conviction at all for a witness, so also certification of insanity suggests somehow or other to the public mind, not to the expert mind, not merely that the person has had a particular form of brain illness, but is also a person who is outside the ordinary pale of humanity. It is that element that one is so anxious to obviate?—Yes; but when we consider it was not so many years ago they were burning these people, when they were supposed to be possessed of devils, and they were driving the devils out of them with sticks and such things, it is hardly a great deal to be wondered at that it is looked upon as something quite outside the ordinary pale of humanity.

3916. Would it not rather assist in the development of this very idea that you have in your mind, the removal of this conception, if people could be treated in the first instance in homes or institutions which were not of the nature of asylums but partook rather of the character of hospitals, in which they might be detained (I appreciate the necessity of some control) for a period before they were finally stamped with the hall mark of certification and remitted to one of your institutions under that category?—After all, if you do that why certify them at all, because you can keep on renewing whatever this authority is you propose to give.

3917. You do not think there is much to be said for a differentiation in certification, so to speak?—You can call it something else. The whole thing amounts to giving a person authority to perform a technical assault upon a person for that person's own good. You can call that anything you like. You can certify the doctor if you like and say: "This man is a certified doctor for looking after patients of a certain class," it is simply protection given to whoever is dealing with a person who requires to have something done that he does not necessarily agree to have done to him; it is an interference with personal liberty. In an ordinary disease a patient is only too willing to undergo treatment, he gives his consent. In a great number of mental diseases too a patient will give his consent, but in some of the very worst cases the patient is not capable of giving his consent, or, if he is capable, he refuses to give it.

3918. Or may withdraw it just at the critical moment?—Yes, all those things may happen. Supposing a man falls down and cracks his skull and is unconscious, are you going to wait till he comes round before you get his consent to perform an operation on his skull to move some depressed bone, or something like that? There ought to be some way of getting over the difficulty of certifying that man as insane because he has met with an accident. After

18 November, 1924.]

Lieutenant-Colonel J. FRANCIS DIXON, M.A., M.D.

[Continued.]

all, all these mental diseases have a physical basis. We do not know what some of them are; we do know what some of the others are.

3919. Have you studied the provisions of the Mental Treatment Bill introduced last Session?—Yes, I read it through.

3920. The cardinal proposal there is for the temporary treatment of mental disorder without certification?—Yes, it all comes back to the same thing in the long run. We should like to get hold of these people early, but the very acute recent cases may be raving mad people. You see this thing does not come on, like some other illnesses, gradually. The ones that come on gradually are the ones you do not have much hope for; but most of the acute mental illnesses are recoverable and they are only temporary, and they are the most difficult to deal with as a rule.

3921. But do not you think that the repulsion from the idea of the asylum may often deter people from taking their relatives for treatment, or the patient himself from going for treatment at the earliest stages when the case might be most hopeful?—I think that is so, but I think it is so to a less extent than it was, and it is probably likely to diminish as time goes on with the improvements of method, and the general reputation of mental hospitals. I think they will go on improving, and I do not see why they should not be ultimately as reputable as other institutions.

3922. The trend of your evidence is the education of public opinion, coupled with greater knowledge of your institutions and progressive improvement of methods placed at your disposal for the treatment of cases?—Yes, that is practically what it amounts to.

3923. *Mr. Micklem*: In the case of the lady you referred to who wrote these papers, if there was anyone outside who was prepared to look after her, would there be any objection to her leaving the hospital?—That question did arise. She has relatives, but they could not undertake to look after her on the one hand, and she herself would not undertake to allow them to have anything to do with her.

3924. Is she dangerous or unfit to be at large?—She is not dangerous in a sense, but I think she is unfit to be at large, for the reason that she spends all her time calling on public officials and presenting the same petition to them irrespective of any chances she has of deriving any benefit; and she is so much occupied in that particular way that she is unable to concentrate her mind on what she says she wants to do, which is to return to the teaching profession, but she could not go on with teaching while she has all these grievances in her mind. What she was brought to the institution for ultimately was in connection with smashing some windows of one of the officials. I do not suggest smashing windows is any reason for people being brought to a mental hospital, but it was in conjunction with other things. That brought things to a head in her case.

3925. In your view are many of the certifications of senile dementia entirely unnecessary?—Quite unnecessary, I think.

3926. And a large number of cases that are found in the asylums you think ought to be referred back to the infirmaries under the Poor Law administration?—I think so. No doubt some of them were at one time suitable for asylum treatment, but they have now reached such a stage that they do not require any longer the peculiar and special treatment of an asylum, and I think they ought to be decertified, if I may so call it.

3927. *Miss Madeleine Symons*: Dr. Dixon, could you give us any figures of the recovery rate of patients admitted to your asylum and percentage of readmissions?—The number of direct admissions previously under treatment here or elsewhere—that means readmissions either from having been discharged from this particular institution or having come from others—842 patients were in the institution at the end of last year, and there were 189

admissions. Of that number 39 were readmissions. The rate of recovery on the direct admissions is not so good this year as it has been in some previous years, but it was 37 per cent.; much bigger on the female side than on the male side—30·88 on the male side and 41·41 on the female side, the combined average being 37·12 percentage of recoveries on the admissions. The general percentage through the country is 31·1, so that it is a bit higher than the general rate. Another way of presenting the particular return I have got here—I have introduced it recently in my report—is the rate of recovery on total recoverable cases under treatment. That was 57·9 per cent. Then the rate of recovery on the total number of patients under treatment was 6 per cent.; that includes all the old residue.

3928. Could you tell us the number of staff you have for those patients?—I do not know that I have the exact numbers here, but there are about 70 female nurses and approximately 50 males; and the number of patients is, males 332, and 510 females.

3929. You have told us that you thought the salary paid to probationers was too high, and the later remuneration perhaps too low. Could you give us any information about what the salary is in the case of both male and female nurses?—I am afraid I cannot at the moment say exactly what it is, because it is very complicated owing to various deductions. What they do now is, they give a salary based on the recommendations of the Joint Conciliation Board, which was a board made up of members of the Mental Hospitals' Association and members of the National Asylum Workers' Union; they formed a conciliation board and arranged for a scale of wages and for general conditions of service. I think that the basis of the initial or minimum salary of the male probationer was what they started with, and that was the agricultural wage in the country. Now whatever the unit was the female got 20 per cent. less, but it was a living wage; it was reckoned to be a living wage; that is to say that the young probationer who knows nothing at all and has to come to be trained is being paid what is called a living wage.

3930. Do you find that under this present system your staff stay with you a long time, or do a good many of them leave in a fairly short time?—I find a good number of the female staff leave. The male staff do not leave so frequently. Some of the changes on the female staff are due to the fact that they are found to be unsuited to the work, because we are making a rather careful selection. A good number of female probationers are told after they have been there a few months that they are not likely to be taken on the permanent staff, and they go for that reason; but apart from that, a considerable number go for other reasons.

3931. A fairly high proportion of them go before they have finished their training?—Yes, they do not stay through the whole length of it, and also there is a wastage of trained nurses at the end who go into private practice, and a proportion of them get married. We make no restriction against the males getting married; they can get married and settle down, and a good many of them do.

3932. But you dismiss the women on marriage if they don't resign?—Or are unable to carry out their duties.

3933. They all live in?—Yes, they all live in, whereas the males do not.

3934. *Earl Russell*: I want to go back to your continuation order. It is under Section 7 of the Act of 1891 I see, and the words used there are the same as in the form prescribed by the Board of Control—that the patient is still of unsound mind and a proper person to be detained under care and treatment. You thought the modification I suggested would still leave it too strong?—I did think so, but it is certainly an improvement.

3935. May I suggest these words, which I think would meet the most tender conscience: "that the patient although convalescent is still a proper person

18 November, 1924.]

Lieutenant-Colonel J. FRANCIS DIXON, M.A., M.D.

[Continued.]

to be detained under care and treatment"?—Yes, I think so.

3936. And if the Board of Control thought that that was not strong enough, and required investigation, of course they would have power to investigate it?—Quite.

3937. Your paranoiac patient you were telling us about is not what you would call a borderland case in the sense that there is any doubt about the insanity?—Not so far as I have been able to discover up to the present. Everybody has ultimately been satisfied; everybody that this lady has written to has been convinced by her letters that she was insane.

3938. A difficult case to diagnose, but with the knowledge of her history and so forth there is no difficulty in coming to a conclusion?—I have been able to satisfy everybody so far. The Board of Control are satisfied; I think the Lord Chancellor is satisfied; I am satisfied and her own people are satisfied.

3939. Are you satisfied that any other competent alienist would come to the same conclusion?—That I could not say, of course.

3940. That is putting it too high?—Yes.

3941. This is the sort of case, is it not, which a visiting committee rashly appointed might discharge by three of their number under the impression that the patient was sane?—I can quite imagine a set of circumstances in which such a thing might occur.

3942. I notice in your *précis* you say that this does occur sometimes?—It has never occurred in my personal experience, but I have heard of its occurring.

3943. You say: "This latter power has been known to be abused where newly appointed members have rashly stepped in and discharged several patients who they thought ought not to be detained"?—Yes.

3944. I should be very glad if you could tell us any place where that has occurred?—As a matter of fact I think you will probably find that that will come up in some of your future sittings. I think it is to be mentioned by a member of the Committee of one of the Lancashire asylums. It was related by him at a meeting I attended.

3945. Do you appreciate that even as the Act now stands it means that three separate individuals who are public representatives must take upon themselves to disregard the medical advice before this can happen?—Yes.

3946. Do you think that limited to three it is still undesirable?—I think the committee as a whole should take the responsibility.

3947. Now about the inside of your asylum, how many bedridden patients have you got?—I should think about 30.

3948. And are you very particular about bedsores and things of that kind?—Yes.

3949. Are the patients examined with sufficient frequency?—Yes. I mean to say they are examined several times day and night. We do not have bedsores arising.

3950. And if they arise they are at once dealt with?—Yes.

3951. Are the wards provided with cupboards in which presents or private property of the patients can be kept?—Not to a sufficient extent; in my opinion there ought to be a lot more done in that direction. Of course, underlying the lack of accommodation for patients' private things is the old-fashioned idea—perhaps not altogether old-fashioned, but the feeling that there is what they call a fear of the patient secreting something that he ought not to have. I was talking to an assistant medical officer from an asylum, and he told me, "None of our men have any pockets in their clothing." That is at the bottom of a lot of the absence of accommodation for patients' private things; they are not allowed to have anything. I think, of course, that is quite wrong. I think in the vast majority of cases they should have

private accommodation for their own little private things.

3952. I was thinking of a cupboard which was kept locked by the matron where the patients' private things were kept, such as cake or fruit?—I have food cupboards distributed about the wards which are ventilated and with a glass front, so that the patients can see what is there.

3953. Who keeps the key of that cupboard?—The sister keeps the key.

3954. And I suppose you have the notices put up about the people they can write letters to?—Yes.

3955. Do you have a separate place where they can post letters in a ward, or are the letters collected by a sister?—They are collected; I have not got separate places. That has been recommended, as a matter of fact, by the Board of Control, but I think it is only based on the supposition that there might be some letters detained. I should look upon it as rather an insult to feel that I had to do a thing like that. I would rather keep in close contact with the people and let them feel and see that no such thing would be tolerated as any interference with their correspondence.

3956. When your female patients are bathed are they bathed together or separately?—There are two arrangements for bathing. There is what is called the general bath. That takes place in a semicircular bathroom with sprays which do not come on to the patient's head, but on the shoulders on either side. There is a seat below the sprays that the patients can sit on, and there are nine compartments each separated from the other by sheets hung on rails about as high as the patient's head, and each of these compartments converges towards a centre point at which the supervising sister is who regulates the spray for the bath. The patients walk into a compartment covered by a sheet, and they hang the sheet over the opening, and they are generally under the supervision, as far as seeing over the top is concerned, of the sister, and there are nurses in each compartment who assist in the bathing of those people who require assistance. Many of them are quite competent to bath themselves.

3957. The particular point I want to put is this: does it involve a number of women seeing each other naked or not?—No, it does not.

3958. They are separated as you describe?—Yes.

3959. And in no case is the bathing done in a public way?—No. There are ordinary slipper baths in each of the wards as well.

3960. Are the slipper baths also screened?—No, they are not.

3961. Are they open to the whole ward?—No. There is a bath-room with a couple of baths in it.

3962. Not screened from each other?—They are not permanently screened, but there are screens there, of course.

3963. Is any complaint ever made about those by the female patients?—No. I need not tell you that I have had complaints made in previous years, before this arrangement came about. I may also mention that a similar arrangement does not exist on the male side, and there is no complaint there at all; the matter is dealt with in a different way.

3964. I want to put this suggestion to you about more ventilation. We have before us a suggestion from a meeting of justices of the peace that they might also appoint visitors to visit an asylum as well as the people who now visit it. You think that would be a good idea in your view, that justices of the peace should visit asylums?—I think in the case of the justices of the peace who are specially appointed undoubtedly it would be a most excellent thing for them to go round and get some experience of these institutions, and learn something about the patients that they have to give directions about.

3965. I know, but I rather meant from the point of view of ventilation and of the public coming in. It would be an additional set of visits if justices of the peace were to visit asylums, and these justices

18 November, 1924.]

Lieutenant-Colonel J. FRANCIS DIXON, M.A., M.D.

[Continued.]

suggested that they thought they ought to do so. Do you think it is desirable?—As far as the justices of the peace are concerned I do not think there is any objection to it.

3966. You know as regards taking the patient to the police court and treating him rather as a prisoner, we have had evidence in some cases that he or she is taken direct to the workhouse, put to bed there, and seen next morning or the day after by the justice?—That, of course, is another matter.

3967. So far as that is concerned, you would have no objection to the intervention of the justice?—No, because he would not approach the patient in that capacity. He need not reveal his capacity necessarily.

3968. Perhaps he need not. One more question again on a question of words. Do you think that perhaps this softer phrase would be better than "Certified lunatic"—"A mental case under compulsory treatment"?—What is this for?

3969. To avoid the stigma of calling a person a certified lunatic, you would call him "A mental case under compulsory treatment"?—You mean substituting that on the reception order?

3970. Yes, using those words as the official words?—I think the word "lunatic" is perhaps rather out of date in this sense, that it conveys a meaning that has been applied to that sort of condition in the past; it would be just as well to drop it and start afresh with a new nomenclature in regard to these proceedings, but whether that particular phrase is the one or not I would not like to commit myself at the moment.

3971. *Mr. Snell*: Dr. Dixon, you said that patients when they were convalescent got leave of absence for week-ends, and so on?—Yes.

3972. What is the effect upon the mind of a patient who, after leave of absence, has to return to a mental institution?—They are all right. They come back and tell you all about what is going on at home, how their people are, and how they have been enjoying themselves, and so on.

3973. It does not have an evil effect upon their condition?—No. I have to select the sort of patients who may do that, of course. Short leave of absence from the hospital has been granted during the year on 1,739 occasions to male patients and on 316 occasions to female patients.

3974. What is the curative effect or otherwise of visits from friends and relatives? If a visit, for instance, is from a wife and children, does it help, or is there a reaction of depression?—It entirely depends upon the case, first of all, upon the mental condition of the patient, and also upon the kind of person who is visiting. A person might be one who would do the patient more harm than good. The patient might be in such a condition as not to derive benefit from a visit.

3975. I think you said that patients might desire to remain in a mental institution voluntarily, and ought to be allowed to do so?—Yes.

3976. Do you think that the fear of the struggle for life outside could enter into any preference of this kind?—I do most undoubtedly.

3977. They are afraid to renew the outside struggle for life?—Yes, provided that the conditions in the mental hospital are tolerable, and not only tolerable, but very good and efficient. The better you make your mental hospital, the more likely are they to want to stop. I have a good number of people that I could not get rid of, if I wanted to.

3978. Supposing a patient forms the delusion that it was a more comfortable and serener life to be inside for ever than to face the struggle for life?—It would not be a form of delusion to want to stay for ever.

3979. Have you any definite separation of patients who are incurable from those who are temporary cases?—No, not entirely. In other words, I cannot

say that I have got all the curable cases *here*, and all the incurable cases *there* (*describing*), but approximately most of the curable cases are in certain surroundings or conditions which are the best suited for their condition, as far as our accommodation goes which, of course, is not ideal. For instance, there is one thing I may mention, namely, the little isolated villa that we have. In the villa all the doors are open, and there is a nice walled-in garden all round, and they do a good deal of their own domestic work there. There are about 20 patients who live approximately a normal existence; they serve out food, and do all sorts of things. The patients do it with the assistance and direction of one nurse. I frequently send my patients who are on the way to recovery over there, in order that they shall get as near as possible to the ordinary domestic arrangements of home life, so as to get accustomed to it.

3980. Then is not the habitual association with incurable cases likely to have a bad effect upon the cases that may be regarded as temporary?—I am not prepared to say that that is the case, because I think if you admit that, you must admit that all people who are for a long time in contact with the insane must begin after a few years to show a certain amount of mental deficiency, and to discuss that would lead us into—well, I do not quite know where.

3981. But granted that your patient is in a highly nervous condition to begin with, and he is thrown into habitual contact with incurable cases, some of which are distressing, is not that likely to have a bad effect upon him?—I think undoubtedly, as the patient to whom I have referred says, it is a most undesirable thing that a patient who is perfectly sane, as she says she is, and perfectly conscious of everything, should be subjected to the noises and abnormal conduct of people round about her. I have to put her in a ward where there are 20 or 30 other patients, some of whom are not everything they should be; but, owing to the fact that I have not got all the accommodation I should like, and all the powers of classification I should like, these things happen. She says, of course rightly, that you cannot move your bricks and mortar about the place, and consequently that is why I cannot get everything I want. She is quite alive to that.

3982. Are children mixed with adults amongst your patients, and, if not, at what age are children considered to be adults for treatment purposes?—I have at the moment some 10 children under the age of 20; they are there simply because the Committee for the care of the Mentally Defective, who have special facilities, or are getting special facilities for that class of case, have not been able to accommodate them up to the present, but that is only a temporary matter. I hope in the course of time those children will be removed.

3983. What chance has a paranoiac patient, such as the one that has been mentioned, of getting any judgment on her confirmed by the opinion of another alienist—another mental specialist?—Do you mean outside the institution?

3984. Yes. Suppose the case were in dispute; she protested that she was sane, and she wanted another opinion, a consultant. Is there any provision for that?—Do you mean financial provision?

3985. No, I mean any provision for her being allowed the privilege of seeing a consultant?—There is nothing to prevent her doing anything which she can get her relatives to do. What she has done already is to write to the Board of Control, who are the specialists; they have alienists there. On the next visit of the Board of Control they make a special point of interviewing this lady, which they have already done—members of the Board of Control.

3986. And they are mental specialists?—Not all of them.

3987. Some of them?—I should think they are mental specialists; they are not necessarily all doctors, but I think it is quite possible that people constantly dealing with mental cases become mental

18 November, 1924.]

Lieutenant-Colonel J. FRANCIS DIXON, M.A., M.D.

[Continued.]

specialists in time, without necessarily holding a medical degree.

3988. *Mrs. Mathew*: I wanted to ask if you thought the seven day report to the Board of Control left you a long enough time to make a really good report?—I think, of course, the more time up to a certain limit the better, but on the whole I think one should be able to arrive at some conclusion in that time.

3989. Have you a dental surgery or dental treatment for your patients?—Yes, we have a dental visiting surgeon who visits regularly, and we have up-to-date equipment for him.

3990. And the patients have access to the grounds on all days, every day, do they?—Which grounds do you mean?

3991. You mentioned a party that they had, when they went out into the grounds. I was wondering whether that is usual or unusual?—It is not unusual for them to go out for walks, but these are special occasions where they have a lot of visitors up in the grounds.

3992. Have you arrived at the cost per head of your patients?—Do you mean for this last year?

3993. Yes, what is the figure?—The figure is 21s. per week.

3994. Does that include everything?—Yes.

3995. Overhead charges?—21s. 4½d. to be exact.

3996. *Earl Russell*: That does not include overhead charges surely?—No, this is maintenance pure and simple.

3997. *Sir Humphry Rolleston*: Dr. Dixon, you say that the machinery of the Act as it stands now is unnecessarily cumbrous and complicated, and you support that view mainly by a criticism of the form of the continuation reports. Is not that so?—As a matter of fact I really think I made a general statement, and I do not think I supported it very much because there is nothing really cumbersome about the particular thing I brought forward.

3998. I was going to ask you what were the grounds. You say it would be fairly easy to safeguard the liberty of the subject. What are the reforms that you suggest?—I do not think that I am quite in a position to go into the question of the reform of the law and the certificates and all that sort of thing. I have not laid myself out for that.

3999. You say it should not be very difficult?—Well it probably is very difficult really.

4000. That is disappointing. Now with regard to the continuation order, you instanced the case of a patient who is convalescent whom you do not feel you can certify as being of unsound mind and who wishes to remain. Can you retain her without signing up the continuation form which says she is unsound?—No.

4001. So that your suggestion would be that the continuation order should be modified so as to allow voluntary detention?—Yes.

4002. Now take another case: you have a patient who is convalescent whom you do not consider to be unsound, and who does not wish to stay. Would it be wise to certify that patient against his will and keep him in?—There are degrees of convalescence—stages of convalescence. Sometimes it is not an advisable thing for a person to leave at one stage of convalescence rather than at another; but I do not know whether, if they can be said to be convalescent, any special rules or regulations are required to cover the few cases which might arise of people who, notwithstanding they were convalescent and not advised to go, still wished to go.

4003. Would not the mere fact of their being retained when they wished to go assert a malignant influence over them?—It is difficult to say.

4004. Now you say that the authority who gives the direction for the detention of the patient should be specially qualified. You mean you would specialise him rather—that he should be always dealing with these cases?—I think that would probably be a very good thing.

4005. So that you would get one justice to devote himself to examining these patients—is that so?—I think so; something of that nature.

4006. Would you treat the doctor who certifies to the justice in the same way: Would you as far as possible get hold of the same man, a man who has had special experience, or would you take a man of general wide knowledge but with no special devotion to that particular question?—If it should be found desirable—and I think it probably may be that the Commission will find it desirable—that the rate-aided patient shall have the benefit of two medical certificates, the same as a private patient, rather than one, I think it is desirable that one of the medical certificates should, if possible, be made out by the patient's own medical man, and that the other one should, if possible, be made out by somebody specially qualified or specially appointed for the purpose.

4007. Now you spoke about the improvement in prospects for the medical profession engaged in the asylum service, and you suggested that the medical superintendent should retire at some age—we will say 60 or 65?—Yes.

4008. Do you think there is any choice between the age or between the duration of the period for which a man is to hold the office of superintendent?—Of course, I think probably the duration would meet the case better than the age.

4009. What period would you suggest?—I think 30 years' service.

4010. What is the average age at which a man becomes a medical superintendent—45, I suppose?—Before that, I think, now.

4011. So that you would say 30 years service or at the age of 60, whichever comes first?—Yes, I should think so.

4012. You referred to the important subject of the out-patient treatment of incipient lunatics, and you suggested that perhaps the best plan would be that the out-patient department should be part of the mental hospital?—I do ultimately. Mind you, I do not think that idea is generally held, for the simple reason that it is assumed that the mental hospital will always have attached to it the reputation that it has at present. I would not like to assume that.

4013. It struck me that your argument for attaching the out-patient department for the incipiently unsound was mainly to remove what stigma there may be attaching at present to mental hospitals?—It helps to remove it certainly.

4014. It cuts both ways, does it not? If a patient attends a mental hospital he is likely to be stigmatised?—If the idea is that once there always there, and that the patient is evidently going to become a permanent inmate, yes, but that is what we are trying to avoid.

4015. If a person has some doubt about the state of his mind, would not he be more likely to go to a general hospital? A mental hospital is generally some way away from the town?—Where they are conveniently situated, I think it ought not to be forgotten that in order to raise the reputation of the hospital you should not detach the staff.

4016. Would it not be better for the medical officer to go to the general hospital and see the patient there?—It has its advantages, certainly; that is what they do at Oxford.

4017. *Sir David Drummond*: Dr. Dixon, I judged from what you said that you did not attach so much importance to the idea of the stigma of certification as some of the public do?—After all, the mere fact of the stigma only arises from what the public think. That constitutes it, does it not?

4018. I thought you said that the stigma did not exist?—What I really think is that the stigma is likely to diminish. I do not think it is very likely to be abolished altogether. As the public get more educated in these matters, when they find a great number of people who have had mental attacks have recovered completely from them, and do not have any relapses, then I think in course of time it will be greatly diminished.

18 November, 1924.]

Lieutenant-Colonel J. FRANCIS DIXON, M.A., M.D.

[Continued.]

4019. Is not the stigma rather that the patient is insane, not that he was certified insane? In the same way as you speak of a patient who is consumptive, the stigma is that the patient is consumptive?—Yes.

4020. So I take it that there is not really the degree of stigma attached to the certificate so much as to the fact that the patient is insane?—Yes, because insanity conveys a feeling of uncertainty as to relapses.

4021. Do you really mean that nine-tenths of the patients admitted into mental hospitals are incurable?—I do not say that nine-tenths of them are incurable on admission, but of the patients in mental hospitals nine-tenths are incurable.

4022. You gave 189 admitted for one year and 57 of those people recovered. That is a very much larger proportion?—Yes, but these are the residue. I have a table here which I have been using for the last two or three years of the admissions and the kind of admissions so far as one can judge. We had 189 admissions last year, and of those admissions there were 71 considered to be recoverable; only 71 out of 189 were considered to have a chance of recovery. I meant nine-tenths of the people in the institution at any given time.

4023. Now the Chairman asked you if you had ever had a case in which you read the certificate of two doctors, or one doctor, and took an opposite view?—I would not like to say an opposite view, but I have on occasions not been able to confirm the view that was expressed.

4024. Can you conceive of a medical superintendent actually taking up that attitude, that he does not confirm, and he discharges the patient there and then?—That has been done.

4025. Can you conceive of it being done frequently at all?—No, it is quite an exceptional thing.

4026. What accommodation is there for private patients in your district?—By "district" you mean the district served by the mental hospital—that is the city of Leicester?

4027. Yes?—I do not know that there is any registered or licensed accommodation.

4028. Do you think throughout the country there is sufficient accommodation for private cases—people who can afford to pay?—I understand that there has not been any addition to permission to have private patients issued for a long time, but the question as to what amount of accommodation is required I could not answer.

4029. What do you think has been the practitioner's difficulty in certifying? You told us that the practitioners of late are rather inclined not to certify?—Their difficulty, as far as I can judge from expressions used, is that they feel they are undertaking a very considerable amount of legal responsibility; they think they are going to be in the Law Courts, and that sort of thing, if the patients get better; in fact, they are not sure what constitutes insanity sufficient to warrant their certifying.

4030. What, in your opinion, constitutes a certifiable case?—That is an extremely difficult question. You flatter me very much by asking me it.

4031. You would not propose to give an answer?—I would not propose to give a general answer to that question.

4032. Therefore you recognise that it is a matter of opinion very largely?—Undoubtedly a matter of opinion to a certain extent. I think there are cases in which there can be no question at all; it is perfectly obvious; but there are a great number of cases in which there is a very considerable amount of difference of opinion.

4033. *Sir Ernest Hiley*: I have only one point to put to you, Dr. Dixon. You let out a large number of patients, both men and women, on what you call

trial during the year; you let them go home?—There is a technical term which means discharging a patient on trial, that means to say that the patient is recommended for leave on trial to the Committee, and the Committee give them that trial leave; but I personally have authority to give the patient 48 hours' leave without reference to the Committee, and I frequently do it.

4034. When the Committee allow them to go out on trial, do you give the patients any advice or prescribe any rule of conduct for them, so that they may benefit by their period of trial?—When they go out on trial the assumption is that they are practically recovered.

4035. You class them as recovered?—When we receive a certificate which they take with them, or rather their friends have it, and that certificate is signed by their medical man who observes the case when it is at home, and he says, "I think this patient is now recovered, and no longer requires institutional treatment," that is sufficient for me to consider the patient recovered.

4036. They are under observation?—They are under observation, but, so far as I know, it is not a systematic observation. I do not know that their own medical man keeps them under any special observation owing to the fact that they have been discharged on trial. I am not aware of that; I do not know that any arrangements exist for that purpose.

4037. Have you any arrangements for after care, or anything of that sort?—We tried to get a branch of the After-Care Association started in Leicester, but we have not been able to raise sufficient enthusiasm amongst the people to get one going. I do, however, make use of the Mental After-Care Association, and I am in correspondence from time to time with them in regard to certain cases that are willing to be helped by them, and in certain instances I have sent cases to them, and they have done very well.

4038. Was I right in thinking that the percentage of these cases that come back to the asylum is 39?—Not the percentage; that is the total number.

4039. Thirty-nine out of 189?—39 out of 189, yes.

4040. In answering another question you gave the same figures as percentages. That is why I asked you. You gave the percentage of recoveries as 37?—That is right.

4041. Out of 842 patients?—Yes, but you must remember that this percentage is a percentage on the direct admissions.

4042. Previously under treatment there were 39. Out of 189 or out of 842?—Out of 189.

4043. *Chairman*: Have you ever had a case under Section 49 of the Act, where two medical practitioners have been appointed by the Board of Control to come and see a patient under your care?—No.

4044. Are you aware that there is that safeguard, that either the patient or any of his relatives may make an application to have two outside medical men brought in?—I am aware of it, but I have no experience of it.

4045. I understand in your institution the patients are allowed to sit up at night?—Yes.

4046. To what hour?—Half the male patients sit up as long as they like. They go practically whenever they like, within a limit of half-past nine.

4047. Practically, you allow a considerable amount of freedom as regards bedtime?—Yes.

4048. That is not universal, is it?—No, I do not think so.

4049. Do you think it desirable to give freedom in that respect? Is it compatible with the proper discipline of your asylum?—Yes, I find it is, but there might be conditions in which you could not do that sort of thing. As far as my place is concerned, I do not find any ill-effects from a disciplinary point

13 November, 1924.]

Lieutenant-Colonel J. FRANCIS DIXON, M.A., M.D.

[Continued.]

of view. A great number of the patients elect to go to bed much earlier than that. I find, when I am going round the dormitories after tea, about 6 o'clock at any time of the year, a certain proportion of the patients walk off to bed.

4050. The importance of your system is that it gives an idea of freedom to your patients?—Yes, that is the idea of the system.

Chairman: We are very much obliged to you, Dr. Dixon.

(The Witness withdrew.)

After an Adjournment:

Dr. O. G. CONNELL, M.C., L.R.C.P., called and examined.

4051. *Chairman:* Are you Medical Superintendent of the Norfolk County Mental Hospital, Thorpe, Norwich?—Yes.

4052. I do not propose to take you over many of the topics which have been discussed by your predecessor in the witness chair to-day, but we should like to have from you some evidence on several points. Have you paid particular attention to the question of the safeguards against undue detention of persons in asylums?—Yes, I have. The present reception order, in my way of thinking, is sound; but I think that the same procedure might be adopted with pauper patients as with private patients, with the two doctors' certificates and a justice's order, and the petition, either of a relative, or, in the absence of a relative, of a responsible officer.

4053. Of course one recognises that would considerably add to the expense if you have two medical certificates for every case?—That is so.

4054. I should imagine there are many cases which are so clear that a second certificate might be redundant?—Yes, I quite agree that is so.

4055. And we have, of course, to think of the question of money in any recommendations we may suggest. Do you think the expense of a second certificate is of sufficient importance as a safeguard to justify the expense in pauper cases?—No, I think not. The point that crosses my mind is this. Occasionally one gets a patient who is not a lunatic, but has been certified as such; that patient is detained, say, for a week, and at the end of the week we send our report to the Board of Control, there is a week's detention, and the patient at the end is discharged. But that is rare.

4056. Might not that occur with any number of certificates, because the patient might have exhibited the symptoms of insanity, but at the time he reached you, you could not say he was insane?—Yes, but take, for instance, the case of a mistake on the part of the doctor or the justice—both making a mistake. I had a case of a woman who was sent to me as insane; she behaved insanely, as far as I can gather, at home; she smashed windows and screamed, and that sort of thing. But it appeared this young lady had a young man whom she introduced to the family, and her sister married him. She was fearfully upset about it, and she behaved in an insane manner, and the doctor was called in, and said she was obviously a lunatic, and the magistrate said so too; but when she came in she said "I am no lunatic at all."

4057. It was merely a manifestation of temper?—Merely a manifestation of temper, but I had to detain her under the order. But at the end of a week I could not see any sign of insanity, and she was discharged.

4058. Might not two doctors have considered she was insane in the first instance?—I think it is a point to be considered.

4059. I suggest that in cases of difficulty, cases which are on the border-line, it might be very proper to call in a second opinion, but I suppose in the great majority of cases which reach you there is very little doubt they are, for the time being, at any rate, of unsound mind?—Yes. My experience of this case was that it was one which I did not find to be insane, but she might have behaved in an insane manner when outside.

4060. Will you tell us your experience with regard to the Visiting Committee of your hospital?—There are 16 members of the Committee who visit. They meet once a month; they go into all applications for discharge, and in the case of any relative making an application for discharge of a patient they go carefully into it, and see the patient and the relative. Most of our cases are sent home on trial; those are also seen. During the month there are visitors appointed. Every alternate month there are two visitors, and the other month one. They go round the whole building, converse with any patients they wish to converse with, and in any case of doubt there are always the records to look up, and I can talk with them on their particular delusion; and the visitors are quite satisfied that there are no people detained who should not be detained.

4061. Through those visits do you think every inmate of your institution gets an opportunity of putting his case, if he has one, to an outside person?—Yes, ample opportunity. Most of those people have friends who come to see the patient, and if they have any doubt they can see the committee. In the case of all relatives or friends who write to me asking for release of a patient, I tell them when the committee meets, and the time, and that they must make application; and they see the committee. I do not frighten them off myself; they see the committee, and the committee deal with it.

4062. That seems to be a satisfactory way of dealing with it?—Yes, and then there are various guardians who visit the asylum from time to time.

4063. But they are interested only in their own cases?—They are interested only in their own cases.

4064. Do they see them?—Yes, they see them, and talk to them, and hear any complaints they may have to make.

4065. One was thinking that it would be very desirable that inmates of such an institution as yours should feel that they are not shut off from all access to the outer world. Do you think the visits of the Visiting Committee and the guardians enable them to think they have contact with the outer world?—Yes, and if they write letters, they have post boxes in each ward which are cleared by the assistant matron, and if there is nothing in the letters which renders it inadvisable to send them, out they go. Some of them are obscene, and some are rambling—those are kept back.

4066. But any letters which have the appearance of seriousness go?—Yes. I very often get letters from relations asking me not to send letters to So-and-so, or to "collect all the letters this patient writes, and send them on to me," and I often do that; that is an easy way of getting rid of them. A patient very often asks me, "Has that letter gone to So-and-so?" and I can say it has gone. The patients are so insane that they add to their own delusions; they keep on adding to them, and one must act very carefully and tactfully, in the interests of patients and relatives.

4067. Do you mean that a patient may continually address letters to some prominent public man, or something of the kind?—Yes, something of the kind. Any letter, of course, sent to a Minister of State goes unopened—uncensored.

4068. To the person designated?—Yes.

18 November, 1924.]

Dr. O. G. CONNELL, M.C., L.R.C.P.

[Continued.]

4069. In addition to the visits of your Visiting Committee and the guardians, do you also have visits from the Commissioners of the Board of Control?—Yes, they come round regularly—when I say regularly, they come once a year.

4070. What do they do when they come?—They go round the whole building; they see every patient. I go into the ward with them, but I do not follow them too near, so that any patient may have the opportunity of discussing any matter quietly with the Commissioners, and, though I may be in the ward, the Commissioners wander about talking to the patients. If the Commissioners think a particular patient has a grievance which ought to be seen into, they make a note of it in a little book they carry about with them, and the records of the patients are looked up, and they are satisfied that everything is being done that is right and proper.

4071. Do you regard the periodical visits of the Commissioners as an additional and important safeguard?—Yes, I think it is a great safeguard, because, as you are probably aware, these Commissioners have themselves been medical officers, and know the inside of an institution from top to bottom; and the legal side of the Board have had so much to do and have come so often in contact with the patients that they have a very good knowledge of mental disease. They inquire very very carefully into things.

4072. Do you receive sometimes complaints of ill-treatment from your patients?—Yes, mainly from patients who are undoubtedly insane, and who make charges. I have had charges brought against me by a relative outside. A patient died in the hospital from pneumonia, and the charge against me was one of murder. I informed the coroner, and asked for an inquiry and also for a post-mortem, so that we had nothing to do with the inquiry into the cause of death.

4073. Was that where the patient had some delusion that you had ill-treated him?—He was always making complaints. He was at one time in prison, and he told me once that the warders had beaten him, and he showed me marks of blood in his mouth, and said that was how they had battered him about, but I found out afterwards that he had broken a pane of glass and cut his mouth. That is the ordinary kind of thing. These patients are examined very very carefully for any marks or bruises. Every week when bathed they are examined by the assistant matron or matron, or head attendant, as the case may be, and these things are all reported, and the whole thing is thoroughly looked into. There is no possible chance of ill-treatment occurring in a mental hospital. It is all a bogey; as far as I can see there is nothing in it. I mean, there are two kinds of people who make complaints, one is the patient who imagines he is not insane, and the second class is the person who has a grievance against the institution.

4074. Have you investigated in your own institution a large number of cases of allegations of ill-treatment?—Generally, yes, but you will always find that it is quite a usual thing. You will not go on a round without receiving some complaint of ill-treatment, but on investigation you find no foundation for it, as a rule.

4075. You in fact find many allegations, but on investigation they turn out to be ill-founded?—Yes. A patient may have a delusion, but to all appearance otherwise that patient is sane. They talk and converse, but on that one point they are very insane. I go round and talk to these people, and ask how they are getting on, and if they get sufficient to eat, but if there is anything wrong, or if there is a little row, I ask about it. They are the first people to complain if anything serious goes wrong.

4076. Of course, cases do occur, and we know of cases where attendants have been dismissed?—Yes, and if you look at the Board of Control's last report, you see cases recorded.

4077. The thing one is most apprehensive of is that unhappy patients might be ill-treated by subordinates,

and have no means of bringing their grievance to a proper quarter for remedy?—Yes. But there is no systematic brutality practised. I have seen patients spit in an attendant's face, and say: "Now, strike me, and I will get you the sack." Well, if the attendant gets annoyed, and gives a slap, that attendant is had up. They have to put up with a good deal, and they have not a happy position. If you get a powerful strong man in a struggle it will probably take about four men to hold him, because when a man is in a maniacal fury he develops four times ordinary strength, and throws people about like a dog shaking a rat; and in the struggle they all come down, and it is likely that the patient gets marked; but these things are reported immediately, and the medical officer sees at once the result, and when the Commissioners visit they see the record and sign it.

4078. Then you do not think there is any risk of ill-treatment passing undetected?—No. As I said before, one might find some junior attendant who will strike a patient; but he would be sent away.

4079. You do not find a patient so cowed and terrified that he might be afraid to tell the medical superintendent or head nurse what was happening?—No, I cannot imagine such a thing occurring, and I should be surprised if it was true. It certainly could not occur in my place; I am positive of that.

4080. I do not think you told us the size of your hospital?—I have 1,033 patients.

4081. Have you any private patients among them?—No. I try to treat all my pauper patients as private patients. Where patients wish to wear private clothing I let them; if they have little bits of jewellery, and want to wear them, I let them. Those patients who have no clothing, have to be dressed in county clothing, but in the case of those who have their own boots and shoes, and that sort of thing, I let them wear them. The place is really a home; the patients can dress in their own clothing. Many of them are on parole, and they go into Norwich and make a little money.

4082. Do you endeavour to give them as much freedom as you can?—Yes. They realise they are in a mental hospital, and many of them, of course, have an appreciable amount of sense, but they are what one may call mild mental cases, cases which might do quite well outside if there were somewhere to send them to, but relatives will not have them in very many cases, and the Unions where they have no mental wards will not accept them, and if one sends them out to the Unions they say, "Why do you send this case? It is a mental case. We have no accommodation." Here is a letter which I received the other day: "As my son has informed me that he is likely to be sent home, I would like to inform you that I cannot possibly be responsible for him, owing to my age and failing health. Also my son's panel doctor has stated that he will not be responsible for him. Under the circumstances, I think something ought to be done by the Ministry of Pensions." This happens to be a service case, and the Ministry of Pensions will take the matter up. This is a case of an epileptic, who developed mania on top of epilepsy. His mania left him, but he has not got rid of his epilepsy, and it is quite likely that if he has any means he might remain out.

4083. Would you discharge him as recovered?—No, because there is still a degree of mental derangement.

4084. But you would discharge him if someone would take him?—Yes. But here is a letter showing that this poor woman could not take him. I have another case which is rather a long story; it is a case of a gentleman who was able to go out, but they would not take him, and I had to get the relieving officer to remove him to the workhouse. The relatives were annoyed that he should go into the workhouse, and the relieving officer handed the case over to the relatives, and they are carrying on the best way they can at home.

18 November, 1924.]

Dr. O. G. CONNELL, M.C., L.R.C.P.

[Continued.]

4085. Is it one of your difficulties in sending people away that they may have to go back to surroundings which are unhappy or unsuitable?—That is so—unsuitable surroundings.

4086. Although, of course, you cannot detain patients after they are recovered?—No; that is the trouble. It may be that there is a case mildly insane, and which would do quite well if they had somewhere to go.

4087. That would be a class of case which might be sent to the care of friends?—Yes; if there was a place one could send them to, one could do so.

4088. But that would still be a certified case, I take it?—Not if discharged to the care of a relative. There are many cases of insanity which are not under certification. I should say there are just as many insane outside asylums as in them, but they are harmless sort of people, and do not give any trouble.

4089. Sometimes we hear there are more outside than inside?—I believe there are, but they do not do any harm.

4090. Will you tell us about the care of the patients in your hospital?—Have you a rigid time at which they always go to bed?—No. My experience has been much the same as that of Dr. Dixon. The dormitories are open, so that they can go to bed when they like; others sit up and play cards. There is no hard and rigid rule, except that those on parole must be in at dark. In summer time they stay out as long as they like. I think every care is extended to the patients, and the conditions in the hospital in a large percentage of cases are better than they were accustomed to at home. There are a few to whom that does not apply, but those few are people who have seen better days, and have come down. It is hard for them to be classed as paupers, and I think the term "pauper" should be altogether removed from the reception order. It is a nasty term. These people are not paupers really, and there are quite a number of these people who pay the maintenance rate, or part of it.

4091. Are not they removed from the category of paupers?—No, they are still paupers. I have one female private case; and there are ex-service patients on the male side; but the conditions for private and pauper cases are alike.

4092. We were told that in the case of patients who had passed through the workhouse, and therefore became paupers, and ultimately found their way to the asylums, if it was subsequently discovered that they were able to pay their way, they were removed from the category of pauper patients, and became private patients?—I do not think so.

4093. So that whether a patient is really paying full maintenance or not, you make no distinction?—They are pauper patients, and are classified alike with the others who cannot pay their maintenance and are dependent on the rates, they are stamped as paupers; and I think all these things help to push the unfortunate lunatic further down, and bring contempt on mental hospitals as a whole. I think we should try and get rid of those conditions. Why call them lunatics, rather than persons of unsound mind, which would be much better than calling them lunatics?

4094. You are in fact in favour of assimilating this form of disease to any other form of disease?—I am; I regard it as a physical ailment. Any of us might get mania next week.

4095. The only difficulty you must have felt, and that is present to all of us, is that this particular type of malady is a form of disease of the reason; but in the case of an ordinary patient suffering from mania, he should be taken to a doctor who is able to deal with his case in much the same way as a doctor deals with an ordinary malady?—Quite so; but taking mania again, the relatives will see to that if the patient is delirious with it. The relatives could easily say to us, "Here is a case not able to speak for itself, and we speak on behalf of it."

4096. But there is the element of compulsory detention, which is an embarrassing thing to deal with from the legal point of view?—Yes. It is a tremendous difficulty, and one wonders how one is going to deal with it, but I think one can safely divide insanity into two categories—the curable and the incurable type. In a few words I will give you the chronic type of cases. You get idiots who make noises, who scratch and bite and scream, and have no control over themselves. Then you pass to a higher grade, still of a low form, but a little better; then you get to the further scales, until you come to the criminal type. For instance, the Dartmoor shepherd has been spending his life in gaol, until some intelligent magistrate has said he is insane. He always will rob poor boxes. If you put a £5 note down he will pass it, but he will rob a poor-box. This type of man you call a criminal, but he is not; nothing can help him. Then you come across epileptics with dementia. These epileptics have been tried to be cured since the time of the Flood. The great St. Paul, I believe, was said to be epileptic. All the world has tried to cure epileptics, but we cannot. Naturally they send them to us and say: "What you want is treatment for these patients"; I do not know how; but there is no form of treatment for them. Then we pass on to the old seniles, who have small hæmorrhages in the brain, perhaps the size of my finger nail. When we hold post-mortems and find these things, we know we cannot cure them. The only really curable cases are melancholias and manias, and we get a fairly good recovery rate from these patients. My last lot of statistics show that in 1923 there was a 35 per cent. recovery rate, and this year there is a 45 per cent. recovery rate of the whole of the patients coming in. The patients coming in are mixed; you get dementia, epileptics, manias, melancholias, and out of that crowd you will find a large percentage of recoveries.

4097. If you were to eliminate the class of chronic patients you have been describing, would you have a much higher percentage of recovery?—Yes, because the chronic cases knock the recovery rate down, and there is no possible hope for them that I can see.

4098. Taking cases where something can be done by treatment, how do you treat them?—Those are cases which I say should not be certified; they could come in as voluntary cases, and I have had people coming to me asking to be taken in.

4099. Do I understand you are an advocate of voluntary admission of patients?—I am.

4100. To follow that up, if someone comes to you as a voluntary patient, sufficiently intelligent to appreciate that he is on the verge of a breakdown, and asks for the shelter of your institution, and unfortunately the attack supervenes after he has been two or three days in the institution, and he says "I am going home now," you cannot stop him?—Quite so.

4101. What would happen there?—We must have some supervision; we must get so many days' notice, and be able to communicate with the relatives and say, "If you want to take him out, take him out."

4102. But would not you require to have some control over the patient—although a voluntary patient—you must have some control over him?—Yes, because a man who was not fit to go out, and went out, would certainly do himself some harm. Do not certify, but give him a chance; he might be better in a week.

4103. Then on the question of treating incipient cases, I suppose a number of cases would never reach certification, if they could be dealt with in some provisional way?—I have my doubts about that. Taking a neurasthenic or neurotic person, they go for years and years in that state, and never develop insanity. The person who goes really insane is the person who goes straight off, and those are the best cases that are going to recover. The old chronic cases that we have with all kinds of delusions become hopeless. You can play about with them and give them bottles of medicine, but it is a waste of time.

18 November, 1924.]

Dr. O. G. CONNELL, M.C., L.R.C.P.

[Continued.]

4104. Are you in favour of some method of out-patient treatment, or an out-patient system combined with institutional treatment, as a sort of preliminary to asylum treatment?—I think if we ran an out-patients' department and saw these cases we could form some idea of their standard, and that sort of thing. But here is a patient going off, and we say, "I think you had better stay with us," and then treat them on the lines of a patient in a general hospital. We could then take them in and treat them, and send them out again. If people felt they could come in and be treated, we should get more coming along; but they have the idea that the moment we get them it is good-bye, and they will never come out again. That is all nonsense; we want recoveries. Personally I would not keep mild cases; I would treat them for a month, and if they could keep out a month they could keep out longer, and even if they kept out three months, it is something, it all counts. In Edinburgh at the Royal Infirmary there were 500 cases of all forms of insanity treated as out-patients and in-patients without certification, and they get a recovery rate of 64, or including alcoholics, 72. That is pretty good. The people there say, "Here is a hospital where I can go for treatment," and they go.

4105. Which hospital is that?—The Royal Infirmary, Edinburgh.

4106. Do you think, if the asylum became more of the character of a mental hospital, people would resort to it as readily as they resort to the Royal Infirmary at Edinburgh?—Yes.

4107. And you might be able to reduce the number of certifications very substantially?—Quite so.

4108. But there is always the difficulty, in contrasting it with a hospital, that you must have certain legal powers of control, must you not?—Yes, but that could be done. There could be some provision if the necessity arose, but if the necessity did not arise, why carry it into force? I mean, if a patient was in, and wanted to go out, and he was unfit, I ought to be able to say, "I want so many hours' notice," and insist on keeping him. In the meantime I could communicate with a relative, and if the relative said, "I will be responsible," let him take the patient. There might be a few disasters at first, but I think it would work out all right.

4109. I am not sure that I agree with that. The relative might be anxious to have the patient at home, but it might not be good for the patient. The patient might be handed over to the relative, and might fling himself or herself out of the window directly they got home?—Let me give you an instance of a case of not being able to evade the law. A woman came to me one night about eight o'clock, shaking and trembling all over and weeping, and talking in an incoherent and rambling manner. She had walked about seven miles to drown herself. It so happened that it dawned on her that she was about half a mile from the mental hospital, and she asked me to take her in. I said I could not; she must be certified, and she said, "I will go back to the river." If she went back to the river, what would be the result? The legal thing to do was to ring up a policeman, to take charge of her, and a magistrate, a layman, would decide what was to happen to her.

4110. So you would have liked power given you to have enabled you to take her in?—Yes. I had another case of melancholia, a woman in my hospital, and I said to her, "If you have a recurrence, come in, and do not waste time." She came in after she had put herself in the water, and I asked her why she did it. She said, "I tried and tried to come in; they would not send me in; they kept putting me off, and I determined I would come in, and I saw a group of people standing by, and I walked into the water." It seems a deplorable thing that a person has to attempt suicide in order to receive treatment.

4111. Suppose you were in a position to be able to receive voluntary cases, would you supplement your

power by having the right to obtain, if necessary, powers of detention?—Yes.

4112. You would receive a voluntary case on the basis of, say, 48 hours?—Well, more notice than that, because in a county like my own it takes something like three days to get a letter a few miles.

4113. *Earl Russell*: Seventy-two hours, I think, has been suggested in Lord Onslow's Bill?—Yes.

4114. *Chairman*: And during that time you should have authority to detain the person?—Yes.

4115. I take it you would have no motive or desire to detain the person?—No, nothing whatever. I have nothing to gain; I am a whole-time official.

4116. And the 72 hours delay would be occupied in communicating with the authorities and getting, if necessary, supplementary powers of detention?—Yes. In the event of any hitch I think there should be some emergency order—what kind of order is immaterial, providing we can do it with safety, our intention being primarily not to have magistrates' orders, but to treat the patients on ordinary hospital lines.

4117. How do you deal with your patients from the point of view of classification on admission?—All new admissions come into one ward. In this dormitory I should think there are about 16 beds; there are all sorts of insanity. Then we classify further. We have, say, an old senile dementia case, and we keep it there for a week, and during that week I have to certify to the Board of Control. If they are chronic, and not going to mend, the patient goes to the chronic ward, or if it is a case of acute mania, and might get better, they are put into a convalescent ward amongst the best type of patients, when sufficiently well.

4118. You do not find it a drawback to aggregate together persons suffering from different kinds of mental disease?—It would not be an economic proposition to do otherwise, because the numbers that come in are comparatively small. Taking this year, from workhouses I have received 55, and from their homes I have received 131 patients. On the female side I have received 34 up to now, and if you divide those into the various forms of insanity, on an average you would want one ward for about three patients; that is working on averages. It is not practicable. If we had plenty of room and plenty of money, we could do it.

4119. I should have thought you might have been able to separate cases of obvious mania and violence from quiet cases in less time than a week?—That is so. They do not leave the ward, but they leave the dormitory. An acute maniac shouting would be put into a side room.

4120. I thought perhaps you might possibly have someone suffering from melancholia placed in the same room with a raving lunatic?—No; they are immediately removed, and if they come in roaring and shouting, they never reach the dormitory, but are put into a side room straight away. The dormitories are quiet; you might hear some poor wretched person weeping, but that is all; there is nothing in the way of shouting or noise.

4121. One has seen in the Press objections to many quiet patients being brought into an asylum and herded with all and sundry, violent cases and so on, much to their horror and distress. Have you any experience of that?—No. The dormitory is reserved for these admissions. Noisy one are put into a side room, and a day room is reserved for old chronics, who occupy special beds in a smaller ward.

4122. But you might very well have a case brought in from the streets of a man or woman using the most foul language, and behaving in a most indecent manner. It would be difficult for that person to be dissociated from some quiet person who was suffering temporarily from an unsettled brain, would it not?—Quite; but that does not occur.

4123. Would you put a person shouting in a separate room?—Those cases go to the worst wards, and all those people who shout and curse are put

18 November, 1924.]

Dr. O. G. CONNELL, M.C., L.R.C.P.

[Continued.]

together, and then you get the quieter lot together. The noisy, troublesome people only torment the better people.

4124. Again I am appalled at the idea of keeping these noisy people together?—Where could we put them?

4125. I do not know.—If you put them amongst the better patients you will upset them.

4126. I quite agree they will do harm there amongst the better patients.—Then, you see, if they are shouting and jumping and swearing, they are not doing it all day; they might do it for an hour, and are perhaps perfectly nice people after that.

4127. Then the next person will take it up, perhaps?—Yes; that is the difficulty.

4128. It is the difficulty, I quite see, that you cannot possibly have a separate room for every noisy patient. I suppose, in the case of a person who is violent and likely to do himself or someone else an injury, he is put in a separate room?—Yes, until they get over the attack. It is difficult to describe. You would probably go round the wards of a mental hospital and you would not know it was a mental hospital. I have taken some guardians round the whole place; there was a lady guardian amongst them, and this lady said on going away, "But you did not show us the worst ones." Here was a woman looking for really troublesome lunatics, but she did not see any, yet I showed her the whole place, the worst possible sides everywhere. But if she came another day she might have seen something which would upset her very much.

4129. *Mr. Micklem*: How large is your district?—I could not give you dimensions; it is a very large district.

4130. Is it the whole of Norfolk?—Yes; it goes all round by Hunstanton on the one side, and Yarmouth on the other. Yarmouth send us their cases.

4131. How long have you been Medical Superintendent?—I have been nearly three years now.

4132. During all that time you have had no cases wrongly certified, except the one instance you have mentioned?—No.

4133. And in most cases there has been a magistrate's order, and one certificate?—Yes—well, in Wisbech Union they do send two doctors' certificates; I do not know why; it is unnecessary.

4134. Do you suggest there should be two certificates?—Well, I put it to you for consideration. Certainly it is an expense, and in these days we have to study economy.

4135. In a case of acute mania you would like to dispense with the signing of an order?—I quite agree, because generally they are the speediest people to get better. I have seen roaring maniacs quite well inside a week. They are in a poor state; they want feeding up; their mental state is clear, but they are suffering from shock, but you cannot send them out. You cannot have hard and fixed rules for a mental hospital.

4136. But, speaking generally, you would like to do away with certification in quite a number of cases?—Quite a number.

4137. In cases of acute mania and senile dementia?—Well, in cases of senile dementia you can. We sometimes get people of 84, and they are marked dangerous, while there is no danger about them. It is not the place in which to keep these people.

4138. *Miss Symons*: Can you tell us what is your maintenance rate?—21s.

4139. How much of that would cover food?—I cannot give you the proportions.

4140. I suppose your committee decide the dietary on your recommendation?—Yes.

4141. And you are quite satisfied?—Yes, I am quite satisfied. My dietary is worked on the suggestions of the Board of Control, who have gone into it very thoroughly, and made recommendations. The patients get quite a good breakfast, bacon one morning, or a boiled egg or fish, with of course the usual bread and margarine or butter, and a cup of tea.

4142. You mentioned some difficulties in discharging patients. I suppose one difficulty is the difficulty they have in finding work?—That is so.

4143. Do you refer them to any employment association?—I have not done so up to now, but I feel that we should refer some of our patients, particularly patients who might be useful people, who might go out and take up domestic work; but the whole trouble is want of funds, and so on. The After Care Association is a voluntary thing, but I think, as far as lunatics are concerned, it should not be voluntary as regards money. Coming in and being treated should be regarded as voluntary, but as regards funds for their after-care, I think there should be some State fund or some Government fund from which an association could receive help.

4144. Do they keep sufficiently in touch for you to know when they get work?—They vary. Some find work and keep work; others find a job, but when the mistress hears her servant has been in a lunatic asylum she goes out quicker than she came in. No one will take the responsibility; because they have happened to be lunatics they are afraid of them. I have tried to get people inside a house, but the moment anything is suggested it is obvious no one will take the responsibility. One does not know what the lunatic is going to do. They might be perfectly well and simple folk, quite useful people, and yet might do something; and if I had a friend I should be chary about recommending a person to be engaged as a maid, especially if the lady had valuables in the house. It is a serious responsibility.

4145. I suppose you try and give them occupation while in the institution?—Yes, they are occupied. It is called work, but they are allowed to look on if they do not feel like work. I should think they work 4 or 4½ hours a day.

4146. What kind of work is it?—They do a lot of crochet work, which they sell, and it is their pocket money. Hospital work comprises the laundry, which is run by the patients, except about four paid hands, laundry maids. They also do all the mending and sewing, darning socks for the male side. Some of them work in the kitchen.

4147. Is there any remuneration or encouragement for that work, other than the remuneration from the work they sell?—No, there is no authority for giving them anything; they are rate-supported.

4148. *Earl Russell*: Do not you stimulate them by additional allowances of tea or tobacco?—Yes, we give it them in kind, not in money. I give them tobacco and tea. Seniles and people who cannot work are also put in the same category as the workers, and receive tea and tobacco.

4149. Have you any other large towns in your area besides Yarmouth?—Yes, there is Cromer, a fair-sized place; there is Dereham, Fakenham and a number of places.

4150. It is an extensive county?—It is an extensive county.

4151. Do you know anything about the business which takes place before the patients reach you—how they are certified?—No, I simply receive the patients.

4152. Do you know whether they are brought to you direct, or through a workhouse?—I generally inquire that, and up to the 10th November I have had from the workhouses a total of 55, and from their homes 131—they mostly come from their homes.

4153. You say the majority are brought from their homes?—Yes; there is no accommodation in the workhouse for mental cases.

4154. Do you find, as a rule, certificates are signed all by the same doctor, or various doctors?—Various doctors sign the certificates.

4155. In most of the cases coming to you, would a second certificate have been of any use at all?—I would not say they would be of any use to me. The only thing is, the public have an idea that patients might be sent to asylums who are not lunatics, and to safeguard that the private patient

18 November, 1924.]

Dr. O. G. CONNELL, M.C., L.R.C.P.

[Continued.]

has two certificates, and I thought I would make the suggestion.

4156. Well, it would cost something like a guinea a case extra, which would have to come out of the rates?—Quite.

4157. Would you be satisfied if the justice has power, as I think he has, to call in a second opinion if he wants one?—Yes, I think that would be satisfactory, but you must bear in mind that the justice very often thinks he knows more about the case than the doctor.

4158. I want to ask a question about the non-certified cases which you say should be treated. Under what authority are you going to detain them as voluntary cases? In a case of acute mania you would not be able to get the consent of the patient, would you?—No, but you could get the consent of a near relative or responsible person. Supposing a person had no relative, then the relieving officer or clerk to the guardians would be only too glad to do that.

4159. I should prefer not to leave it to a near relative, because in many cases is not the near relative one of the people they suspect?—Yes, that is so.

4160. And it might make it more awkward when they recovered if the near relative had much to do with it?—Yes, and then on the other hand, when a case recovers, you would like to hand it over to the relative.

4161. You have read Lord Onslow's Mental Treatment Bill?—Yes.

4162. Do you think the period he provides of 72 hours would meet your requirements?—Yes, if it were done by telegram; a letter takes too long.

4163. You mean you could either get the certificate or let the patient go?—Yes, I could wire, and if I got no reply, I could proceed with the certification.

4164. Would you prefer that method to having the certificate prepared and the justice ready to act, and the justice adjourning?—I think the less we have to do with justices and magistrates the better; there is too much prison about the thing. You see they are mentally sick people. Now if I had a bad appendix and went into a hospital, I should be sorry to have to wait for a justice to come along and say, "Shall we get it out or not?"

4165. You have referred to records of injuries. Have you had any substantiated case of ill-treatment?—No, not what one would really call ill-treatment, but may I give you an example? There was a new nurse in; she was about three days in a ward, and they were playing the piano and dancing, and amongst the patients dancing was one lady who spoiled the set of lancers; she corrected her a couple of times, and she took no notice. Eventually the nurse, it was alleged, slapped her; the patients in the ward were immediately up in arms, and reported it to the charge nurse, who reported to the sister. The nurse was immediately suspended, and in the morning I investigated the thing and saw the patient and the nurse. The nurse admitted she hit her, but did not hurt her, and appealed to the patient, and she said she did not, and another patient said, "You shook her," and another, "You slapped her," but the nurse admitted she struck her, and I had to dismiss the girl. It might seem harsh. The wretched girl had not any money to get home, so I had to keep her for a month and put her on to sewing until she had enough money to find her way back home.

4166. Is that the worst case you have had?—That is the worst. Of course, I have had a case where a nurse has been alleged to have bumped a patient on the head with a broom, but it was the nurse's foolish method of doing it. The patient threw her dinner at the nurse; the nurse swept it up, and the patient started talking nicely to the nurse, and said, "Give me a drink." The nurse came with a glass of water in one hand and the broom in the other; the patient took the water, and before the nurse could realise

what was happening she attempted to throw it, and the nurse in defending herself put out her hand and accidentally bumped the patient on the head with the broom. She came rushing down and said she had hit the patient with a broom accidentally. She was a nurse who had three years' practice, and she ought to have known better.

4167. She ought not to have had a broom in her hand?—She ought to have had another nurse with her. That nurse was dismissed. The patient said the nurse struck her, and from the point of discipline we have to stamp it out, and not tolerate that sort of thing at all. I do not spare them. They have to put up with a lot; and if anyone is persecuted, it is the staff.

4168. Have you had any cases amongst the male patients?—No.

4169. No complaint of twisted arms?—No. That used to be the case, but nurses are a different class now.

4170. Do you yourself visit every ward once a day?—Oh, no. Perhaps I go to one ward three times in a week where I have certifications. I go all over the place; I have no set time.

4171. If you or your medical officers are about to visit a ward, is that known before you reach the ward?—Of course, as to the medical officers doing their regular round, that is known, but not on the night round.

4172. Are there intercommunication telephones in the building?—Yes, but they dare not use those—do you mean to warn them I am coming?

4173. Yes?—No; a man with 15 years' service would not throw that away. It would be a whole life's work gone.

4174. So that when you get there, the visit is in the nature of a surprise?—Yes; they do not know where I am.

4175. Will you tell me, in the daytime how many assistants are in charge of how many patients?—Do you mean nurses?

4176. Yes?—I could not really tell you; they vary so much. The quieter wards have only one nurse in them.

4177. For how many?—Taking the laundry ward, for instance, there are two nurses there for 80 patients; but in a bad ward there would probably be five nurses for 30 patients. My average works out one in six.

4178. *Mr. Snell*: I think you said the visiting Commissioners visited not less than once a year?—Yes.

4179. Is there not rather a long interval there during which a patient might be ill and recover and be able at times to go out?—I quite agree. But you see, we are under discipline the whole time. When the Commissioners come round, then I am somewhat in the position of a sort of naughty boy who is being asked, "Have you done your work?" Now, I think, we have passed that stage and that feeling ought not now to exist.

4180. Is any effort made, in the mental treatment of patients, to encourage them by explaining that any particular disease of the brain is as natural as the disease of any other part of the body, and that if they co-operate with the attempts which are made to treat them they have a chance of recovery?—Oh, yes. Every time I see a patient I chat with him or her and point these things out. Patients get every encouragement.

4181. In cases of children awaiting classification, are they kept with adults?—I have only a very small number of children in my institution. On the female side I have five and on the male side I have two, and they are with the adults.

4182. At what age do you suggest a child ceases to be a child?—It depends on the child, because some of them have never grown up at all. They would probably be 12 years old and look about five years old.

4183. Do you think there is any special danger in children being associated with adults?—No. You see they are a very low form of insanity—they are idiots;

18 November, 1924.]

Dr. O. G. CONNELL, M.C., L.R.C.P.

[Continued.]

they are babies—well, when I say babies, I mean they have no intelligence and they are in cots, although they may be about seven or nine years of age.

4184. And you think there is no moral danger about it?—No, there is not the faintest chance of that.

4185. On the point of classification, I suppose complete or proper classification could only be carried out in institutions which are provided with proper accommodation?—Yes, but you see in a hospital like mine the amount of expense involved in that establishment would be enormous, if you are going to cover every form of mental disease entering and leaving.

4186. What would you say about what we call small country houses, where it is difficult to see that any classification at all could take place?—Do you mean private houses?

4187. I mean small receiving places in detached counties.—You mean public places?

4188. Yes.—I do not think that that is a good idea. I should look at the matter from the broadest point of view and try and do away with all the stigma and do away with all question of pauperism and homes and such like.

4189. You want institutions for the treatment of the mentally sick to be of a suitable size so that proper classification in all cases of mental disease could take place?—No, not quite that, because you see you might get perhaps a chronic maniac who for the first three months might be very ill, but who for the next three months is quite well, although during the last three months he might be liable to a recurrence. During that period I should know what to do with the patient with my experience, but if I sent him out, probably within a week, or before that, he might break down, so that one does not know what to do with them. If you get a case of delusion, you do not want to classify, and with cases of chronic mania and all the other cases apart from delusion you would not have the accommodation.

4190. If after-care were available, do you think it would be likely to help in a considerable proportion of cases?—I think if after-care associations could receive sufficient financial encouragement, many of the mental hospitals would avail themselves of the chance of sending certain patients to them, and those associations could organise smaller branches in various places. Of course, I am only making this as a suggestion. I do not say that the associations would do it.

4191. In answer to Miss Symons, you gave us certain information as to what the women did in the way of employment. On what are the men patients engaged?—In farming, scrubbing the wards and keeping them clean, and some work at mattress-making. Two patients work in the boot-shop, and there are three in the tailor's shop. Some of them are engaged in the bakery. Whatever their calling is outside, if we can find it for them inside, we do so.

4192. That is all institutional work, for which they get no remuneration?—No, but if there is anyone in the neighbourhood who wants his garden looked after, a patient can very often make a small amount of money by being allowed to do the work, or if I can put money in their way in any other way, I do so, but of course I cannot pay them out of county money.

4193. With regard to the certifying justices, do you think it would be a good thing if the certifying justice was obtained from amongst the local doctors who might be justices; and would not that modify your suspicion as to the ability of the justice from outside?—It would help, I think, but then there is just a possibility of creating a monopoly there.

4194. But such a man would be only one amongst many?—But he would get all the cases, and he would soon begin to dictate what he would do and what he would not do—that is the danger of that.

4195. *Mrs. Mathew*: I want to know the age at which junior attendants go into the wards?—At any age from over 18 up to 35 years of age.

4196. Do you really have a girl of 18 years of age in charge of lunatics?—Oh, no, not in charge. The people in charge have years of service, and have passed practically all their psychological examinations. They are not young, but I cannot tell you their age.

4197. But the junior attendants would be only 18 years of age?—Yes, from 18 years of age upwards, not under 18 years of age. You might get a woman in of about 30 years of age as a junior who has not had any experience, but if she was looking for a post we should take her.

4198. Then the word "junior" does not necessarily refer to age?—No.

4199. What hours a day do the attendants work?—They work a 60 hours' week. The hours are arranged between the Asylum Workers' Union and the Mental Hospitals' Association, and we work entirely on the recommendation of those two bodies. We are members of the Association, and whatever they decide my Committee acts upon.

4200. *Sir Humphry Rolleston*: With regard to the maniacal cases which are admitted on the recommendation of the relieving officer, is the recommendation in order to enable you to detain a patient till he or she gets more sensible?—Do you mean when taken in as a voluntary case?

4201. No, because he would not be in a position to enter voluntarily. I am referring to a case of a relieving officer acting for him?—Well, if such a man recovers sufficiently to go out, he could communicate with the relieving officer, and the relieving officer could say, "This man is now well, and desires to go home," and he would act as the petitioner—or at any rate, the relieving officer is the man's next guardian in such a case.

4202. And if the relieving officer said that he could go out, you would let him go, would you?—Yes, if the individual was well enough.

4203. And you think such a system would act well?—Yes, I think so.

4204. Do you have a certain number of cases of delirium tremens sent to you?—No, not a great number. They seldom come in to me, though they might occur in towns, but mine, you see, is a rural area.

4205. I should like your view with regard to having an out-patients' department for incipient cases who might attend voluntarily for treatment?—Personally. I think it would be better in a mental hospital, because we could then act directly, and it would be a move in doing away with the so-called stigma of insanity. The sooner we educate the public to think rightly that the so-called stigma of insanity is not really a stigma, but is simply a misfortune that may befall anybody, the better. We do not talk about the stigma of cancer or the stigma of pneumonia; then why should we talk about the stigma of insanity? Then gradually people would get to say, "I have seen So-and-so, who is very bad; I will take him to the hospital, where there is no chance of his being locked up."

4206. Supposing an out-patient is quite insane, how would you deal with him?—There, again, I would get his relatives or the relieving officer to be his guardian and take him in for any reasonable period, and if he does not mend, then you could certify; but the unfortunate part with regard to that is that you get patients recovering years after admission, and perhaps a patient has been five or six years in a mental hospital and suddenly gets back his reason. The voluntary idea is to give a person the chance, say, within three months, or it might be extended to six months; and after that, certify.

4207. How many voluntary mental establishments are there in England?—I do not know. Do you mean private institutions?

4208. Yes.—I cannot tell you. There are none in the public service, of course.

4209. *Sir David Drummond*: At what time do patients have to get up and leave their beds in the

18 November, 1924.]

Dr. O. G. CONNELL, M.C., L.R.C.P.

[Continued.]

morning?—I would not like to answer that question because I am not sure, but if I might I could write to the Secretary and give the information.*

4210. Are you aware that at certain asylums the patients have to rise at six o'clock winter and summer?—No, I do not think that such a thing exists at my place—no. Six-o'clock in the morning is a bit early, particularly in the winter months.

4211. I was rather concerned at hearing you say that the justice's opinion was not worth much, and I would like you to elaborate that a little?—I think I can give you an example of what I mean. A patient I had was certified by a doctor and sent to a magistrate to sign the reception order, so that I could take the patient in. However, the magistrate would not sign the paper as he could not see anything wrong; but when he finally asked the patient, "Would you like to go into the hospital?" the patient said "Yes." Well, the magistrate simply signed the paper because he thought the patient desired to go into the hospital and not because of his condition, and you know very well how one can be deceived by a mental patient. Even with all my experience I have been deceived myself, and if I am liable to be deceived, I feel that a layman is more likely to be deceived and should be more or less guided by the medical officer or by some medical man.

4212. Do you suggest that some change should be made in the curriculum?—No. I do not admit that the medical profession is behindhand at all with regard to mental diseases—I mean with regard to giving certificates, but at the same time I think more attention should be paid to the subject during the student's time—in the school. I think certainly more attention should be given to the subject then.

4213. Then you think that doctors are not sufficiently familiar with the subject, do you?—Well, experience makes them familiar, but I think when they start they have not enough knowledge.

4214. How would you propose to enforce the 72 hours' detention of a voluntary patient?—Do you mean without the patient being really certified?

4215. I take it the suggestion is that an asylum should be run on the general lines of a hospital?—Yes.

4216. You are aware, are you not, that in a general hospital you cannot keep a patient longer than he chooses to stay?—Yes.

4217. Then how are you going to enforce the 72 hours' detention in the case of an asylum?—I think if the Commission made that law, it could be acted upon.

4218. That is to say, you would certify them after a fashion?—Yes, but we would not call it by that name, because we want to avoid all questions of certification as lunatics.

4219. But still, there is a certain amount of compulsion involved in it?—Yes, but you cannot help that.

4220. *Sir Ernest Hiley*: How many cases have you had this year through your hands. Can you give me any figure?—Up to the 10th November, 197.

4221. How many of those are re-admissions?—The number of patients returned was four males and no females. That was last year; and up to the present time I have had two males and five females returned this year.

4222. That is out of the 197, is it?—No, the 197 were admissions.

4223. But what I asked you was how many of those 197 cases were re-admissions?—I should say seven.

4224. Only seven out of 197?—Yes.

4225. In round figures $3\frac{1}{2}$ per cent.?—Yes, something like that.

4226. I understand you let out on trial or on leave a number of cases every year?—Yes.

4227. How many of those cases come back to you?—Most of my discharges are on trial. Supposing I

have, say, a London case in my hospital, when that patient is well enough he is discharged outright, and, of course, he goes to London and does not return to me. But in my own neighbourhood if they are sent out on trial, they do come back without recertification; and amongst the people I send out are some who I more or less expect to come back, because some of them are on the border line.

4228. How many do you get back, about?—That was the number I gave to you.

4229. The $3\frac{1}{2}$ per cent.?—Yes.

4230. Then really your percentage of recovery is rather high?—Yes. There are better percentages than mine because some institutions send out 70 per cent., but in sending out such a large number one must bear in mind that, though these people might be fit to go out in the charge of relatives, there is something wrong with them still; it is much the same thing as a person who is suffering from a physical ailment.

4231. Do you know whether the workhouses in Norfolk have any accommodation for mental cases?—I believe there are no mental wards in them.

4232. And that is the reason why they come straight to you, is it?—That is one reason. Some patients go to the workhouses, but most of them come to me direct.

4233. Do you deal with the patients from Norwich?—No, there is a City asylum there; I only take the county, which includes Great Yarmouth.

4234. *Sir David Drummond*: What happens with regard to private cases?—There are private hospitals.

4235. Are they sufficient to accommodate the number of people?—Yes, I think so. I get applications now and again to admit private patients, but I have not room for them.

4236. *Chairman*: With regard to patients who are let out on trial, do the visitors to your hospital take advantage of Section 55, sub-section (2), and make allowances to them?—Yes. They generally give them a fortnight's allowance if they are in want; but if they are going direct to a job, they do not. If they are people in a better station of life and do not want help, they do not give them any help, but in any necessitous case they do.

4237. Do you know of any instance in which a visiting committee has refused to help a patient in such a direction?—No, I do not know of any such instance.

4238. When you are treating a patient do you tell him the cause of his certification?—No, and I do not think it is advisable either, especially if you take the case of a dangerous lunatic. My practice in such a case, if I wish to satisfy myself, is to see the doctor who originally certified him. I do not think it is at all wise to let the patient know who the doctor is, so I do not mention his name, because these people keep these things at the back of their heads for years and ultimately might easily cause some serious injury.

4239. Apart from the person who has certified, do you discuss the symptoms with the patient himself?—What I do is this: I read out the particulars, and I say to the patient, "I see you put yourself into the sea—is that true?"

4240. You do that, do you?—Yes, but I do not say who tells me; I do not say, "Dr. So-and-so says so," but I read what is stated on the certificate, and when I have told the patients that, they have discussed the matter with me, and they give their version of it.

4241. Do you think that is always wise? You know in the case of people suffering from ordinary ailments which do not affect the mind, a doctor does not tell always the patient the nature of his ailment?—No, nor do I tell them that they are insane. For instance, you may have a man who has grand ideas of wealth, and in the case of a man I had the

* *Note*.—The patients are called at 6.30 a.m., but many remain in bed until 7 a.m., at which hour they are required to get up.

18 November, 1924.]

Dr. O. G. CONNELL, M.C., L.R.C.P.

[Continued.]

other day he told me he was going to buy up a railway station, and he was going to have the Fleet round to Yarmouth for illuminations. In that case I said to him, "You are a very wealthy man," and he said, "Oh, yes," and I said, "What about the Fleet coming to Yarmouth; have you made all arrangements?" and he said "Yes." But all the while they do not appreciate that you are getting at their delusion.

4242. Supposing the character of the insanity was of an unpleasant nature and the subject of the delusion was connected with, say, sexual matters, would you tell the patient that that was the nature of his aberration?—Yes, I would ask him about it.

4243. But would you tell him that he had actually done so and so, as described by the medical certificate?—No. I would not tell him that, but I would ask him, "Did or did you not do so and so?"

4244. But would you describe to him the nature of the actual form of insanity from which he was said to be suffering delusionally or maniacally or whatever it might be?—No. One cannot do it in every case, but I would do it with certain patients and do it in a particular sort of way. For instance, if I had a patient who was amiably disposed I would not mind doing it, but if I had a surly or nasty patient to deal with, I would not attempt that sort of thing.

Chairman: Thank you, Dr. Connell.

(The Witness withdrew.)

(Adjourned to to-morrow at 10.30 o'clock.)

1, WHITEHALL GARDENS,

WESTMINSTER, S.W.1

EIGHTH DAY.

Wednesday, 19th November, 1924.

PRESENT :

THE RT. HON. H. P. MACMILLAN, K.C. (*Chairman*).

THE EARL RUSSELL.

SIR HUMPHRY ROLLESTON, BART., K.C.B., M.D.

SIR ERNEST HILEY, K.B.E.

SIR DAVID DRUMMOND, C.B.E., M.D.

MR. W. A. JOWITT, K.C.

MR. N. MICKLEM, K.C.

MR. H. SNELL, M.P.

MRS. C. J. MATHEW.

MISS MADELEINE SYMONS.

MR. P. BARTER (*Secretary*).

MR. W. FAIRLEY (*Assistant Secretary*).

Dr. H. DEVINE, O.B.E., M.D., F.R.C.P., called and examined.

4245. *Chairman*: Dr. Devine, are you Medical Superintendent of the Borough Mental Hospital at Portsmouth?—Yes.

4246. How long have you held that post?—Since 1914.

4247. Prior to your assuming your present duties had you had any experience in connection with mental cases?—I had been Senior Assistant Medical Officer at Wakefield Asylum, Assistant Medical Officer at Long Grove Asylum, and Assistant Medical Officer at Cane Hill Asylum.

4248. So that you may be said to have spent your life in this work?—Since 1905.

4249. What is the size of your institution?—It holds about 800 patients.

4250. And where is it situated?—In the district of Portsmouth.

4251. Within the borough?—Yes.

4252. When was it built?—1879.

4253. And has it been to any extent altered or modernised since then?—It has been considerably

enlarged, and also a large number of villas placed in the grounds; there are five separate detached villas, three of them occupied by private patients, who do not belong, all of them, of course, to the borough of Portsmouth.

4254. So that in your institution you have accommodation not only for what we have called the pauper cases, but also for private patients?—Yes, I have about 130 private patients.

4255. Are these included in the figures you gave us a moment ago?—Yes.

4256. How many male patients and how many female patients have you altogether?—I have 597 females and 320 males at the present time.

4257. Now you have read the terms of the reference to this Royal Commission?—I have.

4258. Which, as you will appreciate, relate to two quite distinct matters. It first relates to the present law and system of administration with regard to certification, detention and care of patients. As an officer who has had experience in the working of the

19 November, 1924.]

Dr. H. DEVINE, O.B.E., M.D., F.R.C.P.

[Continued.]

existing code, will you tell us to what extent you have found it satisfactory, or whether you have in any respects found it has embarrassed you, and has not provided you with the powers you require?—I think as an instrument of detention the Lunacy Act is almost perfect. I have found no reason to suppose that it does not protect the patient who is certified. That is my own experience; and with regard to the detention side of it, it seems to me to be perfect, as perfect as any human instrument could be which is dealing with human beings. The defect of the Act from our point of view, that is to say, from the point of view of psychiatrists, is that it is too insistent on the fact that every mental patient who is called certifiable should of necessity be certified under the Act.

4259. I follow. Let us take it by stages, if you please. First of all, the initial stage of certification. You personally, I presume, have nothing to do with that procedure, because the patients reach you after certification?—That is so.

4260. You are brought into contact with them, therefore, for the first time after they have been certified as persons of unsound mind, appropriate for detention in your institution?—That is so.

4261. You do, however, receive with your patients the documents justifying their admission?—Yes.

4262. And as your patients are for the most part rate-aided patients, you receive, I suppose, the one medical certificate which is required?—Yes.

4263. Do you yourself scrutinise those certificates?—Yes.

4264. You must have seen many of them, of course?—Yes, thousands.

4265. Will you tell us what your experience has been with regard to the adequacy of those certificates? They contain, as we know, the grounds upon which the medical practitioner has found that the person examined is of unsound mind. One would like to know from your survey of so many cases, whether you find that those certificates carry conviction to your mind, if I may so put it?—I think the best way of putting it is, in the first place, that in my experience as a superintendent I have only found one case that I described at the end of a week as not insane, and that case was a malingerer, undoubtedly. I discharged him as not insane; we gave him some money to go out of the town, and within a week the man was arrested in a train for travelling without money.

4266. Without a ticket, I suppose?—Yes. He was placed in a prison, and the prison authorities rang me up and said he was insane; he had got hallucinations. He was certified, and put into another asylum, and the doctor wrote to me and said that he had heard that the man had been with me: what did I think of him?—because he seemed to be a malingerer. So that the man, if he was a malingerer, was certainly an abnormal personality. As regards the other point, of course, some certificates are not so worded as those who have had a great experience of mental disorder would word them. It is rather a difficult thing to describe what you see before you in a mental case; but none of these cases have been found not to be insane, as far as my experience goes.

4267. Did all those cases come under your personal survey within seven days of their admission?—Yes. I see them all personally myself.

4268. And is that a detailed examination of them in order that you may acquaint yourself with the facts of the case?—Yes, that is so. The case is taken exhaustively by the assistant medical officer, the actual writing down of the case, and the full details, the case book, and the history, and so on, and I make a personal examination of the case myself.

4269. The results of which I think you have to report, have you not?—The results of which I report to the Board of Control.

4270. May we take it, then, that in your long experience you have only in one instance been satisfied

that the person who had been certified for admission to your institution was not a person of unsound mind?—Yes, and even in that case I think the medical officer who certified him was justified in drawing the conclusion at the time he certified, because the patient had hallucinations and so on, or said he had, at any rate.

4271. I think this is the first instance we have had of a malingerer who feigned madness in order to get the advantage of an institution?—I think he wished to spend the winter there.

4272. While your experience has been so satisfactory in that respect, I understand you do attach importance to the magistrate who signs the certificate personally seeing the patient?—Yes, I think the magistrate ought always to see the case. I also think, though the system may have proved satisfactory as far as I am concerned, that every case should be seen by two doctors; because where it is a question of the liberty of the subject, there is no reason why a person of a certain social position should have more stringent care taken of him than poorer people; so I think there ought to be two doctors to certify, in spite of the fact that it has worked all right in my experience.

4273. We have had that suggestion made to us by some other witnesses who have preceded you, but I would like to put a point to you upon it. I take it that in the great majority of cases the diagnosis of insanity is comparatively simple, is it not?—Quite so, yes.

4274. And in the great majority of cases would not a second certificate testifying to the same fact be really more or less redundant?—It certainly would, but that might apply to the private patient as well.

4275. But the solution might be that one certificate in the case of a private patient might be enough. We have in mind the fact that a second certificate would double the cost of certification, and we have to consider the cost of any suggestions we may make. We are anxious to recommend any safeguards which may commend themselves to those who have experience in working this code, but not to suggest things which may be superfluous?—My experience has shown me that it is not necessary, but is more to alleviate any possibility of criticism on the part of the public.

4276. It is quite important to have that in view. It has occurred to some of us that the doubtful cases, which, after all, are the troublesome ones, where possibly a second certificate might be a re-assurance, could be met by the justice calling in a second opinion upon any case as to which the first medical practitioner had any doubt, or as to which he himself formed any doubt on seeing the case. Do you think that would adequately meet the situation?—I think it would. Of course, as far as my experience goes, the magistrates are extremely conscientious over the matter of signing the certificate. It is a custom in Portsmouth for the magistrate always to see the case, and he quite frequently refuses a certificate.

4277. So that they really do bring a judicial mind to bear on the case?—Yes. Of course, it is much easier for them in the case of Portsmouth, because all the borough cases are first taken for observation; they never come direct to us; they are always taken to the infirmary, and they are detained it may be for a week or a fortnight, or quite a prolonged period.

4278. Do all your patients reach you via the Poor Law institution?—All of them, except, of course, the private patients.

4279. Yes; we will deal with those later. Do you not have any emergency cases brought to you direct by the relieving officer?—Never.

4280. Do the magistrates in Portsmouth attend at the Poor Law institution for the purpose of seeing the cases there?—That is so.

4281. Have you found that the justices are scrupulous in the performance of their duty, having in mind the stigma which certification imposes upon a patient?—Yes. If I may say so, I think that the practice in Portsmouth in a sense is a bad one from the point of

19 November, 1924.]

Dr. H. DEVINE, O.B.E., M.D., F.R.C.P.

[Continued.]

view of the psychiatrist, because the patient in a Poor Law institution, in the acute stage of the illness, when the greatest care is necessary, is not under the most favourable conditions; without saying anything against the infirmary, of course. I mean there are not the medical officers or the nurses and so on. From the point of view of the patient, however, and preventing certification, it is an advantage, and the magistrates do undoubtedly hold up certifying and sending to the asylum, because they feel that it is so prejudicial to the interests of the patient to be certified, if it can possibly be avoided, with which, of course, I entirely agree.

4282. If the patients are taken in the first instance to the Poor Law infirmary they will be detained there for a period, in, I suppose, a mental observation ward?—Yes; they have formed a large block, which takes 400 cases, I think, in the Poor Law infirmary; and in this infirmary are a certain number of feeble-minded, certified under the Mental Deficiency Act. I might say in passing that I am medical officer under the Mental Deficiency Act as well. Some of them are sent there under the Mental Deficiency Act and under the Idiots Act, senile cases and so on, a heterogeneous collection of mental cases, among whom are all the acute admissions.

4283. Yes, but apart from what one may call the more or less permanent population of the Poor Law infirmary, which would include such persons, I am considering for the moment those persons who are passing through the Poor Law institution, either on the way to your institution, or possibly to be discharged after observation. Do you think that that intermediate period in the Poor Law infirmary may be detrimental to the patients at the initial stage of their malady?—Yes, I think it is, and the guardians themselves recognise that it is. If they are taken into the Poor Law institution first, to avoid certification, they should be treated under the most favourable possible conditions, and, as the guardians themselves recognise, they should be treated in the Poor Law infirmary, the hospital part of it, in a separate ward—not, if I may use the term, herded with a heterogeneous crowd of unfavourable chronic types.

4284. I suppose the outset of such mental ailments is probably the most critical period in relation to the future of the case?—Undoubtedly the acute stage of a confusional case is a stage that requires nursing as carefully as a case of pneumonia, and every possible means of medical treatment of the most skilled type applied to it. It may make all the difference. It is a difficult thing to say, of course, but on general grounds it might make the difference between chronicity and otherwise.

4285. And while those in charge of the Poor Law infirmary may do their best with the means at their disposal, they have not the same means of treating and nursing as you possess in your asylum?—No; they do the best with the means at their disposal, and they are fully conscious of the responsibility.

4286. Of course, the patients may be detained not merely for three days till the justice disposes of the case, but they may be detained further for 14 days in the Poor Law infirmary?—They are detained a good deal longer than that. My experience, especially until recently, was that the cases were largely and almost invariably chronic when they came, and had been there some time with extensions of orders and so on. I am not very *au fait* with the details of detention.

4287. But do you attribute that more or less prolonged detention in the Poor Law infirmary as in part, at least, due to the reluctance to certify?—Yes, I do, partly. Of course, there is the question of finance. I would not say it came into it, but there is that question of finance. Mental hospitals are very expensive places now, of course.

4288. And every patient who is sent on to your asylum will cost the ratepayers so much more?—Yes.

4289. What is the cost of a patient per week in your institution?—It is 24s. 11d. I think at the

moment. Of course that is double what it used to be, and I should think there is no prospect of its reduction; in fact, we do not want it to be reduced much.

4290. Therefore there is a perfectly proper element in the minds of those administering the Poor Law, that they do not wish to send cases to an expensive institution unless they are proper cases for treatment there?—Perfectly.

4291. Do you think, looking at it from your expert point of view, that that very reluctance either to certify or to send to your institution and the consequent prolonged period in the Poor Law infirmary, may be disadvantageous to the prospects of the patient's ultimate recovery?—Yes, I do, undoubtedly.

4292. Now have you considered how that might be obviated? Would you be in favour of patients coming direct to a department of your asylum, where you could receive them without certification in the same provisional manner as they are received in the Poor Law infirmary?—That is the solution that I should advocate; an entirely detached part of the institution, and under the same authorities. Of course, I think of these things from the local point of view. It would be grotesque to suggest building an entirely separate institution, a so-called clinic, in a town such as ours, and duplicating the administration and acquiring from goodness knows where psychiatrists and mental nurses and so on; it would be an absurdity. I should suggest a separate department which will take all problems of mental disorder, with which the town is of course full, for observation, for careful study, reports, notes, and so on, and placing them in whatever place they should be placed in, whether they are feeble-minded institutions, or to the care of friends, and to try and solve their problem for them.

4293. I think some of us have been impressed with the undesirability of this transition stage under which all your patients have to pass through a Poor Law infirmary on their way to their ultimate destination, which may be either freedom or an asylum. But to get a practical solution for it, would it be compatible with your administration, which is confined at present to actually certified cases, if you had a department of your asylum to which cases at their initial stages were brought at the outset, and dealt with provisionally, until their ultimate fate might be determined after observation and treatment?—Yes, that is my view.

4294. Of course, one advantage from the patient's point of view would be this, that while they were under observation in this provisional stage you could afford them the benefit of attendance by your skilled staff, and of treatment as well?—Yes, that is so.

4295. I suppose neither of those advantages, with the best will in the world, can be afforded by a Poor Law infirmary, which has to deal with general cases of all sorts?—I do not think so, without very great expense.

4296. And that expense, if it were incurred, would really mean a duplication of mental staff and mental treatment in two places in the same area?—Yes, it would.

4297. Now, you have told us about the stage at which patients reach you. With regard to the next stage, the detention, we shall assume that you have satisfied yourself after your examination that the patient is one appropriate for detention in your institution, and that you have reported the case in ordinary form to the Board of Control. What happens to the patient after the first seven days? Perhaps it would be better to ask at the very outset when the patient first comes to you: Is any classification of the cases made on arrival?—Yes, we have an admission ward on each side where the cases are all admitted provided they are suitable, but if a person was very feeble and so on, he would be obviously better treated in the sick ward in the infirmary; but, generally speaking, all the recent cases are admitted to the admission ward.

19 November, 1924.]

Dr. H. DEVINE, O.B.E., M.D., F.R.C.P.

[Continued.]

4298. Are they received by one of your assistants?
—Yes.

4299. And does the case receive at the outset individual consideration as to the proper way to deal with it?—Yes, certainly.

4300. We have heard it suggested that in some institutions patients of all types of insanity, whether they are quiet melancholic cases, or whether they are more or less violent cases, are at first herded together, to use your own phrase, for a time, which does seem undesirable. Is that not so in your institution?—It depends on the structure. The structure of our acute ward, unfortunately, is not a separate villa such as some asylums have, but our structure is a large ward with side rooms and a large bed space with not very many beds in it, and a very large verandah opening out into the garden. If a case required treatment in a side room, which is not by any means a disagreeable thing, (it is a nice airy room, heated, with a big window and a bed), the case would be treated there; and another case of acute melancholia could be treated in a separate part either on the verandah or elsewhere. Unfortunately, it would be impossible in many institutions so to arrange that every type of case had a separate room. That is the whole trouble of treatment of mental disorder: that the more one feels that more ought to be done for the cases, the more you realize that you ought to have more little wards, because so much individual treatment is necessary for a case; and to get ideal conditions which, of course, we always visualise, the expense would be simply enormous.

4301. One has, of course, to have that in view, but, speaking as a layman, one cannot but feel this, that a patient brought for the first time to an asylum, probably in a condition of excitement, or, at any rate, strange to the new surroundings, and for the time being off his balance, might find it very painful to be associated at once with a large number of cases possibly much worse and more violent, and that the start of the asylum life, so to speak, might frighten or distress such patients very gravely?—I fully agree with that, but the picture of an acute ward as stated by you is surprisingly different from the reality; there is not the noise and excitement, and so on, that is anticipated, and it is really a fairly quiet sort of place. There might be rather a restless case in a side room, but the majority of cases would be quiet.

4302. If you had an acute maniacal case you would segregate that from the others?—Yes, certainly. Of course, I would like to point out this, that the problem is most extremely difficult with our present conditions, because the so-called acute ward—if you take my male side, for instance—is largely filled with chronic patients. The cases of the acute admissions are so few, and when they do come in they are not acute at all, that you would find you really want quite a small ward. Most of my admissions, as I say, especially on the male side, are chronic from the start. The last four cases I have had have been general paralytics in an advanced stage; there is no question there of acuteness; the only acuteness about them is that they have just come in.

4303. No doubt the popular impression of a lunatic is of some person who is raving. Your experience shows you that a large number of cases are not cases of excitement, but cases of depression or general breakdown?—We endeavour in every possible way by a human and sympathetic attitude to deal with the patients, because the more you live in an asylum the more sensitive you are to the atmosphere, and you feel the disability of the patient and the sadness of his coming in, and the more you try to reassure the person on admission the better. Admission is not a kind of scene in which there is a great disturbance. A person simply comes in, is carefully talked to, and reassured and made as happy as circumstances permit.

4304. I understand that as a matter of practical working you have a reception department, and that associated with it you have a certain number of small rooms in which you can put cases which it is undesirable should be with the others?—Yes.

Sir David Drummond: I do not think we have yet heard from Dr. Devine how long a time elapses before these people are separated.

4305. *Chairman*: Just tell us this, doctor, following Sir David's point: These people come in dribblets, one one day and one another, and so on; how long are they in your institution before they are apportioned out in the way you indicate?—It depends entirely upon the case. The usual routine would be, supposing you had a very restless and excited case who would disturb the others on arrival, that patient would be put into the observation room in the ward.

4306. Separate from the others?—Yes, an observation room in the admission ward, and he would be treated for the excitement. Of course, you have to consider what the patient likes first, but, unless the patient is happier where he is, he is moved out as soon as possible into the common life of the ward, and then as soon as possible, or even at once, he is placed out into the verandah, the open air verandah, depending entirely, of course, upon his mental condition..

4307. I think what Sir David wants to get at is this: On actually arriving at your institution is each case considered on its merits by your medical assistant?—Yes, and instructions given as to what to do.

4308. He may be dealt with in this fashion. It is a case which obviously must be treated alone and he is put into one of those separate rooms. If, on the other hand, the case is a quiet case which may be quite safely placed with the others the patient will be introduced to your general ward?—Yes, certainly, or the verandah, as the case may be.

4309. *Sir David Drummond*: The point is that these single rooms are just off the reception ward, and a noisy patient would be heard in the reception ward?—Yes.

4310. *Chairman*: Then you still have association to this extent, that those who are quiet or depressed patients in the general reception ward may be distressed by hearing what goes on in the side rooms you have?—Yes, they might undoubtedly. Of course, the verandah is a great blessing there, because you can put them out into the verandah straight away, and there they escape it, but the fact does remain that a quiet patient might be distressed by the noise of another one.

4311. Now in practice have you patients of violent or destructive types generally in these side rooms—I mean is it a matter of common occurrence?—Yes, as a rule, but with an acutely disturbing case who disturbs other people, I should like to move them as quickly as possible to a ward where it will not be so disturbing; that is so, especially on the female side. On the male side you would hardly ever hear a sound in the acute ward.

4312. *Earl Russell*: What do you mean by "it will not be so disturbing"?—Where there is a case that is noisy.

4313. (*Chairman*): That is after the initial stage?—Yes.

4314. For the moment we are contemplating what happens to the patient who arrives. I can well conceive that it could be very distressing for the quiet class of case I have in mind to be housed in the ward, where could be heard through the door, so to speak, very distressing incidents, shouting and possibly the use of obscene language. Might not that be very detrimental to a case which was just hovering between soundness and unsoundness of mind?—Yes, I think so; I agree with that in every way.

4315. I would like to know whether that occurs often. I mean in your reception ward where the cases are for the moment housed, is there generally

19 November, 1924.]

Dr. H. DEVINE, O.B.E., M.D., F.R.C.P.

[Continued.]

somebody in the adjoining rooms who is violent and possibly shouting?—No.

4316. I want to know how often the patients in the general reception ward are exposed to such incidents. If I visited your ward to-day, for example, and walked through it, would I hear unhappy sounds coming from the adjoining single rooms?—I do not think it is so much sounds, it is a question of restlessness; you might do, of course. I have no hesitation in saying that I quite frankly admit that between what we should like and what we have got there is a certain gap, however hard we try. I mean to say my own attitude to this business is that you have got to think personally what it feels like to the patient all the time. That is the whole object of managing an asylum. You are bound to say that with the structure and with the means at your disposal, there are things for a patient that you would feel you would not like yourself and that is one of them; but you are the victim of an antiquated structure. I do not approve of these large barrack asylums at all. I should be delighted if there was a large sum of money placed at our disposal so that we could build an asylum on an entirely new plan with our modern ideas, a purely villa asylum, but we have not got it.

4317. I quite understand the difficulties with which you have to cope, because you are the inheritors of a system which was undoubtedly less enlightened, but with the means at your disposal you have explained to us what has happened.

4318. *Sir Humphry Rolleston*: With regard to the conditions which the Chairman has pictured of a very noisy patient disturbing and distressing patients in the main ward—would it not be probable that when a patient showed himself to be in that excited state he would be very soon transferred, and that that would justify his classification?—I hardly think so, because this case that is so restless and confused is the very case that we pin our hopes of recovery upon, and this case wants all the very marked nursing treatment—baths, and so on.

4319. *Chairman*: But wait a moment. I think you rather misapprehended *Sir Humphry's* question. *Sir Humphry* suggests that such a case on admission would be at once taken to the portion of your institution devoted to cases of that type?—No, I am afraid not. The case that I should move to a ward with more cases of that type would be the case that I did not regard hopefully, but I could not move this case that I did regard so hopefully because I should be introducing the patients themselves to the atmosphere of chronicity. These excited cases are very sensitive to their environment of course. A very extraordinary thing is that one often finds, if you ask the patients themselves, that they do not seem to object to the noisy case very often and they are extraordinarily sympathetic to it, and they do not seem to be very disturbed by it. I have got private cases now. I have a lady under my care at the present time; that lady came in in a very excited state; I put her into a special room in the sick ward, and she broke a window, and I had to move her to the acute ward; she was disturbing all the old people. I put her back afterwards; she got better in the sick ward, and then I thought as she was a lady of position, and I told her so, that she should go to the private villa, and I sent her to the private villa; but she begged me practically on her knees to come back, and she came back to the sick ward, where she now is and insists on staying there. The fact is she is an individual; you cannot treat a human being by rule. She likes the old people, looks after them and is happy. If you try and think as much as you can of the patients and as far as possible do what they like, it is all to the good.

4320. *Sir David Drummond*: Are these acute hopeful cases treated in the side rooms of the reception ward?—Yes, you keep them in the side room first, and the minute you get the chance you take them out of the side ward on to the verandah. If

they get restless and disturb the other cases, then you put them back again.

4321. So that as long as they are noisy they are within the hearing of the patients in the reception ward?—Yes.

4321A. *Chairman*: Are there many cases, if it may be taken as a normal circumstance of your reception ward, in the side rooms which are noisy and acute cases?—Yes, undoubtedly, especially on the female side. A large proportion of the female admissions are people acutely confused and excited.

4322. The difficulty from your administrative point of view is that you have not got in your institution the means of separating completely the two broad classes of cases, the quiet and well behaved cases on the one hand, and the more or less violent and excited cases on the other?—Only a partial separation. I must insist on a partial separation, because there is an open ward and there is the verandah, and side-rooms. The noise would not be heard on the verandah, and they sleep out there, of course.

4323. But as one appreciates, after all we are dealing with people who may be in a very sensitive state of mind, and undesirable associations at that stage may be unfortunate, you would agree?—I do.

4324. Then your conception of an ideal institution would be where such noisy cases were from the outset kept quite apart from the quieter cases?—Yes, and in this sense, that ideal is actualised in the case of the private patients; the private villa is much more ideal. A very acute private case I should always put into the main building, but the private villa has got a small ward for the acute cases and an entirely disconnected part in the villa for the quiet admissions.

4325. And that is what you regard as the ideal method to which you would like your whole institution to approximate?—Yes, that is so.

4326. Now we have carried the patient this length, that you have, first of all, put the entrant either into the general reception ward or into one of the side rooms; you have made your examination within the seven days. What is the next stage in the patient's history?—The patient stays where he is as long as he requires the treatment in the acute ward. As soon as possible one transfers him to that part of the institution most suited to his needs. If he is a sick man, we send him to the sick ward. If he comes round, we send him to what we call the convalescent ward.

4327. May I take it that apart from the reception ward and the reception rooms, the ordinary wards in your institution are so arranged that separate wards are allocated to separate types of patients?—Quite.

4328. So that you have a sorting out of the cases in this clearing house as I call it?—Yes.

4329. The ultimate destination of the patient is a ward in which other cases of the same sort are accommodated?—Yes.

4330. How many patients will you have of one type, let us say, in a particular ward?—You might have 45 in a ward; there are none much bigger than that; that is quite big enough.

4331. In these wards do you find patients more or less of the same type?—Yes, certainly.

4332. Looking at it from the curative point of view, do you find that it is detrimental to patients to be in the presence of a large number of persons suffering in the same way as themselves?—No, I do not think so.

4333. Passing to the question of detention of cases, your warrant to detain is dependent, is it not, upon the continued unsoundness of mind of your patient?—Yes.

4334. What in practice are the precautions you take to see that the conditions of that warrant are fulfilled, namely, that the persons whom you are detaining are patients who ought to continue to be detained?—On a given date, as you are aware, this continuation certificate has to be written, and my own practice is that, provided the patient is fit to be up, the patient is brought to my office at nine o'clock

19 November, 1924.]

Dr. H. DEVINE, O.B.E., M.D., F.R.C.P.

[Continued.]

in the morning, and there I have the case records before me, I have a talk with the patient and decide whether or not he is a fit subject for detention.

4335. We had yesterday some evidence that was interesting on the subject of these continuation certificates. One medical superintendent said that it was difficult at the convalescent stage to say of a particular case whether it had passed out of the region of insanity into the region of sanity. Have you found difficulty in signing continuation certificates in cases of convalescence?—No, I do not think so. Of course it is a very great responsibility, this recertification or continuation, and if one were supposed to find at the time of examination lunacy of such a kind that the person would be certified at the outset, one would certainly not find it in quite a number of cases. One has got to draw on one's large experience, one's knowledge of the case, the knowledge of the whole situation, domestic and otherwise, and his reaction as exhibited during the year.

4336. What one has in mind is this, that you may be quite satisfied as a medical man that in the interest of the patient, although the progress to recovery is marked, nevertheless the case is not one which ought to be set at large. You may be just at the stage when another fortnight or another month may complete the process of recovery which you are observing. Does that occur?—I cannot say that. I find no difficulty whatever in such a case, because if the case was in the condition of being fit to go out in a fortnight I should simply recertify the case and state it on the certificate.

4337. The certificate requires you to state that the person is still of unsound mind?—He is of unsound mind if he is not fit to go out. As a matter of fact I should consult with the patient and see what he thought himself. I should say to the man or woman "Well, what do you think about it? You have had this bad illness, and I think you would be better for a fortnight or three weeks more stay. What do you think about it yourself?" And if he said "I would like to go out now," I should send him out. It is very difficult to tie down to a formula a human being—the mental reaction of a human being. If you state on a certificate that this person is in a convalescing stage and feels much better but does not feel quite fit to go into the world, you send that to the Board of Control, and within a fortnight or three weeks the Board of Control most certainly write to us and say "Have you discharged this man?"

4338. I can quite understand that the premature discharge of a case might well undo the beneficial work you have been achieving?—Certainly.

4339. So that it might be in dubiety whether the patient had actually ceased to be of unsound mind at the moment of your continuation certificate; you might have no doubt that for the completion of the cure and for the benefit of the patient a short further period of residence in your institution would be desirable?—I do not think those cases constitute the difficulty. The cases that constitute the difficulty are the kind of case in which a magistrate coming to see the patient would say, "This person is not of unsound mind," and we know perfectly well that he is. Then take such a case as maniacal depressive insanity; that is a patient who has frequent episodes either of excitement or depression, and at the date of certification he is in a normal condition. You would not put down on the certificate: "This person has this symptom, that symptom and the other symptom," because at that moment he has not got them; but you would state on the certificate: "This person during the time of observation has had frequent episodes of depression," and you would describe them, and say he is now in a quiescent stage. Then you sign the statement at the bottom that the patient is of unsound mind; so he is *in toto* of unsound mind. In a fortnight that person is going to be in a state of extreme depression or excitement.

4340. Then in practice you do not find any embarrassment from the terms of the continuation

certificate in cases of convalescence?—I interpret it as I say.

4341. Is the difficult class of case in your mind the class of case where there is no doubt as to the necessity for detention, in your medical mind, while the lay mind may think that the patient is one quite suitable for discharge?—I do not think there is a single case that I have got under detention with regard to which, if I laid the facts before an intelligent layman, he would not agree. All I do say is that at the moment of the conversation the insanity may not be obvious. Our patients are not behaving grotesquely, and talking nonsense, every moment of their lives, they are highly intelligent, charming, and nice, and so on.

4342. But they are nevertheless in a pathological condition?—Undoubtedly, of course.

4343. Now have you had in your large experience any case where a patient has been detained improperly, or has been found to have been detained improperly?—No, I have never had one.

4344. In public asylums such as yours have you any motive for detaining a patient after cure?—Certainly not; one wants to get them out. That seems to be the whole essence of any discussion of this kind, because what possible reason have we got for not wanting to get the patients out?

4345. I think almost the only reason that has been suggested to us has been that some of the patients, particularly those who are most intelligent, may be found to be most useful in the institution?—So they are.

4346. And free, unpaid work may be a great advantage to the institution. That is the innuendo, if I may put it so?—The thing could be said, obviously, because as a fact the work of patients does diminish the cost of the institution; that is a fact. It is a very proper fact, too, in my opinion, that the more these people, who, unfortunately, have to live away from contact with society—the more they are useful to the community in which they live, the better for them and the better for the community, and we do encourage work. If persons do not want to work for the institution they can work for themselves; they can make their own blouses, for instance; but it seems to me a very proper thing to encourage them to work.

4347. No one disputes that, and I can imagine that some wholesome work in carrying on the institution may in itself have a steady effect, and be a part of the cure?—It is *the* thing.

4348. The suggestion is this, that when a person is found to be very useful in the laundry, or any other part of the institution, that supplies a motive for detaining such a person longer than is proper?—As far as my experience goes, the suggestion is utterly grotesque; it would be criminal to take such an attitude. The bias of the doctor is always to get the patients out, and the more patients he gets out the more he is pleased. There is no possible motive why any doctor should ever wish to detain a patient, so far as my experience goes. I deny that entirely.

4349. Of course you understand why I am putting it to you? It is because we are here to alleviate public anxiety, and one is anxious to find out from your administration whether such cases occur?—I certainly hope not, in my administration.

4350. Now there is another aspect of the detention period, and that is to what extent have your patients means of communicating with the outside world, access by correspondence or by interviews with persons who are not officials of the institution?—They have every possible access. I simply speak from my own experience. I do not think anybody could have more opportunity of airing their grievances than the patients under my care.

4351. How do they air them?—They can air them to me in private; they can have an interview with me at any time they like, whether they are homicidal or whatever they are; they can always have that; they have only to ask. They can see their friends;

19 November, 1924.]

Dr. H. DEVINE, O.B.E., M.D., F.R.C.P.

[Continued.]

they can see the committee; and I should like here, if I may, to interpolate what I consider to be the most important thing, namely, that the future asylums should be an organic union, so far as possible, with the towns in which they are located. I think it is one of the most important things of the whole business, that instead of multiplying these enormous asylums, it is infinitely better in every way to have the asylum as a part of the town which it serves. I have had experience of both places, and it is when you get them as part of the town that the personal relationships of the patients to their friends and the community as a whole are very much greater. Now hundreds and hundreds of people visit our patients every month; they have every opportunity of quietly telling their friends what they think, or of making any complaints they have. The committee belong to the town and know the patients and their friends, as a rule; there is a member of the committee from each district. The committee make frequent visits to the wards. Any patient can speak to them, and does speak to them. The patients can write practically to whom they like; possibly I exceed what is intended to be done; I practically always send the patients' letters, even if they are complaining, to societies or whatever it may happen to be; I let them go; so that it cannot be said that the patients have not an opportunity of airing their grievances.

4352. You have opened a large topic just now, which we appreciate. I understand that you are desirous of doing away with what one may call the isolation of the asylum from the ordinary communal life?—Yes, I am very strongly of that opinion.

4353. Just as the ordinary general hospital in a town is recognised as one of the ordinary institutions of the town to which people go, and in which they take an interest, so also the mental hospital should form part of the ordinary life of the town?—Yes, I think so. Perhaps I may just expand that view. After all, what am I? I am a citizen of the town to which I belong. Everybody knows me, in a sense. Many of the nurses and their friends have been to school with the patients. The nurses live out. The committee are part of the community. The patients can go down the road. They are known by all the inhabitants of the neighbourhood. They can go to the town and shop; they can go to the local football matches, to the pictures, or anything else. They are in organic relationship with the community in which they were born, and I think it is a matter of enormous importance.

4354. You think that this is a step, if it were taken generally, in the direction of doing away with the old idea of the mentally afflicted being a stricken class, apart from the rest of the world?—I do, most undoubtedly. Perhaps I may give an instance. You get a local place; you get a brotherhood choir coming up to sing to them, say 150 men. A lot of these men are the patients' relatives; they certainly know them; they can intermingle together. How can you have concealment? Everything is absolutely open.

4355. Then you would welcome increased publicity in the administration of your institution?—Undoubtedly. I hardly see how it could have increased publicity. Everybody can come in and see the patients. Hundreds of visitors come up every week and sit in the wards, and it is part of the life of the community. The patient has every possible opportunity of stating any grievance he may have. The friends of the patients sit for hours in the wards.

4356. Do you think that system is beneficial as making the patients feel that they are not cut off from the ordinary life of their fellows, but are still in association with them?—I think it is essential. The more social contact of the ordinary kind that a mental case can have, so much the better for him.

4357. Then you must be rather against the policy of having large isolated institutions for the treatment of mental cases, to which cases are brought from various surrounding areas and are treated together?—I am entirely against it; I think it is a legacy of

the past. It is much better that Southampton and Bournemouth should have their little mental hospitals than that the patients should be sent miles away into the country. They say it is beautiful to have the fresh air of the country. Nothing of the kind. It is very much better that they should go up to Handley's and do their shopping, and mix with the life of the community.

4358. Of course we have also heard that it is very advantageous to the mental institution to have associated with it a farm and a means of outdoor work. You cannot get that very readily right in a town, of course?—I freely admit that, and I also admit that what I say is a kind of Utopia. How can you have it in a monstrous town like London? You must have it some way out. As a policy I think it should be done as far as possible. It is much better that wherever possible you should have a small asylum attached to a town, even if it costs more. What do a few pounds matter? It is much better to have a small asylum to which the patients can go, rather than to have these immense county asylums very far away, in many cases, from the relations and so on. I fully admit that it is an ideal, but we have to think for the future.

4359. There is one aspect of it upon which you might give us your view. I could imagine that a large institution, of which we have many examples in this country, while it might be farther away from the general life of the community and from the homes of the patients, might be able to supply special curative appliances and so on on a more elaborate scale. We must have a certain concentration in these matters?—I admit that. I admit that the London County Asylum, for instance, in which I used to be, might have much more scientific equipment and scientific people dealing with the matter than I have got.

4360. Take the small institution that you figure: I can quite see the desirability of the homelike atmosphere, but on the other hand it would be very difficult to institute at small local asylums pathological laboratories, and the equipment which we know is becoming more and more elaborate in connection with the treatment of mental disease?—I do not think every place can be expected to be a centre of research, any more than a little hospital in a county town is a centre of research. The main thing is that these elaborate asylums, and the Maudsley Hospital, with which I am connected, may well discover things which we can use; we apply what they discover. Let there be your little asylum, and the local hospital, and the general hospital staff coming up and treating the cases, as long as you treat them on ordinary, reasonable, medical grounds. There is no mysterious treatment we have got that the ordinary doctor does not know about. Treat them on general grounds. It is far better than some scientific research, in a sense, for the patient. He would be happy, being near the town and his friends.

4361. There are such small institutions as you figure in the country, as it is, of course?—There is Canterbury.

4362. Could those small institutions get the benefit of the work of the laboratories and the research equipment of the more elaborate institutions by being associated with them? What I am thinking of is this, for example: A patient's blood might be sent to a central pathological laboratory for examination?—Undoubtedly. I quite agree with that. The ordinary biological methods of examination must be carried out. For instance, we have a laboratory at our asylum which is very little used, because we have not enough staff to do it. All our biological examinations, blood tests, Wasserman and so on are carried out at the local hospital.

4363. Even at present you avail yourself of services outside the institution quite satisfactorily?—Undoubtedly.

4364. That rather answers my point, that the research department and the laboratory department might be centralised, while you might have the insti-

19 November, 1924.]

Dr. H. DEVINE, O.B.E., M.D., F.R.C.P.

[Continued.]

tutions more or less dispersed?—Yes, I think it is essential it should be so, because amateurish research is totally useless, as we know. Where you are going to have research you want it concentrated for the purpose.

4365. Now, there is another point I should like to take you to. Are you crowded in your institution?—Yes, we are.

4366. Is there any difficulty, when a relieving officer desires to have a person destined to your institution, in the reception of the case?—We have not quite got to that stage, but, in my opinion, the place is overcrowded. We have not beds on the floor, or any dreadful thing like that, but we are overcrowded, and it is essential to build very shortly.

4367. Have you any views as to the desirability of removing cases from your asylum, cases which are manifestly chronic and hopeless cases, to a Poor Law institution?—I do not think I have many cases which could be so moved. As a matter of fact, the Poor Law institution itself is crowded; it would be out of the question. One has got a certain proportion of senile cases and so on that perhaps might be moved, but it would not be practical in this case; besides, they do not want to move.

4368. But, in point of fact, in the Poor Law institution properly so-called, the workhouse, there are a considerable number of chronic cases resident, I understand?—Yes.

4369. And you also have some of the same type of cases resident in your asylum?—Yes.

4370. So that one may find a senile dement, a case of that sort, in one or other of the institutions, permanently resident?—Yes, but I think the term "senile dement" ought to be expanded more or less. I only get admitted quite bad cases of insanity. I get cases of senile dementia, but those cases are very restless and excited, and some of the worst sort of cases you can have, and they require very, very skilled nursing. They are restless and agitated. I think I might say that practically all the cases that I have need the sort of care they get. I do not get a big group. Having the Poor Law infirmary, I do not get an admission of the quiet senile case.

4371. I rather gathered from what you said earlier that in Portsmouth the cases that are sent on to you are really cases appropriate for asylum treatment?—That is so.

4372. While the authorities deal with the chronic, quiet, old case, or the case that might as well be in the Poor Law infirmary, without sending it on to you at all?—Yes, that is so.

4373. Have you ever had, in your experience, to give what we know as a barring certificate, that is to say, a certificate by the doctor that the patient ought not to be allowed out under the Act?—I have only given one, I think, as far as I remember.

4374. It is Section 74 of the Act, "Restriction on discharge." You have only had to do that once?—Yes.

4375. It would be interesting to know if you recall the circumstances of that case—we do not want any names?—In this case the patient had delusions against her husband, and the husband was also mentally queer himself. This man wanted the wife out, and as the man was already in some friction with the police, and the woman had delusions against him as well, I thought it was a case in which I would not agree to his request to have her out, and did not do so. The man was totally unsuitable, and the patient as well, so it was a very strong combination.

4376. Was an appeal taken under the provisions of Section 74?—No. The man had the case transferred from a county asylum to me as a private patient. I took the case with reluctance, but he begged me to take it; his purpose was because he thought then that he could exercise this legal right by having the case as a private patient, and he thought he could take her out under that Act. I was of opinion, for the sake of the patient and of her mental condition, that he could not do it, and reported it in the usual way

to the Board of Control. Then I think he did not want to pay any more, and the patient went back to the other asylum.

4377. In that case your barring certificate was apparently acquiesced in?—Yes.

4378. There is machinery, you know, under Section 74, for going behind your barring certificate?—Yes. In such a case as that, of course, one gives a very exhaustive report to the Board.

4379. And it was regarded as satisfactory?—Yes.

4380. Is one of your difficulties in discharging patients that some of the unfortunate persons have no place to go to when they are discharged?—It is not much my experience, because in the state of affairs which I cite practically all our patients have homes in the town. I think it is a difficulty that would probably arise very much more in the case of a county asylum; people are very often homeless and so on, but we do not get cases that are homeless.

4381. *Earl Russell*: Are there not stranded sailors at Portsmouth?—We used to get them a lot when we had Southampton cases, but it is the rarest possible thing now.

4382. *Chairman*: Have you always found that there is a home to which the patient may go, a relative or somebody, or the patient's own home?—Just very occasionally I find I have to send a case to the infirmary, but I cannot recall a case lately where I have had to do it.

4383. Is there any after-care association in conjunction with your asylum?—I have the mechanism for using it, but I do not use it, because the patients go to their own homes, and I do not think they want a lot of people round them. If they are poorly they can come up and see us again. I think the after-care is a good thing, but I do not find any necessity to use it. After the patients have gone out, they do not want a lot of people going into their homes and fussing round. They want to forget it. But I have the mechanism that I could use; the association for voluntary welfare would do it.

4384. Now we pass to the other aspect of our inquiry, namely, the question of the treatment of cases without certification. Do you think that the present system, whereby a person does not reach an asylum or get the benefit of its treatment until the stage of certification, may militate against cases being dealt with at the earliest possible moment?—I think it is a most serious barrier.

4385. Is it a deterrent?—Do you mean certification is a deterrent to going to the hospital?

4386. Yes?—Undoubtedly.

4387. A deterrent against bringing cases in their incipient stages under medical observation, lest they may be certified and sent to an asylum?—Undoubtedly.

4388. In your experience is certification regarded as a very grave slur, shall we say, upon a patient's reputation?—It is a very serious slur; it is irrational that it should be so, but it is. If a patient is certified, not only is that patient subjected to a very insidious and unpleasant social censorship hereafter, but the children are as well. I see it repeatedly. Take the case of a woman who is certified for puerperal insanity. I can think of a case at the moment in which the children have been brought up with everyone round them watching every mortal movement they make, and finding evidence of abnormality, creating neurosis. These children are brought up with a sort of biological inferiority, which is the worst thing anybody can have. I have no hesitation in saying that many people become confirmed neurotics from the fact that their relations have been certified, and from the attitude of society towards them. I have seen it repeatedly.

4389. Have you any suggestions to make to us as to how that may be mitigated or diminished?—I think the general principle that no certifiable case should be treated without certification might undoubtedly be relaxed. There are a large number of

19 November, 1924.]

Dr. H. DEVINE, O.B.E., M.D., F.R.C.P.

[Continued]

cases of temporary psychosis, some of them quite severe, which could quite adequately and well be treated either in nursing homes or in separate clinics, with a very minimum of formality. The Scottish system of a simple notification to the Board of Control is perfectly adequate. There is no publicity; there is no stigma; and the thing works perfectly well. I do not think that a mental case, that is to say, a person who is irresponsible, should be treated unless there is some supervision. I am bound to say that.

4390. Of course the difficulty of the problem, as you appreciate, is this, that the particular malady we are concerned with is one which necessitates control in treatment?—Yes.

4391. And control in turn connotes deprivation of personal liberty?—Yes.

4392. And it is just round that aspect of the problem, unfortunately, that a certain element of doubt or suspicion has so long gathered in the public mind?—Yes.

4393. It is from that point of view that one has to tackle the problem?—Yes.

4394. Would it be necessary in dealing with incipient cases, short of certification, or avoiding certification, at the same time to have certain powers of control or detention against the wish of the patients?—No, I do not think so. I think if a patient objects to treatment or resents treatment, that patient should be certified fully because everybody has got to be protected; but where you get a non-volitional type of case—for instance, a great number of cases are purely delirious—there is just as much reason to treat these delirious cases without certification as there is in the case of typhoid delirium. In a case of typhoid delirium you restrain, of course. If a patient wants to get out of the window, he is not allowed to do so, and it is the same with alcoholic delirium. The same sort of restraint would have to be exercised with the confused delirious type of case, which is very often of brief duration, and eminently recoverable.

4395. I quite appreciate that in the voluntary case, that is to say, the person who either himself observes, or whose relatives observe, that something abnormal is happening to that person, just as if they saw the symptoms of an ordinary disease coming on, it is desirable that he might go either to an out-patient department of an infirmary, or ask for admission to the infirmary; so also you suggest that a person at the outset of a mental malady might voluntarily ask for treatment?—That is covered by the voluntary boarder system.

4396. Yes. What rather strikes one as a practical difficulty is this: Supposing a person presents himself for voluntary treatment and desires the benefit of treatment, such a person within a day or two may become very much worse, may become irrational, and may desire to get out. You might then find the purpose of your treatment entirely defeated. You would have no power to detain that patient, and the patient might insist on going out. What then?—I know this is a thing that is criticised. The patient simply has to be certified. There is nothing behind-hand or secretive or wrong in certifying a case. If a case gets to that condition the case will have to be certified. It is said "Oh, the case was brought in under wrong pretences." Not at all.

4397. But certification would ensue in the case you have figured as the means of continued detention against the wish of the patient. But take your case of puerperal mania: It may well be that the state is entirely transitory, although for the time it may be quite an extreme case. Would it not be desirable that you should be enabled to detain that case for a short time with a view to cure without certification, because you seem to me to be defeating your object if every case detained against its will must be certified?—No; that is the very point I make, that certain cases that ought not to be certified in the ordinary way are not covered by the voluntary system; but if a patient insists on going out, and refuses treatment, I think in all those cases the patients should

be certified, whether it is to their advantage or disadvantage. It is the case of confusion and indifference to the whole situation that you can treat without certification. It would be a very serious matter for us if a patient who came in as a voluntary boarder became very seriously hostile and so on, and threatened murder, which condition might last a week. I personally should not like to have that case under my care without a certificate.

4398. You are aware that under the Mental Treatment Bill it was proposed that a patient could leave on 72 hours' notice, which seems to imply that during those 72 hours the patient may be detained?—Yes.

4399. *Sir David Drummond*: How are you going to detain the patient for 72 hours, when the patient is perhaps recovering, and a doctor would not propose to certify a patient who is recovering and elects to go home?

4400. *Chairman*: You see it is a practical difficulty?—Yes, very. The whole subject is very difficult.

4401. What one would aim at would be that in cases where insanity is a temporary thing the permanent stigma of certification should not be imposed. We have been discussing with other witnesses the possibility of dealing with these cases on a provisional basis; that there should be some method, short of certification, which would give you a certain degree of control, but only a temporary control, over that patient, awaiting the determination of the ultimate fate of the patient. Would something on these lines work: That you should have a notification of the case, communication with the Board of Control, and certain powers, not of permanent detention, but of detention for a limited period, to be used for observation and treatment, during which period the patient might recover and leave without any certification?—Yes, that is what I do advocate. If a Mental Treatment Bill of any sort is to be of any value whatever, it must permit real psychoses to be detained. There is no need to alter the law to put a lot of psycho-neurotics in these places. If the Bill is to be of any value, it must give power of detention on a simple system of notification of people who are really insane.

4402. People who would be certifiable, but whom it is undesirable to certify, because their prognosis is good and they may be relieved?—Yes, that is so.

4403. *Earl Russell*: What is psychosis?—Insanity distinct from a neurotic or hysterical condition.

4404. *Chairman*: At present, of course, it is illegal to treat a case of insanity in a nursing home for gain?—It is; of course, they are so treated, I have no doubt, but I do not think it is right that they should be. I think it would be an additional protection, because I think that any place that takes these uncertified cases should be under control by some central authority or local authority. I think there should be a system of notification, for instance.

4405. One has, of course, at the same time to look at it from the public point of view as well as the medical point of view. The medical point of view naturally concentrates on the welfare of the patient, but the public point of view is concerned with the prevention of possible abuses?—I think there certainly should be control of some sort. For instance, I have seen a patient in a nursing home suffering from senile dementia, whose daughter was getting her to write cheques. No one recognises more than I do the enormous necessity of some supervision. I mean, human nature is such—they are not all virtuous, and the people who are queer in mind will be taken advantage of from time to time. I think there should be supervision. All I urge is this very private method of notification. Take a citizen in a town such as mine: She may have a brief psychosis of two or three weeks. She is known socially to everybody; if she has got to go through this process, everybody in the town knows it, and she is at a serious social disadvantage hereafter. I make this point, that the hospitals which provide for the treat-

19 November, 1924.]

Dr. H. DEVINE, O.B.E., M.D., F.R.C.P.

[Continued.]

ment of mental disorder which the community provides are the very last places that I myself should advocate for a friend to go to.

4406. Why?—I will give you an instance. A personal friend of mine came up to me the other day and said, "For God's sake, doctor, take me into your asylum." He said, "I am going to commit suicide; I put my head in a gas oven this morning, and took it out again. I am in a dreadful state, and I want to come in." I said, "My dear fellow, if you come into this hospital, everybody knows you. You are only in a psycho-neurotic state; you can soon be cured. The instant you get in, all the people in the town will know of it, and you will be at a social disadvantage for a long time." I was quite right; the man cleared up. You have the grotesque situation that I actually tell a man not to come to my own hospital.

4407. Now is that because the public asylum is associated in the public mind with certified cases?—I think so. If a different atmosphere were created by these clinics—I know this is a thing which people object to—if I had this separate part for uncertified cases in the asylum, I think it would make a great deal of difference; people coming in and going out of the place would get still more known. Of course, there would always be a stigma of insanity, the same as there is in any disease, because people fear it and they naturally fear it because it is a terrible thing to lose their reason. The fact is that there is a certain biological inferiority in certain cases. The horror of the public is in a sense based on realities, but we ought to diminish it as far as we can.

4408. Then you would find it a positive advantage from your point of view if you felt that you were able to take cases on a voluntary basis, or on a modified basis of temporary restraint without certification?—Yes.

4409. Do you think that the association of such cases with your asylum would have this advantage, that the mere fact of frequenting your institution would not necessarily mean that the person was a permanently afflicted mental case?—Yes. I do not believe in detaching these cases from the asylum and only having chronic cases in the asylum, because what will people think of the certified case? You have not got to make that big difference between them, because the lot of the certified case will be worse than it was before.

4410. One view has been put to us, namely, that simple mental cases might be treated in association with general hospitals so as to promulgate the idea that mental malady is just a form of human affliction like any of the other cases that go to a hospital. Is that feasible, do you think?—I am in the strongest possible favour of it, because this Bill was proposed in order that the local authorities should be empowered to look after cases under this modified form of notification; they could do it wherever they wished; and especially where teaching hospitals are concerned. I think it is absolutely necessary that they should take mental cases because the student at the present time has a most grotesque idea of insanity. If a student walking round the wards saw a case of melancholic stupor next to other cases, or he had a special ward with people suffering from some forms of mental disorder which could be suitably treated in the hospital, I think it would make an enormous difference, and he would see then that he treats these cases on the same biological lines as a case of pneumonia, or anything else.

4411. But must not one keep this in mind also, that, after all, the treatment of mental cases is rather apart? The ordinary case in a general hospital is usually suffering from some more or less defined malady, which is treated and cured, but the insane person, although of course in a pathological condition, may be physically quite fit and quite healthy. Is not that so?—Yes.

4412. Therefore you have to provide in an asylum for a continuous life; people have to live in those institutions?—Yes.

4413. People do not live in ordinary general hospitals; they are there for a special purpose; they are cured, and one knows that their period of residence is only a period of weeks, on an average, but people who go to an asylum may have to live their lives there. That is a different conception from the conception of a general hospital altogether, is it not?—Yes. Do not think for a moment that I consider that the general hospital is a general solution of the problem. All I do say is that certain cases that were suitable would be very properly treated in that way, and it would actually cover a class of case which would not get to the asylum, certainly, in another way. The thing has been actually done in Edinburgh by Dr. Comrie, at the Royal Infirmary. They get their alcoholic psychoses, they get operation psychoses, and a lot of depressions, the type of person who is brought in by the police as being suicidal and so on. I think that, if the law were altered, that would be a valuable thing; it would be valuable for the student, and valuable for quite temporary psychoses.

4414. With regard to those cases which in Edinburgh go to the Royal Infirmary, where would a comparable case go in Portsmouth?—I suppose they do go to the infirmary.

4415. Do you mean the Poor Law infirmary?—Yes. I read this account of the Edinburgh cases very carefully, and they are certainly not the cases I get in my place.

4416. *Sir David Drummond*: You do not mean the Poor Law infirmary; you mean the general hospital, do you not?—I think they would be transferred from the general hospital.

4417. *Chairman*: The Royal Infirmary at Edinburgh has no stigma of pauperism about it at all. It is an institution kept up by voluntary contributions, and a patient treated there has merely had that episode in his life, but has no stigma whatever. Do you think that the same case which in Edinburgh receives treatment in that way at the Royal Infirmary in England might find its way to a mental hospital?—As regards my own town, it would find its way undoubtedly to the Poor Law infirmary, where it would at least be made a pauper in the mental block.

4418. Is there no general hospital in Portsmouth supported by voluntary contributions?—Yes, but the point is that the hospitals do not take these cases. The Edinburgh scheme is a very exceptional matter.

Sir David Drummond: Is it not a fact that it is only an out-patient department?

Chairman: I think it is.

4419. *Sir David Drummond*: They have no in-patient department at Edinburgh, have they?—Yes.

4420. *Chairman*: I hope we shall have some evidence from Dr. Comrie.—Dr. Comrie wrote a very important article for the British Medical Association quite recently, which was commented on in the *Journal*.

4421. You think that is a suggestive idea?—I think it is of the greatest importance; not that it would cover all that is wanted, but with the relaxation of the law, the hospital by taking a few of those cases suitable for the hospital, would not be breaking the law, at at present it would.

Sir Humphry Rolleston: Before we get away from the question of notification and stigma, would it seem to you that this system of notification, which entails detention, might, after having an admirable effect for a time, eventually become smudged with the same stigma?

4422. *Chairman*: *Sir Humphry* suggests that any institution which is associated with the detention of persons of unsound mind is liable ultimately to attract to itself the same unfortunate associations which now gather round the asylum. That is the difficulty?—Yes, I think it will; I quite agree with

19 November, 1924.]

Dr. H. DEVINE, O.B.E., M.D., F.R.C.P.

[Continued.]

that. But meanwhile public opinion may be educated not to so regard it. As a matter of fact, if anyone is associated at all with being queer in the mind, people know that it is treated in that way. I have had absolute proof of that in the war. I was in a large general hospital, and I was looking after the mental cases, whether they were psycho-neurotics or hysterics. Everybody looked upon them as "balmy"—that was the term they used; they were Americans. They called it the "balmy" ward; it did not matter whether they were just hysterical or had lost their voices; anybody who had anything whatever the matter with the mind was looked upon as "balmy." That is why we cover it; we say they are suffering from "nerves." If a doctor tells a patient his mind is wrong, he would never be called in again; he has got to cloak it with "nerves." But I think that it will gradually be an educative process, and we have to think for the future.

4423. Let us follow up that idea?—Take the Maudsley Hospital, for instance; that will be educative, not merely for the patients, but for the public; and gradually, by a process of educating the public as to what is meant by mental disorder, and having an objective proof in the fact that people come in and walk out and so on, perfectly well, this will gradually teach the public to take a more enlightened view of mental disorder.

4424. May one look at it historically for a moment? Of course, in the past one knows the perfectly preposterous ideas that were entertained with regard to mental disease. Do you hope that, as education progresses, and the scientific side of this disease is more understood, there will be greater advancement in the public appreciation of the true nature of the disease?—That is so; that is what we do hope.

4425. Perhaps it is in a state of transition just now. You are hopeful that by proper means of education and publicity we may advance still further in putting mental maladies in their proper place as a social incident?—That is so.

4426. Must not we take into consideration also that we cannot burke realities? After all, insanity is in the general case an indication of a biological inferiority, as you put it?—In a very large number of cases it is.

4427. Therefore there is no use in pretending by expedients of one kind or another that such biological inferiority does not exist in the case of persons who have had to undergo such treatment. One cannot burke that?—Quite.

4428. No amount of altering phraseology or opening the doors of your institutions and so on will remove that inevitable association with mental disease?—No, but the thing is over-emphasised, I think, because after all many sorts of physical inferiority or physical illness is really a form of biological inferiority, and the children of such a person will probably not be as well as the children of other people; but it is setting it in a special class. Any disease by its very nature singularly unpleasant will be regarded by the public with horror, and the children as well. For instance, the subject of cancer is regarded rather unpleasantly by the public; and so are the children. If you tell someone that your mother died of cancer he will think slightly less of you. It is only more marked in the case of mental disorder.

4429. But I think there is a speciality about it, if I may say so, in the case of this malady, because of its seat in the reason, and its effect upon the responsibility of the citizen. It is different from other maladies. Take the kind of illustration that occurs to me: A judge's mind would not be affected in estimating the value of testimony, which is an important public function, by the fact, which might be brought out in evidence, that three years ago the patient had an attack of scarlet fever or typhoid. No counsel would think it worth while to bring out that point; but he might think it well to bring out that the patient had been detained for six years in a lunatic asylum?—It might not be quite fair.

4430. It might not be quite fair, but at any rate in the present state of public education that is just the kind of difficulty you have in mind?—It is rooted in all of us. If my wife became insane I should avoid in every possible way her going to the asylum, for the sake of the children and so on, and one would have a special horror of it. All you can do is by a process of education in some way to diminish it, and get people to realise that there are quite a number of cases that are due to purely physical causes, infection, and so on, and that they clear up entirely.

4431. Just one other point. Have you found in your experience that a very large number of your cases are quite willing to submit to treatment in your asylum?—Yes, a lot of them.

4432. Is this element of compulsion which the public apprehend present to any large extent in your cases in your experience?—No, I think it is very much exaggerated. The compulsion is very slight. Your admissions as a rule are perfectly indifferent to the situation, or thankful to get to a refuge, and so on, and on the whole one does not get an attitude of antagonism; some of them are quite willing.

4433. I think you can give us a survey of your last 50 admissions of females?—Yes, I believe I have it here. This was *apropos* the possibility of admitting cases without certificate.

4434. You have made an examination of your last 50 female admissions. What has been their attitude to treatment?—Nine willing cases (pleased to be under care); thirty-three indifferent cases (confused, etc.); nine unwilling cases (ascribed their position to the machinations of others—persecutory delusions). So that quite a number of these cases could have been treated without being detained against their wish, apart from certificate.

4435. *Mr. Micklem:* Dr. Devine, I am anxious not to repeat any question that has been put to you, but I should like you, if you would, to tell me exactly what you understand by notification as distinct from certification?—I should mean by notification that a doctor recommends to the hospital to which it is intended to send the patient, similar to an urgency order; that is what it amounts to. The urgency order is just an order from the doctor and from the relative to send the case to a mental hospital without any other intervention, and this case is notified to the Board of Control as having gone to this place.

4436. You mean that what I will call, perhaps improperly, the detention order should be made simply by the doctor and the relative?—Yes.

4437. *Chairman:* And notified?—And notified to the Board of Control or to some health authority. I think there should be some supervising authority in addition to the person in the home, and the doctor.

4438. *Mr. Micklem:* Taking the ordinary case of a poor person, I suppose he would come under some panel doctor, or he would have no doctor?—Yes.

4439. Usually in the case of one of the poorer patients it would be a case of the relieving officer making the order?—One hopes that the relieving officer's business will be done away with. I have advocated complete dissociation from the Poor Law. The panel doctor and the relative recommend this case to go to the public mental hospital.

4440. Do not you think that the notification would be just as much known in the family and in the neighbourhood as the certification? What difference would it make as far as the stigma upon the person was concerned?—No magistrate intervenes, there are no magisterial functions going on; there is no legal process occurring of an impressive kind, in which magistrates are called in, and so on.

4441. But in the case of notification I suppose it would still be necessary, would it not, to have some compulsory order against the patient? Notification, would carry, would it not, compulsory detention?—Yes, it would, certainly. The order would be of a

19 November, 1924.]

Dr. H. DEVINE, O.B.E., M.D., F.R.C.P.

[Continued.]

kind, as I say, practically like an urgency order, which exists now, in which only two people intervene.

4442. But where you have an urgency order you mean an order to operate in three days?—My idea would be that it should be something like an extended urgency order.

4443. It would carry exactly the same right to compel detention as the magistrate's order. Is that your view?—As regards the patient; but, of course, if the relatives want to take them out they can take them out now. It would be just the same as it is.

4444. The petitioner could take the patient out now?—Yes.

4445. At any time, even against your certificate?—You would never give one; it is very seldom necessary to do that. I mean it is quite easy for anybody to get out of an asylum.

4446. Do you think that, as far as regards the feeling of the relatives and the feeling of the neighbourhood, there would be a very considerable distinction between the two orders?—Yes, I think there would be a great deal. There is the formality and distress of getting a magistrate to come in. It is only a matter of practical experience. I see it with private patients; it causes a lot of worry and anxiety.

4447. And to what institution should they be notified?—I think they should be notified to, say, a nursing home, and, of course, that nursing home would be subject to supervision by some authority, or to a hospital, and uncertified clinics, and so on.

4448. That means in an ordinary case having an entirely new institution for them to go to in every town? Take the case of Portsmouth: Should they be certified to your hospital?—Personally I think they should be, if the hospital has the confidence of the town. If it has not, they will not go to it; but if it has, you could have a separate block or villa for these cases; that is the only way you could do it.

4449. Take the ordinary case of a comparatively small town of 12,000 inhabitants, such as mine, where there is nothing but the Poor Law institution and a county hospital near it, which would not take mental cases. What are you to do then?—You would not have a great number of cases. I should think you could easily erect some cottages or villas. What we call a villa in an asylum, with 30 or 40 cases, would cover the whole thing.

4450. A sort of receiving house for all cases?—Yes, that would cover the whole thing.

4451. You send out cases from time to time on trial?—Yes.

4452. Supposing that a patient does not return at the end of the trial period, is he deemed still to be in your custody?—Under what circumstances does not return? Simply does not appear?

4453. Yes?—Undoubtedly he is still in my custody.

4454. Under those circumstances, what steps do you take?—Let me give a concrete instance of a patient I had. It was a young girl; she was out on trial for five months, under the most extraordinarily favourable conditions, with a clergyman and his wife, whom I know. She was living in the town on trial, and she used to come up to see us from time to time. The trial was extended. It was a case you had to keep on trial, because it was of a very difficult kind. The girl gradually became poorly; she came up to see me on a Monday, and I thought she was not anything like as well. I took her back to the clergyman in my car, and hoped she would pull round, but that night she disappeared, and she wandered off to Southampton; walked all the way. She is a girl of education and position. She walked to Southampton. I went to the police and told them that this girl had gone; she was on trial. Later the police rang me up and said that the girl had been picked up by the police in a very confused state in Southampton. What I did was to send a taxi with nurses, and fetch her back.

4455. Supposing anybody disappeared altogether, you would communicate with the police?—Yes; but

I look on it as my case. I am letting her out, and I can bring her back whenever I like, if she is unwell; she is simply on a holiday.

4456. I think there is a time under the Statute; if she escapes for 14 days she is free?—Yes, quite so, with that limitation.

4457. I think you are of opinion that there is no risk of anybody being detained in one of the mental hospitals beyond the absolutely necessary period of their detention?—That is my view.

4458. It was suggested to us, I think, certainly by one witness, that there is just a risk which might be got over by having a periodic revision by the justice. What is your view of that?—I think I can say, as a doctor, that the more responsibility that is taken off me from the point of view of detention the more I am pleased. The detention part of one's work one dislikes intensely. If the justices took it off our hands, so much the better for us, but the only point is that it does seem to me rather emphasising to the patient a rather disagreeable state of affairs. I have a chat to the patients and say, "Well, you had better stay on here," and I explain why. If this girl had got to come before a justice and clerks, and reveal her delusions and so on, it seems to me rather inconvenient, and, of course, it is a big affair, because every day I have a case or two coming into the office, and I certify them. It would be a great burden on the justices.

4459. It would be something off your shoulders, but you do not think it is necessary?—I do not think it is necessary.

4460. Do you think it is desirable that there should be some periodic revision by somebody?—Frankly, I do not. I go on my experience. I know it is being advocated by my own association. All I can say is that, in my experience and with my knowledge, it seems to me quite unnecessary.

4461. You have had experience in what I should call a large isolated hospital, and at Portsmouth, and you have given us exceedingly interesting reasons for thinking that the method you adopt at Portsmouth is the right one in the case of these mental patients. Now, could you say whether, comparing the two hospitals, there was any essential difference in the quickness of the recovery or the number of recoveries of patients as between the two?—No, I could not say that.

4462. Should you say that more cases recover or are relieved in one hospital than in the other?—No, I do not think so; I could not say that. Of course, the great advantage is for the chronic patient rather than for the acute case.

4463. *Miss Madeleine Symons*: Dr. Devine, on the second page of your *précis* you tell us that in Portsmouth you adopt the same principle with regard to rate-aided cases as in the case of private patients, and that you let them go to their relatives wherever possible?—Yes.

4464. Do you use Section 57 of the Act and board them out with relatives?—No, we do not do that. I have never used that section at all. The relatives apply, and, of course, they have to apply, to the committee. I do not put a barrier to them; but we do not board them out.

4465. These are really discharged cases?—Yes.

4466. And where you say that the figures lead you to think that many of the chronic inmates could be cared for at home if the conditions were more favourable, do you mean the housing conditions and social conditions generally?—Yes, I do; and, of course, the fact that the world has no use whatever for the person who is not efficient and able to carry on; there is not much scope for him. If it were an agricultural country a lot of these people might be working in a simple capacity on the land, but it is out of the question in this country.

4467. You have never tried the boarding-out provision at all?—No, I have no experience of that.

4468. When you were telling us about the advantages, in your opinion, of having the hospital in a town, you said that the nurses live out. Does

19 November, 1924.]

Dr. H. DEVINE, O.B.E., M.D., F.R.C.P.

[Continued]

that apply to the women nurses as well as to the men?—No; I did not mean that. I meant that the majority of the nurses have their homes in the town, and that they come from the town; that is, that they are part of the town. I do not mean that they live out of the asylum, but they are local nurses, and they are known to the patients and their friends and so on.

4469. I misunderstood you. They actually sleep in the institution?—Yes, except a few of them. They can if they like, but some do not do it.

4470. What hours do they work?—They have three weeks' holiday a year. They work from 7 to 7, with a day off, and that includes the meal times; the hours of service are those agreed between the workers themselves and the committee; they are the hours set down by the Mental Hospitals Association; we always follow that. The hours are slightly longer now than they were.

4471. Do you experience the same difficulty as some witnesses have told us of in getting nurses, particularly women nurses?—Yes, there is a difficulty in getting nurses. The basic body of the staff is a very good one—I mean the trained nurses, and so on—but there are a fluctuating lot of people who come and go; they do not stay long; they do not take it up as a career; they just come, and do not like it, and marry, or something like that, and they go. There is a difficulty in getting the best candidates amongst the probationers, but you get quite enough of very good nurses to be gradually trained up to build up the body of the asylum staff, of course.

4472. Do you have any children in the admission ward you have told us about? We have heard from some witnesses that cases of children—I think they were usually cases which could be dealt with under the Mental Deficiency Act—came into the mental hospital?—We have very few; unfortunately we have got two or three, and they are difficult to get rid of; they are bad cases. Of course, we strongly deplore having them at all, not so much for the children's sake, because they are generally very bad cases, but for the sake of other patients. Nothing could be worse than a patient coming in and seeing an idiot child, because the patient would think, "Oh, that is what I shall become." We do not take many.

4473. *Earl Russell*: You know the provisions of the Mental Treatment Bill I suppose?—Yes.

4474. It provides roughly for six months voluntary treatment, which may be extended if the Board of Control approve?—Yes.

4475. And during that time the patients are there voluntarily, subject to the fact that they may not leave for 72 hours?—Yes.

4476. That gives time, if necessary, for certification?—Yes.

4477. Now supposing the voluntary treatment were not quite enough, would it be possible for them to go through the initial process of certification, and then for the justice to suspend his order, as he now does, for 14 days, and to have power to suspend it for a longer period so that the patient may never be certified?—I think it would be a very good idea.

4478. If you gave him power to extend it from time to time the patient need then never be certified?—Yes.

4479. Whereas if anything went wrong everything would be ready for certification when required?—Yes.

4480. The Bill, I see, provides for two medical certificates. You would not think that necessary in this case?—No, I should not.

4481. Then I wanted to ask you about the earlier stage of the patients. They come into the workhouse infirmary and we know that they can be detained there for three days and for 14 days, and perhaps sometimes for another 14 days, but I did not understand how it was possible for them to be detained for longer periods. Can you tell us that?—I think there is some provision for it.

4482. *Chairman*: It is a permanent order under Section 24?—Yes, there is some permanent form.

Earl Russell: A permanent workhouse order.

Chairman: They may not be detained for more than 14 days unless you get an order under the hand of a justice, which must be backed up by the medical certificate of a medical practitioner, not an officer of the workhouse.

Witness: Those are the cases I get; they have been in some time under that provision.

Earl Russell: They remain in the workhouse after certification?

Chairman: Yes.

4483. *Earl Russell*: Can you give us, or can you get for us, the proportion of those who are taken to the workhouse by a relieving officer, or otherwise, with a view to certification, and how they are dealt with, say, within the first 14 days, how many are discharged, and how many recover?—I have no idea of that.

4484. In some cases the proportion that has been discharged at an early stage has been very large. You do not know?—No, I have no idea of that.

4485. With regard to the continuation order, you do not find any difficulty, you say, in filling it up in the form in which it now is?—No, I have found no difficulty.

4486. We had a witness yesterday who said it was somewhat of a strain upon his conscience to say that a patient was still of unsound mind, when he was convalescent?—I have not felt that strain on my own part.

4487. Do you think that can be got over, either by modifying the words of the certificate, or, while keeping the formal words the same, by allowing the person who signs the certificate to add a qualifying note at the bottom, as I understand you do?—Yes, I think that should cover it. Possibly as it is so stringent I think it might allow for these facts to be stated: that the patient is convalescent but might stay a little longer.

4488. The form of the certificate does require you to state in terms that the patient is at the time of unsound mind?—Yes, quite. Of course, it does not often happen, because in a case that is recertified at the end of a year the patient either is or is not fit to go out, and if I discovered a case fit to go out I should immediately discharge it.

4489. But their point more or less was that the patient may at the moment appear to be comparatively of sound mind but unfit to go out?—Yes, I think that ought to be allowed for in the statement.

4490. In considering whether you should make the continuation certificate you said you had the patient up and made a special examination for the purpose of the certificate, but in actual fact you are required in your own mind to make continuation orders every day. I mean if you think the patient has recovered it becomes your immediate duty to discharge?—Quite; in a sense one does do it every day. We have a weekly committee meeting, and you make all inquiries and approach the medical officer and matron.

4491. You do not wait for these periods to consider the cases?—Oh, no.

4492. It sounded as though you meant that?—No, you make a weekly discharge of all who are fit.

4493. I did not quite understand whether it was your patients who went shopping in the town?—Yes.

4494. Do you give them short leave for two days under one of the sections?—Yes, we do that a great deal.

4495. Without a regular trial?—Yes. You can do it so easily in the towns; they go out for week-ends.

4496. When you speak about these numbers of visitors, do you have limited visiting days, or do you allow them on every day?—We have six official visiting days a month, the first and third Wednesdays, the first and third Saturdays, and the first and third Sundays. Of course for sick cases visitors come in at any time, and in the private villas they come in at any time. The only possible objection to daily visits is that you could not administratively do it, because the law demands that a nurse must be in

19 November, 1924.]

Dr. H. DEVINE, O.B.E., M.D., F.R.C.P.

[Continued.]

attendance when a person is visited, in the vicinity, and you simply could not do it. As a matter of fact people do come when they like

4497. So that although you have a good many people on the visiting days the actual number of visiting days is only six in a month?—Yes, officially.

4498. Do you when you discharge patients generally discharge them outright or send them on a month's trial first?—Practically always on trial.

4499. That is, I gather, the modern practice now?—Yes.

4500. *Mr. Snell*: Dr. Devine, you must forgive me asking what may appear to be an ignorant question, but it is very important that we laymen should really understand the difficulty. Are the symptoms of unsound mind fairly obvious and convincing to a doctor, or are there border line cases in any considerable number where there would be reasonable doubt?—I think there are a lot of cases in which it is definitely difficult.

4501. Cases that require observation for some time?—Yes, definitely. There are heaps and heaps of cases that I think no doctor can certify on a single visit. May I add that I think very often the most dangerous cases are the most difficult. The paranoias and the delusions of persecutions are the most difficult. That is the trouble.

4502. In your *précis* you say that you have known of many cases which justices have refused to certify. I would like to know how far a justice of the peace is capable of deciding on any other than social grounds in a case of this kind?—I do not think he is qualified to do so at all beyond the social grounds.

4503. But in the majority of cases he accepts the decision of the doctor, whatever it may be?—Yes, in the majority of cases.

4504. You said that the ordinary facilities of the Poor Law infirmary were not suitable for cases requiring careful nursing. If the cost of upkeep and administration, and so on, in public mental hospitals, were reduced very much, would it result in a reduced standard of efficiency?—Yes, undoubtedly; I do not think they ought to be reduced.

4505. The point I want to bring out is whether a bigger proportion of cases might be cured if the facilities for nursing and treatment were increased?—I think a certain proportion might, but I do not think we have experience enough to say. I think the ordinary treatment that any well-managed mental hospital provides at the present day is adequate. I do not think I could suggest anything that would make a very marked difference.

4506. You would not feel that the small hospitals attached to little townships that you are advocating would result in a lower standard of treatment?—No, I do not think so.

4507. Would the possible loneliness of a private ward or room be worse for a patient than the average association with fellow patients?—No, not the sort of cases that would be put in one of these side rooms. The case you put in a side room is a person with regard to whom you want to avoid any stimuli, and to shut off every distracting stimulus. The side room is definitely a special method of treatment which is necessary.

4508. Then you said that you, as a doctor, and doctors in your position have no sort of interest in detaining a person, but rather an interest in getting rid of them?—Quite.

4509. Do you think that same reason might apply in any institution where considerable private fees were paid for treatment?—I have no experience of it. I suppose so.

4510. You think the same reason would apply?—I should think so undoubtedly. I hope so, at any rate. I think so, too.

4511. *Mrs. Mathew*: Dr. Devine, have you many cases of mental defectives?—No, not very many. If we get them, they are mental defectives with psychosis and symptoms of insanity on top of it. Sometimes the symptoms of insanity clear up and leave behind a mental defective.

4512. You have not got many of those?—Not many.

4513. I was wondering if it would not be possible to combine the senile demented with the mental defectives in some way so as to clear some of your villas or wards for the more, shall we say, effective cases, the cases you can treat more effectually?—It might be possible; there are quite a number of cases that could be moved into a suitable institution and other more acute cases brought in, of course, but the mental defectives require a very expensive mode of treatment and facilities for the work, and grounds, and so on.

4514. There would be a difficulty, I suppose, because they are not legally under the same Act?—It is rather troublesome mechanism to get a case transferred from the Lunacy Act to the Mental Deficiency Act.

4515. That would be difficult?—It is possible, but it is rather a difficult thing; and, of course, the other point is that it is impossible to find enough homes for these mental defectives. In the mental defective work Porstmouth is simply crowded with cases I have examined and which urgently need to be put into homes, and there is no home for them. It is a most distressing affair. They are really bad idiots and that sort of thing—really bad cases; there they are in these slums, looked after by the mothers, and you cannot get them away anyhow. It is dreadful.

4516. Have you thought at all of any reason for the number of mental defectives; have you any view on that point?—It is difficult to say whether there are more now than there used to be; it is a very moot point. The high grade mental defectives, but for the complexity of life and the conditions of life in civil communities, would have been regarded as normal and would have carried out their work in the world, but they cannot react to our complex civilisation; there is no place for them.

4517. In our overcrowded cities?—Quite.

4518. Then I wanted to know the cost of food per head. You gave the figure of 24s. 11d. I want to get an idea of the cost of food per head?—This is last year's report; the total amount was 24s. 9d.; 6s. 0½d. for provisions a week.

4519. Per head for food?—Yes; 6s. for food; clothing 7s. 8d.; salaries and wages 11s.

4520. How many medical officers have you on your staff?—Two besides myself.

4521. That is three; for how many patients?—800.

4522. I think you said you had a private case?—Yes.

4523. How much does it cost?—It costs about 30s., and I think one case is paying five or six guineas a week, but the average would work out at, I think, about 2½ guineas a week.

4524. That is the charge?—Yes.

4525. What is the cost?—I have no idea of the cost.

4526. Could you tell us about your verandah; what sort of a place is it?—The verandah is external to the ward, a broad structure with beds all round and a garden opening in front.

4527. Really a sort of open-air ward?—Yes.

4528. *Sir Humphry Rolleston*: I should value your opinion very much on a subject which perhaps you can judge of better than people who are more likely to be affected. It is this: Do you think that the Act should be modified in any way in order to protect doctors who certify from actions brought against them which are vexatious and unjustifiable? It is obvious that the patients must be protected from any possibility of conspiracy, and so on; but we must also look at the protection of the doctor. Do you think that the Act could be suitably modified so as to protect the doctor without removing the protection from the patient?—I think it might be, because there is no doubt that the doctor merely takes the part of a witness in this procedure of certification. He states certain facts which are obvious to the magistrate, and so on, and the magistrate either agrees or disagrees. Throughout the whole of society the community settles whether a man should be detained or

19 November, 1924.]

Dr. H. DEVINE, O.B.E., M.D., F.R.C.P.

[Continued.]

not; whether it is in a police court or anywhere else. We are only giving evidence. As a matter of fact, of course, the reluctance of doctors to certify is very great; they simply dislike it intensely; many of them will not do it even. Of course, if vexatious litigation occurs frequently, they will still less be inclined to do it. I think they should be protected to an extent.

4529. How would you do it? You would not propose to remove all liability from them, I suppose?—No, I really think it is more a matter for the law. I do not think I could make any recommendation of that kind. One is a doctor, and you can merely assert that you think you ought to be protected when you are doing your duty.

4530. The certification by two doctors of private patients, of course, is designed to prevent any conspiracy, is it not?—Yes.

4531. Do you think it would be of advantage for a second medical certificate to be given by an expert, the first certificate to be given by the general medical attendant. He might in a case of suspected conspiracy call in a friend of his?—An independent psychiatrist would be valuable, there is no doubt about that.

4532. And in many cases it would be quite practicable to do it?—Yes. I think an expert is of value. My own experience is that I go out to see cases that doctors in the neighbourhood want me to see, and they are most thankful for advice about this problem, and are often very much at sea with mental cases. I think it would be a good thing to have an expert, if possible.

4533. Of course the suspicion of conspiracy arises almost entirely in the case of private patients?—Yes, quite.

4534. With reference to what you suggest and what other witnesses suggest, namely, that there should be two certificates for the rate-aided patients just as there are for private patients, would it not be possible to have as the second certificate the certificate of a medical officer of the mental hospital to which it is designed that the patient should be admitted. He has got nothing to gain from detaining a patient. He would not be open to the suspicion which might be attached to a medical officer interested in a private institution. It seems to me it might be a great advantage?—I think it would be a great advantage. Of course, it is suggested at Portsmouth that I should act as consulting psychiatrist to the infirmary. The thing has not actualised at present, but if it did do so, it would mean that I should take a part in prejudging the removal of a case to my hospital. But, as you say, no one could possibly object to that, because it is no advantage to me the patient coming there. I should think it would be a good thing.

4535. You would know rather more about the patient when he arrived?—Quite.

4536. *Sir David Drummond:* Dr. Devine, would you tell us something about your private patients. What difference obtains as between the treatment received by the private patient and the rate-aided patient?—I have three villas—one for male and two for female private patients. I agree to take a private patient for a certain sum, which does not depend upon what they are going to have, but rather on what they are in a position to pay. If people are poor you would take them at a reduced rate. I want to make the point that you do not alter the treatment according actually to what is paid. The patients are admitted to these private villas, where they have different amenities altogether to the other patients; they have people of their own social standing, and they have different diet; a different sort of table; it is like a little boarding-house in short. In all these cases, whatever they pay, or say they are going to pay, I always tell the friends that if their mental condition alters in such a way that they require treatment anywhere in the hospital, I will do it; so that I should transfer these cases to any part of the mental hospital that I desired, if it were necessary for treatment.

4537. Then the distinction in practice is not so very great?—It is great, because they quite definitely have special amenities in the form of a private villa; I mean the conditions are quite different; they get definite advantages in view of their social position, and so on; they are clergymen and doctors and that class of people.

4538. If a patient pays 30s., I suppose the hospital bears the difference?—Yes.

4539. That is to say, there is some other means of making up the difference?—It becomes very hard on the local ratepayers; we are very lenient with the local ratepayers, but if a person has got to be in an asylum for 10 years, it is not like a nursing home; there might be people of high education who could not afford more than that, so the committee would meet them very much as local ratepayers, but we should not take cases away from our district. We have a lot of cases from all over the country, but we should not take those at a reduced rate. You may say that in a sense they help to pay for the others.

4540. With regard to medical certificates, do you find them often defective?—I find little defects.

4541. Are these defects due to imperfect general education, or is it a question of inexperience in lunacy? I am speaking as a doctor interested in medical education?—I think they might be better done probably if doctors were taught more about psychiatry, but we are all pressing our claims for our special things to be pushed on to the unfortunate student. I mean it takes a long time to get into the way of describing a person's attitude.

4541A. It is not a question of imperfect general education on the part of a doctor?—No, I do not think so. There are little technical errors, not filling up the form in the proper way, and so on.

4542. Now with reference to early treatment, and this proposal to institute hospital wards and out-patient departments, do you not think that in the course of time these institutions would become so popular that they would be sought after by the public, and there would be no necessity to impose compulsory detention in any way? Take our general hospitals; you could hardly get patients to come into our general infirmaries. Now the hospitals are so popular that they are clamorous to get into them?—I think it would apply to a lot of cases who shun the asylum now, but I do not think it would be entirely general, because of the fact that a great number of people with mental disorder do not realise that there is anything the matter with them, and that is the whole trouble. Take the paranoiac case: You say, "What is the matter with you?" They say, "There is nothing the matter with me. You are persecuting me by putting electricity on me." There are a large number of cases of that kind.

4543. There are a large number of cases that might be treated purely in a voluntary way?—Yes, I should think 60 per cent. of the admissions, and even more.

4544. I am afraid doctors would object to notifying these cases. They objected in the early days to notify scarlatina and measles, and so forth. I am afraid they would object to notifying people as insane?—I think the only point is that they would welcome anything that would make it easier than it is now. I mean to say they so strongly object to certifying, and the friends as well, that where a case was necessary they would welcome that alternative.

4545. *Sir Ernest Hiley:* Could you tell me how long the practice at Edinburgh to which you have referred has been in vogue?—I think about ten years, because I have looked up the point in an old article.

4546. Has it been running so long as to have caused any appreciable difference in public opinion with regard to the stigma?—I could not say that because, of course, I am not an Edinburgh man, but I think there is no doubt that in Scotland there is a much happier spirit about the whole thing from the very fact that the notification I suggest is in operation, and that many nursing homes take these cases.

19 November, 1924.]

Dr. H. DEVINE, O.B.E., M.D., F.R.C.P.

[Continued]

Professor Robertson has several homes in which they are merely notified; and the whole attitude is more agreeable in Scotland than here. The opposition is not so great, because the facilities are greater, but I take it that these cases are not certified at all.

4547. Public opinion then is more educated in Scotland in consequence of this innovation than it is in England?—I should think it is, yes.

4548. Then it has been suggested to us that not in every district, but in groups of districts, there should be established places of observation or homes of rest (they have been called both names) where the patients should be removed before they are certified and sent to an institution. Do you approve of that idea?—Do you mean clinics?

4549. Rather more than clinics. The point was that they should not be attached either to the Poor Law infirmary or workhouse or to the county mental hospital, but that it should be as it were a clearing house?—There would be the enormous expense of the thing, the expense of getting the nurses and the psychiatrists. They would only be mental hospitals.

4550. I wanted to get that from you, because the idea has been put to us. You would prefer that a small institution in the nature of a clinic should be established in a district?—Yes, I should do that in connection with a mental hospital if it were in the district, though I am quite aware that people say how undesirable that is, but that is what I think. All these clinics must be clearing houses, unless like the Maudsley hospital they start on a specific line, and do not make it a clearing house. The Boston psychiatric clinic is only a clearing house, and, probably, the community looks upon it as a lunatic asylum as much as other mental institutions.

4551. Could you give me the proportion of recoveries in your own institution?—They were 25 per cent. last year; they are considerably less this year, but, of course, the recovery rate depends upon the material you get. If you get your cases direct from home, the kind of case that goes to the infirmary in my town, of course you get a high rate of recovery. If on the other hand, you get the chronic incurable types, then we cannot cure them.

4552. From what you have told us you get more chronic cases than acute cases, therefore naturally your rate of recovery would be low?—Yes, I am afraid it will be deplorably low this year.

4553. Could you also tell me what is your percentage of re-admissions?—They are not very many. They are well-known people to us, and they come in and go out. I could not say without looking it up. The remarkable thing is they all come from the same district, and they go out, and it is surprising how few do return over a period of years.

4554. Do you get many cases of the recurring decimal sort that come back?—Yes, we get that. You get a man coming in, and directly he clears up, you send him out knowing that he will come back again. He works for a few months and back he comes again. I should think we have four or five of those cases.

4555. When you are discharging a patient, do you ever take into consideration his environment, or the environment you are going to send him into when you discharge him?—You know what it is, but one has little capacity for modifying it. If he is going out on trial you give him money for the time he will be out, but after the trial they get on; of course they go back to the environment they are used to.

Mr. Stewart (Counsel for the National Society for Lunacy Reform): Mr. Chairman, would you put this question to the witness, if it commends itself to you? The witness has said that with regard to certification he holds the view that the doctor should play the part of a witness and not of judge. Does the witness hold the same view with regard to the question of discharge or detention in cases which are doubtful?

4556. *Chairman*: Do you follow the line of question, Dr. Devine? You have suggested that in the process of certification doctors are giving testimony upon which the magistrate proceeds. Then at the other end of the process, when discharge comes to be considered, are you not in that case acting in a judicial capacity?—No, I am still a witness.

4556A. *Mr. Stewart*: Now, may I put this question through you, Sir? In doubtful cases is it not of essential importance that the medical man should have opportunity for sustained observation of the case—long personal observation of the case?

Chairman: Do you mean the medical superintendent?

Mr. Stewart: Yes.

Chairman: If a question of discharge comes up, is a person who does not know the whole history of the case competent to deal with the question of discharge?

Witness: May I expand the thought. One is a witness in this sense exactly as you are a witness in certification; in other words, you bring this patient up to the committee, and say, "I think this patient is fit to discharge," and the committee says, "How do you feel now?" The patient says, "Quite well." The committee say, "Have you been kindly treated?" and he says, "Yes." The committee then discharge the case. I do not discharge the case.

Mr. Stewart: I think the witness has not answered the question, whether it is necessary that there should be opportunity of sustained observation on the part of the person who has to give the evidence.

Witness: My observation is sustained.

Chairman: You, as Medical Superintendent, have charge of the institution generally. The question is this: When a matter of discharge comes up, very properly you put your views before the discharging authority, namely, the visitors, or the Commissioners. It is necessary that whoever is charged with the task of discharging should know the whole history of the case, should have the means of judging, in short?

Witness: Yes.

4557. Are you as Medical Superintendent the vehicle of that information?—I cannot say that. When I recommend a person for discharge I do go exhaustively with the committee into the whole history. I say the person is well, and they talk to the patient for four or five minutes and see themselves that the patient is better, and they discharge him.

4558. It may be all right in the case of discharge, but suppose you are refusing the discharge, or recommending that the case be not discharged: Do you then put before the visiting committee the whole history?—Certainly.

4559. Have you means of knowing personally the record of the patient and all the facts that are relevant to be considered?—Of course, I am the doctor. Who does know them if I do not? Is that what you mean?

Mr. Stewart: Not quite. Is it possible in practice for the medical superintendent of a large county institution, for instance, with all the executive duties he has to perform; to maintain sustained observation on each doubtful case?

Chairman: Will you just answer that question? I have no objection to it being put.

Witness: I think he knows his cases very well in my experience. The doubtful cases are congregated in the convalescent ward in these big places. Take Long Grove Asylum. The Superintendent sees those cases from time to time, has them brought up to him, and when he recommends a discharge he goes into them very exhaustively. That the medical superintendent of an asylum with 2,000 cases can know anything like as much about them as I do with

19 November, 1924.]

Dr. HERBERT WOLSELEY LEWIS, M.D., F.R.C.S.

[Continued.]

800, or, in the case of a small one, still more so with 20, of course it is obvious he cannot.

4560. *Chairman*: Of course, on the other hand, you would know much more about the case than any

person who was brought in from the outside?—Undoubtedly.

Chairman: We are much obliged to you, Dr. Devine.

(The Witness withdrew.)

(After an adjournment.)

Dr. HERBERT WOLSELEY LEWIS, M.D., F.R.C.S., called and examined.

4561. *Chairman*: Are you Medical Superintendent of the Kent County Mental Hospital, Maidstone?—Yes.

4562. How long have you occupied your present post?—For 20 years.

4563. And you are familiar, I think, with the terms of reference to this Royal Commission?—Yes.

4564. I think I observed you were in the room during the examination of the preceding witness, Dr. Devine?—Yes.

4565. And no doubt you listened with interest to what he told us?—Yes.

4566. It occurs to me that we might shorten your stay in the witness chair if I ask you, having heard his views, if you have anything to add by way of criticism or supplement to the views he put before us?—There was one point particularly I took exception to, and that was that in speaking of clinics he rather inferred that they should be clearing houses for certified cases—that is to say, that cases should be certified from them. Now my notion of clinics, especially as applied to a county, is that they should be brought as near the homes of the people as possible, that they should be entirely voluntary, and that there should be no fear of certification from them—that either a patient should be suitable to be treated in the clinic or not, and that if he went to a clinic he should go there voluntarily, and if he was not a suitable case he should be sent back to his friends.

4567. Your idea being to dissociate the certification from the clinic?—Exactly. The object being that, as it seems to me, it is very important to get hold of these cases as early as possible, and to afford them really expert treatment at the earliest possible moment; and in order to do that you want to make the clinics of such a nature that the public would be rather encouraged to go to them voluntarily.

4568. Do you think it would be a discouragement to the public in resorting to a clinic, if they thought the ultimate fate might be certification?—I think so. I think it would be a pity to have formal powers of detention of any kind in a clinic.

4569. Of course, one can see difficulties—in that an incipient case might go to a clinic, and after being treated and advised, might deteriorate, and perhaps suddenly develop graver symptoms?—Yes.

4570. And it would be unfortunate if such a case might have to be sent back to his home?—Of course, if the friends were unable to remove them, you would have to report the case, as now, to some authority to deal with. I do not know that the relieving officer would be the best authority.

4571. You could not interpose another institution, could you?—No, I am not suggesting that. I am only anxious that clinics should be quite free from the suggestion that it was a preliminary to certification. I think that would do harm.

4572. With that reservation, may I take it generally that you agree with the outlook on the whole problem which has been expressed to us?—Very largely, yes.

4573. In that case I do not think it would be desirable to duplicate evidence, but I think you have a special contribution to make to us on one or two topics. In relation to the very matter of dealing with cases which are incipient, would you tell us what your experience has been at Maidstone with regard to the number of cases which have manifestly

been ailing for some time before they reach you?—Sixty per cent. of all the cases admitted to the Kent Mental Hospital at Maidstone for the last 20 years are known to have been ailing a month or more previous to admission, which seems to me a serious indictment on our present system. That is to say, that in these cases the patients have been unable to get any expert treatment until they have been allowed to get bad enough to be certified, and until the general practitioner, if I may use the expression, has been driven to certify. That seems to me a great indictment on the present system.

4574. We all know the effort which is being made in preventive treatment nowadays, and the prevention of the causes of disease at the earliest possible stage. Do your views fall into line as to that?—Yes, because at a clinic you would have, not only the in-patients, but an out-patients department, and I think it is quite probable that you might prevent a considerable number of cases getting worse by treating them in the out-patients department. I think that would also apply to some extent to recurrent cases, because in one's experience there are a good many patients who are liable to recurrent attacks, and would seek treatment.

4575. But they wait until the last moment, just because of the fear of certification?—Perhaps that; but they have nowhere to go to for advice—they have nowhere, if I may say so—and I say it with every reservation—except the general practitioner who is not very expert in these cases.

4576. And they cannot get the facilities for treatment which you can afford?—Yes.

4577. And the only means of securing the benefits of your institution is to have been certified?—Yes.

4578. But you would like the treatment to be at the incipient stage when it might be most beneficial?—Yes.

4579. Would you advocate the clinics being associated with public asylums such as yours?—Not directly. I think it would be wise for the whole of the mental health of the community that it should be under the control of one central authority, and I also think it would be a great advantage if the mental health was not associated with the Poor Law at all, but was associated with the local, county, or county borough authority and a Government Department only, and all branches should be under that.

4580. One quite realises the desirability of dissociating the element of pauperisation, but I am thinking of the facts at the moment. This clinic would obviously have to be either a separate institution altogether, or an institution running alongside the asylum, or running alongside some general hospital?—Exactly.

4581. It would have to be either independent, or associated with another institution?—Exactly.

4582. Now an independent institution might cost money, and would not have enough work to do. Which of the methods commends itself to you?—What I recommend is the introduction of separate institutions which may or may not be associated with a general hospital. Where there is a general hospital, by all means associate it with a general hospital, but where there is no general hospital, I should say have a separate institution; and I do not think it would be necessary to build such an institution at the present time. You could find probably large country houses, a great

19 November, 1924.]

Dr. HERBERT WOLSELEY LEWIS, M.D., F.R.C.S.

[Continued.]

many of which are in the market at the present day, in the neighbourhood, or on the outskirts of large towns, which could be rented for the purpose in an experimental way.

4583. There is this to be said, of course, that if you had all the curable cases, the hopeful cases being dealt with in the clinic, would not you rather depress the atmosphere of your asylum as a place where you must abandon all hope?—Not at all, because a clinic should deal only with the willing—with purely voluntary cases. Now there are a very large number of curable cases, the most curable cases, perhaps, which would still have to go to mental hospitals, either because they were definitely unwilling, or because they were indifferent, or because they were noisy and could not be kept in the clinic, and did not care how or where they were treated.

4584. That seems to me to leave one class of cases uncovered. Take the case where for the time being a man is no doubt insane, it may be of short duration, but for the time being detention is absolutely essential, or take, for instance, puerperal mania, which might be violent—now if there were no powers of detention in the scheme you are putting, that case would have to be certified?—I would suggest some form of provisional certificate, and such a case should go to the mental hospital. I am not saying that a noisy case should be treated in a clinic, because other patients would object. Those cases, no doubt, would have to go to the mental hospital, and personally I should like to see perhaps something on the lines of the Mental Treatment Bill—some powers on the lines of temporary detention, but they should be exercised at the mental hospital.

4585. Then we are getting three stages; we have the clinic, where the case is one which is not pronounced, and where treatment and advice may be given, altogether apart from certification. Then you have the case where it is desirable that there should be a provisional period of observation, during which the case may recover, possibly without certification; then you have the last and most unhappy state, where the patient has displayed symptoms which are likely to be of long duration?—Precisely, with this addition, that you would have in these big county mental hospitals, I think, in time a large number of voluntary patients; that is to say, you would allow a very large number of chronic cases to remain as voluntary boarders.

4586. It rather occurs to one that this system of different stages might be quite conveniently carried on in association with existing asylums. Why should not you have an out-patients department at Maidstone, and one or two wards or a detached pavilion where you could deal with cases which had not been certified, but could yet get the benefit of your specialised treatment?—For one very good reason. I receive patients now from a distance often of 30 miles, but I want to bring these clinics as near the homes of the patients as possible, so that they can attend them. I am also anxious that these clinics should be attractive to persons suffering from mental diseases. People suffering from mental diseases are very shy birds, and are not likely to take a journey of 30 miles to consult a doctor.

4587. *Earl Russell*: On what population basis would you provide the clinics you suggest?—I should say, to take a concrete instance, that the whole population of Kent is about a million, and the population of Chatham, Strood and Rochester, one town, is about 100,000. Well, I should think one of these clinics would be necessary in a place like that, and you would want to have perhaps 20 beds and an out-patients' department.

4588. *Chairman*: As regards these people who are suffering from a mild form of mental disease, do you contemplate that they would be certifiable cases?—Yes, certifiable, but not necessarily certified.

4589. But then you have the difficulty that they are certifiable persons, but not under any form of legal control?—I have already said I should like

these places to be open to the inspection of some Government Department and a local authority too.

4590. But from the point of view of the patient, the patient might say, "I am going to be put away," would not that be the very worst thing for the patient?—But he would not be any worse off than now, would he? It would mean that he would have to be certified by a modified form of order, or under the Lunacy Act as he is now.

4591. If the case developed suicidal tendencies, what then?—One would notify the friends.

4592. Then you do contemplate some restraint?—Obviously you would notify the friends in a case like that, and ask them to take him away.

4593. What if there were no friends?—Then you must have some authority. I should like to avoid the relieving officer if possible.

4594. But it would not give you time to communicate with any authority. You must surely have some hold on a patient of that kind? Supposing a person attending one of these clinics has been put to bed and is getting the best possible treatment, but unhappily is not recovering, and he says suddenly, "I want to get up," and threatens to drown himself or throw himself in front of a train, what power have you there?—Merely the power you have in a general hospital. When I was surgeon at one of the large London hospitals, I remember a case of delirium tremens—a man who actually said, "I am going out to jump into the river." Our duty under those circumstances was to inform the local policeman; that is all we can do.

4595. But what would he do in the meantime?—You would simply take the ordinary precaution to prevent a person jumping into the river.

4596. You would see he did not get out—lock him up if necessary?—Within certain limits you would use a certain amount of restraint.

4597. I was thinking whether there could not be some resource provided—something short of an absolute order of certification, which would entitle you to keep the patient, say, for 72 hours. Is something of the kind not appropriate, do you think, or do you like to keep out of view altogether the power of detention?—I should like to keep it out altogether.

Earl Russell: And when you exercise compulsion, you would do it illegally?

4598. *Sir Humphry Rolleston*: Is it not the fact that in a general hospital you have to exercise it illegally?—Yes.

4599. *Chairman*: Of course, every operation on a patient's body is an assault, but a person may be brought in whose only chance of life is an immediate operation, and you commit the most violent assault on his body, but it is done in the interest of the patient. Would you rather leave it in a somewhat indefinite position?—I would, because I am so anxious to popularise the clinic.

4600. But what about popularising the asylum by taking from it the elements of hopelessness?—I would like to do that, too, but I agree with what Dr. Devine said this morning; I think the popularising of the asylum is coming about, and I believe it is an educative process. Unfortunately, we suffer from the sins and superstitions of the past, but there is no doubt we are becoming much less suspect and much more popular than we used to be. I mean that in common, of course, with most Superintendents of large mental hospitals, I have not infrequently received letters from ex-patients asking that they may be allowed to come back to the hospital for treatment, but unfortunately I have to refuse them, and say, "You must go to the relieving officer."

4601. You are in favour, I gather, of being empowered to receive voluntary patients in the asylum?—Certainly.

4602. As well as in the clinics?—Yes. You will observe that in mental hospitals under those circumstances you would have three classes; you would have voluntary boarders, who, I think, would be an

19 November, 1924.]

Dr. HERBERT WOLSELEY LEWIS, M.D., F.R.C.S.

[Continued.]

ever increasing proportion of the population—you would have definitely certified people whom it was necessary to detain there for their own welfare or the welfare of the public; and you would have also people who are under some detention order, obviously recoverable cases, but over whom you would have to have some temporary power of detention.

4603. And the first and last of the three classes are now inadmissible?—Exactly, and I think if those classes were in the institutions, it would educate the public to seeing that we would not detain people if we could help it.

4604. In the case of such voluntary boarders, I suppose you would contemplate that they would come under the purview of the Board of Control under some machinery of report?—Yes, you would have to report them to the Board of Control, or send a report on their mental condition at stated intervals to show that they were proper people to keep.

4605. Have you any suggestions to make on the subject of continued detention in and discharge from institutions?—Yes. I ought to say, it seems to me the question of detention under certificate is more a legal question than a medical one—it is a question of depriving the patient of civil rights, because he is unable to live as an ordinary citizen; and, I think, while it is necessary that there should be certification, every legal precaution should be taken in the case of people certified, and I do not think the onus should be put upon the medical man—it certainly should not be put upon the superintendent of the particular mental hospital in which the patient is confined. His object is to do everything he can for the welfare of the patients, and it very seriously militates against that object if the patient knows that the superintendent, in fact, is the person who is detaining him. I think it would be much better if the question of detention was entirely a matter for an outside authority.

4606. But, of course, no outside authority can judge of the propriety of the detention of a particular case, except on the evidence of a doctor?—Quite.

4607. Take myself or any of my legal colleagues here, we should be quite incapable of judging of the propriety of the detention of any particular person brought before us, but we should have to proceed on the evidence before us?—Quite.

4608. And that evidence is only available from the superintendent or other medical man who has been in contact with the case?—Yes.

4609. While you rather welcome the idea of the intervention of a legal or judicial personage, such personage would proceed on your evidence, would he not?—He would proceed on the case book notes really—in practice every patient has a medical sheet, which is duly filled up, as in any other hospital.

4610. Is your idea this, taking the periodical reports you have to give on cases, that these are really a warrant of the condition of the patient?—Yes.

4611. Do you suggest that on those reports the question of discharge should be decided?—Not necessarily. I think it would be much better if an independent doctor from outside did it.

4612. We have heard a great deal about the reluctance of doctors at all to certify nowadays, because of the legal terrors which surround them?—Yes.

4613. The point you are putting now is rather differently expressed. You say there should be another medical opinion, but I thought you wanted a legal or judicial person to intervene?—What I feel is that it would be very much better if, instead of it being in the hands of the committee, there should be some judicial authority who at stated intervals would act. There might be some system by which a number could be called together, and decide that such and such an authority should attend and deal with certified cases, and should call to his aid any medical opinion he likes.

4614. Then your view is that cases should be passed in review at stated intervals?—That is practically what it comes to.

4615. And I suppose the material such reviewing authority would have would be the case records—the evidence of the medical superintendent or any person he might like to call before him?—Certainly.

4616. And if the case is a difficult one, possibly independent medical testimony could be called in?—Yes, or the nursing staff, or anybody they might think it proper to examine.

4617. And possibly an interview with the patient himself?—Yes, certainly.

4618. This difficulty presents itself to one's mind, that this machinery might cost money, and there must be many cases as to which it might be idle, because the case is one of hopeless insanity, and I am a little puzzled to see how one can discriminate. There are, no doubt, many cases in which the process you suggest might be desirable, but are not there cases of mental degenerates as to whom nothing could be done whatever?—I think it would become very largely formal in those cases, but I rather visualise that a great number of our chronic cases would become voluntary boarders. I do not know whether the Commission are aware that at the present time I have some 1,800 patients in the hospital of which I am in charge. Out of those, 300 to 400 of the women are in open door wards, and there is nothing really to prevent their going away. Some 200 of the men could escape if they wanted to; they are not locked up in any way; they are in open door wards, and a considerable number have parole. They are allowed in certain hours to go down to the town and shop and come back again; and a good many of the chronic delusional cases have sufficient insight into their condition to recognise that they are really better off in a hospital than they would be outside.

4619. Still following the idea of the periodical review, a topic which one wants to explore a little, it seems to me with regard to certain of the asylum population, a considerable number of them, indeed, it would be a very idle ceremonial, would it not?—Yes. I think as to a number of them if they had been seen once or twice by an expert he would be satisfied, and would say at once, "I am satisfied that this is a case for detention."

4620. But it would be a valuable thing to have, and time would not be occupied, except in cases of difficulty?—Quite. In practice I do all the continuation cases at my institution myself.

4621. In your view, as the initial delegation to your care has been done by some legal personality, so the periodical certificate of detention should be given at the sight, shall we say, of a legal authority?—Yes.

4622. And the discharge also should be done at the sight of a legal authority?—Exactly, with certified cases.

4623. And that all being for the reason that in the case of certified cases this element of legal restraint is necessary, which you think should not be imposed or continued or relaxed, except with some legal sanction?—Exactly.

4624. Mr. Micklem: Taking the common case in an asylum where you send out patients from time to time on trial, say for four weeks, if they get a certificate from a doctor in the meantime that they are quite sound, might not they get their discharge?—At the end of the period of trial, yes.

4625. They are discharged?—Yes.

4626. They do not come back?—No.

4627. They send the certificate?—That is right.

4628. In that case do you think they should be discharged without a judicial order?—Not in the case of certified patients.

4629. But all these are certified cases?—But I am pre-supposing that we should have a number of cases which are not certified cases—people under detention orders, or voluntary patients.

4630. I am putting the certified cases?—Yes.

4631. In that case, you see, you would be interfering with a very common method of discharge now, would you not?—Yes. Those would not be for the most part the cases that are necessary to certify. The

19 November, 1924.]

Dr. HERBERT WOLSELEY LEWIS, M.D., F.R.C.S.

[Continued.]

cases I am visualising in connection with judicial review are delusional cases of the paranoid form. Those are cases which are not likely to be discharged on trial, or anything of the kind.

4632. Still, you appreciate that the suggestion you are making would make it much more difficult than it is now, or would add an additional formality to the present process by which they can get discharge?—In certified cases, yes. I should like to see formal certification only used in cases in which it is, shall I say, absolutely essential; that is to say, I should like to eliminate voluntary and curable and temporary cases.

4633. The difficulty is, is it not, to say which are the necessary cases?—I do not know that I should be willing to admit that. I know pretty well when cases are going to get well or not. If they are going to get well, I do not want them certified; that is what it amounts to.

4634. Would it be possible to indicate a certain class of case which should come, and another class of case which should not come before a judicial authority?—I am not quite sure that I understand what you mean.

4635. *Chairman*: What is your criterion?—Whether it is necessary for their own sake or the safety of the public that they should be certified, is really what it amounts to.

4636. *Mr. Micklem*: I find that you, in common with many other witnesses, seem to have a great prejudice against the Poor Law authorities having any control in these matters, or anything to do with it. Why is that?—It seems to me a great hardship that a very large number of the patients who come to us should be pauperised in order to get treatment, when they are not paupers. A very large proportion of my patients are not paupers at all, and yet it is necessary that they should apply to the Poor Law authorities in order to get treatment.

4637. I follow that. But your suggestion with regard to clinics is that they should be established by the municipal authority?—Or the county authority.

4638. Do you know at the present time we have no hospitals of that kind?—The county authority runs the Mental Deficiency Act, which is a tendency towards it.

4639. I was thinking rather that so far as either medical or other relief can be given to people who cannot afford it, the Poor Law authority is the only authority existing?—Yes, but is there any reason why it should not be done in the same way as on the principle of the Education Acts, that it should be done partly by a Government grant and partly by a county grant?

4640. I do not know, but there is nothing of the kind at present. Taking a general hospital, you get no grant?—No, but for the medical treatment of school children you get a grant.

4641. Under the existing system a great deal of work is thrown on the relieving officer in mental cases?—Yes.

4642. And commonly a case comes through the relieving officer?—Yes.

4643. Have you found generally that the work done by him is well done, or not?—Very well done, as far as I am acquainted with it. I think the relieving officers as a body do their work very well.

4644. You know that in common cases they are sent to the workhouse for three days, and an extension order for 14 days is made for observation, which is sometimes extended to 28 days?—Yes.

4645. In your opinion is that period of observation wisely given, or would you send the patients direct to the asylum?—I should think it would be better to send them direct from their homes, and I think it could be arranged that better facilities for taking them from their homes could be devised. There might be ambulances in connection with a mental hospital, and a trained expert staff should attend with those ambulances, because one finds in practice that a very large number of patients are brought to

mental hospitals under false pretences; they are told, for instance, that they are going to convalescent homes, but I think that is absolutely wrong.

4646. *Miss Symons*: I think you heard the evidence this morning about the structural difficulties. Are you faced with the same difficulties?—No, not particularly. To describe it shortly, both on the male and the female side of the Maidstone Hospital there is a floor on which all the recent cases go in the first instance, and if they are recoverable cases, they do not go off that floor; that is to say, they are in one of three wards, and are discharged from that floor. I mean, they do not mix with the chronic cases.

4647. Have you facilities for segregating in cases of noisy patients?—Yes. We do not have noisy patients in these admission wards—as far as possible, we eliminate them from the admission wards.

4648. Could you tell us what staff you have?—The proportion of staff is about one to nine; it varies.

4649. *Earl Russell*: With regard to discharge, I understand your view to be that the relations between yourself and the patients would be better if they felt you were only their doctor, and not also their gaoler?—Exactly.

4650. I entirely sympathise with that point of view, but as to the remedies you suggest, do not you think in the instances the Chairman put to you that they are not very suitable?—I am rather reluctant to say they could not be carried out.

4651. Let me put the cases separately. Take first of all the obvious cases for discharge; in those cases you agree the tribunal you suggest would be a mere formality, would it not?—I beg your pardon; the case I am visualising is more the case of people who are under a detention order, who are essentially recoverable cases. Those are cases I do not want under certificate.

4652. Then are we to take your evidence on this head as not applying to the present system?—As not applying to the present system, quite.

4653. Then whatever system it applies to, in the case of an independent outside doctor, unless he spends at least some days on a case, and very possibly some weeks, can he do more than repeat second-hand the information you give him, and the information in the case book?—It depends on whether he has had experience of this kind of work. There are a considerable number of delusional cases, in which, if you are accustomed to them, you can very soon get at them.

4654. But these are *ex hypothesi* cases which have recovered?—The question of discharge, you mean?

4655. Yes. What can an outside doctor say in a case like that, beyond what he learns from you?—Nothing, if they are recovered. When I say discharged, however, I do not mean only discharged recovered cases. Of course, there are other cases discharged besides recovered cases.

4656. If you desire to avoid the appearance of the air of a gaoler, I am entirely with you; but I put it that it does not strengthen in any way the facts on which the discharge is granted?—No—quite.

4657. I want to ask about another matter in your *précis*, about the judicial authority. Do not you say something about patients being certified by a special magistrate?—Yes.

4658. You say, "If unwilling, under a reception order made by a judicial authority appointed as having special knowledge of the subject"?—Yes.

4659. Are you suggesting there that the judicial authority, who represents the public, should to some extent take the place of the doctor, or act as a third doctor?—No, but I think instead of any justice of the peace, certain justices of the peace should make it, as they do now, to some extent, their business to know something about these mental diseases.

4660. But the justice of the peace is interposed, not as an expert, but as a person representing the public, for protection?—Yes, quite.

4661. Surely that could be done by any reasonable man who gives his mind to the matter?—Yes, but I fancy in practice some are much more expert than others.

19 November, 1924.]

Dr. HERBERT WOLSELEY LEWIS, M.D., F.R.C.S.

[Continued.]

4662. I dare say they are, but if you appoint them as experts, do not you get the danger that the justice may be looked upon as no longer representing the public?—Yes, there is that danger.

4663. And, therefore, you would rather shake public confidence by your suggestion?—Yes, there is that danger.

4664. *Mr. Snell*: You say in your *précis* that "Over 60 per cent. of all patients admitted to the Kent County Mental Hospital at Maidstone during the last 20 years are known to have been ill for a month or more previous to their admission." Would it be permissible to assume that some proportion of that 60 per cent. would not have been certified if earlier treatment had been provided?—Exactly; that is the inference.

4665. Would you care to mention any proportion in your mind?—No, I should not like to commit myself to a proportion, but I think an appreciable proportion.

4666. It would not be a negligible proportion?—No. It would be an appreciable proportion.

4667. Have you any system of training for your attendants and staff?—Yes.

4668. They must conform to a certain standard?—Yes.

4669. Do they receive any special training in mental treatment?—Yes.

4670. There is a feeling, I understand, that the amount of training required now is rather hard on the staff which is there; a man may be a good attendant or nurse, and may not have given in his younger years attention to these things, and therefore cannot meet the obligations?—Quite.

4671. Is that enforced?—No. I think as a matter of fact the whole of this matter is dealt with in the Nursing Report just issued by the Board of Control, and you will notice that we have recognised there that probably always—at any rate, for many years—there will be a certain number of attendants as distinguished from male nurses—people who are very excellent up to a point, but who are not highly-trained nurses.

4672. Would it be your general view that new attendants would have to meet certain technical standards which would not necessarily be enforceable on the existing staff?—Yes, quite so.

4673. *Mrs. Mathew*: You said that clinics should deal only with the willing patients—do you mean they should be residential houses?—Yes, with both an in-patients' and out-patients' department.

4674. Then you suggested a sort of medical board to pass out cases which should be discharged. Do you mean a sort of visiting medical board?—No, not quite that. In the cases of the unwilling, that is to say, patients who are certified and detained against their will, I think it wise to have a judicial authority responsible for their discharge, with any medical assistance they like to call.

4675. I think you said your staff is as 1 to 9?—Yes.

4676. Is that what one might call a practical staff, or are some of them away?—No, that means on duty.

4677. *Sir David Drummond*: On the question of voluntary hospitals, do not you think it is conceivable that a department of that hospital might be set apart for the treatment of puerperal cases and acute mania cases?—Yes. In the experience of people who have such places—and I am speaking now of the Edinburgh Infirmary mentioned this morning, and also of the Maudsley Hospital, they manage to retain a considerable number of acute cases without any forcible detention in fact, and I should be very hopeful that in clinics a very considerable number of such cases as confusional insanity would be treated there and recover.

4678. You would like to see the voluntary hospital enlarged to that extent?—Yes, quite.

4679. *Sir Ernest Hiley*: Would you propose to take away the powers under Section 77 of the visiting committees to discharge, and give them to somebody

else—is that your idea?—My idea is that in these recoverable cases, or cases discharged recovered, and the willing cases, the cases of voluntary boarders, they should be discharged on the authority of the doctor alone; but in the unwilling cases, the certified cases which must be compulsorily detained, they should call in some outside judicial authority.

4680. What do you mean exactly by a judicial authority?—I mean a justice of the peace.

4681. I had rather in mind that you were suggesting another doctor should be called in?—If the justice of the peace or judicial authority thinks it wise, he can call in a doctor.

4682. Would you have visiting justices, then, in all the county towns?—I think it could be fairly arranged. There is generally a local justice who lives somewhere near, who could make it his official business.

4683. Then in effect it would mean that the man who certifies the patient should discharge him?—Yes—it is the same body, not perhaps the same individual.

4684. But very often it would be the same individual?—Yes.

4685. *Chairman*: Have you any idea as to the branch of local government to which the control or supervision of those clinics should be entrusted?—Yes, I would have a committee of the county council.

4686. *Sir Ernest Hiley*: Would that apply to a non-county borough?—No, the county borough would have their own control.

4687. I mean the non-county borough?—They would be included in the county council.

4688. You mean everything but a county borough?—Yes.

4689. *Chairman*: Your idea being, I take it, to dissociate from these non-certified cases any element of certification, one of which is the Board of Control—is that the idea?—No, I do not think so. It seems to me that the mental health of the country should be under one central governing authority and one local government authority.

4690. But the Board of Control has very important duties confided to it?—Quite.

4691. And those duties relate primarily to the supervision and care of certified persons?—Quite.

4692. Now you are proposing that persons should be dealt with without certification, and the question is whether the uncertified cases should be associated with the Board of Control from the point of view of supervision, or should be associated with the local authority in its health aspect?—I should say the Board of Control. All that it amounts to in these clinics is to see that they are properly run. You are not going to certify these people, and it means that you must have some sort of inspection to see that they are properly run.

4693. But could not the local authority through a committee carry out that duty under supervision?—Then you surely would have the Board of Control accusing you of taking certified cases in an uncertified place.

4694. I do not think they would, if legislation imposed the duty on them?—The Board of Control, I understand, are quite in favour of people being treated without certification in proper cases.

4695. As far as one can judge from the material before us, they are quite in favour of treatment without certification, but at the same time they advocate, if such treatment is introduced and becomes a branch of our mental administration, that it should be in their hands. Now the question is whether you approve of that, or whether you would rather have this branch of medical treatment out of the hands of the Board of Control and in the hands of the local authority or under the Ministry of Health?—The Board of Control are now attached to the Ministry of Health.

4696. But they are more or less independent?—Yes, but it is a pity, I think, to multiply the

19 November, 1924.]

Mr. HENRY FURSE KEENE, O.B.E.

[Continued.]

authorities which have to do with the mental health of the country.

4697. *Chairman*: You approve generally of the recommendations of the English Lunacy Legislation Committee?—Yes.

(The Witness withdrew.)

Mr. HENRY FURSE KEENE, O.B.E., called and examined.

4699. *Chairman*: Are you Chief Officer of the Mental Hospitals Department of the London County Council?—Yes.

4700. Have you been authorised to attend before this Royal Commission for the purpose of giving us evidence on matters falling within your particular province?—Yes, evidence limited to facts.

4701. You are not going to favour us with views upon policy, I understand?—No.

4702. We shall be glad to have from you quite shortly a description of how the local authorities in this country come into contact with lunacy administration?—In the first place, the local authority under the Lunacy Act is the council of every administrative county and county borough, and it is constituted under the Local Government Act of 1888. There are certain boroughs, 28 in number, that have their own special authority under the Lunacy Act.

4703. In the case of the City of London, I think it is the Common Council?—In the case of the City of London it is the Common Council. The Lunacy Act also provides that the local authority is to appoint a visiting committee consisting of not less than seven members for every asylum. Then there is a provision for visiting committees of asylums which belong to more than one authority. In the case of a local authority having more than one asylum, it is allowed to appoint one committee for the management and control of all the asylums, and the committee appointed has power to appoint a sub-committee for each separate asylum, delegating to the sub-committee such powers and duties as the committee from time to time think fit.

4704. One is anxious to see the points on which the local authority which is the general administrative authority of the district comes in contact with the lunacy administration. You say one of their duties is the duty of appointing committees, which varies according to the particular case?—Yes.

4705. Is the purpose of the visiting committee to bring the local authority as the representative body of the district into contact with the administration of the lunacy laws within its area?—Yes.

4706. I do not think we need consider the position under the Mental Deficiency Act, because that is excluded from our consideration. But in the case of the London County Council under the powers given by Statute, and by authorisation of the Home Secretary, I think the Committee appointed for mental deficiency work is also the visiting committee for the purposes of the Lunacy Act?—Might I say that in a sense the Mental Deficiency Act does help you, because the committee that is appointed under that Act may also be the Lunacy visiting committee, and it is important in this way, that the power under the Mental Deficiency Act is to appoint the committee with co-opted members, and if that visiting committee becomes the visiting committee under the Lunacy Act, as it may under section 28, it has co-opted members, some of whom are women.

4707. In that way you mean you can get your visiting committee to contain co-opted members?—Yes, that is important. It is section 28 of the Mental Deficiency Act.

4708. Where does one find the provision whereby the committee for the purposes of the Mental Deficiency Act may become the visiting committee for the purposes of the Lunacy Act?—Section 66.

4709. Consequently, by invoking the provisions of the Mental Deficiency Act, you may get your visiting committee under the Lunacy Act to have co-opted

4698. That is accessible to us, and if necessary we can refer to it, and you approve generally of their policy?—Yes.

Chairman: Thank you very much.

members?—Yes; the London County Council took advantage of that before obtaining special powers to take over the duties of the visiting committee.

4710. Why did it do that—what was the advantage of it?—It enabled it to get sufficient members to carry out the work under the Mental Deficiency Act and the Lunacy Acts.

4711. It had the advantage of obtaining persons who had a special interest in that particular department of work?—That is so.

4712. Are there any co-opted members in the case of the London Committee?—There are ten co-opted members.

4713. And they visit the public asylums, of course?—They do.

4714. I think some of the areas in England have special Acts dealing with them?—Yes, there are three, I think: the Lancashire Asylums Board, the West Riding Mental Hospitals Board, and more recently the County of Stafford has a special Act appointing a Mental Hospitals Board.

4715. There is a peculiarity, I think, in the case of the London County Council that the executive authority obtained in 1915 all the powers of a visiting committee under the Lunacy Act, and they have been transferred to the County Council itself?—That is so.

4716. And all matters relating to the exercise by the Council of the powers so transferred stand referred to the Committee for the care of the Mentally Defective, as you have explained?—Yes.

4717. Is the result this, therefore, that the County Council of London, having all the powers of the visiting committee, must exercise those powers through the medium of some committee of its members?—That is what it comes to; all matters stand referred to the Committee appointed under the Act, which we know as the Mental Hospitals Committee.

4718. But taking certain things which can be done under the Statute by the visiting committee, are those performed formally by the London County Council as a body, but in practice through the medium of the Committee?—In practice the powers are delegated; there is very full delegation to the Committee.

4719. In the case generally, apart from the speciality of London to which you have alluded, will you give us an outline of the powers and duties of a local authority and visiting committee with reference to lunacy administration?—Yes. In the first place the local authority, that is the council, has to provide accommodation for the insane, and it has power to provide for private as well as pauper patients. They may provide separate asylums for the pauper and private patients, or make provision in the same asylum, and they have power to provide separate asylums for idiots or patients suffering from any particular class of mental disorder. But the local authority again, under the Lunacy Act, Section 239, is required to exercise its powers in regard to providing this accommodation by a visiting committee, subject, if it thinks fit, to its directions as to which of the methods authorised by the Act shall be adopted. Then the committee which has this authority may agree upon plans and estimates, and contract for the purchase of lands and buildings, and for the erection, restoration, enlargement and furnishing of buildings, and for the supply of clothing, and for all matters necessary for carrying into effect the authority conferred upon them to provide accommodation.

4720. To pause there for a moment, before going to the machinery by which they exercise those powers,

19 November, 1924.]

Mr. HENRY FURSE KEENE, O.B.E.

Continued.

is it an obligation upon the local authorities of this country to see that adequate provision is made in a district or in co-operation with other districts for the care of cases of mental illness?—There is no doubt about it being an obligation on the local authority, as there is a provision in the Act for the Secretary of State to step in if the local authority fails to provide the necessary accommodation.

4721. But there is a general statutory obligation on the local authorities to see that adequate provision is made throughout the country for dealing with mental cases?—That is so. I ought to say that it is only for pauper patients, because it is not obligatory to provide for private patients—it is permissive.

4722. With regard to that, of course, having the means, the demand creates the supply within the limits we know of. But that is the general obligation as far as the local government of this country is concerned?—Yes.

4723. Take, for example, a question which occurs to one, following on previous evidence—suppose an institution is rather antiquated, and suppose that the medical superintendent says he would like to have structural improvements carried out for the purpose of enabling him to deal with his patients in a more up-to-date way, to whom would he address his recommendations?—In the first place, I should think he would address his recommendations to the visiting committee. Some visiting committees might have power to carry out the alteration, provided that the cost was not prohibitive, or if it were a very small alteration it might be done under a provision which allows a visiting committee to spend not more than £400 a year in alterations. But there is also another provision in the Act for a building and repairs fund. This is a fund to which excess profits on certain patients—private patients and patients from other counties—are put, and I know that in some counties they have this fund. In the case of the London County Council the money is always paid over to the county council by the visiting committee, and the London County Council, being the visiting committee, has full charge of any such improvements. But in the ordinary way, if the sum is more than a few hundred pounds, it would be necessary for the county authority or the local authority to vote the money, and the visiting committee would, no doubt, make recommendations to them.

4724. One looks at it from the point of view of the responsibility of the local authority to meet requirements, and then from the point of view of persons interested in lunacy, more particularly the medical superintendent—whom should he set in motion? It would really mean that the visiting committee would be the first persons approached, but they might have to carry the matter further for the necessary authority, if it was a large expenditure?—Yes, that is so—of course, the visiting committee might not have funds; the only fund they would have would be the £400 a year, which is of course a very small sum to carry out any alterations—and the amount they have in their building and repairs fund.

4725. One so often wants to know in public administration who is the body really responsible. Suppose it was felt on all hands that a particular institution was so antiquated or so imperfect in its methods that it ought to be replaced by a more modern institution, who would be the body responsible, or on whom would lie the duty of modernising or rebuilding?—In the first place, the visiting committee would be responsible, and if the visiting committee made representations to the local authority, and the local authority did not act on them, the local authority would take the responsibility.

4726. They would be answerable?—Yes.

4727. You were speaking as to the actual machinery provided by the Act for dealing with plans and estimates, and so on, for accommodation, and I think we had got to the point that any plans and contracts under consideration could only be provisional, except on the approval of the Minister of Health?—Yes, that is so—that is on the recommendation to the Minister of Health by the Board of Control.

4728. The Board of Control is the first body to whom the plans are submitted, and they pass them on to the Minister of Health?—Yes.

4729. That is provided for by Section 254, subsection (2) of the Act of 1890, as amended by the Order made pursuant to the Ministry of Health Act, 1919. In addition to the submission of plans and contracts to the Board of Control and then to the Minister of Health, what else is necessary?—The approval of the local authority itself is necessary, if the sum to be expended is more than has been already authorised by the local authority.

4730. Then a matter we may note is that the visiting committee also have responsibility for providing for the burial of patients who may die in the institution?—Yes; they have the power to provide burial grounds for the patients, or to make arrangements otherwise by contracting with the ordinary cemetery authorities of the neighbourhood.

4731. That is not merely for the patients, I think, but also for the officers?—Yes, for the officers of the institution as well.

4732. Then may they order all necessary repairs?—Yes.

4733. And you have already explained about the £400 limit?—That is for additions and alterations; but ordinary and necessary repairs may be ordered to any extent, and the committee is authorised to make an order for the payment of any expenses so incurred upon the treasurer of the local authority, and the treasurer is bound to pay the amount mentioned in the order.

4734. You have told us of the relation of the local authority to lunacy administration, first of all in the matter of the appointment of the visiting committee; then in regard to the provision of accommodation and the responsibility of upkeep of the institution. Do we next find the local authority concerned with the staff of the asylum?—Yes.

4735. What is their function in that relation?—It is the duty of the visiting committee to appoint the staff of the asylum, and to fix their salaries, wages and remuneration, and they are required by the Lunacy Act to appoint a chaplain, who must be a priest in orders, a medical officer, a superintendent, or, if there is more than one division of the asylum, a superintendent of each division, who is to be the resident medical officer, or one of the resident medical officers of the asylum or the division of which he is appointed superintendent, unless the Ministry of Health authorise the committee to appoint some other person than a medical officer to be a superintendent. They also have to appoint a clerk of the asylum, and a treasurer, and they may appoint a minister of any religious persuasion to attend patients of the religious persuasion to which the minister belongs. They may also appoint visiting physicians or surgeons.

4736. That is under section 276?—That is under section 276.

4737. So that they really seem to be responsible for the staffing of the institution?—Yes, for the whole of the staff. There are some officers they must appoint, and those I have given you.

4738. Some are discretionary?—Some are discretionary.

4739. And they have the responsibility of fixing salaries, wages and remuneration?—Yes.

4740. Then you tell us of the duties of the visiting committee regarding the patients personally who are in institutions?—Yes. One of the duties of the visiting committee, or at any rate of members of the visiting committee, is to make a visit every two months at least to inspect every part of the asylum and see every patient, so as to afford full opportunity of complaint, and to examine the order and certificates for admission of every patient admitted since the last time a visitation was made, and they have to enter in the visitors' book any remarks they think proper with regard to the condition and management of the asylum and patients, and to sign the book on every visit.

19 November, 1924.]

Mr. HENRY FURSE KEENE, O.B.E.

[Continued.]

4741. That is under section 188?—Yes.

4742. Is that duty imposed upon them for the purpose of keeping the patients in touch with the outside responsible authority?—I think one must assume that is so.

4743. Then is the visiting committee of the local authority again associated with the matter of discharge?—That is so.

4744. In what way?—The majority of patients in a county or borough asylum are either wholly chargeable or partly chargeable to a parish or union. The Act, as the Commission knows, refers to these patients as paupers, and patients who are not so chargeable are private patients. A private patient can be discharged if the person on whose petition the reception order was made so directs in writing. If there is no petitioner, as in the case of a patient admitted as a pauper patient, and who has afterwards been classified as a private patient, then the person who made the last payment may discharge, or the husband or wife, or failing there being a husband or wife, then other relatives named in section 72 of the Lunacy Act. If there is no person qualified or willing to direct the discharge of a private patient, the Commissioners of the Board of Control may order the discharge. Where the patient is ordered to be discharged under this section, and the medical officer of the institution certifies in writing that the patient is dangerous and unfit to be at large, with the grounds for his certificate, then the order is of no effect unless

two of the visitors of the asylum consent in writing to the patient's discharge.

4745. That is the barring certificate we have heard of?—That is the barring certificate. Then the Commissioners of the Board of Control have no power to discharge a pauper patient in a county or borough asylum—that duty is cast entirely on the members of the visiting committee, and section 77 of the Lunacy Act provides that any three members may order the discharge of any patient, pauper or private, whether he is recovered or not, and any two visitors, if advised in writing by the medical officer, may order the discharge of any patient detained in the asylum. Then there is a provision in section 79 of the Lunacy Act—and this is a section which is at any rate called very much into use in the London County Mental Hospitals—this section provides that where a friend or relative of a pauper patient confined in the asylum applies to the committee for the patient to be handed over to their custody, any two members of the committee may, if they think fit, discharge the patient on the undertaking of the relative or friend, to the satisfaction of the members, that the patient will be no longer chargeable and will be properly taken care of and prevented from doing injury to himself or others. In the London Mental Hospitals during 1923, 178 patients, 56 men and 122 women, were discharged under the provisions of this section.

4746. You do not utilise that section, I understand, in the case of patients who are fully recovered?—No, there is no necessity to do that.

(The Witness withdrew.)

Adjourned to Tuesday, 2nd December, at 10.30 o'clock.

5, OLD PALACE YARD,

WESTMINSTER, S.W.1.

NINTH DAY.

Tuesday, 2nd December, 1924.

PRESENT :

THE RT. HON. H. P. MACMILLAN, K.C. (*Chairman*).

THE EARL RUSSELL.

SIR HUMPHRY ROLLESTON, BART., K.C.B., M.D.

SIR THOMAS HUTCHISON, BART.

SIR ERNEST HILEY, K.B.E.

SIR DAVID DRUMMOND, C.B.E., M.D.

MR. N. MICKLEM, K.C.

MR. W. A. JOWITT, K.C.

MR. H. SNELL, M.P.

MRS. C. J. MATHEW.

MISS MADELEINE SYMONS.

MR. P. BARTER (*Secretary*).

MR. W. FAIRLEY (*Assistant Secretary*).

Mr. HENRY FURSE KEENE, O.B.E., recalled and further examined.

4747. *Chairman*: Mr. Keene, since we last met, you have been good enough to supply us with two documents, one dealing with the patients' dietary, and the other dealing with the salaries and wages of the officers and servants in your employment?—Yes.

4748. I do not know whether there is anything you wish specially to draw our attention to in connection with these documents. I have read the dietary with much interest. It was apparently instituted as an experimental scale?—Yes; the superintendents re-

2 December, 1924.]

Mr. HENRY FURSE KEENE, O.B.E.

[Continued.]

porting every six months as to the result of the new dietary.

4749. How is it working out?—It is working out very well indeed; very satisfactorily.

4750. It provides, I see, for a certain amount of elasticity?—Yes, that is really the object of it; it supersedes the old dietary scale which was based on a *per capita* allowance, and afforded very little elasticity.

4751. This is much less rigid, and a different provision is made for those who are doing manual work from that for those who are not so engaged?—Yes.

4752. I am interested to see the provision for more green food, which we are told is a very important thing?—Yes, there is provision for the vitamins.

4753. It is really based on a more or less scientific theory of the food value of the diet?—Yes. It was very carefully considered by the medical superintendents of the London mental hospitals, and was put forward by them, and was adopted by the Council on their recommendation.

4754. Then although it was only instituted for six months, an experimental period in 1923, it is still in operation?—It is still in operation.

4755. I see there are one or two variations in manuscript upon it?—Yes.

4756. Have you a farm in connection with your institutions?—We have farms at each of our institutions.

4757. Do they supply the fresh food—dairy produce and vegetables?—They supply milk. We have cows; we keep pigs and poultry, and we have market gardens.

4758. And are you able to supply yourselves entirely with market garden produce from your own farms?—Entirely with green food, but such produce as potatoes we have to buy a certain amount of.

4759. Then as regards the salaries and wages, the scales are evidently somewhat complicated, to judge from this paper which you have handed us?—It refers to a very large number of grades of staff.

4760. It is all on the principle of a basic scale with bonus additions?—Yes.

4761. That, of course, always complicates matters a little. Then at the different institutions you have different staffs, dependent I suppose, upon the size and character of the institution?—The salaries of some of the officers at the smaller institutions are less than those of the officers at the larger ones.

4762. Each institution has certain officers of its own with separate salaries of their own?—That does not happen very often. I think it only refers to some of the chief officers. The medical superintendent of a small institution would not get the salary of a medical superintendent of the largest institution.

4763. Naturally; and similarly with regard to the other superior officers I notice there are different rates of pay for officers of the same standing?—Yes.

4764. But when one comes down to the people perhaps most important for our purpose, the actual attendants—is your scale uniform for them?—The pay of male and female nurses is the same at all the institutions.

4765. That is naturally a part of your table which is of most interest to us, because we have to consider whether the remuneration of these attendants is adequate to attract a good class of officer?—Yes.

4766. And also whether there are prospects in their work which are likely to encourage them to remain?—Yes.

4767. I think you have a rising scale of remuneration, have you not, according to the period of service?—The probationer nurse at the present time has an increase on passing an examination of the Medico-Psychological Association.

4768. One finds that on page 7, I think—is it 4s. a week extra?—You find that first of all on page 4—the nursing staff.

4769. Yes, I beg your pardon. So that there is some pecuniary inducement to the staff to improve their qualifications?—The male probationer nurse starts at 34s., and there is an increment of 3s. a week on passing each of the two examinations of the Medico-Psychological Association. That makes a total of 6s. The period during which they have to prepare and sit for this examination is about 3 years. When they get the diploma they become staff nurses and receive 40s. a week, and they have then four increments of 3s. a week a year, and one of 2s., which brings them up to 54s. a week.* These scales are inclusive. Out of that the members of the staff have to pay for their board, lodging and washing. The charges are given on page 4.

4770. Then I suppose they have prospects of promotion to the higher grades, have they?—They have prospects of promotion to the position of charge nurse, and special charge nurse—head nurse; and male attendants may become inspectors. There is only one inspector at each institution. The women nurses may rise to the position of assistant matron or matron, and much has been done recently to encourage the women nurses to go to general hospitals for training, so that they have that experience which would make them much more fitted for the higher positions on the nursing staff.

4771. That is alluded to in the recent report, I see, as being a desirable feature?—Yes.

4772. Then may one say that there is a career offered in your institutions for those who show efficiency?—There is no doubt about that.

4773. Are the scales of wages subject to adjustment by any Board, representative of the employees of the Council?—Not with the London County Council. Outside the Council there is a Mental Hospitals Association which, I believe, negotiates with the Asylum Workers' Union; but the Mental Hospitals' Committee is in close touch with representatives of the National Asylum Workers' Union, and we always negotiate with them on any question of rates of pay for the nursing staff.

4774. One is familiar with this that in some of the departments of the London County Council wages are adjusted by a Conciliation Board, are they not?—Yes.

4775. But you do not have that formality in your department?—We do not have that formality with the nursing staff.

4776. But you are in touch with the representatives of the Association?—We are in frequent negotiation with the National Asylum Workers' Union representatives. As a matter of fact we have followed very closely the arrangement come to between the Mental Hospitals Association, which represents many of the Lunacy Authorities in England and Wales, and the National Asylum Workers' Union.

4777. Then you have given us the scale with regard to the male nurses; I think we find on page 6 the corresponding information with regard to the female nurses. We find item 87, "nurse probationer." There are certain manuscript alterations on the print?—Yes.

4778. They appear to start at 27s. 3d.?—Yes.

4779. Then they also have an inducement to obtain qualifications?—Yes, they get 3s. on passing the first examination, and another 3s. on passing the final examination.

4780. That is the same as the men?—Yes. Then when they become staff nurses they have 33s. 3d., and they can rise to 43s. 11d. by four increments of 2s. 5d. each, and one of 1s.

4781. Then similarly in their case one observes various higher grades with better remuneration and better conditions of employment, which are held out to them should they prove satisfactory; rising, I suppose, to the post of matron?—Yes.

* Note.—At the present time the male nursing staff receive in addition war wages of 17s. 6d. a week and the female nursing staff of 12s. a week.

2 December, 1924.]

Mr. HENRY FURSE KEENE, O.B.E.

[Continued.]

4782. I think that gives us information which will be of great use to us. We might now resume the general evidence you were giving us; and we had reached this stage. You have, I think, given us some information regarding the discharge of patients, and in that connection you might tell us to what extent you avail yourselves of the power to allow patients out on trial?—It is the usual practice in the London County Mental Hospitals for patients before being discharged as recovered to be allowed out on trial under the provisions of section 55 of the Lunacy Act. The authority is given by two members of the committee on the advice of the medical officer. A money allowance is given where necessary, and the usual period of trial is four weeks. This affords an opportunity of ascertaining whether the patient's mental condition has sufficiently improved to allow of him resuming his normal life and activities.

4783. Then do you find that as a result of the trial period a considerable number of patients do not require to return to your institutions?—They only require to return to be discharged. Usually they make an appearance and see the committee; the committee hear from the friends who have taken them out how the patient has behaved, and the order for discharge is then signed.

4784. Do you get a medical certificate from the medical practitioner who is attending the case at that stage?—At times, where there is any difficulty in the patient returning, a medical certificate from the practitioner who has been looking after the patient is accepted; but the members of the committee encourage the patients to come back, because they are anxious to know that they have been doing well.

4785. Is the trial sometimes a failure?—Yes, at times, patients are brought back before the period elapses.

4786. But on the whole do you find that the trial period is a valuable interregnum, so to speak, between residence in the asylum and complete restoration to normal life?—It is most valuable.

4787. During the period of trial the patient, of course, remains certificated?—Yes.

4788. And is therefore under the control of the asylum authority?—Yes.

4789. And can be taken back at any moment if necessity requires?—That is so.

4790. Now in the case of private patients, there is some difference in procedure, as we know; and in particular there is a requirement that at the end of the first month of the patient's residence in the institution a formal report shall be made to the Board of Control, what we call the month end report?—Yes. We have some private patients in the London mental hospitals, and we are required to carry out the Commissioners' desires. The report of the medical officer is sent to the visiting committee, and one or more members will see the patient and report on the condition of the patient.

4791. So that a special visit follows upon the lodging of that report with the Board of Control?—The members would see the patient, but in practice the Commissioners themselves do not visit for the purpose of examining the patient. They can do so under the provisions of the Act.

4792. But the work is actually done by the visiting committee?—Yes.

4793. May one regard that as a real investigation of what I may call the merits of the case?—The members who see the patient would satisfy themselves that the patient is a person who is proper to be detained. However, that only affects quite a small number of the patients with us.

4794. It would be interesting if you gave us some statistical information as to the number of re-admissions?—I thought this information would perhaps be very interesting to the Royal Commission. Statistics were started in 1895, and as the London County mental hospitals have so very many of the lunatic population of England I think the figures are rather valuable. 3,153 patients—that is, 1,382 men and

1,771 women—were admitted to the London mental hospitals during 1923.

4795. Are those new admissions?—Those are new admissions.

4796. Would it include those who are re-admitted on a relapse?—Yes.

4797. Those are persons who have entered or re-entered the institutions in that year?—They would come in on new certificates. It would not include patients transferred from one institution to another; they are all newly certified cases.

4798. Now of those admissions how many were discharged recovered in the course of the year?—The recoveries for the year 1923 were 348 men and 533 women.

4799. Let us just pause there a moment. That looks as if about a quarter recovered within the year of those who entered in that year?—881 is the total number of recoveries for 1923, and would include patients admitted prior to 1923.

4800. Then you have kept track of your patients in order to see which of them are re-admission cases?—Yes. In 29 years 30,718 patients were discharged recovered, and 9,177 of these patients, that is 29·87 per cent. were re-admitted at some time or other to one of the London mental hospitals. 3,375, or 10·98 per cent. were re-admitted within 12 months of their discharge. We cannot follow all those cases. Some of them may be admitted to institutions outside our ken.

4801. That just occurred to me, that you cannot keep track of them all, because some of those patients may after discharge be removed into another area, and may have been admitted to an institution elsewhere?—That is so.

4802. Then you have a system of re-classifying patients after admission; that is to say, patients who come to you as paupers may become private patients?—Yes; that is under Section 3 of the Lunacy Act, 1891, which provides that a lunatic who is sent to an institution for lunatics, under Sections 13 or 16 of the 1890 Act shall be classified as a pauper patient. Those sections I think the members of the Commission will remember are the sections dealing with patients admitted on summary reception orders, that is a patient not under proper care and control, a patient who is admitted as a pauper and a patient wandering at large. All these patients are to be classified as paupers until it is ascertained that they are entitled to be classified as private patients. For many years the London County Council has caused special enquiries to be made, with a view to ascertaining whether the patients or their friends have sufficient means to pay the full cost of maintenance; and where this can be arranged and payment is made direct to the Council, the patient is classified as a private patient, and, consequently, has such advantages as to discharge which the Lunacy Act provides for private patients. At the present time we have just over 300 patients on the private list.

4803. Some of those will have been originally admitted as private patients; others will have been re-classified as private patients?—All these patients are on summary reception orders.

4804. All admitted as paupers?—Yes. It may interest you to know this: All these 308 patients were admitted on summary reception orders. 274 of them were admitted as patients in receipt of relief, 27 as not under proper care and control, and 7 as wandering at large; but as a result of our inquiries we found that friends were able to pay, or the patient himself or herself had sufficient means to allow of the charge for maintenance being paid direct to the institution.

4805. Now as regards the treatment of such patients, is there any differentiation between them and the pauper patient who remains a pauper patient?—There is no differentiation except that patients on the private list are permitted to wear their own outer clothing, but I should at once say that even with the patients who are chargeable to the parish

2 December, 1924.]

MR. HENRY FURSE KEENE, O.B.E.

[Continued.]

permission is given, where it is deemed advisable, for the patients to wear their own clothing.

4806. So that that is not necessarily a differentia between the two cases?—No.

4807. Are there any privileges that they have?—The only privileges are those accorded by the Lunacy Act, that is to say, the person who made the last payment or a near relative can discharge the patient.

4808. That is only in the matter of the machinery of discharge?—Yes.

4809. I was thinking of their treatment while they are in the institution. Is there any difference in their treatment?—No; the charge is exactly the same as would be made for a patient chargeable to the parish.

4810. So that the benefit is really a benefit to the ratepayer rather than to the patient?—It may be a benefit to the individual. I think the relatives appreciate that the patient has not been classified as a pauper, which is very distasteful to many people.

4811. *Earl Russell*: I did not understand that last answer. Do you mean that they pay no more than the guardians pay for a pauper patient?—They are not bound to pay any more than the guardians pay.

4812. *Chairman*: So that they are not really a source of revenue to your institution?—No, they are not a source of revenue.

4813. There is no profit on them, if one may put it so?—The present rate is 24s., and if that sum is paid, it is the duty of the Council to put that patient on the private list. That 24s. does not include any capital charges, or costs of upkeep; it only includes the cost of maintenance, and if the amount which is usually paid by boards of guardians is paid to the Council then we are bound to make the patient a private patient. The amount is 24s. 6d. a week.

4814. It would rather appear as if the chief advantage, which a patient derived from transfer from the pauper class to the private class, was first what we may call the sentimental advantage of being no longer regarded as a pauper, and, secondly, the special provisions with regard to the discharge of such patients?—Yes.

4815. The person who has made the last payment is treated as the petitioner is treated in the case of a private patient, and may call for the discharge of that patient?—Yes, that is so.

4816. I would like to ask you a question about a topic that is a little outside your *précis*. You spoke of those cases that are transferred because it is found that the patient has means. How is it ascertained whether a patient has or has not means; whose duty is it to investigate their financial position?—We endeavour to get as much information as we can from the board of guardians, and the majority of the boards of guardians will let us know if a patient has means of his own.

4817. Has the board of guardians naturally an interest to see that, if a patient has means, those means are applied to his upkeep?—That is so.

4818. Because every patient who is discovered to have means, and who can pay for his own upkeep *pro tanto* relieves the rates?—That is so.

4819. Therefore there is an interest, and probably a duty also upon the board of guardians to investigate the financial position of cases in your hands, to see whether or not they ought to be chargeable to public moneys?—Yes.

4820. And if they ascertain there is money available for the maintenance of the particular patient, they apprise you of the fact?—The majority of the boards do, and then we get information sometimes from patients themselves, and the friends of patients will perhaps at times give us information by asking that certain documents may be signed; that gives us information that the patient has means, and we at once proceed to make enquiries to establish the fact whether these patients are able to pay the full charge.

4821. One is a little impressed with the absence of machinery for ascertaining the property or the

financial position of patients, either private or pauper patients. I see in the case of pauper patients there is a duty upon the board of guardians to investigate that matter, but do you concern yourselves, apart from that circumstance, with the property of your patients at all?—No, it is only for one purpose; that is, for the purpose of the provision in section 3 of the Lunacy Act of 1891. The Council years ago had an action brought against it, and, as a consequence, we have taken very great care to see that all patients who are entitled to be classified as private patients are so classified.

4822. But beyond that you really have no interest in their property?—We have no interest.

4823. Then we might just get on the note one or two formal matters. The visiting committee have a duty under section 275 to prepare general rules for the government of the asylum?—Yes.

4824. And these require the approval of the Minister of Health?—On the recommendation of the Board of Control.

4825. Then in turn the visiting committee also make regulations which we may call the bye-laws, really, I suppose, for the governance of their institution?—An amplification of the general rules.

4826. Dealing with more detailed matters?—Yes.

4827. It would be rather interesting if you could furnish us with a copy of the general rules and regulations applicable to one of your institutions, at any rate; and of the general rules which you have adopted.—I can furnish you with a copy of the general rules which have recently been approved by the Minister of Health. The regulations approved in 1906 are somewhat out of date. There have been many changes, and they are at present under revision. Shall I hand that in?

4828. If you please. (*The general rules were handed in.*) These are dated in 1923, I see, but you are in course of revising your regulations at present, are you?—That is so.

4829. Then the visiting committee also have to determine the diet of the patients; and you have given us, in the print that you have handed in, the regulations which have been approved on that subject, and which are at present in operation?—Yes.

4830. Then the committee have also to fix the weekly sum to be charged to the parish or county responsible for the maintenance of each pauper lunatic?—Yes; that, as I have explained, is 24s. 6d. a week at the present time. The expenses of maintenance of the pauper patient are repaid by the guardians of the parish or union to which the patient is chargeable, or by the county, if the patient's chargeability has been adjudicated to the county in the absence of ascertainable settlement.

4831. I do not quite follow the point about the 14s. limit—what is the meaning of that? You tell us that if the charge exceeds 14s. a week the local authority is required to order such addition to the weekly sum as seems necessary. What is the meaning of that?—Before the war the cost of maintenance in county lunatic asylums was somewhere in the neighbourhood of 10s. or 11s. a week. The cost of living of course has increased very much, and alterations have been made in the pay of officers and servants, and expenses are very much heavier; but this provision no doubt was placed in the Lunacy Act to provide that the local authority should have something to say if the expenses of maintenance went beyond a certain figure, so that if the cost of maintenance was more than 14s. the committee have to go to the County Council and get approval.

4832. Does that mean that up to 14s. they have a free hand?—They have a free hand.

4833. But if they proposed to exceed 14s. a week then they had to get a special sanction from the local authority?—Yes.

4834. The general authority extended to 14s., but special authority was required for any sums above?—Yes.

2 December, 1924.]

Mr. HENRY FURSE KEENE, O.B.E.

[Continued.]

4835. Is that statutory?—That is statutory; I take it that every county authority now is approving the weekly rate fixed by its visiting committees.

4836. Of course, as you told us, in London it is 10s. above that datum line of 14s.?—Yes. It has been considerably higher.

4837. Is it tending to come down a little now?—It is about stationary now.

4838. Hitherto I think you have been giving us an account of the duties cast upon the visiting committee by the Lunacy Acts generally, but in the case of the London County Council there is, is there not, special legislation applicable to it?—That is so.

4839. And these duties of the visiting committee have been transferred to the Council itself?—Yes.

4840. Then does the machinery which is in operation consist firstly of a Mental Hospitals Committee of the County Council?—The Mental Hospitals Committee is the statutory committee appointed by the Council.

4841. That consists, does it not, of 35 members, of whom nine are women?—That is so.

4842. Ten being co-opted?—Yes.

4843. And are the women introduced through the medium of the co-optation?—Some of the women members are members of the Council itself.

4844. Then that same committee is responsible for the carrying out of the duties of the Council under the Mental Deficiency Act of 1913?—Yes.

4845. I am going to ask you a little later to be good enough to give us copies of the special statutes applicable to London that deal with these matters, either the sections if they are contained in omnibus Acts, which they probably will be, or the Acts themselves if they relate specially to the lunacy. I would like to see this private legislation. You also have special legislation authorising you to receive boarders. One wants to know to what extent you differ from the general code, and what special powers you have, so that we may study these and see whether they are in advance of the general law; because very often in private Acts, as one knows, you see the forerunner of general legislation?—I can hand in the London County Council (General Powers) Act of 1915, which contains these provisions. (*Handing in the same.*)

4846. May I take it that this statute of 1915 contains all of what I may call the specialties of London county?—It contains all the specialties with regard to the powers of the Visiting Committee and the Committee itself; it does not deal with the special powers we have at the Maudsley Hospital.

4847. When we come to that perhaps you will be good enough to hand that in also?—Yes.

4848. Now in the case of London you have some statistics to give us?—Yes. On the 1st January this year, there were 18,918 patients, 7,728 males, and 11,190 females, for whom the London County Council had to provide accommodation. Of these the majority were chargeable to parishes or to the county. 1,063 (861 males and 202 females) were private list cases, and 120 were women patients admitted as private patients for whom special provision has been made at the Horton Mental Hospital. There were also 40 private male patients at Claybury Hall. Claybury Hall is an annexe of Claybury Mental Hospital: Included in the private list cases were ex-service men, the charge for whose maintenance is paid by the State.

4849. That is rather interesting. If the State pays for an ex-service man's maintenance the ex-service man is then transferred to the private list?—*Ipso facto* he becomes a private patient. A private patient is one who is not a pauper—that is the definition in the Act.

4850. This class is rather different from those cases in which the patients are transferred from the pauper list to the private list in consequence of the patients themselves having means. In this case the means are provided by the State?—Yes. In fact a criminal lunatic (we have some of those) whose maintenance is paid by the State is a private patient, because he is not a pauper.

4851. It seems rather anomalous, does it not?—Yes.

4852. Then as regards the accommodation which you possess, you have nine mental hospitals, and I do not think you need recite the list here of the accommodation?—The total accommodation is 8,300 beds for men, and 11,042 for women, a total of 19,342. Then in addition there is the colony for epileptics, which at present is leased to the Ministry of Pensions, where they take their neurasthenic cases. We also have the Maudsley hospital with 157 beds.

Sir Humphry Rolleston: Would this be a convenient place to ask Mr. Keene to clear up the question as to any overlapping there may be between the London County Council and the Middlesex County Council?

Chairman: I think it would, Sir Humphry, if you would be good enough to ask the witness any question arising out of that. We are to have a Middlesex witness later in the day.

4853. *Sir Humphry Rolleston*: Yes. (*To the Witness*): Of course all London is not confined to Middlesex, but when you speak of the majority chargeable to the parishes, or to the county, I do not know whether the words "the county" mean Middlesex, or whether they mean any county?—It means the County of London. It comes to this, that there are certain people who come into our hospitals who are *prima facie* chargeable to a parish or a union. We get a number of foreigners in London and, first of all, they are chargeable to the parish where they are found. That parish seeks to get rid of the chargeability. If we cannot find that the patient is chargeable to any other parish in England or Wales, then the patient is made chargeable by notice given by the guardians to the County Council.

4854. *Earl Russell*: Is that provision peculiar to London?—No, it applies everywhere.

Earl Russell: I understood every pauper had to have a settlement in a parish.

Chairman: He must, I should have imagined, unless he was an alien.

Earl Russell: If there was difficulty about it, there were means of giving him an ascertainable settlement.

Mr. Snell: After three years, is it not?

Chairman: Three years to acquire a settlement, but if a pauper is found, so to speak, at large in any area, is he not primarily chargeable to that area?

Earl Russell: Primarily to that union, until they can plant him on some other.

4854A. *Chairman*: But, of course, he may have no legal settlement. If he has been born abroad, let us say, or has not acquired a settlement by the necessary three years' residence, then the union to which he becomes chargeable will not be able to shift the burden on to any other union.

Witness: That is so.

4855. *Earl Russell*: If he were an ordinary pauper resident in the workhouse would he be chargeable to the local rates, or to the county?—I think he would have to remain chargeable to the local rates.

Earl Russell: That is what I thought.

4856. *Chairman*: There are cases undoubtedly where the settlement is unascertainable?—That is so.

Chairman: Wherever they become chargeable, so to speak, they remain chargeable without any relief against any other local authority.

Earl Russell: I just put to Mr. Keene the analogy of a non-lunatic pauper.

Witness: They say they cannot get rid of his settlement; but a person who becomes a lunatic is chargeable for the time being to the union or parish where he became a lunatic, wherever he was at the time, and the guardians would seek to put the chargeability on any union or parish which ought to bear the chargeability.

4857. *Chairman*: Is not that just the same in the case of ordinary poor law relief?—I cannot say. If there is no proper settlement, or ascertainable settlement elsewhere, and the patient has not got a

2 December, 1924.]

Mr. HENRY FURSE KEENE, O.B.E.

[Continued.]

chargeability to the union, then the guardians through their officers give notice to the County Council, and unless the Council can resist the application before a justice of the peace, the patient becomes chargeable to the County of London.

Chairman: I think we may help you and ourselves on this point by referring to Section 290 of the Act. There does seem to be, as the Secretary reminds me, a special statutory provision which governs this. The side note is "If settlement cannot be ascertained a pauper lunatic may be made chargeable to a borough or county." That probably is the answer to our difficulty.

Earl Russell: Yes, that is the section it arises under. In the case of an ordinary pauper it would lie where it fell.

Witness: We have 478 patients chargeable to the County of London, and all these cases have been adjudicated.

4858. *Chairman:* On Sir Humphry's point as to overlapping among the county authorities—does any difficulty arise in that way as between the County of Middlesex and the London County Council?—I do not quite follow in what way you mean.

4859. If you take the Middlesex County Council, that is a separate local authority, I suppose, with its own duties?—Yes.

4860. Is it quite distinct from the London County Council?—Quite distinct.

4861. And are its patients drawn from different areas?—All the patients who are properly receivable in the London county mental hospitals come from the union or parishes within the County of London; and the Middlesex County would only receive in its institutions patients from the parishes or unions which form the County of Middlesex.

4862. Just follow that a little further. Suppose you found as a result of investigation that a particular person received into one of your asylums is really chargeable to another county, do you then have that patient transferred to that other county's care, or do you merely obtain repayment of your outlays from that other county?—It depends. In most cases the guardians of the parish, to whom the patient is made chargeable, would apply for the patient to be removed to the asylum which is the proper asylum for patients of that union to go to. We have quite a number of cases in the London mental hospitals of patients who have been living in London for some time; they have become pauper lunatics, and when the question of settlement has been gone into it has been found that their settlement might be right away in the north, or, at any rate, quite a distance from London.

4863. Possibly in Scotland?—We cannot send patients to Scotland, or to Ireland. Frequently the friends of the patient, on hearing that there is a possibility of the patient being transferred from London to a distant asylum, make application to us that the patient may remain there, and that is frequently acceded to, if the guardians to whom the patient is chargeable raise no objection. They might have to pay more for the patient in London than they would in some remote place.

4864. I could imagine the converse case also, that the relatives in the north of England, let us say, whose relation had become chargeable in London, a pauper lunatic in London, might wish to have him transferred to their own neighbourhood for the purpose of being able to visit him easily and see him from time to time. Does that occur?—There may be some cases, but the majority are the other way about.

4865. Pursuing the system on which the London County Council works, we first have the general committee, the constitution of which you have explained, the Mental Hospitals Committee, and then there is a standing sub-committee, is there not, for each of the nine hospitals you have enumerated?—Yes; it consists of at least five members. Usually we have eight members on the sub-committees.

4866. What are their functions?—The sub-committees exercise powers delegated by the Mental

Hospitals Committee for the government of these hospitals. The sub-committees of the large hospitals meet usually once a fortnight. At a meeting held once in four weeks the ordinary business of the hospital is conducted, and at the intervening meeting the business consists of discharging patients, interviewing applicants for discharge of patients, and visiting the patients in the wards. It might help you, Sir, if I handed in the Orders of Reference to the standing sub-committees; that would complete the arrangements which are dealt with under the General Powers Act.

4867. Yes, we should like to have that. (*The same was handed in.*) This gives you the general scheme of the duties?—Yes, the references to the sub-committees.

4868. That will be very useful. Is there any official record kept of these fortnightly meetings?—Yes, minutes are kept.

4869. And are the meetings of the sub-committees held at the hospitals themselves?—At the hospitals themselves.

4870. Do they then interview patients?—Yes.

4871. Is any record kept of those interviews between the visiting committees and the patients?—The visiting of the patients is recorded in the visitors' book. The members who visit would say that they had visited such and such wards and seen the patients, and they would make any comments that they had to make.

4872. Supposing I wanted to know in a particular case whether a patient had or had not been seen by a visiting committee, if I consulted the books kept at the asylum should I find whether that particular patient had or had not had an interview?—I think not.

4873. I am thinking of the case of a patient who had some complaint to make and brought it before the visiting committee on the occasion of one of their visits. Would any record be kept that such a complaint had been made, and what was done upon it?—If a patient attended before the sub-committee and made a complaint there would be a minute of it; but if a patient were seen during the visit of the members to the wards there would be no record of it, except any record that the medical officer might keep in his case book. He might think it advisable to make a note that the patient had spoken to members visiting the wards.

4874. Then you distinguish between an interview which takes place formally between the visiting sub-committee and the patient, and what may be a more or less casual conversation taking place while the committee is going through the wards?—Yes; in one case it takes place at the meeting of the committee and is properly minuted; in the other case it would be not a meeting of the committee because you would only have members of the committee visiting.

4875. Individually?—Yes.

4876. *Earl Russell:* You would yourself be present to take the note if it came before the committee?—Yes, that is so.

4877. *Chairman:* Have you cases of patients making complaints of their treatment to the visiting sub-committee?—Many patients write letters to the committee. The letters are read at each meeting; they are placed before the committee. Some patients are constantly complaining.

4878. What action is taken on such complaints?—If the complaint appears to be one that should be investigated, the members would ask the doctor's views about the patient.

4879. Supposing a complaint were made about treatment by a particular nurse, let us say, a complaint of ill-treatment by an attendant, would the visiting sub-committee investigate the case?—If the complaint appeared to be a genuine complaint, the committee would most certainly investigate.

4880. Have you had in your experience any instances of that sort?—Oh yes.

2 December, 1924.]

Mr. HENRY FURSE KEENE, O.B.E.

[Continued.]

4881. Have you found that the patients have any difficulty in bringing complaints before you?—None at all.

4882. And do you receive quite a number of them?—Quite a number of complaints.

4883. Some of them, no doubt, will be on the face of them irrational, but others merit investigation?—Quite.

4884. And where they appear to have any foundation do you investigate them?—The medical superintendent would no doubt bring before the committee a complaint of a patient which had any foundation, and the committee would proceed to investigate the complaint.

4885. What I have in my mind, and I think my colleagues have too, is whether patients have means of getting in touch with outside independent persons, independently, that is to say, of the staff in whose hands they are—a very important safeguard as you recognise, I am sure?—Yes.

4886. And one is very anxious to see that there should be no obstacle between the patient and this outside and independent body. Do you find that there is free access as between the patients and the visiting committee who are charged with their welfare?—When the visitors go through the wards the patients have an opportunity of speaking to them.

4887. That is one way?—And handing letters to them which the members can read afterwards.

4888. The visitors, as individuals, pass through, as we know, the whole institution within certain stated times—then do you say the patients can speak to the visitors, or hand them letters?—Yes.

4889. Do they also address letters to you?—Letters are addressed to the members of the visiting committee, and those letters have to be handed to the members unopened.

4890. And are they dealt with then as part of the business of the sub-committee?—Yes; a letter addressed to an individual member would be forwarded to that member.

4891. Unopened?—But a letter addressed to the visiting committee would be placed on the table, and would be opened by members of the visiting committee when they are meeting.

4892. Have you any criticism or suggestion to make with regard to the facilities which exist for a patient making known his troubles to responsible persons distinct from the staff of the institution?—At one or two of the mental hospitals we now have unpaid visitors.

4893. Do you mean persons of philanthropic instincts who want to take up that work?—People who give up time. They have no connection with the visiting committee. They come into the institution, and they go round the wards, and they do what they can to help the patients. Sometimes they visit the homes. It is a sort of liaison between the home of the friends and the patients in the institution.

4894. That, of course, is voluntary effort?—Yes.

4895. I was thinking at the moment of the existing machinery, whether you regard the machinery as adequate, the means available at present for communication between the patients and the outside world?—I do not know that the present system affords sufficient opportunity for all complaints to be carefully investigated by the visiting committee, but I should think that the present arrangement does safeguard the patients.

4896. You see what I am thinking of is this, that the patient is to a certain extent shut off, and must be shut off, of course, from the general community; at the same time it is very desirable that persons so shut off should feel that they have access to some independent body interested in their welfare, who will concern themselves with any complaints or difficulties that they may have. One would have liked your view, as an experienced officer, upon the extent to which that feeling exists, that is to say, whether patients do have a sense that they are not entirely shut off, but have means of access to independent persons who will concern themselves with

their affairs? If you do not think that the existing machinery is adequate, one would be very glad to have any suggestions you can make upon that, although I know you are not here really to speak upon policy; but if you have any suggestions, we should welcome them from you as one who has practical knowledge of the working of the code?—My own view is that the present machinery probably is adequate; because these patients are visited by the medical officers of the institution, by the chaplain, and I feel that the medical staff and the chaplain and other visiting ministers would give that opportunity of looking into any question or any complaints that the patients might wish to put forward.

4897. Of course one realises that the success of the system will depend upon the qualities of the superintendent and of the staff, but one has to reckon with the cases which might be less satisfactory; and what one is anxious to know is whether there exist safeguards adequate to enable any person who may be in a less fortunate position, in the hands of a less responsible superintendent or attendants, to make known his grievances. At present I rather seems to me that the visiting committee is the safeguard—I mean the safeguard as distinguished from the staff of the institution, and one is anxious to see that there are no obstacles between the patients and the visiting committee. Do you think there are any?—I think that every patient when the members visit the wards has free access to those visitors, but whether the patient has sufficient opportunity at the visit to make known his complaints is another matter.

4898. *Earl Russell*: But he would never be denied access to the visiting committee if he asked for it?—He never would; a private patient can demand a private interview. There is that differentiation again between the private patient and the patient chargeable to the parish.

4899. *Chairman*: We have already had a considerable body of evidence to the effect that the existing legal differences between the positions of the private and of the pauper patient are both undesirable and unnecessary, and that the position of the two ought to be assimilated so far as regards their legal rights. Do you see any reason why the pauper patient should not equally be entitled to demand an interview?—I know no good reason why they should not.

4900. Are the patients made aware by notices that they may write letters to the various authorities—have you notices posted up?—The notices are posted in the wards; but those notices, generally speaking, refer to private patients.

4901. Yes, that is quite true. I do not quite see why a private patient should be told he can write, while a pauper patient is not afforded the same information?—With the pauper patient the letters are perused by the medical staff, and it is within the discretion of the medical officer whether the letters are forwarded or not.

4902. *Earl Russell*: Except in the case of the official persons, to whom they must go surely?—That I think again refers only to private patients.

4903. Surely not—does it?

4904. *Chairman*: I think it applies to any patient. I have perhaps taken you a little beyond your immediate province; it is not a matter you have prepared yourself specially to help us upon; therefore I do not want to take you beyond the topics you have come to speak upon, but one is anxious to see that there is no obstacle interposed at all. As Lord Russell has just pointed out there is provision for letters going to certain official persons unopened?—That is so,—I ought to correct what I said. That applies to all patients, but with regard to other letters it is within the discretion of the medical officer to forward a letter if it is written by a private patient.

4905. *Mr. Snell*: What section is this?—Section 41.

4906. *Chairman*: However, within your province, comes the question of the consideration of the actual written complaints which are submitted to the sub-committee?—Yes. I might remind you, Sir, that

2 December, 1924.]

Mr. HENRY FURSE KEENE, O.B.E.

[Continued.]

the friends of patients are allowed to visit them very frequently; there is an opportunity of visitation twice a week, and that if the patients have complaints to make they can make them through their friends. We should hear of complaints in that way.

4907. Then, of course, one knows also that the guardians who have patients in your institution are entitled also to come and see the patients who are chargeable to them?—Yes, and many of them do.

4908. But the more opportunities that there are afforded to the patients to feel that they are not segregated, but are in touch with responsible persons outside the institution interested in their welfare the better, one is disposed to think?—Yes.

4909. However we may now resume the general evidence you are giving. Is it the case that in London almost all your patients reach you through the workhouse?—That is so.

4910. That is to say, they come through Section 20?—Yes.

4911. I think you have some figures for 1923 showing us the extent to which that is so?—You have had a certain amount of evidence about this, and I thought you would like to know what is the practice in London.

4912. Yes, we would?—I have figures for the year 1923. There were admitted to the London County mental hospitals 3,152 patients, and of these 2,978 were admitted as paupers in receipt of relief, or in such circumstances as to require relief for their proper care and maintenance; 128 as lunatics wandering at large; 39 as not under proper care and control, or cruelly treated or neglected, and 7 as private patients on petition. That is, of this large number with the exception of the private patients on petition, there were only 39 who had the advantage of two medical certificates and had been dealt with by a specially appointed justice, the judicial authority.

4913. One is struck with the extent to which the workhouse in London is the portal to the asylum?—Yes. I have already told you this morning that out of the 308 patients we have on our private lists 274 came to us in receipt of relief.

4914. There seems to me to be a distinction to be drawn here. You may have a person who is a pauper in the ordinary sense, a sane pauper chargeable to his union, and possibly resident in the workhouse. Such a person may become insane. There is no change in their status, it is merely a change in their state of health?—No. There may be persons also who were visited by the district medical officer who were receiving outdoor relief.

4915. That is one class of person, and in their case the insanity does not bring a new stigma of pauperisation because they are already paupers?—No.

4916. But I take it that far the larger proportion of the 3,152 who came in 1923, would be persons who were not paupers at all, but became paupers as a concomitant of their insanity?—That is so; they were taken to the workhouse as a precaution for their own safety, or for the safety of the public. They received relief, and they became paupers.

4917. They became paupers by virtue of the statute?—By virtue of the statute.

4918. Although up to that time they may have been self-supporting persons?—Yes.

4919. As you are not speaking on policy I will not ask your opinion as to that system?—I am obliged to you.

4920. Then in London has your Council made special provision for chronic and harmless lunatics in premises outside the Metropolis?—The Metropolitan Asylums Board has made this provision. You are aware, Sir, that there is provision in the Act for a certain class of lunatic to be kept in the workhouse.

4921. Yes, Section 24, I think it is?—Yes, Section 24. There must be sufficient accommodation for the lunatic's proper care and treatment, and the lunatic must be a harmless lunatic, and no doubt in the country workhouses you will find a number of these chronic harmless lunatics; but in London the pro-

vision of workhouse accommodation for this purpose is undertaken by the Metropolitan Asylums Board.

4922. And have they special hospitals for such cases?—They have special hospitals at Caterham, Fountain, Leavesden, Tooting Bec, and Darenth. These institutions also now receive cases certified under the Mental Deficiency Act, they having been certified as proper institutions for the reception of mental deficiency cases under the Mental Deficiency Act.

4923. Now may I take it that in London these special institutions really take the place of the mental ward that one may find attached to a Poor Law infirmary in smaller cases?—Hardly, Sir, I think. The mental wards probably are the wards where you would have the acute cases awaiting removal to the asylum. You might have some of the harmless lunatics in the mental ward, but they might be perhaps with the others.

4924. Then it is merely due to the circumstance that in London, owing to its size, you have a sufficiency of this class to justify the provision of special hospitals for them?—Yes.

4925. Whereas in other areas with smaller populations they may be found mixed with the general poor workhouse population?—What I wanted the Commission to appreciate was this: You asked me a question last week about the responsibility for providing accommodation; the local authority is responsible to provide whatever accommodation is wanted. Now that is dependent to a great extent upon the accommodation provided somewhere else. If there is accommodation in the workhouse for the chronic harmless lunatic, then the local authority, the County Council, has not to provide for so many lunatics; but assuming the workhouse authority does not provide that accommodation, then the county authority is not relieved to that extent, and must provide sufficient accommodation for all classes of lunatics.

4926. Then in the case of those chronic harmless lunatics, I suppose they are mostly patients who would not benefit from the special treatment of an asylum—that is to say, they are hopeless cases, I take it?—Yes. Some cases are sent direct by the justices. If a lunatic is seen by a justice of the peace, and he deems it to be an imbecile case he will send the case direct to the workhouse, or to the Metropolitan Asylums Board institution; but a considerable number of the cases are cases that become chronic with us, and are transferred there under Section 25.

4927. That has the advantage, I suppose, of relieving the asylums of those cases for which little or nothing can be done?—Yes; it does to that extent. I give figures here which show that 24 years ago we had 10,104 certified lunatics in the mental hospitals, and there were 5,566 chronic harmless lunatics in the Metropolitan Asylums Board's institutions, and on the 1st January this year we had 18,000 certified lunatics in our institutions, and the Metropolitan Asylums Board had 5,148.

4928. We have the exact figures, 18,918 in the Council's institutions and 5,148 in the Metropolitan Asylums Board's institutions. What strikes one about that is that while the population of the County Council's mental hospitals is very nearly doubled there is actually a diminution in the number of chronic and harmless lunatics in the Metropolitan Asylums Board's institutions?—Yes.

4929. Does that mean that they are full, or that they are not being used?—That means that we have to provide for more chronic lunatics than we did 24 years ago, and these institutions are also being used for cases of mental deficiency; that reduces the accommodation for the chronic harmless lunatics. It is an example of two authorities dealing with the same class of person.

4930. Then you are prepared, if necessary, to give us some information regarding the Maudsley hospital, but we are going to have a representative from that hospital who will give us all the details necessary; so I do not propose to take you into that matter beyond

2 December, 1924.]

Mr. HENRY FURSE KEENE, O.B.E.

[Continued.]

including in your evidence a note that there is such an institution of a special character. You can, I think, assist us by giving us a reference to the Parliamentary powers which were obtained by the County Council in 1915, enabling the County Council to receive boarders at the Maudsley hospital?—There was a short provision* in the London County Council (Parks, &c.) Act of 1915, by which the Council was authorised to receive as boarders and maintain and treat at the Maudsley hospital on such terms as to payment and otherwise, as it may determine, any person suffering from incipient mental infirmity who is desirous of submitting himself voluntarily for treatment, and to defray the whole or any part of the costs of treatment.

4931. Can you give us a copy of the Act which contains that?—Yes, I will send one to the Secretary.

4932. I would like to see the exact terms of it. And at Maudsley you have only voluntary patients?—That is so.

4933. Is it a feature again of Maudsley, without going into the matter fully at this stage, that you have an out-patient department?—Yes.

4934. A small charge is made, is it not?—For the out-patient department, yes, not exceeding 2s. for each patient.

4935. To avoid repetition I will not take the statistics of Maudsley from you, because we hope to have some detailed evidence upon it; we are specially interested in that. The principal features of it are the reception of boarders, the out-patient department, the facilities provided for scientific research, and for clinical instruction?—Yes.

4936. It represents, does it not, a new departure?—Quite a new departure.

4937. And is no doubt being studied by your Committee with special interest?—That is so.

4938. Mr. Micklem: Mr. Keene, would you kindly turn to your table of rates of pay and hours of duty that you have given us, and may I ask you first this: Have you any difficulty in filling the medical posts in the asylums?—No, not at present.

4939. There is a certain competition whenever a post is vacant?—Whenever we advertise. You were talking of the junior medical officers?

4940. I was thinking of the medical officers generally?—Yes. Whenever we advertise we get quite a number of applications.

4941. Both for senior and junior officers?—No, we do not advertise for the senior officers; we only advertise the junior appointments; all promotions are made from the staff.

4942. Have you any difficulty in getting the attendants?—We have a difficulty in getting women nurses—not in getting male nurses.

4943. I suppose they are obtained by advertisement?—Yes, we advertise very largely.

4944. Would you turn to item 66, nurse (staff), and 67, nurse (probationer), on page 4 of your *présis*?—Yes, I have it.

4945. Then would you turn over to page 6, 86, nurse (staff), and 87, nurse (probationer). I do not quite follow what the difference is there?—On page 4 you have the male staff. The attendants now are called male nurses. On page 4 you have the pay of the male nursing staff, and on page 6 the pay of the female nursing staff.

4946. Thank you. Then on items 66 and 67 you are dealing only with male staff?—Yes.

4947. I understand you do not wish to give any opinions, but you are confining your evidence to facts?—Yes.

4948. Miss Madeleine Symons: Mr. Keene, just following on what Mr. Micklem was asking you, in the case of a matron, or an assistant matron,—would they have to have general hospital training as well as training in a mental hospital?—We consider it very desirable they should have—I would not say it would be a *sine qua non*.

4949. I was wondering about that when you were saying they did have a chance of becoming matrons?—Laterly the Mental Hospitals Committee have shown a distinct preference for matrons who have had that training—general hospital training.

4950. And that would mean presumably as things stand that they would have to serve their probation over again—I mean they would have to put in a double period on probationer rates and conditions?—It would mean, if anybody is appointed from the staff, that they have had previous experience in a general hospital either before they came into the mental hospital service, or that after they came into the mental hospital service they had special leave in order to acquire knowledge and experience and a certificate in a general hospital.

4951. Were there some special difficulties with regard to getting staff at Horton? I understood that there you have taken uncertificated nurses, and I wondered whether there was some special cause for the difficulty in getting staff there?—All our probationer nurses are engaged as such, and they are trained while they are with us—they get their certificates while they are in our service. The difficulty is in getting the probationer nurses.

4952. I see. They were no special difficulties at Horton, it was just a difficulty that applied everywhere?—Horton mental hospital was for several years in use as a war hospital, and although some of the old mental hospital staff served in the war hospital, when it was reopened as a mental hospital, there was only a nucleus of the original staff remaining; therefore it was necessary to restaff the place, and we had a large number of beds there for women patients. Consequently we wanted a larger female staff. The difficulties were perhaps accentuated by the fact that it was a new hospital, and that such a large number of nurses was required.

4953. You told us, I think, that wherever the patients can pay the 24s. 6d. you put them on the private list?—Yes.

4954. I think when we had evidence from Dr. Bond he stated that they now added something to the cost of maintenance to cover interest on capital charges, and I wondered whether perhaps your practice varied?—We should endeavour to get that, if possible. That would be another 4s. a week, which would cover the interest on capital and repairs, but if we can only get the 24s. 6d. then we are bound to take that amount. We have been advised by Counsel about that; and so if payment is made to us instead of to the board of guardians, the patient becomes a private patient.

4955. On your dietary that you kindly supplied us with, do fats there include a certain amount of butter?—It would include any butter that is given, but butter is not usually given except to infirmary patients.

4956. Earl Russell: Just go back for one moment to the private patient, do I understand that if an additional 4s. were paid that would represent the whole cost to the County?—Yes, that would recoup the County for the whole.

4957. There would be no loss then at all?—There would be no loss.

4958. As to the enquiry you make about private patients is it one you make of your own motion?—We make enquiry wherever we have cause to think that there are means.

4959. It would be in cases where you thought the enquiry would be fruitful?—Yes; any information, either from the boards of guardians or from friends, or from the patient himself, that there are means, would set us on enquiry.

4960. Now I just want to ask you two questions about the practice of discharge. You know the provision in the statute that any three members of the committee may order the discharge of a patient without the certificate of the medical superintendent?—Yes.

4961. Have you ever known that power exercised?—Yes—not frequently.

* See Appendix XIII.

2 December, 1924.]

Mr. HENRY FURSE KEENE, O.B.E.

[Continued.]

4962. How often?—I have known that done some years ago in connection with the re-certification, where the medical superintendent did not feel that he could give a certificate; he did not recommend the patient's discharge, but the three members would sign the discharge. I remember only one case recently.

4963. Just to stop with your first case; in that first case it would not be, as I understand, against the superintendent's advice, but rather without his advice?—No, he had not sufficient evidence of insanity to give a continuing certificate.

4964. So that the patient would have had to be discharged in any event by somebody?—Yes, by the Board of Control.

4965. Now the other instance?—In the other instance more recently three members discharged a patient, not with the advice of the medical superintendent.

4966. Against his advice?—He did not raise any great objection to it.

4967. And did any harm come of it?—I have not heard of any.

4968. That is two cases in about ten years?—Several cases of the first kind; because one medical superintendent, the late Dr. Seward, thought that was the proper way of dealing with such cases.

4969. It became a practice in that asylum?—Yes, there might have been a dozen or so cases of that sort.

4970. But practically you have only known one case in which it has been against the advice of the medical superintendent?—It is the only case in my memory.

4971. I was going to ask you about patients who come in freshly certificated: Have you many cases where it has been thought that the certificate was improper, or that the patient was not of unsound mind?—We have a number of cases each year of patients who are found not to be insane.

4972. And there you mean the seven days' certificate is not given?—They are promptly discharged.

4973. Because the medical superintendent does not give the 7 days' certificate—is that it?—Yes, or he gives the certificate to the effect that they are not insane. It does not follow that the patient when certified or when seen by a justice was not insane; it may be the case has cleared up; but when the case got to the institution signs of insanity were not discovered, and naturally the medical superintendent would recommend the patient to be discharged by the committee promptly.

4974. Perhaps as you are not giving evidence on policy you would not express any opinion as to whether that was due to carelessness in certification or not?—I think it would be very very difficult to say it was carelessness.

4975. Mr. Snell: Mr. Keene, in the co-option of members to the Mental Hospitals Committee of the County Council it is the practice, is it not, to co-opt persons because of their fitness to render administrative service rather than to give specialised service such as medical service, and so on?—They are co-opted under the Mental Deficiency Act because of their experience, for example, as poor law guardians and their interest in the work generally.

4976. Is it always possible for a patient to make a complaint to a member of the committee privately?—Do you mean in a private room?

4977. Can he take the member of the committee in a corner, for instance, and speak to him so that attendants or doctors would not hear the conversation?—I doubt whether such a procedure would be advisable. You have to remember that in a mental hospital there are many dangerous patients, and it would not be safe for a member to have a patient alone.

4978. I understand that difficulty, but what I want to find out is whether when a member of the Mental Hospitals Committee or visiting committee goes round the ward, it is possible for a patient to make any complaint he has in the absence, say, of doctors, or of staff, who he might assume might be hostile

to him?—The patient could ask a member for a private interview.

4979. He could?—Yes.

4980. And that would be granted?—That would depend upon the decision of the member.

4981. Now would a letter of a patient be forwarded unopened to a member of the committee?—Yes.

4982. Would the same course be followed in the case of a letter written to any other member of the Council, say, than a member of the Mental Hospitals Committee?—It might or might not; I do not think that a member of the Council is one of the individuals specified in Section 41, but I know that members of the Council do get letters from patients, because I am frequently asked to express an opinion upon them.

4983. That would be at the discretion, would it not, of the medical officer under Section 41—whether it was forwarded or not?—Yes.

4984. Now if a doctor or medical superintendent refuses to pass on a complaint, the patient has no redress there, has he? Suppose a patient had the feeling: "Well, I know this visiting committee, I have complained before and nothing happens; I will write to a member of the Council who is not on the Committee"—if the doctor did not pass that on, the patient would have no redress?—He might complain to his friends, who could take some action by writing to members of the Council.

4985. His visiting friends?—Yes, his visiting friends.

4986. Suppose the patient wants to write a letter, say, to his lawyer or partner, or business adviser, or close family friend—that again is at the discretion of the doctor?—Yes, but I should think that a doctor would invariably send a letter on to a solicitor if addressed to a solicitor.

4987. Unopened?—I would not say unopened, because all letters are seen by the doctor, and he would have to see that the letter is a letter that can be sent out. We have had complaints of letters getting out of institutions which have caused a great deal of pain and trouble to people outside.

4988. But there are some letters forwarded to people unopened. Does the doctor see those? Those may also contain distressful things?—Those letters, if they are sealed, he would not open.

4989. So that you feel, out of your experience, that there is no real danger of any legitimate complaint that a man wishes to make to an outside person such as his lawyer being suppressed?—I do not think there is.

4990. Mrs. Mathew: Item 61, I think refers to the male nurses. I have been adding it up, and I think in the case of a person who has not had any rise his net earnings are £1 5s. 7d. a week. Is that right? That is with the deductions for board and lodging and washing?—Is this the head nurse?

4991. Yes, head nurse, male staff, page 4, item 61.—Yes.

4992. Am I right in thinking that before he gets his rise he only gets 25s. 7d. a week?—He would have about 30s. a week if he had all his meals except supper.

4992A. I suppose he would want supper, would he not?—Many of them do not; but as a matter of fact the head nurses do not live in the institution, they live outside. They take no meals; they have their breakfast before they come on, and then they have their dinner after they go off, so there are no charges here probably that would be made against a head nurse.

4993. I am sorry; I have been misled by the column marked "Remarks."—Yes; that is, if they do live in those would be the charges; but, as a matter of fact I should say there is hardly a head nurse who is living in the institution. If he has any of those meals inside he will have to pay for them.

4994. What are the hours?—The hours are 96 a fortnight.

4995. That is how many a day—eight hours a day. He would want some meals in the eight hours?—It comes to an eight-hour day.

2 December, 1924.]

MR. HENRY FURSE KEENE, O.B.E.

[Continued.]

4996. On an average it is an eight-hour day?—We have a scheme by which the men go on duty for one long day, that is from seven o'clock in the morning to eight at night, and that is one day in the week. The other five days in the week are short days; they go on at 7 in the morning, and they go off at 2.10. Then in the following week, the alternate week, there is the long day again, and four days they come on duty at one o'clock and go off at eight, and one day they come on at one and go on till ten minutes past nine.

4997. I quite follow. I do not think the charges are excessive. I was only trying to get at what they really receive a week, if they had these deductions for breakfast, dinner, board and lodging, and so on. Of course that would leave them really, if they never have any meals in the hospital, with £2 12s. a week for a head nurse?—But you have to put on to that the bonus—this is the basic rate. The bonus on 52s. a week is a fairly high one.

4998. *Chairman*: I should think it is between 20s. and 30s. is it not?—I should think it is quite that.

4999. It varies with the cost of living?—Yes, it is down a little bit now, because the cost of living went down to 70.

5000. *Mrs. Mathew*: About how much a week is it at present?—I am afraid I have not those figures* with me.

5001. *Sir Humphry Rolleston*: What is the age of retirement of the superintendents and the assistant medical officers—is that fixed?—Everybody in the Council's service is expected to retire at the age of 65, but a medical superintendent under the provisions of the Asylums Officers Superannuation Act can retire at the age of 55, and be pensioned if he has had 20 years' service.

5002. And the matrons?—To matrons it would apply equally.

5003. And the head nurses?—Yes, it applies to all the staff; they can all retire at the age of 55, and be pensioned if they have had 20 years' service. They would not be allowed to remain in the Council's service over the age of 65.

5004. Supposing that a nurse—it is a hard profession—began to wear out a good deal sooner than 65?—Yes, she can retire at the age of 55.

5005. Before 55 would she get consideration?—She would get consideration if she is permanently incapacitated. That would depend on a medical certificate, but she could not retire before the age of 55, unless she was certified to be permanently incapacitated.

5006. Are there many cases of that kind in which, without being absolutely incapacitated, it is obvious that the person is not what he was as a nurse?—I am afraid that is so.

5007. It is a difficult thing to arrange, I suppose?—It is the Act of Parliament which provides the age of 55. It does not differentiate between a man and a woman.

5008. Another point is with regard to the after-care of people who have gone out. The numbers are so enormous, that I suppose there is no internal arrangement for inspecting people after they have left. You depend, I suppose, on the After-care Associations, and so on?—Yes: the visiting committee has no duties in connection with a patient after a patient is once discharged recovered; but quite a number of cases from the London mental hospitals are looked after by the Mental After-care Association; some during the period of trial, and some after they have been discharged recovered; and we have fortunately in our service a fund, the Queen Adelaide Fund, which enables grants to be given to deserving patients on their discharge. In that way we are enabled to help; but it is all voluntary

effort, and there is no responsibility at all with the visiting committee.

5009. Those patients are ex-patients and they are put under the care of the After-care Association, by recommendation from you, and it does not depend entirely upon the friends?—No.

5010. *Sir David Drummond*: You gave us some statistics dealing with cases from 1895 to 1923; 881 patients were discharged recovered in 1923. Can you compare the results in 1895 with those of 1923? I should just like to know if the results are better than they were?—The admissions in 1895 were 3,221. The discharges "recovered" in the same year were 1,090, i.e., a percentage of 33·84 on admissions. The discharges recovered are not quite as high as they were.

5011. Not quite so good as they were?—Not quite so good.

5012. You referred to a certain number of cases discharged by the medical superintendent after a very short residence in the mental hospital. Is there a considerable number of that class?—Do you mean discharged as not insane?

5013. Discharged within a few days?—Last year I think there were six such cases.

5014. Is there an enquiry into the previous history of these cases—as to their nature and how they came to be certified? Do you know anything about that class of case in this connection?—The committee do not have the facts brought to their notice; they will only discharge a patient. The certification of the patient is not within the jurisdiction of the committee.

5015. I was wondering if you could give me any information. One is very anxious to know why these people who are discharged so soon were certified?—It is information I could obtain for the Commission if it is required. I could get a history of these cases.

Sir David Drummond: One wants to know, Mr. Chairman, something about these cases of only very short residence.

Chairman: I think Mr. Keene explained to us that these were cases which were possibly afflicted with a merely transitory attack of insanity, which might have justified the justice and the medical practitioner in certifying their insanity, but that the insanity had actually passed off.

Witness: Personally I do not know the history of these cases, but if it is any use to the Royal Commission I could get a report* on the six cases and send them on.

5016. It think it might be useful to us, as illustrative of the principle. Of course one would obviate that if we had a provisional system of dealing with cases which has been suggested more than once to us.

5017. *Sir David Drummond*: Can you tell me about the appointments to the senior position on the medical staff. Is it by seniority?—Seniority does count, but not altogether. It would be the ability of the doctor, and his degrees, and so forth.

5018. *Sir Ernest Hiley*: Mr. Keene, with regard to the figures you gave us of re-admissions, I think you said the percentage was 29·8?—Yes.

5019. Of whom 10 per cent. were re-admitted within 12 months?—Yes.

5020. Have you ever heard it discussed by your Committee as to whether or not that percentage is unduly high?—I do not know that the Committee have said it was unduly high. There was nothing to compare it with. We have no reason to think that the patients are too freely discharged from the London County mental hospitals.

5021. We had a witness at our last sitting from Norfolk who told us that the percentage of re-admissions was 3½ for the County of Norfolk. There is a very wide difference between that and your figure, and I should be interested to know whether the difference is attributable to the peculiarity of the

* Note.—The basic rate of pay for a Head male nurse is 52/- a week rising by 2/6 a week to 62/-. The present remuneration with bonus is 84/1 rising to 97/7. The charges for meals taken in the institution are: breakfast 8d.; dinner 1/1; tea 4d.; supper 6d. Charges for lodging and washing 9/11 a week.

* See Appendix XIV.

2 December, 1924.]

Mr. HENRY FURSE KEENE, O.B.E.

[Continued.]

population you have to deal with as compared with a rural population like that of Norfolk?—I should be interested to know what the discharges were in Norfolk—what the percentage of discharges was.

5022. Of course the figures for Norfolk are very much smaller as compared with those of the County of London; but, speaking from memory, I think the discharges are somewhere about 189 in a year?—I have not heard that these figures are high. I do not think there are many authorities who keep such figures as these. Of course these figures have been kept over a very long period of time, and you will find that the percentage is much higher in the older institutions than it is in the newer institutions. The newer institutions are gradually getting higher and higher in their percentage.

5023. Do you mean the percentage of re-admissions?—Yes, of re-admissions.

5024. I do not quite follow the reason why that is so?—The patients come back at some time or other. The longer you keep the records the more chance there is of them appearing in the figures. Now take the figures we have got at the different asylums: The percentage of Banstead is 31·28; Bexley which was opened on the 19th September, 1898, 25·70—that is after these figures were commenced. We commenced keeping records in 1895.

5025. When did you begin your record for Banstead?—In 1895.

5026. Then your percentages are not calculated over the same period—is that what you want to bring out?—That is so.

5027. How do you arrive at this 29·8 then that you gave us—over what period is that taken?—The whole period in the case of institutions that were in existence in 1895, and in the other cases from the time they have been opened.

5028. I see, it goes back to the opening of the institution?—No, to 1895 only; we start from 1895, and any institutions that have been opened since have been added. Bexley, for instance, was opened in 1898—that is three years after we commenced these statistics. Then we have Horton, which was opened in 1902 and Long Grove in 1907.

5029. That is an average over a period of years?—Yes.

5030. Are there any great fluctuations in comparing one year with another over that period?—I am afraid I have not got the percentage for each year; I have only got them in total.

5031. Might I just pass on to another point. Have you any record with regard to these ten per cent. who came back within 12 months—as to how many of those had been under the care of after-care visitors?—We have records at the institution, but we have not got them tabulated.

5032. Could you, without very much difficulty, get us that figure?—It would mean a lot of research into the records.

5033. I do not want to give trouble, but it would be rather interesting to know how many of those who came back once have been constantly visited?—I could get that for one institution. Would that suit your purpose?

5034. Yes.

Chairman: I think, Sir Ernest, we are going to have an after-care witness later on, who may be able to give you some information generally of that character.

5035. *Sir Ernest Hiley:* Very well. (*To the Witness:*) I should like just to go back to the figure with regard to the pauper patients whom you have turned into private patients, if I may express it in that way. You gave a figure of 308?—Yes.

5036. Is that for one year, or is that to be compared with the total of the admissions to the asylums?—That is the number we had on the 1st January this year.

5037. You compare that then with 18,918 patients?—Yes. I can give you the number of patients who

were transferred in one year, if that is of any use to you? We transferred during 1922, or during the year ended 31st March, 1922, 158 patients to the private list.

5038. Really it is a very small percentage of the total?—A very small percentage of people who can pay the full amount.

5039. That is after really careful and diligent enquiry by you, and by the guardians?—Yes.

5040. Then I just want to ask you one other question of another character altogether. Taking these scales of wages in connection with the female staff, do you deduct from the domestic servants charges for meals and lodging, and washing, and for board?—Yes.

5041. Although, I suppose, they sleep in?—Yes.

5042. Take, for instance, item No. 98, maid (domestic) with a maximum wage of 33s. 2d.—can you tell us how much you deduct in a year for board and lodging, etc.?

Chairman: You have to go back to the male nurses to find out what the deduction means.

5043. *Sir Ernest Hiley:* Can you give me an idea of what is the net wage that the domestic maid gets?—She has a net wage, after making deductions for all meals, lodging and washing, of 10s. 7d. a week at the minimum, and 18s. 6d. at the maximum. This is equivalent to a yearly wage of £27 10s., rising to £48 with “all found.”

5044. That is taking into account the bonus?—Yes.

5045. *Chairman:* Is it taking into account the bonus?—Yes.

Mr. Stewart (Representing the National Society for Lunacy Reform): On the question of the efficacy of complaints by patients to visitors, would you think it proper to put this question, Sir? Out of all the complaints made by the 18,918 inmates in 1923 how many of such complaints were followed by disciplinary measures against the persons complained of?

5046. *Chairman:* You see the point, Mr. Keene. You have a certain population in the asylums, and you have told us that complaints are received and dealt with. In how many cases have you had to deal with attendants in a disciplinary way in a year?—I have not the statistics, but I can say that the complaints are gone into very frequently by the sub-committee.

5047. You have told us about their investigation, but, as a result of investigation, in how many instances have you had to deal with attendants from a disciplinary point of view?—I have not got the statistics.

5048. *Earl Russell:* But you could tell us whether it is 10 or 100, could you not?—I am afraid I could not.

5049. *Chairman:* One wants to know to what extent investigation has shown that complaint was well founded, and required you to deal with your servants?—There again I will let you have the figures.*

5050. In some cases I suppose a nurse would be brought before you and reprimanded; in other cases I suppose a nurse would be dismissed. If you could tell us how many persons were reprimanded or dismissed in consequence of complaints made by patients in one year that would give one an idea?—Complaints may be made by the responsible officers.

5051. Quite?—You would wish that included.

5052. No. Patients' complaints followed by disciplinary action—how many instances will you have had of that in a year?—It would be very difficult to say, because a patient might complain to the medical officer, and that would result in the employee being brought before the committee.

5053. It may be that the patient goes first to the medical officer, and the medical officer brings it up, or the patient may bring the case up directly?—Yes.

5054. Perhaps you will give us the extent to which disciplinary action has followed in consequence of complaints made to you in the course of a year, and

* See Appendix XV.

2 December, 1924.]

Mr. HENRY FURSE KEENE, O.B.E.

[Continued.]

the form of discipline taken, either reprimand or some other form, or actual dismissal—that would give one a useful idea?—Yes. There were three cases dealt with by the visiting sub-committee on Monday last.

5055. That is rather interesting. On whose complaint did they come before you?—I was not present myself at the committee; my assistant was there, and he has only told me what took place. I fancy that these cases were reported by the staff. In one case I think a probationer nurse reported another nurse, and in the other case I think a patient complained.

5056. Was that case of one nurse reporting against another a case where that other nurse had maltreated a patient, or was it a squabble between the nurses themselves?—I think it originated with a squabble between the nurses.

5057. That does not interest us quite so much, but the other two cases were cases of alleged illtreatment of a patient?—Yes. I am afraid I cannot give the Commission the details, because I only just heard the report of my assistant who was at the committee.

5058. What happened in those three cases?—In one case I think the nurse was dismissed the service. In the other cases I think that the nurses were reprimanded.

5059. If you were not there yourself you cannot tell us about them, but you will be good enough to give us that general statistical information as to the number of disciplinary cases you have had to deal with for the year 1923?—Yes.

5060. Mr. Stewart: Resulting from complaints of patients to visitors—that is what we want to get?—It would be very difficult to make that distinction.

5061. Chairman: I do not see how you can. Of course you could tell, I suppose, whether the case you were dealing with was one that had been brought to the notice of your committee by a complaint made by a patient, could you not?—I think we should be able by our records to tell whether the complaints originated by a complaint to the visitors; but there would be very few of those, I think.

5062. Perhaps you can make a column of remarks at the end, and so far as you have information of that sort, give it us; it would be useful?—I could state

the origin of the complaint, whether it was through a complaint made to a visitor, or through a complaint made to a medical officer, and so forth.

5063. Where you have the material to do it, you could put it in a column of remarks.

5064. Earl Russell: Or through the chaplain?—Yes.

5065. Chairman: It is really in order to see what advantage is taken of the means of communication with the patients, and what effective step, if any, follows upon that?—Yes.

Mr. Stewart: I am asked to submit this question, Sir: Is it a fact that in order for a patient to be a paying patient, or to be transferred from the pauper class to the paying class, a payment in advance for four weeks of the minimum sum accepted by the Council's institutions is required.

5066. Chairman: Have you to pre-pay?—The answer is, Yes, usually.

5067. You must have an assurance that four weeks at least will be paid before the transfer takes place?—Yes. There is a very good reason for it, and that is that the Council is not allowed to incur any bad debts; the auditor would want to know a great deal about it, and somebody might be surcharged. If we take the responsibility away from the guardians who would always pay and accept it ourselves then we must see that we get the money, and we can only do that by making it a condition that the money should be prepaid.

5068. Earl Russell: That means £5?—Quite. But there are exceptions.

5069. Is 28s. the maximum sum which is ever charged in respect of patients transferred from the pauper to the paying status?—The sum at present is 24s. 6d., and 4s. 1d.—28s. 7d. The maintenance rate itself has been up to 39s. 1d.

5070. Chairman: I think the general question is this: Do you ever charge more than the existing maintenance rate for the time being, as the ticket of admission, so to speak, from the pauper to the private status?—All we ask is an extra 4s. 1d. to cover capital charges. We ask for that when we can get it.

5071. But you do not exact more than the current rate *per capita* of your institutions?—That is so.

Chairman: We are very much indebted to you for the most useful evidence you have given us.

(The Witness withdrew.)

Mr. WILLIAM GEORGE LOBJOIT, O.B.E., J.P., called and examined.

5072. Chairman: Mr. Lobjoit, are you Chairman of the Visiting Committee of the Middlesex Mental Hospitals?—I am.

5073. And an Alderman of the Middlesex County Council?—Yes.

5074. I think you are also Chairman of the Mental Hospitals Committee for the County of Middlesex?—Yes.

5075. Has the County got two large mental hospitals, and is it in course of providing a third?—Yes.

5076. I think you have had very considerable experience in this particular department of public work. You are an ex-officio member of the Springfield Standing Sub-Committee and also of the Napsbury Standing Sub-Committee?—Yes.

5077. Those are the two Sub-Committees of the two existing hospitals?—Yes. I have been a member of the Napsbury Committee for 17 years.

5078. And you have been for 5 years Chairman of the Sub-Committee of Springfield?—No, I have been Chairman of the full Mental Hospitals Committee for 3 years. For 5 years previously I was Chairman of the Napsbury Committee.

5079. I think you are aware of the Terms of Reference to this Royal Commission?—Yes.

5080. And you have come here to give us the benefit of your views on the matters that fall specially within your own cognisance?—Yes.

5081. As you are aware, we have to consider the adequacy of the existing safeguards against improper

detention of persons in asylums. Upon that matter do you hand us a report of your Committee on the question of proper precautions?—Yes, it is a report which we had prepared based upon the report of the London County Council Committee.

5082. I see that you incorporate in your report the report prepared by the London County Council Mental Hospitals Committee?—Yes.

5083. And having incorporated it, your own Medical Superintendents of Springfield and Napsbury add their reports?—Yes.

5084. We have had the advantage of reading the report, both the report that is embodied and the remarks of your own Committee, and the general purport seems to be that you think the existing safeguards are adequate?—Generally, yes. I cannot imagine any County Mental Hospitals Committee keeping anybody any longer than is absolutely necessary, particularly when we are so pressed for accommodation.

5085. I observe that the general conclusion that you reach, after considering the London County Council report and the joint report of your own two medical superintendents, is that you "are satisfied that all proper precautions are taken, both in the Springfield and Napsbury Mental Hospitals, against improper detention of patients, both private and otherwise, and that no alteration of the existing practice or regulations is necessary?"—That is so.

2 December, 1924.]

Mr. WILLIAM GEORGE LOBJOIT, O.B.E., J.P.

[Continued.]

5086. Now, as a person who has had to deal with the actual visiting of patients, do you find that you have many complaints from patients that they are being improperly detained?—One gets them occasionally. As a rule the more insane a patient is the more frequently he makes that sort of complaint.

5087. You do in fact, however, receive from patients, whether they are well founded or ill founded, a number of complaints upon that topic?—You cannot go round the wards without a number of patients coming to you and saying “Why cannot I be let out; why am I kept here?”

5088. Quite. What one is concerned with is that among those complaints it is conceivable that there might be a genuine case; and we should like your view as to the adequacy of the existing safeguards which would insure that every case which ought to be investigated is investigated?—Perhaps if I describe the general practice of a visiting committee, it would be the best way of answering your question.

5089. I think it would. We would like you to give us an account of your actual visit, and what happens?—I should say, of course, that the Mental Hospitals Committee consists of the visiting sub-committees of the two hospitals. Each visiting committee is independent, except for the making of the maintenance rate. When a visiting sub-committee visits the hospital the members are divided up into sub-committees again. One sub-committee is the house sub-committee which goes round with the medical superintendent a certain portion of the hospital every visiting day, in such a way that the whole of the hospital is covered in the course of two months. The visiting committee goes round a particular portion agreed upon for that day with the medical superintendent.

5090. We have had indications from some quarters that the visits are apt to be perfunctory; that there are a large number of patients to be seen, time is limited, and the visitors are often busy men. What one is concerned with is to know to what extent these visits are a reality, real visits in the sense that the patients know that here is somebody to whom they can speak and to whom they can look for sympathy and consideration. What has been your experience of that? Is there any personal element in the visit, as distinguished from what I may call the official aspect of it?—As a rule some of the members of the visiting committee are known to certain patients; that is to say, men who are prominent locally are usually known to the patients from their locality, and frequently that particular member stops and talks to the patients who know him and whom he knows. Any patient who wants to speak to the committee comes up and speaks to them, and if there is anything which, in the judgment of the Chairman of the committee requires further investigation, there is a discussion between the committee and the doctor and the nurse of the ward; and occasionally a patient is taken aside by the committee and talked to privately—in a semi-private way. I cannot conceive of any occasion on which the committee goes round when there is any difficulty in any patient seeing and speaking to the committee. Of course you must understand that in certain of the wards many of the patients are very noisy and sometimes very aggressive, so it is difficult. One must go by the advice of the medical superintendent. Frequently where a patient seems to be reasonable and sane a special consultation takes place between the committee and the doctor.

5091. What one is anxious about is to be satisfied that the patient really has access to the visiting committee. The possibilities of access seem to consist in the patient, so to speak, stepping out of the ranks and addressing the visitors. Is that so?—Of course there are no ranks; the patients are sitting about reading, or otherwise amusing themselves.

5092. I was using a mere figure of speech, of course, but I mean a person stepping forward and saying “I want to speak to you.”—They are sitting about reading or playing at games. In the case of very acute patients they are walking about and shouting.

Generally speaking, members of the committee go up and speak to the patients themselves and say “How are you to-day; how are you getting on?” and after a time you begin to know the patients; they have been there some time; you are not strangers to them; you know them and talk to them. Very often you know their idiosyncracies and you talk to them about them.

5093. But it has been suggested that the patients are deterred from speaking to the visiting committee by the attendants, who are averse from having any grievances ventilated in the presence of the visiting committee. Have you ever had any instance of that?—I have never seen any case in which an attendant has attempted to prevent a patient speaking. Of course you will realise that in the case of a very aggressive patient or a very noisy patient the attendant has to stand by.

5094. That one could understand.—In one of the very acute wards that we have, it would not be safe without the presence of an attendant, but in the majority of the cases the patients are quite quiet and to all outward appearance are quite reasonable; they are sitting about with no attendant near. It is only in the acute cases where the attendant is standing by, so-to-speak.

5095. But it has been suggested that cases have occurred in which a patient, for the very reason that he wrote or made complaints, was victimised afterwards by the attendant of whom he had made complaints. Have you ever come across anything of that sort?—We have had complaints, of course, of nurses or attendants maltreating patients; we have had them from the medical officer; and the practice universally with us is that whenever a case of striking a patient is substantiated the attendant or nurse is dismissed. The doctor always suspends them until the committee meets.

5096. I can see your method of paying your visit and possibly talking to some of the patients, and so on. Might it not be, however, that some of the patients were afraid to talk to you because they were afraid of what might happen to them afterwards, if they made a complaint against a rather unpleasant nurse of whom they were afraid?—I am afraid I cannot say that could not possibly happen; but speaking from my experience of going round and talking to them I cannot imagine how it is going to come about; you get complaints which are manifestly part of the delusion of the patients—I mean they are freely made. They are always looked into on the spot, but many of them bear on the face of them the fact that they are delusions.

5097. Of course, if a patient stepped forward and said: “I wish to tell you, Sir, that my food is being poisoned regularly every day,” you do not require to investigate whether the food is being poisoned regularly every day, because that is on the face of it an irrational complaint. But if a complaint was that the food was inadequate, or that a nurse was unduly harsh, or that medicine was being given when it was not required, or that there were insufficient sanitary appliances and things of that sort—would they be considered?—The provision of sanitary accommodation, for instance, is a question of the construction of the building itself. I cannot conceive how it is possible, with the procedure we have, for a patient to be prevented from making any complaint he wants to make. There is another way. Most of the patients are visited by friends, and the friends see them alone. If they have a complaint of that sort they will make it to the friend and the friend would write to a local representative on the Council, and that would come before the committee.

5098. What one is really thinking of is the existence of means of contact between the patient and the responsible outside authority. Is the medical superintendent always with you when you are going round the wards?—Yes. The medical superintendent or his deputy; they always go round with the house committee, certainly.

2 December, 1924.]

Mr. WILLIAM GEORGE LOBJOIT, O.B.E., J.P.

[Continued.]

5099. Have you ever had a patient saying that he or she would like to talk to you apart from the medical superintendent?—I do not remember a case where that request has been made. I know of cases in which the committee have taken a patient aside and talked quietly with him themselves, or one or two members of the committee.

5100. Supposing the patient, rightly or wrongly, wanted to tell you that the medical superintendent was not paying attention to his case, and was not investigating it and considering the propriety of his further detention or not, it is rather difficult for a patient to make such a complaint to you in the presence of the medical superintendent himself?—It is difficult for me to give you an idea, but except in the acute wards the committee scatter, and they are talking to patients all over the ward; frequently the medical superintendent goes on a ward or two in front of the committee or leaves a member or two of the committee behind talking to patients, particularly where they are known to them; so I cannot conceive where the opportunity of a patient speaking in a most private and intimate manner to a member of the committee would be prevented. Then there are the chaplains. In Napsbury, with which I am most familiar, there are three chaplains—Anglican, Non-conformist and Roman Catholic. Neither of them is resident in the place; they are all outside men brought in. The Anglican chaplain is the rector of a parish church in St. Alban's, who works with his curates; the Nonconformist chaplain is a retired minister who lives in St. Alban's; and the Roman Catholic chaplain comes in from St. Alban's. So these men are not officers of the institution in the sense of living there. They each of them have intimate and quiet converse with the patients. If the case you are visualising did occur, there could not be any difficulty in the patient speaking to his chaplain or to a chaplain.

5101. Do you get letters from the patients?—Yes; there are generally several letters addressed to the chairman of the committee on the chairman's table. There are some patients who write about four letters a day.

5102. I think those letters, being letters addressed to the visiting committee, have to be sent unopened?—Yes.

5103. And you get quite a lot of them?—I should not say a lot of them—probably three or four at a meeting; they usually come from the same patients. Then of course there is a box of letters which have been opened and not sent by the medical officer of the hospital, and these are examined by the committee.

5104. It is not left merely to the officers to decide whether a letter shall be sent on or not, but the visiting committee pass their opinion upon it also?—Yes; if the visiting committee think it should be sent, it is sent on.

5105. *Earl Russell*: If the Medical Superintendent thinks it a proper letter he may have it sent on without waiting for the visiting committee?—Yes; a great many are allowed to go out, but those considered not to be fit to go out are kept for the committee to see.

(After a short adjournment.)

5106. *Chairman*: Mr. Lobjoit, you were telling us before lunch that your committee gave its general approval to the report of the London County Council's Committee?—Yes.

5107. I have looked through the report of the London County Council Committee and I observe that there are one or two recommendations which they make. They draw particular attention to the question of the existing differentiation between a private patient and a pauper patient as regards certification. May we take it that the Middlesex County Committee share the London County Council's view that that differentiation should not occur?—Yes.

5108. In so expressing yourself, is your view that one medical certificate should be sufficient alike for

the pauper patient and the private patient or that there should be two certificates in each case—I would rather say that there should be two certificates in each case.

5109. There is this point to be considered of course, that two medical certificates cost more than one, and we have heard from previous witnesses that in the great majority of cases there is really no dubiety, and that a second medical certificate is more or less redundant. Do you not think the case would be met if there were liberty to call in a second opinion in any cases in which either the first doctor or the justice felt any difficulty in certifying, so as to obviate calling in two doctors for cases as to which there could be no dubiety?—Under the present procedure it nearly always happens that the medical opinion one gets in certifying a patient is the opinion of the doctor of the workhouse, who only sees the patient after he or she is brought into the mental ward by the relieving officer; and as a certifying justice I feel that one ought to be armed also with the opinion of somebody who had more knowledge of the patient than the doctor of the workhouse can have.

5110. That may be incidental to the present system under which the patient passes through the workhouse on his way to an asylum?—I am speaking, of course, of the present system.

5111. *Earl Russell*: But it is also rather peculiar to Middlesex, is it not, because in other cases where they have gone through the workhouse the certifying doctor has not been generally the workhouse doctor?—It is incidental to my experience; I have rarely certified a pauper case in which I have not had the opinion of the medical officer of the workhouse only.

5112. *Chairman*: One is not so much impressed by the mere number of certificates as by the value of the certificates, and at the present moment we have the two systems in vogue; two certificates for a private patient and one certificate for a pauper patient. I do not know whether your experience would show that there is any more risk of improper detention in the case of the private patient who has had two certificates than in the case of the pauper patient who has only had one?—What I feel is that in taking away the liberty of the subject one cannot be too careful to stop up every possible loophole of error.

5113. We entirely agree with that view.—And the responsibility of the justice is so great that I think if it is desirable that a private patient should have the safeguard—one assumes it is a safeguard to have the two medical certificates—the pauper patient also should have them. I think his liberty is as valuable as the liberty of a person who is able to pay for his detention.

5114: Of course the assimilation might take the form of only requiring one certificate in the case of the private patient?—I think in that case, if the one certificate were given by a specially appointed medical man for mental cases, one might agree to it.

5115. If one were assured that under the present system pauper patients, in consequence of there being only one certificate, were being improperly detained, that would be a grave state of matters and one would want to reinforce the safeguard of medical opinion; but if the experience has been that, with the justice of the peace and the single certificate, cases of improper detention are rare, then the adding of a new precaution at double the expense might not be justified in the public interest. You see the difficulty one has; we do not want to recommend otiose safeguards that are a mere tribute to apprehensions that are not justified. One wants to know whether there is a genuine apprehension and a genuine risk which would be safeguarded in the case of the pauper patient?—I certainly think the procedure should be the same in both cases, and if it is decided to depend upon one medical certificate, I think that there should be some person appointed who is specially qualified. You will realise that I do not want to say anything derogatory to the medical officers of the Unions at all. But manifestly they are not always men who are specially

2 December, 1924.]

Mr. WILLIAM GEORGE LOBJOIT, O.B.E., J.P.

[Continued.]

qualified to examine mental cases; and the responsibility of a justice is so great. If he feels he has got to refuse a certificate, as I have had to do in cases, I think it is throwing a greater responsibility upon the man who does his work for nothing than he ought to have.

5116. One has to balance so many considerations, as you will see. Again, if you have the liberty of the subject in the hands of the expert, rather than of the more or less ordinary practitioner, there is a risk that the public may say that the expert is inclined to find us all insane?—Of course you do not suggest that the justice should be done away with?

5117. No?—I think that the lay mind coming to it purely without any scientific bias at all is very important.

5118. Some safeguard of that sort is essential; it represents what you may call the public interest; but I take it that your suggestion is that the certifying doctor might be an expert in mental disease?—A doctor in the neighbourhood specially qualified and specially appointed.

5119. Do you think he would command more confidence because he had those special qualifications than if he were a general practitioner of standing?—Yes. I think it is largely a question of confidence—I agree. I do not think there are very many cases in which there has been wrong certification; it is largely a question of public confidence.

5120. I do not think it would be proper to recommend expensive safeguards which, as I say, were merely otiose, or merely a tribute to apprehensions which were entertained, but entertained without foundation. What one wants to know is what are the real risks?—In considering the matter one has thought of it from the other end rather; that if it is considered necessary to have two medical opinions to justify the detention of a private patient, the same safeguard should apply in regard to the parish patient.

5121. Perfectly; but if it is found in practice that a single certificate, and the justice of the peace in the case of the pauper patient has not resulted in improper detentions, then one would imagine that in the case of the private patient it would be equally effective?—Yes, and I think there is a good deal to be said for that particular point of view; but at the present moment where you have two systems, it is rather invidious.

5122. Yes, but as a large number of cases present no difficulty—and controversy has always arisen with regard to cases on the border line—does the idea commend itself to you that in cases where either a medical practitioner or the justice of the peace feels any difficulty, he should then be entitled to call in the assistance, if you please, of an expert or specially qualified medical man to supplement the medical testimony already received. How does that strike you?—I think that would be a safeguard. I think one would be glad to have it. The cases that I have in mind are cases of senile patients who have been in the infirmary and whose habits have become dirty, and so on; one would like to have another medical opinion besides the opinion of the doctor of the Union in such cases.

5123. Of course there is some doubt as to whether cases of mere senile dementia should be sent to an asylum at all?—Yes, but at the present time they are; that is the difficulty one has; the border line is so very close sometimes.

5124. Then we may take your approval of the London County Council report, subject to the observations you have made to us just now on the question of the two certificates?—Yes.

5125. There is another matter with which the London County Council deal in this report, and that is with regard to the desirability of having what are called receiving houses, that is to say, premises to which patients may be brought in the first instance with a view to their ultimate disposal. Do I take it that you and your committee favour the institution

of such places?—Of course the difficulty at the present moment is that you must first alter the law.

5126. But then we are here to consider that?—Yes. My own opinion is that any arrangement that can be made for securing the early treatment of cases is desirable. At the present moment the Middlesex County Council is concerned in the building of a new hospital, and we are trying to make arrangements so as to have a receiving hospital in conjunction with a London general hospital, in order that the patients can be received into this receiving hospital and receive the benefit of expert treatment—"team" treatment before passing on to the mental hospital.

5127. *Earl Russell*: Would it be technically a lunatic asylum?—It would have to be attached to it unless we could make arrangements for a section in connection with the general hospital.

5128. *Chairman*: But you could not detain there without certification, unless we have some alteration of the law?—Yes. I think that there is a great deal of, may I say, wrong sentiment in regard to the question of certification. I regard it as a safeguard to the patient. I do not think the stigma is in certification. The stigma is that the certification in so many cases comes through the Poor Law.

5129. I do not know that we should all agree with you upon that, Mr. Lobjoit. The fact that a person has been hall-marked as a lunatic, putting it in its most crude form, is a mark against that person which may affect his whole future life and prospects?—I am inclined to think that is only because of the surrounding circumstances that have attached to it; it is part of the old superstition about lunacy. What I feel is that if you are going to detain a patient at all—I may say I agree with extending the facilities for voluntary boarders—but if you are going to detain a patient against his will at all, I think certification is a safeguard to him, particularly with regard to his property.

5130. We have had suggestions made to us—indeed they are embodied in Lord Onslow's Bill—that the voluntary boarder system ought to be permissible in the case of public mental hospitals?—I agree to that.

5131. But that there should also be a provision for a limited period of notice before a patient can leave—72 hours, I think it is?—Yes.

5132. Now if you had a voluntary system coupled with this measure of involuntaryism, that the patient could be detained for, say, 72 hours, so as to allow time for certification if necessary, would not that meet the case?—I agree to that, but I think that the 72 hours is the maximum; and further, there should be certification. I think that the justice representing the general public should be brought in before a patient is detained against his will.

5133. Let us examine that for a moment and see if there is much hardship?—He comes in, first of all, voluntarily.

5134. And he recognises that he will be the better for treatment?—Yes.

5135. Therefore we are not dealing with a person whose detention has begun against his will?—No.

5136. The only case in which the involuntary detention might supervene would be a case in which a patient, having come in voluntarily, desires to get out, against his own interest?—Yes.

5137. The assumption in that case is that the patient has got worse probably, because if the patient has not got any worse he would probably still be of the same mind in wanting to get the benefit of the treatment?—Yes.

5138. In that case does it strike you that it would be a hardship to detain such a patient, who had begun voluntarily, for a period of 72 hours against his will, to allow of some protection being obtained for him?—No, I think that should be the maximum. It is quite necessary to bring in an independent mind on the question. He may be only said to be in voluntarily.

5139. What do you mean by that exactly?—A man may want *bona fide* to get out, but he may be detained for other reasons.

2 December, 1924.]

Mr. WILLIAM GEORGE LOBJOIT, O.B.E., J.P.

[Continued.]

5140. One would assume that the medical officer in charge of the institution would not wish to detain him if he were a voluntary patient and had recovered?—No.

5141. So that the hypothesis of the case really is this, that he is a person in whose interests compulsory detention is desirable, but who does not recognise that it is in his own interest?—Yes, I agree the 72 hours, but I think that should be the maximum time.

5142. Now you, I understand, are in favour of some provisional method of dealing with patients prior to certification, and you suggest that the three days, which is the present period before the justice has to decide upon the case, should be extended. Is not that one of your suggestions?—No. I think that three days is the utmost. What I suggest is that the urgency order which now applies only to private patients should be used for parish patients.

5143. Then let us follow that out. Of course the urgency order has to be reconsidered?—Yes. Somebody has to see the patient within two days as a petitioner, and then the order lasts for three days.

5144. After that, what should happen, in your view?—If the detention is continued longer than three days, then the justice should be called in to justify the detention for longer than the three days.

5145. Where do you contemplate the patient would be detained for longer than three days in the case you figure? Where would the patient be?—In an admission hospital. Failing the establishment of clinics in connection with general hospitals, I would suggest an admission hospital to a mental hospital.

5146. Because you would be reluctant to extend the period of detention in a workhouse?—Yes. My reasons for suggesting the application of the urgency order to parish patients was to switch off from the workhouse altogether, and to enable patients to be sent right away to the admission hospital of a mental hospital, which would have more entirely the atmosphere of a hospital.

5147. This part of your evidence proceeds upon the assumption that you have eliminated the workhouse altogether?—Yes.

5148. And that you have been successful in establishing, either in connection with general hospitals or independently, some form of receiving house where patients could be kept provisionally as voluntary boarders?—Yes.

5149. Subject to some limited restraint?—Yes.

5150. After discharge, have you in connection with the Middlesex asylums any provisions for after care?—We work in connection with the After-care Association. We have, in conjunction with London, the benefit of Queen Adelaide's Fund; two-thirds is for London and one-third is for Middlesex. I am one of the trustees. We make contributions to the After-care Association, and cases discharged from our hospitals are referred to them at the discretion of the committee. Frequently grants are made to individual patients from the fund, and sometimes those grants are administered by a member of the committee living near the patient, or sometimes by the After-care Association.

5151. Do you find that that is a valuable provision?—In certain cases, I think it is. I think the cases want selecting with a good deal of discretion, because people who have been in mental hospitals and have got out again do not want people fussing round and creating a continuing remembrance of the association; it is very much like the ticket-of-leave with the criminal; but sometimes, of course, it is very helpful indeed. Where a patient goes out manifestly weak, and wants cheerful advice and supporting and so on, it is very useful.

5152. Now you have been good enough to give us some records of your experiences on the committees. We shall not, of course, embody these lists that you have given us in our report, because they contain the names of patients, and we do not want anything of that sort to be published; but I understand that the purpose of your embodying your experience is

to show the attitudes of patients towards your institution so far as you are able to gauge it by the meetings?—I thought I should help you best by giving actual papers circulated to the committee.

5153. You have, of course, the patients who come before the ordinary meetings of your standing sub-committees?—Yes.

5154. And these are patients who are to be discharged, are they not? First of all the new patients come before you?—First of all there is a list of the new patients who have been admitted since the last meeting of the committee.

5155. Is that the first business at the meeting?—Yes; that is placed on the table; the members of the committee can examine the certificates under which the patients have been sent in; the case books are all on the table so that they can be examined.

5156. So that the committee considers the admissions since the last meeting?—Yes.

5157. Then do they have to consider the cases for discharge?—Cases for discharge are taken then, after the house committee has been round the hospital. Very frequently they particularly interview patients who are down for trial and not for discharge, and they also interview the patients who are the subject of petition. Relatives can always petition; they can petition at every meeting, if they like, for the release of a patient, and the committee is always bound to hear the petitioner.

5158. Do you keep records of any observations made by your patients when they are leaving you?—We always tell the patients that if they have any complaint to make they can make it now. We ask them to give their view as to how they have been treated.

5159. Do you see the patient on discharge?—Yes, the patient comes before the committee and the Chairman asks a few questions as a rule and generally tries to express a few encouraging words, and every patient is asked, "How have you been treated?" and what he says is taken down.

5160. Then you have furnished us in the case of these patients with the remarks they make?—I have given you the whole list for certain dates; I have not made selections. You will find there is one instance in which a patient did make a complaint. Our experience is that that is very rare indeed. It is on the first page.

5161. Yes, I have it.—She mentions the nurse's name, and said she did not wish the matter to go any further—did not wish the nurse to get into any trouble. It is dated 28th October, 1922.

5162. It does not seem to be a very serious matter, at the most?—I believe that has been the only one we have had.

5163. At any rate, what is of importance for us to know is this, that on the patient being discharged he (or she) comes before your committee, is asked whether he has any complaint to make, he now being more or less a free agent, both recovered and about to leave; and you have given us the records of a considerable number of cases, taken at random, and among those there is only one case of a complaint?—Yes.

5164. *Sir David Drummond*: May I ask whether any of these people whose statements on discharge have been furnished had made complaints during their residence in mental hospitals?—Of course I cannot answer that question. All I can say is that if patients make complaints we investigate them immediately.

5165. It would be very interesting to know if any of them made complaints during their residence in the mental hospitals?—There is one here who says she was not comfortable when she first came in; she misunderstood the nurses and so on; she probably was one who might have made a complaint at the beginning.

5166. *Mr. Jovitt*: Are the statements made after the patients have been notified they are going to be discharged, or are they made while the patients are waiting to know whether they will be discharged?—

2 December, 1924.]

Mr. WILLIAM GEORGE LOBJOIT, O.B.E., J.P.

[Continued.]

They come into the committee to say good-bye; one asks a few questions about them—one asks questions as to the attack, how it came about and so on, and tries to give them a little advice; and then the question is always put by the Chairman: "How have you been treated?"

5167. *Chairman*: If they like they can give a parting kick at the institution?—Yes; they are perfectly free agents.

5168. They would not have their discharge recalled because they turned upon you and said they had had a very bad time?—That is unthinkable, Sir. You will notice that we also give the weights on coming in and on going out: 7 stone going in, 8 stone coming out; 5 st. 13 lbs. going in, 7 st. 8 lbs. coming out; 6 st. 10 lbs. going in, 9 st. 11 lbs. coming out; 8 st. 10½ lbs. going in, 11 st. 3 lbs. coming out. That is always done at Napsbury.

5169. Judged by *avoirdupois*?—Yes.

5170. *Mr. Micklem*: Mr. Lobjoit, I observe that in your *précis* you suggest that whenever an order for detention is made, wherever, in short, there is certification, a register should be kept covering the name of the doctor and the magistrate who makes the order. What is at the back of your mind there; why is the register necessary?—First of all I feel that there is a certain atmosphere of haphazardness about the procedure. The relieving officer has to find a justice; he sometimes comes to the police court while we are sitting, and it is generally a job to find anybody who can spare the time to go. Sometimes it falls on an *ex officio* justice to go. I feel there should be no suspicion of haphazardness at all. Justices have said to me (it has never happened to me personally) that after they have declined to certify a patient, the papers have been taken to another justice without him knowing that they had previously been before a justice. I feel that if the justice had to initial his remarks on the case that suspicion could not exist, and it would do away with the sort of atmosphere of haphazardness which exists. I also think that as special justices are selected for dealing with private patients under the Judicature Act, so special justices should be selected for dealing with parish patients.

5171. There is some difficulty about that, is there not, where you have sudden cases of mania, where a magistrate must be called in at once?—Well, justices now are fairly numerous in places, and it would be quite possible to get enough justices. What I feel is that it should not be put upon quite a new man; it is a great responsibility. A man wants to know the ropes a little before he knows how to act. When I was an *ex officio* justice I was invited to go and deal with a case, and I remember then I felt I ought not to have been asked to do it; I had not had the experience. One does not read up the duties and so on when one is simply an *ex officio* justice.

5172. *Miss Madeleine Symons*: Mr. Lobjoit, at Napsbury and Springfield do you employ occupation officers to assist in arranging suitable occupation for the patients?—No.

5173. Do you find that can be done with your ordinary staff?—Do you mean in the hospital?

5174. In the hospital. It has been put to me that for those patients who cannot do the ordinary work of the house, either because they are bedridden or because they are not well enough, the arrangement of occupation for them, which is probably very desirable, is a matter which takes up a very great deal of time?—Of course, we have the tailor, the shoemaker and the people who make mattresses and so on; we have special officers for those; and patients who can do the work are detailed for it; and also in the case of the gardens and farm, about 100 patients work on the farm at Napsbury, and the gardener depends upon the patients' help for looking after the garden and greenhouses; but I do not think we have appointed any special occupation officer.

5175. Do you have any children admitted as patients?—At Springfield, not at Napsbury. At

Springfield we have children who have been in for years as part of an old system; we do not get fresh cases now.

5176. *Earl Russell*: With regard to the voluntary cases, Mr. Lobjoit, you know, I daresay, that 72 hours has been named as a maximum period, not because you could not get the man certified well within that time, but to give you a chance to communicate with his relations and friends and see what steps they would like taken?—Yes.

5177. It might be possible to remove him to their care rather than to certify the voluntary boarder, if certification became necessary?—Yes.

5178. It is rather felt that less than 72 hours might be not enough?—That is the Mental Treatment Bill, is it not?

5179. Yes. Of course, if it were a mere question of getting in the nearest doctor to certify, you could do it within 24 hours. It is rather with the hope of avoiding certification that the longer period is put in?—I quite agree; but that should be the maximum, I think.

5180. It is the maximum suggested. I see you say in your *précis* that you think "continuation orders might with advantage be signed by two members of the visiting committee." You mean the continuation order in which the doctor certifies the patient is of unsound mind and a proper subject for detention?—Yes, within the maximum period of 28 days. That is the continuation order. That is the provision, is it not, in the Mental Treatment Bill?

5181. Yes. You are not talking of ordinary certified cases. You are talking of the Mental Treatment Bill?—Yes. I do not agree with the suggestion that the visiting committee should see every patient at the anniversary of his coming in. I think one must depend upon the Board of Control for safeguarding the liberty of the subject there.

5182. You realise, do you not, with regard to what the Chairman was asking you about two medical certificates, that if you give a justice full authority to make the necessary adjournments of the case if he has any doubt, and full authority to call in a second medical man if he has any doubt, you would really achieve what you desire by having two certificates in all cases?—I think you would.

5183. You would not feel that there was any danger left over then, would you?—No.

5184. *Mr. Jowitt*: I want to ask you a question or two about the visiting sub-committees in relation to the question of discharge of patients. The great majority of cases which come before their notice are either brought to their notice by the medical staff or by the relatives of the patients?—Yes.

5185. Can you give me any idea at all as to the number of cases which they consider from the point of view of discharge which they themselves bring forward?—Do you mean the committee?

5186. Members of the visiting committee, as opposed to the medical staff and as opposed to the relatives of the patients?—I could not give you any numbers. I know that members of the visiting committee frequently come up to the committee and say that they have interviewed so and so, and as far as they are concerned he seems to be recovered and safe to discharge, and then the medical officer is asked there and then before the committee. I have known cases in which on the advice of the visiting committee a patient has been discharged whom the doctor has been unable to certify as cured—I do not say in direct opposition. I do not think, if a doctor had said, "You are incurring a great responsibility if you discharge this patient," the visiting committee would say, "Well, we think differently." But on occasions when the doctor says, "I am unable to say that the patient is cured, but I think it is a harmless case and probably no harm will be done if the patient is looked after," then the vote of the committee has been taken.

5187. The doctor is always present, is he, at the meeting of the visiting committee?—Yes.

2 December, 1924.]

Mr. WILLIAM GEORGE LOBJOIT, O.B.E., J.P.

[Continued.]

5188. The doctor would be in rather a difficult position, would he not, if the visiting committee brought up, so to speak, before themselves a case which the doctor had not reported to them?—I do not think so. I do not think that a doctor has ever felt himself in a difficult position in the matter. I can remember cases in which the visiting committee have brought up cases, having interviewed them on their going round the wards.

5189. Now let me put it to you: Supposing the doctor, when the name was brought up, said: "Oh, I think that patient is perfectly recovered," surely the retort would be: "Why did you not bring the name before our committee?"—I do not think that. If the committee discharge on their own responsibility a harmless patient, I do not think any harm would come about, provided that the committee see that the patient is properly looked after.

5190. Can you help me at all—it may be you cannot—as to what proportion of the number of patients discharged are discharged by means of a process which originates not from one of the medical staff and not from relatives?—I cannot give you any percentage or actual figures, but I should say it is a very small percentage indeed in my experience, but it has occurred and does occur.

5191. The visiting committee, of course, have no professional medical opinion or advice available to them except that of the local staff?—On the Middlesex committee there are two doctors.

5192. As members of the committee?—As members of the committee.

5193. Apart from that, there are no facilities for the members of the visiting sub-committee to call in a doctor from outside?—They can if they want to, or the patients can, or the patients' friends can call in a doctor from outside.

5194. Can the patient himself call in a doctor?—The patient can himself call in a doctor through his friends.

5195. But not without his friends?—I do not think there would be any objection. I do not remember a case having come forward. Of course, you could not say that every patient could do it, because those who were the worst would be the very ones to do it.

5196. And, as Lord Russell says, he has to pay for the doctor if he does call him in?—Yes, he has to pay for it.

5197. You are dealing here with a class of people who may be presumed, perhaps, to be slightly unbalanced, or to have been unbalanced. I want you if you will for this purpose to differentiate two questions in your mind altogether. First of all there is the question as to whether they have been ill-treated, and, secondly, there is the question as to whether they imagine they have been ill-treated. In your experience, and you have had a very large experience, whether the imagination is well-founded or not, have you formed the opinion that there are a lot of people who imagine they are ill-treated?—There are all sorts of delusions patients have, you know, but I cannot imagine any patient saying that he had been ill-treated by a specific officer and that that case would not be investigated. The officer would be called up and confronted with the patient first of all, and if there were any *prima facie* case the officer would be brought in before the committee.

5198. So that a patient who makes that sort of complaint knows that he or she is going to be confronted by the officer?—Yes.

5199. Does that happen very often?—No, I do not remember many cases; I do remember some.

5200. Now tell me this: Supposing a patient knows that that is going to be the result of a complaint, does

it occur to you as quite possible that that patient may anticipate that there will be some trouble for him or her in the future, if he or she makes a complaint?—Of course, you cannot say that such a thing is impossible, but knowing Napsbury as I do—I speak more of Napsbury because I am so much more familiar with it—I cannot for the life of me see how a patient would be prevented ultimately from appealing to the committee. If you visualise what happens: the committee do not walk through the wards in a bunch, with the doctor with them; they go into a ward and scatter about, and spend some time sitting and talking with the patients. The doctor and two or three members frequently go on a ward or two in front, leaving the other members behind talking to the patients; sometimes they have to be sent back for, so that I cannot imagine that there would not be plenty of opportunity for a patient telling a member of the committee quite quietly if that sort of thing had happened.

5201. What is sometimes said, you know, is that patients are afraid to complain, because they think if they do complain some hard treatment will be measured out to them?—Of course, knowing human nature as one does, I cannot say that that is impossible; I do not think any arrangement you could make could make it altogether impossible. But what I cannot understand is how the patient would be prevented ultimately from making a complaint to a member of the committee, and the moment a complaint is made it is investigated. One of the things we are strict about is that whenever a nurse or attendant is convicted of striking a patient, there is no appeal; that officer is suspended.

5202. I see; and the patient knows that if he or she makes a complaint it will be investigated, and, of course, that necessarily means investigated in the presence of both parties?—It must be so in the first instance. I do not see how it can be otherwise in justice to the attendant.

5203. *Sir David Drummond*: May I ask your opinion upon the proposal, for treatment of early cases, to institute clinics and special departments where the patients will not be certified? In your opinion, would it be more desirable to have these departments attached to a general hospital, or to a mental hospital?—I think to be attached to a general hospital would be the better.

Mr. Stewart (Representing the National Society for Lunacy Reform): Might I put a question through you, Sir, to this witness? In connection with the matter of certification, does the witness think that in doubtful cases it might be more helpful, instead of getting a second doctor, that the patient should have the assistance of a neutral person similar to the "prisoner's friend," for instance, in court martial proceedings, to elicit facts favourable to the patient?

Chairman: Will you take that point, Mr. Lobjoit?

Witness: I think that the justice is the "prisoner's friend."

5204. I meant, to assist the justice, so that the facts may be got out?—No. I view with a great deal of abhorrence the appointment of any more official persons in connection with this matter. He would, after all, be an official, and look upon the matter with an official mind.

5205. *Chairman*: I suppose one has to keep in mind the desirability of preventing the appearance of a court or of a judicial investigation as much as possible. I suppose that is what you mean when you say you do not want any more officials?—I think the more that you can bring it into line with ordinary hospital treatment the better.

Chairman: We are much obliged to you, Mr. Lobjoit.

(The Witness withdrew.)

2 December, 1924.]

Mr. WILLIAM EDWARD LOVSEY, J.P., and
Dr. T. C. GRAVES, B.Sc., F.R.C.S.

[Continued.]

Mr. WILLIAM EDWARD LOVSEY and Dr. T. C. GRAVES, B.Sc., F.R.C.S., called and examined.

5206. *Chairman*: Mr. Lovsey, I understand you are accompanied by Dr. Graves?—That is so.

5207. Is Dr. Graves Superintendent of the Rubery Hill Asylum?—Yes, and Hollymoor.

5208. You yourself, Mr. Lovsey, are an Alderman of the Birmingham City Council, and have been a member of that body for 24 years?—That is so.

5209. And have you been for 14 years a justice of the peace for the City of Birmingham?—That is so.

5210. A member of the Asylums Committee for 10 years and chairman since November, 1923?—Yes.

5211. You have had to work the existing code in so far as it falls within your province?—Yes.

5212. In the matter with which we are concerned, of certification, detention and care, have you encountered any difficulties in working the Act, any points at which you considered there might be improvement in procedure?—Only what I have suggested in the *précis* of my evidence.

5213. I understand that you consider it desirable that in the case of private patients as well as pauper patients the magistrate should see the patient?—I do.

5214. That is to say, he should see the patient before admission?—Quite so.

5215. Have you private patients in your asylum?—Yes.

5216. They have, of course, the right, if they have not been seen before admission by a justice, to ask to be brought before a justice within seven days, have they not?—I believe it is incumbent upon the medical superintendent to inform them that such is the case.

5217. Do you know if that has been taken advantage of to any extent by patients under your charge?—I cannot say that I have any personal knowledge of it at all.

5218. Then as regards the different procedure in the case of pauper patients and private patients, are you in favour of abolishing the distinction in the matter of certification?—I would place them exactly on all fours with each other, that is to say, I would treat the rate-aided patient exactly as the private patient is treated.

5219. Have you considered from the public point of view the question of the necessity for two certificates for every rate-aided patient?—I am certainly in favour of it. The committee have never discussed it as a policy, but I am certain that they would be quite in favour of such a policy.

5220. You see, what we are rather impressed with is this, that it might in many cases be superfluous. For instance, take cases as to which there can be no doubt at all: a second medical certificate merely means saying ditto to the previous one at double the cost. The real difficulty arises in cases that are on the border line?—Yes, but I would even go further than that. I would do it to allay any legitimate apprehension that certain people might have as to the probability of someone being incarcerated in a mental hospital who should not be so incarcerated, and if it were verified by a second medical man it might allay that apprehension.

5221. Let us examine that a little. I am not at all sure that there is not as much apprehension in the public mind that private patients are being improperly detained as there is that pauper patients are being improperly detained; and now every private patient has two certificates?—I should say there is more apprehension, probably, in the case of private patients.

5222. Is it the presence or absence of two certificates that really is the important matter from the point of view of allaying public apprehension?—To be perfectly candid, speaking for myself at the moment, I do not raise any objection at all from the point of view of there being only one certificate, because I am convinced that every inmate in our institution is there justifiably; but I repeat that I do appreciate that it is possible that others do not

agree with me, and I would do it to allay their legitimate apprehensions.

5223. But the whole question which we have to consider is whether the apprehension is legitimate?—I have not any doubt about it. I am certain it exists—wrongly, I think.

5224. But the question we have to consider is whether the second certificate which you suggest would really have any substantial effect in allaying such apprehension?—Only that there is safety in numbers.

5225. Apparently the doubt is entertained even more in the case of the private patient, who has already two certificates?—Yes, I am afraid that is so.

5226. If the doubt exists, and exists in even stronger form, in the case of the private patient, how are we to allay anxiety in the case of the pauper patient by giving him another certificate?—Might I reply to that by putting a question to you, Sir?

5227. If you will?—Why should a man or a woman who is a rate-aided inmate not be treated exactly the same as a private patient? That is the question that is frequently put, and it is really hard to answer.

5228. Personally—I am only speaking for myself—I do not think there is any answer. But it may be that the assimilation should be in the form of having only one certificate for the private patient?—Probably that would meet the case. I think the contention is verified rather more in the case of a private patient than it is in the case of a rate-aided patient.

5229. The way I am putting it is this: Every new formality that one adds costs money; money is in one sense unimportant, contrasted with the question of public safety and public assurance, but, on the other hand, before any additional safeguards are devised, any Commission would have to be satisfied that they were of real value and therefore value for money, if I may so put it, and that they were not empty formalities?—Quite.

5230. I suggest for your consideration this, that whereas in the general case there is very little doubt at all of the insanity of a person brought before a justice, there are a certain number of cases as to which there is really room for doubt; and that if in those cases a second opinion were called for by either the justice or the doctor, so as to protect such a case, in that way you would get an adequate security without the formality of having two certificates to certify a raving lunatic, so to speak. How does that idea commend itself to you?—There is a good deal of truth in what you have said, Sir. As a matter of fact I do not think the question would have ever been raised, were there not the differentiation between the two classes of patients.

5231. That of course at once leaps to the eye, and does not seem to have any justification. The protection of one is just as important as the protection of the other, of course?—Exactly so.

5232. The question we have to consider is what is the best form of protection for both. Do you say that it is necessary for the protection of both that there should be two certificates?—I did not start with that premise, Sir. My contention is that if it is deemed necessary for the one, equally it is necessary for the other. That is the sum and substance of my submission.

5233. And the differentiation is liable to cause the feeling that the one class is not so well protected as the other?—That is the gist of the whole thing.

5234. But what we are particularly concerned with is to see that all classes are adequately protected, either by the existing law or by some modification of it?—I am sure of that.

5235. What one wonders is whether the existing system, modified in the direction of assimilating the rate-aided cases to the private cases, would be suffi-

2 December, 1924.]

Mr. WILLIAM EDWARD LOVSEY, J.P., and
Dr. T. C. GRAVES, B.Sc., F.R.C.S.

[Continued.]

ciently protective, by having the justice of the peace or judicial authority, plus a medical certificate of one practitioner, coupled with the right to call in an additional opinion in any case in which either the justice of the peace or the medical practitioner had any doubt at all?—And who would determine that, Sir?

5236. Of course, again you would have to leave it to the medical practitioner or the justice of the peace, who might have some doubt?—Quite.

5237. Either of them should have the right to say, "This case must not be disposed of without an additional opinion"?—I quite agree.

5238. In any procedure that you have, at some time or other one has to rely upon the discretion of somebody who is carrying it out. The whole point is at what point are we to rely upon the safeguard?—Would not that largely depend upon the condition of the patient under discussion?

5239. Yes, that would be the obvious fact; but if a person were brought before a justice of the peace in a condition in which even a layman could have no doubt whatever, would another certificate, at the cost, I may remind you, of an additional guinea, probably be of any real value, do you think?—Only, to fall back upon what I have submitted, to allay the apprehension. I might say that in the case of patients I have seen prior to signing orders for their admission, as a layman I should have no doubt whatever in my mind as to the legitimacy of those persons' detention.

5240. That is interesting. You have had considerable experience, have you not, in acting as a judicial authority in private cases?—Not in private cases.

5241. You were acting as justice of the peace in certification?—Yes.

5242. You must, of course, have seen the patient yourself?—Yes.

5243. Do you say that in a considerable experience you have never had a case in which there was any doubt present to your mind as to the insanity of the person before you?—Not the slightest. It would be obvious to anyone who had small powers of observation that it was a fitting case for detention.

5244. Apart from a perusal of the medical certificate?—Absolutely.

5245. Is not that rather unusual, that you have had no cases that presented any difficulty to your mind? Cases are not always easily discernible by the layman?—I do a lot of knocking about amongst people of all descriptions, particularly the class of people who find their way into our mental hospitals. Whether it is because of that or not, I do not know, but I have not the slightest difficulty in my mind in declaring that that person was a fitting subject for detention in a mental hospital.

5246. Then you have no cases which have been border line cases in your experience?—No, they will have been well over the border.

5247. Another matter you wish to draw our attention to is the number of aged persons who are sent from the workhouses to asylums because they show signs of mental unsoundness towards the end. What is your view about them?—Well, Sir, it does appear to us, as a committee, undesirable to have sent to our mental hospitals men and women who are fairly aged, who show no signs of insanity, as I should term it, but who are suffering more from senile decay or ultra-senility. It does appear to us undesirable that people who have been in the workhouse, either in what is known as the body of the workhouse or in the infirmary for years, simply because they have become rather troublesome and probably certifiable should be certified as being insane, and sent to the asylum, to end their days in such an institution. The friends and relatives resent it, and it is hard work to convince them that the patients are mad. They contend, and we think rightly, that they should be

allowed to remain in the workhouse or workhouse infirmary to end their days rather than end them in a lunatic asylum. It is looked upon as being a stigma; in fact, they look upon the stigma of lunacy as being more pronounced than the stigma of felony, and they would prefer to remain under the parochial authorities rather than be sent to a lunatic asylum, and I personally very much share that objection.

5248. Of course, we know that there is a hope that these unfortunate associations with asylums may diminish as time goes on, with more enlightenment and improved administration?—It is a long way off, I am afraid.

5249. You think the stigma will remain for some time to come?—I am positive of it, it is so deeply rooted, particularly among the working classes and the poorer section of the community. It may or may not be so with other classes, but I know it is with those particular classes.

5250. Various expedients have been suggested for getting rid of it, such as associating mental wards with general hospitals, so as to give the impression that it is just a form of illness like any other illness, or by associating cases which are not certified with the asylums and allowing voluntary boarders to enter for voluntary treatment without certification, in order to avoid the idea that every person who went to an asylum was necessarily certified as a lunatic. Do you think that some expedient of that sort would help to remove the stigma?—I think it would. It would then be known that a man or woman could enter voluntarily, and it would help largely to mitigate the objection that now obtains. The question of allowing voluntary boarders to enter our institution has my hearty approval, and also the approval of the committee of which I am a member.

5251. If there were boarders in your asylum it would not be the case that every person in your asylum was a certified person?—No. Might I give an analogous case to that which you have just suggested, Sir?

5252. If you please.—Prior to the war there were many (without giving any numbers at all) people who were very ill, who would never allow themselves to be removed to a workhouse infirmary. During the war we all know that those infirmaries were used similarly to a general hospital, and to-day we find in Birmingham, and presumably right up and down the country, that the workhouse infirmaries are taking in what one might call paying guests; and that has to a large extent broken down the antipathy that existed prior to the period I have just mentioned. So that I think what you have just suggested is a very good idea and would help largely to break down the objection that one has to allowing one's friends to enter a lunatic asylum. I think it is an analogy, Sir.

5253. You want to get away from the idea of a place in which all the persons are stamped with the hall-mark of certification?—Either as paupers or lunatics, exactly.

5254. Now as regards the important matter of detention, you, of course, have been on the visiting committee, have you not?—Yes.

5255. Is it Rubery Hill?—I am on the Winson Green sub-committee and the Rubery Hill sub-committee, which of course form the full committee when combined.

5256. As a member of those committees do you visit the institutions yourself?—Yes, frequently.

5257. There seems to be prevalent an idea that patients do not really get access to the visitors and talk to them about their grievances, and that the visits do not afford a real opportunity to patients of communication with the outside world through the members of the committee. Will you give us your own experience, Mr. Lovsey? To what extent have you found patients taking advantage of your presence to discuss their troubles with you?—Well, Sir, whenever one visits the asylum one is always approached

2 December, 1924.]

Mr. WILLIAM EDWARD LOVSEY, J.P., and
Dr. T. C. GRAVES, B.Sc., F.R.C.S.

[Continued.]

by many inmates who are always ready to lay before you their troubles, and particularly their desires to obtain their discharge. Every facility is granted to any inmate who wishes to approach any member of the committee. They are always listened to with great care and attention, and if they have made an impression upon any member of the committee, they are particularly mentioned to the superintendent, and, again, the superintendent is very willing to listen to the impressions which have been made after conversations with the patients.

5258. Of course you must rely, I suppose, to a considerable extent upon the medical superintendent, must you not?—Undoubtedly.

5259. Suppose a complaint is made to you by a patient who says that he or she is ill-treated, and then you refer the matter to the medical superintendent afterwards, and he says: "Oh, you need not listen to him, that is just one of his delusions"—what would happen then? What would your own attitude be if that happened in one of your cases?—It does not follow at all that we should accept the dictum of the superintendent. If we thought that the patient had just cause for a complaint, an inquiry would be instituted; they have been instituted before now on more than one occasion.

5260. I think in your institutions you show a considerable degree of independence with regard to your medical superintendent; because you have discharged patients, I believe, against the wishes of your medical superintendent, or at least without his approval?—Yes. You are referring now obviously to the case I mentioned in my *précis* of evidence?

5261. Yes?—That is so. Might I explain how that happened?

5262. If you please?—It was a case of a man who was admitted into the asylum after an attempt to commit suicide. His wife and friends thought he had sufficiently recovered and they made an application to the committee for his discharge. I happened to have known the man personally and his friends, and they approached me, and I interceded personally on behalf of the patient.

5263. What were the medical superintendent's views about it?—I was just coming to that. The medical superintendent warned us that it would be rather a dangerous thing to allow the patient to take his discharge. Well, Sir, we politely ignored the warning of the medical superintendent and the patient was liberated.

5264. That would take place before three members of your visiting committee?—That was before the whole sub-committee. The patient was liberated, and within a few weeks of his liberation he drowned himself, and strange to say, I met the patient himself, as he was evidently on his way to do it, as it only happened within an hour or so after my seeing him.

5265. When you saw him did he seem to be all right?—Quite all right.

5266. Although he was on his way to commit suicide?—Yes. Of course the way we should argue in a case like that would be this, that when a man or woman who had attempted to commit suicide is taken before a magistrate, invariably the case is adjourned for a month by the magistrate and at the end of that month that individual is discharged, and we argue that if the justices are prepared to take that risk, we, in that particular case, felt that we were not doing a deal of harm if we took a similar risk. We did it, and, if I may say so, it has taught us a lesson.

5267. Of course it is exceedingly difficult to diagnose the state of mind, and it is particularly difficult for a layman, even an experienced layman, to know?—Just so.

5268. Pursuing the question of your visits, do you think it is possible that patients might be afraid to put complaints before you, lest they might be hauled over the coals by the persons they complain

against. A tale-bearer, even in ordinary society, is not much appreciated?—Quite so.

5269. And it has been suggested that patients might have it made worse for them if they went and complained to the visitors?—That is quite a natural conclusion, I think; but replying to your question generally, it is rather remarkable the few complaints that one does meet with as to any individual or individuals. On the contrary, one has had expressions of appreciation of the help the staff have given to the patients.

5270. Of course the hypothesis of my question was this, that the complaints did not reach you at all, because the patients were afraid to make them?—That is not my experience at all.

5271. On the other hand, have you had patients coming before the committee with complaints?—Yes.

5272. And have such cases been investigated by you?—Yes—not in every case, because they have been so trivial. We have not really thought it necessary to investigate them.

5273. Have you found to any extent that the attendants are liable to lose their temper or to ill-treat patients? Have you had any disciplinary cases to deal with in recent times?—If I were to say that we have not had cases where an attendant has lost his temper, it would not be strictly accurate. We have had one or two cases where they have lost their temper, and it is a marvel to me, if I may say so, that the attendants really keep their temper as well as they do. We instruct all the attendants, male and female, that under no circumstances, whatever provocation they might receive from the patient, must they retaliate, and I believe on the whole that that is loyally adhered to by the attendants.

5274. One can readily realise that the provocation in many cases must be very severe?—Extraordinary provocation. I will give you a case if I may. It was in the airing court, and a female nurse was there, of course, with the patients, and without the slightest provocation one of the patients went up to this lady, making use of a vile expression, and struck the nurse a violent blow on the face. I am afraid if I had been the nurse I should not have taken it so philosophically as she did, but she did; she acted like a heroine, and I am afraid that is probably only one example of what happens on many occasions.

5275. One can well understand the strain to which the attendants are put. Now have you, in point of fact, had to dismiss any attendants in recent years for ill-treatment of patients?—There was one occasion where a patient did bring a charge of alleged assault against the attendant. We could not get any reliable corroborative evidence, but we had it at the back of our minds that there was more than a semblance of truth in what the patient said. The attendant, being a probationer, was told that his services would be no longer required; in short, he was dismissed.

5276. Then you must have been pretty well satisfied that the story was true, or true in part?—I have just admitted that while we had no corroborative evidence, there was more than a semblance of truth in the patient's story. On the other hand, we were convinced that the attendant had had great provocation, but he was comparatively a new hand who had not become inured to his surroundings, but, still, the man's services were dispensed with.

5277. Is that the only case in which you have had to dismiss an attendant within recent years?—That is the only case I can remember during the whole of my service on the committee.

5278. Have you had to reprimand in any cases?—No, that is the only disciplinary case of such a character that has been dealt with in 10 years.

5279. Then you have had complaints of ill-treatment which you have investigated, and is that the only one in which you have found what you call a semblance of truth?—No. We have had cases where

2 December, 1924.]

Mr. WILLIAM EDWARD LOVSEY, J.P., and
Dr. T. C. GRAVES, B.Sc., F.R.C.S.

[Continued.]

patients have made a complaint that they have been rather roughly treated, but when we investigated the charge it was found probably that the patient had had a fit or had become very obstreperous, and that it had been necessary for the attendant to hold him or her down, and the patient had been under the impression that he or she was being ill-treated in a culpable way.

5280. Is there anything else you would like to put before us that we have not elicited from you?—Yes, if I may do so. I am certain that a deal of the opposition and adverse criticism that are meted out to those who administer the Lunacy Acts, and those who are employed in our institutions, largely comes from, as I have said in my evidence, busybodies. I say it advisedly, because I think I know what I am talking about. I know some of these people. Every locality has got them. My experience is this: There is a certain section of the public who are never happy except when they are blaspheming the people who hold public positions. I hear a certain amount of dissent from the members of the public who are present, but that is a proof that I am not pleading to the gallery when I make that statement. If this is considered in any way irrelevant I will not pursue it, but I feel very strongly on the matter.

5281. I think every public official who does any form of public work is exposed to criticism both adverse and favourable; it is an incident of public life?—That is all that he or she expects. Take that case quoted in the *précis* of my evidence with regard to what was stated in the election literature.

5282. I am afraid we cannot go into that; that is a very large topic?—Yes, but my point is this, that it is statements of that character that keep alive and foster the prejudice meted out to institutions like lunatic asylums.

5283. There is no doubt that the subject matter with which you have to deal in administering the Lunacy Laws is peculiarly subject to sinister suspicions; the subject matter you are dealing with is peculiarly open to that class of suspicion. That is one of the difficulties. I do not suppose you mean more than this, that people who have to administer a subject which is so suspect are more exposed than probably any other persons to adverse criticism?—I think they are in connection with the administration of the Lunacy Laws.

5284. You have yourself spoken of the stigma which attaches to lunatics; therefore the whole subject itself is apt to be invested with a more than usual degree of suspicion?—Quite so.

5285. You would welcome any means that could be taken to allay such suspicion, and to remove the causes of it?—Absolutely.

5286. *Miss Madeleine Symons*: Mr. Lovsey, is there any reason for the transfer of this considerable number of old people from the workhouses to the mental hospitals in Birmingham?—I believe the real reason is, or largely is, because of the want of space in the workhouses; it is a case of overcrowding; that is the primary reason why we get them.

5287. Probably your asylum rate is not any lower than the workhouse rate?—In our case it is lower.

5288. Do you think that may have anything to do with it?—I do not think so at all. Whether it is because the attendants in the workhouse have not the same experience in dealing with people who are deemed to be mad or not, I really do not know.

5289. *Earl Russell*. Might I suggest to you, Mr. Lovsey, that perhaps one method of dispelling this prejudice of which you speak would be for people like you, who know what an asylum is really like, to give an occasional popular lecture upon the subject, so as to get into people's heads the fact that it is a place for treatment like sick treatment, and not a dungeon?—I am afraid if I were to do that, if I were to point out the advantages of an asylum over a workhouse, we should have more than we wanted.

Earl Russell: Did we not have some evidence from Birmingham of a certifying justice?—

Chairman: Yes, Mr. Lord and Sir John Barnsley.

5290. *Earl Russell (to the Witness)*: You have certified cases also, I understand, in Birmingham?—Yes.

5291. Do I remember rightly that in Birmingham it was the habit to take them direct to the mental hospital and not through the workhouse?—Quite. They come from their own homes largely, and sometimes we get them from the police.

5292. Generally direct to the asylum and not through the workhouse?—That is so.

5293. Is the patient generally brought to the justice, or does the justice go to the patient?—In my case they have taken me to the patient.

5294. You do not generally, I suppose, bring the patient anywhere near the police court if you can help it?—Not if it can be avoided—never—except when it is a police case, of course.

5295. And if I remember rightly, the other certifying justice who gave evidence said that he had never had any difficulty in the cases that were brought before him—he never had any doubt?—Were they not dealing with private patients?

5296. No, I do not think so; I do not recollect that they were. Now I want to ask you about a sentence in your *précis* in which you say “The committee have on several occasions, against the advice of the medical superintendent, taken full responsibility and have either discharged the patient or allowed him or her out on leave of absence on trial.” Do you mean that although the medical superintendent said the patient was not fit to go out, the committee have sent him out under the three signatures, as they can do?—Yes, and excepting the case that I quoted to the Chairman I do not know that anything serious has happened; it was never reported to us.

5297. Are those cases where the medical superintendent did not say it was dangerous, but said he did not consider the patient was cured?—Yes, that is so, exactly.

5298. If he had said he was dangerous, you would not have done it, I suppose?—We should have hesitated, undoubtedly.

5299. Would you have done it just the same if he had said it would be bad for the patient's ultimate chance of recovery?—I am positive we should not have done it.

5300. But you see it is a considerable responsibility to take, for three lay members of the committee entirely to disregard the medical superintendent's advice?—Yes, but let me say it is not done very often; I have, however, known of cases where it has been done.

5301. You finish, I notice, by saying that the “results have not always been satisfactory from the point of view of the life of the patient”?—I said that in view of the case that I have just mentioned.

5302. *Mr. Jowitt*: I want just to follow up Lord Russell's line of thought, Mr. Lovsey. You have told us of this case of the man who committed suicide. How many cases have there been that you can recall?—Not another at all.

5303. Then may I take it, that in only one case to your knowledge at the present time have the visiting committee acted without the approval of the medical officer?—No, I do not say that. I thought you meant how many cases do I remember where we have acted against the medical officer's advice that we should not let the case out, and it turned out badly.

5304. No, I am asking you about the general principle. In how many cases have you acted without the approval of your medical officer?—I should say, at the very outside, in my 10 years' experience, it would not exceed 15.

5305. The number surprises me very much; it seems to me a large number?—In 10 years?

2 December, 1924.]

Mr. WILLIAM EDWARD LOVSEY, J.P., and
Dr. T. C. GRAVES, B.Sc., F.R.C.S.

[Continued.]

5306. Yes?—I do not think so, if you will allow me to say so.

5307. You used a very significant phrase about the case you were telling us of, the man who committed suicide; you said that it "taught us a lesson"?—Yes. I mean as far as a suicide is concerned.

5308. Was the particular lesson that it taught you this: that in future you were not going to let people out without the express approval of the medical officer?—I should hesitate once or twice before so doing.

5309. It means to say that in future you will, perhaps wisely, be slow to disregard medical opinion?—No, not necessarily that far. I said in the case of a man who had been admitted into the institution as a result of an attempt to commit suicide, yes; but in an ordinary medical case I do not know that if I thought I was justified, even against the doctor's advice, I should refuse to allow that patient to go out.

5310. We shall agree about this, I think, that as the result of the case you have mentioned, the opinion of your medical officer will weigh with you very greatly?—As it should do.

5311. Now I want you to help me on this point. Does it occur to you that the safeguards existing to-day may be sufficient in that very few people who are not properly certifiable get into an asylum?—Would you mind repeating your question?

5312. The safeguards to-day are such that the people who are certified are, in fact, insane at the time of certification?—Yes, I believe so.

5313. Let us assume that for the time being. The treatment in hospitals is such and so skilful that fortunately a considerable number of these people recover?—Yes.

5314. Now I want you to consider with me, if you will, the difficulty under which a person who was rightly certified, but who since certification, through the treatment, has recovered—the difficulty which that person has in getting out. Do you follow that?—Quite.

5315. And you know the old proverb, "Give a dog a bad name and hang it"?—I have heard it before.

5316. Does it not occur to you that it is probably much more difficult for a person who has been certified to get out than for a sane person to be certified?—Yes, to a large extent, but it is a question of placing confidence in your medical superintendent.

5317. Now really it comes to this, does it not, that apart from 15 cases in 10 years, that sort of case, a patient's only chance of getting out is if he can win the approval and support of the medical officer?—I think obviously so.

5318. It is perhaps inevitable, but that is the fact?—Yes, exactly. Apart from that, of course, his friends can bring the phase of the patient's condition before the doctor, who will then inquire into it, probably.

5319. But in practice that means calling in another doctor, and that involves expense?—I do not mean exactly that.

5320. But it does involve expense, does it not?—It would involve expense, but I do not exactly follow as to bringing in another doctor.

5321. You do not mean bringing in another doctor?—I do not think so.

5322. That, again, is a case where you would depend upon the report of the medical officer?—Yes, entirely.

5323. Now let us look at it for the moment from the point of view of the medical officer. Letting a patient out is obviously incurring a considerable amount of responsibility?—Yes.

5324. I mean to say even medical officers, I presume, are human?—Exactly.

5325. And the medical officer is bound to ask himself, "Well, if I let this fellow out and he goes and

commits suicide, or something goes wrong, there will be an awful lot of trouble about this"?—It would depend. If the patient committed suicide while he was on trial, we probably should hear something of it, but if he or she committed suicide when they were totally discharged, the chances are that we should not.

5326. You might or might not, but, at any rate, you will agree to this extent, that the task to which the medical officer has to address himself is one which does involve great responsibility?—Undoubtedly.

5327. And you can readily understand, can you not, that a man may hesitate to take great responsibility?—And rightly so.

5328. Quite so. Therefore you can quite understand a medical officer of an asylum who is reluctant, naturally and properly reluctant, to say, "You may go; I discharge you as cured"?—Unless he is quite convinced, exactly.

5329. Can you suggest to me from your great experience any procedure, or do you think it desirable to have any additional procedure to enable people who have once got in, and rightly got in, to get out?—Other than the procedure now in existence, of course?

5330. Yes?—I am afraid I cannot. I mean it all depends upon the competency or otherwise of your medical staff. If the medical superintendent is backed up, as I am certain we are, at all events in Birmingham, by a reliable medical staff, what you have just suggested should be very improbable, if not impossible.

5331. Your experience comes to this, does it, that nobody is detained longer than is absolutely necessary?—Well, Sir, I make allowances for the weakness peculiar to human nature which you suggest even doctors possess, but apart from that I have no apprehension at all as to there being anybody in our institution who ought to be out. I cannot see the advantage of it. There cannot be any advantage in keeping a patient in who ought to be out.

5332. What I am putting to you is simply this point: The reluctance of a medical man to incur what is, you and I agree, a very grave responsibility?—Exactly.

5333. You cannot suggest any improvement in the existing regime though?—I do not think I can. Again it is a matter of competence on the part of your medical staff.

5334. Do any members of your visiting committee happen to be doctors?—There is one just recently added, but the answer to your question is really in the negative, because he has not sat on the committee.

5335. But I may take it that you would welcome the inclusion of doctors on the visiting committee?—Quite.

5336. And you would do what you could to support it?—Undoubtedly.

5337. Do you know with regard to certain asylums there are voluntary associations of people who make it their business to go round and visit? Have you heard about that?—I believe I have read somewhere of where they do exist, but anyhow they do not exist in Birmingham, and I should very much question whether it is desirable.

5338. You would not think it desirable?—I do not think so.

5339. Now just a question or two about a different matter. With regard to complaints, here again, rightly or wrongly, as you have just been saying, there is a popular impression that certain patients in your asylums are not well-treated?—Yes.

5340. And your conviction after years of close experience is that it is quite unfounded?—Absolutely unfounded.

5341. Let me just ask you this: Can you give me any sort of figures as to the number of complaints which are brought before you in the course of a year?—I could not.

2 December, 1924.]

Mr. WILLIAM EDWARD LOVSEY, J.P., and
Dr. T. C. GRAVES, B.Sc., F.R.C.S.

[Continued.]

5342. Should I be right in saying 50, or 10, or 100?
—You are nearer the mark at 10.

5343. A very small number?—A very small number.

5344. Did I understand you to say—I think it was in answer to the Chairman or to Lord Russell—that you had only once in consequence of a complaint taken disciplinary action?—That is so.

5345. How long ago was that?—I should think it was two years ago.

5346. And in the course of your 10 years' experience that is the only time you remember disciplinary action being taken?—Absolutely.

5347. So that if that is known, the odds against a complaint being found proved would appear to be heavy?—Exactly.

5348. Does it occur to you, that that might make people reluctant to put forward complaints?—I do not think so for a moment. I can only speak again of the personnel in the Birmingham institutions, and knowing them, as I think I do, they would not be backward in coming forward if they had any complaints to make. There is no real risk at all, apart from their apprehensions of what might happen.

5349. Quite, it is just that; it is the apprehension, be it right, or be it wrong, of what may happen to them?—Yes, but I do not think they would hesitate to say so at all. I mean if their apprehensions were well founded, and it came to our notice that any of the officials had in any way attempted to "get their own back," that man or woman would be instantly dismissed, I am positive of that.

5350. Do not you think that the apprehension, which might be quite ill-founded, that steps might be taken, might prevent people putting forward complaints?—I can assume it is quite reasonable to suppose that.

5351. We can test it to a certain extent. You tell us what the patients say after they have been discharged, because after they have been discharged they are free agents, and after they have been discharged that apprehension need no longer exist?—True.

5352. And your evidence is that when they are discharged they are asked to make complaints, and I think you told us that you had practically had no complaints made?—Practically none.

5353. I should like to clear this up. Are you quite clear that, when you ask for complaints, at that moment of time the patients understand that they have been discharged?—They are before the committee to be discharged; they know that. This happens before they are discharged.

5354. But "to be discharged" is rather an ambiguous phrase. Are they before the committee who are going to consider whether they will be discharged or not, or has the sentence of discharge been pronounced before complaints are asked for?—It is before.

5355. Does it not occur to you that it would be very much more valuable if you got your complaints after the sentence of discharge had been pronounced?—Let me correct, if I may, my statement. The patients are very often told that the committee are considering the advisability of discharging them, or allowing them out on parole. They are told at the same time, "You will be pleased to know that the doctor has recommended you for consideration for discharge because of your improved condition." I think I can see what is at the back of your mind; they would be afraid to say they had been unkindly treated lest it should interfere with their discharge.

5356. Quite?—I do not think that obtains; they frequently speak across the table to the medical superintendent, and say how pleased they are with the doctor who has been attending them, and so on.

5357. This is the point: supposing a man, before the sentence of discharge has been pronounced, makes a complaint; that involves an investigation?—Yes, but it would not involve his or her incarceration pending an enquiry into that complaint.

5358. Do you think the patient is quite clear as to that?—The patients are all right; I mean they are not greenhorns; they know exactly what the position is; they are not so simple as some people imagine. What I should like to see, if I might suggest it, is that some members of the Commission should come and see the procedure and watch the discharge of patients.

5359. I would like you to consider in your own mind as to whether you would not get more valuable evidence in the future if you were to say to a patient, "You are now discharged, and nothing will make any difference to you. Now have you any complaint to make"?—I will give you this promise on behalf of the committee, that that procedure shall be adopted.

5360. *Sir Humphry Rolleston*: You said that you had never had any difficulty in making up your mind as to whether a person brought up before you as a supposed lunatic was other than insane?—That is so.

5361. Have you ever had any difficulty in deciding as to whether a patient is so far recovered that he should be discharged from hospital?—No.

5362. So that you would be rather of opinion that a decision as to whether a person is sane or insane is a matter which a person with a lot of experience in the world like yourself is capable of deciding?—I should say it is helpful anyhow. I should say "yes" to your question.

5363. Do you think it is necessary to have justices specially detailed for the purpose of dealing with cases who are suspected of being insane, or do you think it would be a matter which every man who is fit to be a justice could deal with?—I have submitted that every justice should be someone eligible to sign the documents in question.

5364. Do you think it would be an advantage to have the medical certificates given by men who have specially studied this subject, and have devoted themselves to certifying these cases?—I think so, yes, because the disease of insanity is one with regard to which the man who deals with it should be a specialist; it is better to have a specialist in such diseases rather than an ordinary medico. That is how it appeals to me as a layman.

5365. Which would you consider would be the better able to judge, an ordinary medico or a justice of the peace?—An ordinary medico, surely, just as a doctor could not do a policeman's job.

5366. Have you in Birmingham any arrangement for looking after patients who are let out on trial?—Yes.

5367. Is that attached to the hospital, or is it merely part of the After-care Association?—No, we have not an After-care Association, but we have a paid official who visits the patients during their parole, and who gives them the necessary advice and frequently monetary assistance.

5368. *Earl Russell*: I suppose they have the ordinary allowance anyhow?—Very often, but not in every case. If it was a case in which it is deemed necessary, it is done on a fairly decent scale, while they are on their parole.

5369. *Sir Humphry Rolleston*: That works very well, indeed, does it not?—Very well, indeed.

5370. *Sir David Drummond*: Have you a hospital for incurables in Birmingham?—Perhaps *Sir Ernest* can help me here; I do not know whether *Jaffray Hospital* comes under that head.

Sir Ernest Hiley: No, I do not think it does.

5371. *Sir David Drummond*: You know that in many districts there are hospitals for incurables; some are rate-aided and some are voluntary hospitals?—I believe that is so.

5372. Is it not conceivable that some of the senile patients, these incurable patients, could be treated in an incurable hospital just as in the case of any ordinary incurable malady, instead of being sent to a Poor Law institution to die there?—I do not think

2 December, 1924.]

Mr. WILLIAM EDWARD LOVSEY, J.P., and
Dr. T. C. GRAVES, B.Sc., F.R.C.S.

[Continued.]

so; I think the idea is to let them remain where they are.

5373. I am sorry to hear you say that. I think that suggestion is rather a happy one, and it might be a solution of the difficulty?—I was wondering whether the two cases are parallel. Here are people who have been for some one reason or another in a workhouse, and they are suffering from old age or senile decay. Why not let them remain where they are?

5374. They are incurable cases, but you have no experience of them, I understand?—No experience at all.

5375. *Sir Ernest Hiley*: Can you tell me what is your percentage of re-admissions in Birmingham?—(*Dr. Graves*): Our figures have varied lately, and I really could not give you them. I could let you have them before the Commission finishes.

5376. If you would, please. I would like myself to compare them with other figures that have been given us?—(*Mr. Lovsey*): I should think they are fairly large.

5377. Are they more than 30 per cent.?—(*Dr. Graves*): When I made up the figures in 1922 they were 25 per cent. Last year they worked out to about 10 per cent. I understand you to mean by re-admissions, cases which have broken down a second time over any period during their lives.

5378. That is quite right.—That might be 30 years' interval.

5379. How many come back within 12 months?—I could let you have the figures if you name 12 months.

5380. *Chairman*: Perhaps you might be good enough to write a letter to our Secretary, and let him have the figures* *Sir Ernest Hiley* desires?—Certainly.—(*Mr. Lovsey*): Might I say that if the Commission do visit any of these institutions, we should be delighted if they would include Birmingham in their itinerary.

Chairman: Thank you; we will make a note of that. We are much obliged to you for your evidence.

* See Appendix XVI.

(The Witnesses withdrew.)

Adjourned to to-morrow at 10.30 o'clock.

5, OLD PALACE YARD,
WESTMINSTER, S.W.1.

TENTH DAY.

Wednesday, 3rd December, 1924.

PRESENT:

THE RT. HON. H. P. MACMILLAN, K.C. (*Chairman*).

THE EARL RUSSELL.

SIR HUMPHRY ROLLESTON, BART., K.C.B., M.D.

SIR ERNEST HILEY, K.B.E.

SIR DAVID DRUMMOND, C.B.E., M.D.

MR. NATHANIEL MICKLEM, K.C.

MR. W. A. JOWITT, K.C.

MR. H. SNELL, M.P.

MRS. C. J. MATHEW.

MISS MADELEINE SYMONS.

MR. P. BARTER (*Secretary*).

MR. W. FAIRLEY (*Assistant Secretary*).

Dr. HENRY YELLOWLEES, O.B.E., M.D., accompanied by Mrs. CONSTANCE M. R. CROSLAND, called and examined.

5381. *Chairman*: This morning we have the advantage of the attendance of Dr. Henry Yellowlees, O.B.E., M.D., and Dr. Yellowlees is accompanied, I understand, by Mrs. Constance M. R. Crosland,

who is a member of the Managing Committee of The Retreat. Dr. Yellowlees, you are Medical Superintendent of The Retreat at York?—That is so.

3 December, 1924.]

Dr. HENRY YELLOWLEES, O.B.E., M.D., and
Mrs. CONSTANCE M. R. CROSLAND.

[Continued.]

5382. The Retreat is a registered hospital, I understand?—A registered hospital, yes.

5383. And you have only private patients in the Retreat?—Only private patients.

5384. Therefore we are not concerned with pauper cases at all?—That is so.

5385. You have been good enough to furnish us with some heads of the evidence which you are prepared to give us this morning, and perhaps we might just go through the several topics which you have noted. First of all, will you tell us about your registered hospital. When was it opened, and what has been done in the way of extending it or modernising it from time to time?—The Retreat originally was founded in 1792. It is unique among the registered hospitals, of which there are only 13 in the country, by being founded by the members of a religious body, namely, the Society of Friends. It is run and managed, however, on lines parallel to those of the other 12 registered hospitals in the country. The special feature of the management of a registered hospital is that it is run by a voluntary committee who receive no pay for their services, and who have no financial interest in the prosperity of the hospital; all the staff of the hospital are their salaried servants. Any surplus of income over expenditure in any year goes either to the improving of the institution, or to the lowering of the rates of board which are paid by patients.

5386. Then who appoints this Managing Committee?—It varies with the hospital. In the Retreat, which as I have said is unique by being founded in the first instance by the Society of Friends, the Committee are appointed by a larger body of directors who are themselves appointed by the Society of Friends at their quarterly meetings.

5387. You have told us the foundation is a very early one. What premises have you now?—Do you mean for how many patients?

5388. What class of premises? Sometimes the premises are all in one block; sometimes they are divided on the villa system. What type of house is it that you have?—It suffers like most old foundations from being rather ramshackle and unwieldy, inasmuch as new wings have been added on from time to time. It is not on what is called the villa system, but it has two or three detached villas in association with it. A larger number than that for a hospital of the type is not usual, nor is it very specially advisable.

5389. Are the buildings really the original buildings, which have been from time to time extended?—That is so.

5390. How long have you yourself been in charge?—I succeeded Dr. Bedford Pierce in March, 1922.

5391. And before that—it is interesting to have the record of your experience—what had you been engaged in doing?—I had been engaged in mental work, I was going to say since I was born, because I was born in a mental hospital.

5392. I was going to ask if we have the pleasure of seeing before us the son of a very distinguished Scotch alienist. You have been brought up in the atmosphere, so to speak?—I have, and in the faith. I was brought up in a mental hospital till I was 14. After doing general hospital work for a couple of years after I qualified, which was in 1910, I started mental hospital work in Perthshire in a small county asylum under Dr. Lewis Bruce. After about a year and a half of that I went to Morningside, Edinburgh, under Professor Robertson. I had not been there so very long when the war broke out. In France I was for three years mental specialist to the largest hospital area in France, and I personally saw and examined 2,200 cases of real or suspected mental disease, in addition to about twice that number of nervous cases and "shell-shockers," so called. After the war I worked for over two years more as senior assistant and deputy at Morningside, and then I was appointed to the Retreat.

5393. It is interesting, of course, to know the qualifications of gentlemen who hold such posts as you do. Evidently you have spent your life in the study and practice of this branch of medicine?—That is so.

5394. You have told us the general physical features of your institution, and how it is administered through a committee which is appointed by a body which originally founded the hospital?—That is so.

5395. Will you next tell us the number of patients and the number of beds you have?—We have nominally about 180. At the present moment we have 170 odd patients on our books. We are the fifth largest of the 13 registered hospitals in the country. The largest is St. Andrew's, Northampton, with 480 beds; the smallest is, I think, the Lawn, Lincoln, with 90 beds.

5396. Just before we come to further details as to your system, you might tell us how the finance is managed. Where are the funds obtained for the conduct of your institution?—Some of the registered hospitals are wealthy institutions and are endowed; many of them are poor, and practically their entire source of income, as in our case, is from the board paid by patients. There are a few small donations, bequests and legacies, and such like things, but by far the largest part of our income is the yearly income from the patients' fees.

5397. So that in a sense it is really a self-supporting institution?—It is a self-supporting charity.

5398. With some endowed funds?—And in a few cases with endowed funds.

5399. Then will you tell us next about your staff; what is it composed of?—Male and female mental nurses, and administrative officials over these. In our own case we have 53 female nurses and about 30 male nurses—I do not remember the actual number, but that is very near.

5400. What is the organisation of the staff?—It is precisely as in any other hospital—a matron, under whom I have three assistant matrons. The matron is over all the nursing staff, male or female. Under her there are three assistant matrons, all doubly qualified—that is to say, with qualifications both in general nursing and mental nursing, at least. One of these is over the male side, one of them is over the female side, and the third is the night superintendent—that is to say, over the whole house during the night.

5401. Have you charge of both the medical and the administrative business of the institution?—Certainly.

5402. A question has been raised as to whether entrusting the administrative business, the routine business, to the medical superintendent, is not apt to divert him from his purely medical work. Have you found that your administrative business occupies too large a part of your time?—I have not. It is a point on which I feel quite decidedly. Even if there are drawbacks in it, it is quite essential in a hospital of the kind that the medical head and the administrative head should be the same person.

5403. Why do you say that; we would like to know the reasons for that view?—I am afraid the reason is the good old reason of practical experience; it simply will not work otherwise.

5404. Of course, yours is relatively a small establishment; but when we come to the large public institutions, up to 2,000 beds, it has been suggested that the medical superintendent might be relieved of some of the routine administrative work, as it is apt to distract him from the special medical problems which he has to attend to?—I think that question was best answered in my knowledge by Dr. Shaw Bolton of Wakefield, who, when he was approached on the matter—I think it was a committee of the Board of Control or some committee who were investigating the matter—said, "Yes, my administrative duties are very, very serious; I have no doubt they occupy me a full quarter of an hour every day," and he is the head of an institution

3 December, 1924.]

Dr. HENRY YELLOWLEES, O.B.E., M.D., and
Mrs. CONSTANCE M. R. CROSLAND.

[Continued.]

with 2,000 patients. In other words, he has the wisdom to delegate his duties.

5405. *Earl Russell*: You have an efficient private secretary and steward, or somebody of that sort, to relieve you of the routine duties?—I have, indeed, in this way: In some of the registered hospitals the whole financial business of the institution is carried out by an official in an office perhaps in the town, not in the institution at all. That, I think, is the ideal way. In our case it is not so; we have an official who lives in the place, and does all the financial work there. He is a trained accountant, and so on, and in some ways that arrangement has advantages. It means that whenever I am faced with anything of that kind, I can put it over to him at once, and he is immediately on the spot, and we work together. It avoids correspondence. Then I have a very efficient personal secretary, and a very, very fine staff.

5406. *Chairman*: Of course, in some cases it would depend upon the ability of the medical superintendent to delegate his work?—That is so, entirely.

5407. But with appropriate delegation of the merely routine matters, do you find yourself left sufficiently free to attend to your medical duties?—I think so, I am very certain of it; and, of course, I would like to add that almost every administrative problem in a mental hospital has a very strongly medical aspect, and you cannot differentiate the two without finding yourself in serious trouble very soon.

5408. You are conducting, in a sense, an hotel as well as a hospital?—That is so.

5409. Then I suppose what you wish to put before us is that the régime of your hotel is itself part of the treatment?—Exactly; it is subordinate to the hospital idea, which is the first thing.

5410. But as you have patients who are resident for long periods, a great deal of the benefit of the institution would depend upon the way in which the institution is conducted, as an hotel or as a home?—I agree with you entirely.

5411. Therefore you regard it as important that the medical superintendent should have a voice in the arrangement of matters that are not purely medical, but which may have an indirect bearing on the treatment of your patients?—I do, and I should think that the committees of management share that view.

5412. I think you have some views on the desirability of having women on the staff of registered hospitals?—Yes; I noted it down, because it has been a feature of the Retreat for many years. When I was speaking of the foundation of the Retreat I omitted its greatest glory, which I must be allowed to mention, namely, that it was the pioneer institution to initiate the humane treatment of the insane. It was the first institution in this country where the insane were treated humanely, and its founder was William Tuke, who was not, a physician but was a tea merchant in York. The story of the founding of the Retreat is possibly familiar to some of the Commission; in any case it is a thing upon which one could spend a long time. It is of interest to say that William Tuke gave evidence before a Select Committee of the House of Commons in 1815 upon his methods in the Retreat, and the revolution in the treatment of the insane; and Mrs. Crosland, who is giving evidence before you to-day, is a lineal descendant of William Tuke.

Chairman: That is very interesting.

5413. *Sir Humphry Rolleston*: You do not suggest he was before Pinel?—I do not suggest it at all. As a matter of fact they were almost simultaneous. In the year 1792 Pinel was carrying on his work in the Bicêtre, but before that Pinel had done something at the Salpêtrière; and, I believe, that in actual time possibly Pinel may have been first. As a matter of fact, it is now said that both of these movements were later than one in Italy.

5414. *Chairman*: You might tell us—you, of course, are the head of the whole institution—what medical staff have you under you?—On the medical

staff I have in normal times two besides myself. At the moment, or in a few days, I shall have three, but that is owing to incidental facts. My proper staff is two, one man and one woman.

5415. And do you consider it desirable that the medical staff should include, if possible, one qualified woman?—On the whole, yes. There are certain little drawbacks in working, especially in a small place where your male colleague may be off duty, where you have not another woman to relieve her, to take her duties when she is away, or where she has to relieve her male colleague when he is away; but on the whole, even admitting that, the advantages very much outweigh the drawbacks, especially in a hospital for private patients, I should say—in a hospital of this type.

5416. Do you allocate your patients as between your male and female assistants?—Yes, the male assistant has to be in charge of the male side, and the female assistant has to be in charge of the female side, which is rather a pity in some ways, because the male assistant is the senior, and it is an interesting fact that the female side is invariably in such hospitals as the Retreat, the bigger, and contains the more difficult and acute cases.

5417. Of course, one can appreciate that owing to the peculiar nature of the malady you have to deal with, many cases practically require a male practitioner, I should think?—Very often; but I do not think (certainly not in my experience at the Retreat, and also at Edinburgh, and I do not think in Dr. Bedford Pierce's 30 years at the Retreat) that there was ever really any difficulty owing to there being a lady on the staff.

5418. Then you think the presence of at least one woman on the staff of an asylum is desirable?—I do, and my Committee feel so very strongly, and on the whole I agree with them.

5419. Then we gather from Mrs. Crosland's presence here to-day that the Managing Committee has ladies on it? How is your Managing Committee composed at the moment?—(Mrs. Crosland): There are four women—three are appointed in the same way as the rest of the Committee by the directors, and I am appointed from the central governing body of the Society of Friends.

5420. They have the right of appointing?—They have the right of appointing two; they appoint one man and one woman.

5421. *Earl Russell*: How many men are there on the Committee?—Twelve altogether.

5422. *Chairman*: The whole Committee consists of 12 persons, of whom four are ladies?—Only four women. (Dr. Yellowlees): Twelve, and the Chairman and Treasurer—14 in all. That would be 10 men and four women.

5423. And do you find that the ladies interest themselves specially in the female side of the institution?—(Mrs. Crosland): Yes, I should say that, and, of course, in the general administration—all the kitchen part, and so on.

5424. And no doubt that assistance is very valuable. Now will you tell us next with regard to your nursing staff, how do you obtain them, and what qualifications do you require?—(Dr. Yellowlees): We obtain them either as the result of advertisement, or more usually because they apply to us. We happen to have a reputation as the best training school in the country for mental nurses; we have therefore practically never had any difficulty in getting candidates; even in the war years we were able to a certain extent not to take applicants whom we thought were unlikely to make good nurses.

5425. You have a choice, then?—As a rule we have a choice.

5426. Do you require any qualifications in those whom you appoint?—The usual references as to character and ability, and so on, just as a general hospital. We give a form of application—usually the last two posts held, or something of the kind; we

3 December, 1924.]

Dr. HENRY YELLOWLEES, O.B.E., M.D., and
Mrs. CONSTANCE M. R. CROSLAND.

[Continued.]

send out the usual form of application, giving personal details and where educated, profession of father, general health, the last post of any kind, with name and address of employer. Then we write for references.

5427. These are persons who will have had no previous nursing experience?—None.

5428. You do not draw upon the general hospitals for nurses who have had some training in general hospitals?—The order of doing it is generally the other way; after they have had the mental training they proceed to the general. A nurse who has had general training sometimes comes to us and asks if she can go on, and we allow her a year off our course.

5429. We have heard, and indeed it is a matter of common knowledge, that some experience of general nursing is desirable for nurses who specialise ultimately in mental nursing, and it does seem to us a little difficult to accommodate the two together. Take the case you have given just now. A young probationer comes in, has been on for some time, shapes well, and has had some experience with you, and risen perhaps to a position of ward nurse with you: suppose she desires to have some general nursing experience, and goes to a general hospital, would she have to begin there as a probationer again?—The great majority of hospitals allow a year off the training to qualified mental nurses.

5430. To enable them to go to a general hospital, do you mean?—No. The general hospital has a three years' training course—issues its certificate at the end of the third year: if a nurse comes to a general hospital having already qualified in mental nursing, the general hospital will take her for a two years' course and give her a certificate at the end of it—some will not.

5431. She has not to begin at the beginning with the relatively menial work which one knows falls to the probationer in the first year?—That is so. Almost all the hospitals of note accept the arrangement I have mentioned, and the matter is reciprocal, although it is not nearly as reciprocal as it ought to be. The general hospitals sometimes show a little difficulty about it, whereas we are perfectly prepared to take any general qualified nurse and take a year off her training with us, and give her our certificate at the end of two years.

5432. Do you approve of the policy of interchangeability in this matter, that a nurse should pass from one to the other?—It is awfully difficult. We have an arrangement of the sort with the York County Hospital. Our nurses go there for six months' training to give them some idea of what a general hospital is like, and the difficulty is that it is hardly fair on the nurse. You get a half trained nurse in the end—you are apt to. If a person does not go through the proper course both of mental or of general, or whatever it is, but just has a look for six months here and exchanges with another nurse for six months there, she is apt to be a half trained person at the end—the continuity of the thing is broken.

5433. I suppose the idea of the advantage of general hospital training is this, that patients in the mental hospital may of course feel ill as any other persons may, and consequently a certain amount of general nursing would have to take place in a mental hospital?—That is so, but I do not think you have quite got it.

5434. Let us have it then?—For this reason: general nursing is essential in a person who is in a position of authority, and is going to stay permanently, or for any length of time, in a mental hospital; but you do not require general nursing to start with in the probationer whom you are going to train in your hospital just as fully, though possibly somewhat differently to the nurse who is being trained in a general hospital.

5435. Let me illustrate what I am thinking of by a concrete example. Suppose a patient in your

institution becomes ill with pneumonia?—But they are all in bed to start with.

5436. But you have many of them who are up and about?—Later on.

5437. Supposing you have a patient who is resident in your institution in quite good health except for his mental disability, and that patient may take pneumonia, or any other illness, one knows that various forms of illness require special nursing, and pneumonia is a very good example: how would that patient be treated for pneumonia in your institution?—The sister in charge of every ward has got some other training in addition to her mental training.

5438. That is the point we are coming to?—Certainly, all the administrative officials, all the sisters and higher officials have got other training. The nurses are trained, not only in mental nursing, but in nursing the sick.

5439. You really have, therefore, on your staff nurses who are qualified to do general nursing, and would know what to do?—Certainly; we have a large proportion of doubly qualified people, which is more than a general hospital has. You might as well ask me what does a general hospital do when a case in it becomes mentally ill.

5440. Quite?—I am afraid I have not made it very clear. I am very sorry.

5441. Yes, you have.—How does the general hospital treat its pneumonia?

5442. But there would be in a general hospital nurses who have acquired experience in the well-known ailments?—And there always should be in a good mental hospital.

5443. That is the point I meant. In order to get that experience they must have had some general hospital experience before?—That is so. Everyone in a position of authority, and every department in a mental hospital, should have other nursing training as well as mental.

5444. Now on that practical question, we will have to consider whether any recommendation should be made that on the staff of mental hospitals there should always be nurses who have had general experience in a general hospital, and thus be able to deal with cases of ordinary illness arising in a mental hospital?—I should think you ought to consider that.

5445. Then that means again that some scheme would be required whereby nurses could pass for a time either from a general hospital to a mental hospital or vice versa?—I object to "passing for a time."

5446. Take your own nurses who are coming to you, intending to engage in the career of mental nurses. Is it your practice that such nurses leave you for a time to go to a general hospital?—It is the routine that they leave us. In this matter we are rather unusual, but we engage our nurses precisely as a general hospital does for a four-years' training. At the end of the third year they pass, what is up to now recognised as the standard examination on the subject, namely, the examination of the Medico-Psychological Association, which has recently been supplanted by the State examination. We keep them just as a general hospital does for a fourth year, during which we give them our own examination, and issue, just as the general hospital does, our own certificate. We are almost the only mental hospital that does so, and our certificate is known throughout the country as the stamp of a properly trained nurse. At the end of that training they leave us by routine automatically; it is a four years' contract.

5447. *Earl Russell*: Do you mean that you send them away at the end of the time even if they wish to stay?—If they wish to stay I think we should say we could not have them; we should possibly put them on our trained nurses' department for supplying to private cases.

3 December, 1924.]

Dr. HENRY YELLOWLEES, O.B.E., M.D., and
Mrs. CONSTANCE M. R. CROSLAND.

[Continued.]

5448. *Chairman*: Does that mean that they leave at the end of four years unless they are promoted to some higher position?—That is so, and we will not promote them without further training.

5449. So that a nurse who has had the four years' specialised training with you would in the ordinary course go to a general hospital for a time?—That is what they very often do if they are going to continue; then they come back to us as sister or assistant matron. Just before I leave that: of late the method I have adopted in special circumstances is that I sent some of our fourth year nurses away to the County Hospital for six months, and at the end of six months brought them back, and they are now sisters. I have been sorry for it ever since, because they have had a certain amount of insight into the general work, but it is a half-and-half business, they are half-trained people; and I would rather have waited the full three years to give them a proper general hospital training as well.

5450. Then when you get past the stage of the probationer who is training, and when she has completed her four years, she would in the ordinary case, of course, pass to a general hospital and then come back to you for one of the higher posts?—That is so.

5451. So that the nurses who occupy the higher posts in your institution are persons who have not only had the specialised training, but have also had general training?—That is so.

5452. Is that invariable?—With us it is invariable.

5453. How many have you on your staff who have had the benefit of both specialised training and general hospital training?—The matron, her three assistants, and the sisters—nine people altogether.

5454. Then, of course, the advantage of these nurses who have not only a specialised but general training, is that they are able to direct the younger nurses in the treatment of cases?—That is so, and the training of nurses is a very important feature of our work.

Sir Humphry Rolleston: Before you leave this, would you ask Dr. Yellowlees why for these higher posts it is not better to have a nurse who has, first of all, had the complete hospital training and has got a really good general education, and then comes to them and has a specialised training.

5455. *Chairman*: What do you say to that—do you think the general hospital training should be the beginning of the career, as *Sir Humphry* suggests?—I would like to hear what *Sir Humphry* said about general education.

5456. *Sir Humphry Rolleston*: It would seem an advantage that they should have a special education after, not before, they had a general education. There is probably some good reason in experience why that is not so?—I think, on the whole, that is true. One of the difficulties is this, that a general trained nurse will not be willing to come into a comparatively insignificant post in a mental hospital, and be under nurses who have not got a general certificate. On the other hand, if you bring your general nurse in and give her a fairly high post, her mental colleagues resent it very much. It is a constant difficulty. A mental trained nurse has to learn a good deal of general nursing. The preliminary examination of the General Nursing Council is precisely the same for all grades of nursing. There are certain fundamentals in nursing which are common to every special branch of nursing, hence the mental nurse is not nearly so much at sea in a general hospital as is the general nurse in a mental hospital. There are few things more pathetic than to see a nurse whom you know to be a good general nurse trying to deal with a mental case, if she happens not to have the ability or the training.

5457. *Chairman*: *Sir Humphry's* question really illustrates the difficulty that one feels of taking a person who has acquired a specialised training and putting her in among people possibly at a lower

stage of their profession.—That is so; it is awfully difficult.

5458. Questions of prestige, of course, come in?—They constantly arise. On the whole, it seems to me to work better for the mental training to come first. I like the nurse to have her mental training, then go into general, and then proceed to get some higher post if she is going on in mental work. *Mrs. Crosland* has reminded me of a most important practical point, that most mental hospitals take nurses very much younger than a general hospital is prepared to, hence they start earlier.

5459. *Sir Humphry Rolleston*: Is that an excellent thing for them—is it not very bad for their health?—I do not think you would say so if you saw ours.

5460. What age do they come in at?—We have no specific limit at the Retreat, but we do not like to take them younger than 20. Many general hospitals do not have a nurse under 23. I believe 23 is the usual age.

5461. *Chairman*: Then following the suggestion that has been made, what may one take to be the complete curriculum. You start with the three years to get a Medico-Psychological certificate, and a further year to obtain the benefit of your special certificate—then possibly a year with a general hospital?—No, a full general course.

5462. Two years in a general hospital?—Yes.

5463. That would make six years?—Yes.

5464. At the end of the six years that nurse would be qualified, in your opinion, if she had shown reasonable progress, for one of the higher posts in your institution?—That is quite correct.

5465. Then with regard to obtaining the advantage of general training for your nurses at the end of their four years, have you any difficulty in getting places for your nurses, or have they difficulty themselves in getting places in general hospitals?—We have not.

5466. Where do you send your nurses to, is it in York?—No, by no means. The Edinburgh Royal has got a great attraction for our nurses—I do not know why. A good many of the Scotch places have; they write back to the matron saying, "If you have any more nurses like the last, I will be very glad; I can always do with probationers like the last." If they live near a large centre they get into one of the large hospitals in that centre.

5467. I have been told there is reluctance on the part of some of the general hospitals to take mental nurses and give them those advantages. Have you heard of that?—Yes, in some cases I believe that is so. We have not experienced it.

5468. Can you see any good reason for such reluctance?—Except, I think, the general public impression that a mental nurse is a person of a lower social status, and generally of worse behaviour than the completely untrained person.

5469. Is there any foundation for such a suggestion? Your experience does not look like it?—I must say we do not think there is, but of course we are a very small place, and we have got peculiar methods. We are a large and happy family, but I have not the least doubt there are bound to be black sheep everywhere. We are no better than our neighbours, but we have had a fortunate experience.

5470. At any rate, you give your approval to the principle that before a nurse completes her training for the position of permanent nurse in a mental institution, she should have had the advantage of some general training at some stage of her career?—Yes. It is a hard saying you know, when you are going to deal with a very large place which is going to support almost entirely chronic patients; it is a hard saying, but I believe it is the ideal thing. Before we leave the subject *Mrs. Crosland* asks me to add that it should be remembered (you spoke of the six years necessary) the nurse is earning during

3 December, 1924.]

Dr. HENRY YELLOWLEES, O.B.E., M.D., and
Mrs. CONSTANCE M. R. CROSLAND.

[Continued.]

all this time, and incidentally she is earning very much more when she is a mental nurse than as general. That perhaps is the reason why they come to it first. There is no state of training which I know where a person is paid so well to be trained.

5471. You might tell us a little about that subject. Give us the conditions of the service, that is to say, the hours and wages and conditions generally?—May Mrs. Crosland answer that? She has the figures.

5472. If you please. Tell us what your nurses begin at, what their remuneration is, and what their hours are, and the conditions of the service.—(Mrs. Crosland): Shall I take pay first?

5473. If you please.—With regard to the women nurses, during the first year they earn £36 a year, in the second year £48, in the third £60, and in the fourth £72.

5474. Do they live in?—They live in.

5475. And is that with board found?—Everything found, including uniform. They begin with their own uniform, but if after a month it is decided to keep them on the staff they have a grant made for the cost of the uniform.

5476. That is the rate of remuneration.—Will you have the men's rate now?

5477. If you please.—First year £60; second year £72; third year £84; fourth year £96.

5478. Do these men live in also?—Yes.

5479. Are none of them married men?—I think there are one or two of the married men who live out. (Dr. Yellowlees): They can marry after that. With the men we do not keep so strictly to the four years' contract for many reasons; and if they marry they are allowed an additional sum of £35 per annum instead of the lodging which they lose, and they make their own arrangements to live out.

5480. The majority of your staff, both male and female, all the female and most of the male, seem to be resident?—No, not most of the male, a fair proportion of the male.

5481. Earl Russell: Less than half?—Rather less than half.

5482. Chairman: What about the hours of work?—(Mrs. Crosland): The women begin with breakfast at half past six; they are on duty from 7 a.m. to 8 p.m. which sounds terrible, but they have off that half an hour allowed for lunch, half an hour for dinner, half an hour for tea, one hour allowed for rest, and then they have entirely off one whole day in the seven, half a day in the seven, and always half the Sunday, alternately the morning or the afternoon.

5483. If you add those up it seems to be 2½ hours in the day, and 2 days in the week in the aggregate?—Yes; the total working hours are four days of 10½ hours, one day of 5½ hours, one day of 6½ hours; that is an average week of 54 hours. (Dr. Yellowlees): With the men the average hours of work are 55.

5484. Earl Russell: On the same principle?—Except that they do not have the daily rest hour; they have it put together and added in half days, and so on. (Mrs. Crosland): Then they are paid rather more.

5485. Chairman: With regard to the hours of work which you have given us, of course the class of work which these nurses are engaged in is not continuous work; it is supervision, of course, but there must be periods when the nurse is sitting in a ward, not necessarily doing something all the time?—(Dr. Yellowlees): That is so. It depends entirely upon the part of the house the nurse is in. It may be going down town with a couple of ladies, it may be going to a theatre, and it may be a cricket match. These are the points that are never by any chance mentioned when we read of the terrible hours of people shut up with raving lunatics, and foolishness of that kind. In any wise hospital it is your duty to make the nurse's training include properly spaced spells with the various kinds of patient, and experience in the different classes of work.

5486. Would it not be more accurate to say the 54 hours you have given us are hours on duty, that

is to say, at that time they are bound to be attending to their duty?—That is so.

5487. But the class of duty that is imposed upon them consists, I suppose, to a large extent in entertaining and amusing patients and looking after them?—At times. At other times if they are in the reception hospital it is jolly hard nursing. It varies. Sometimes it is as you say.

5488. They are moved about to the different departments?—Yes.

5489. A spell of work in one department, and then a spell in the other?—That is so, and incidentally they are extremely contented.

5490. For the actual menial work in the hospital, by which I mean scrubbing floors and washing up, and things of that sort, is that done by the nurses, or have you a staff of servants?—We have a staff of maids who do that.

5491. So that the work of your nurses is really nursing work?—It is really nursing work. Of course there is a certain amount of hewing of wood and drawing of water which does come into their probation work, and that is done, but I do not think there is nearly so much as a probationer in a general hospital gets.

5492. A certain amount of experience in all departments is quite useful no doubt. A great part of their work is not in any sense menial, but is really nursing work?—That is so.

5493. Apart from the experience which the nurses gain by the actual nursing which they do themselves under the supervision of the ward sister, and so on, do you give them any lectures, any form of teaching?—In each year of the training there is a course of 20 lectures by a medical officer. In addition to that in each year of the training there is a course of 20 practical demonstrations by the matron, or one of her trained assistants; that is to say, if you take each of these weekly you have 40 weeks in each year out of the 52 when there is a lecture or demonstration of some kind.

5494. Do you find your nurses are successful in the examinations which they have to pass for their qualifications?—Yes, we happen to have a fairly high proportion of passes.

5495. Do some fail to qualify?—Very few fail eventually to qualify. We only allow them two failures. There is a preliminary examination and a final both in the Medico-Psychological and the General Nursing Council, and if they fail twice in the preliminary, the matron and I see them, and just discuss with them whether they are really fitted for the profession, and are they taking it seriously, and have they ability for it.

5496. Have they time for study?—Ample, I should think.

5497. And have they facilities for their studying?—I mean have they a nurses' room, a quiet room where they can work in their rest time?—As regards the Retreat, they will have this in the course of a few months, when our new nurses' home is complete. At the present moment our accommodation is one of our weak points, but each nurse has a single bedroom for herself.

5498. And have you a library of books?—There is a small library.

5499. Of technical books, I suppose?—Not a technical library. Each nurse gets a present of technical books when she passes, but that is rather late to help her to study, is it not?

5500. Mr. Jowitt: She can borrow, I should think.—She can borrow or buy. The pains that are taken in the teaching of nurses, I think, in almost every mental hospital, is a thing for which on the whole sufficient credit is not given.

5501. Chairman: Do you find that you have a contented staff?—Of course, we think our staff are simply splendid, but we do not want to say we are different from others at all. My own experience is that they are extremely fine; they are very contented. Of course, a lot depends upon how you deal with them. Take the hours which Mrs. Crosland has read you. I thought the men's hours were

3 December, 1924.]

Dr. HENRY YELLOWLEES, O.B.E., M.D., and
Mrs. CONSTANCE M. R. CROSLAND.

[Continued.]

ridiculously short, and I simply spoke to them about it, and between us we hammered out that list which I have read to you, and it was they who accepted it and agreed to it; it was not imposed upon them in any sense. I said, "I think you are being paid too much and doing too little." They said, "We would do a little more if you will not alter the pay," and they did. Of course, it is a small place, as I say, and one can get on on those terms in a small place more easily than in a large one.

5502. Do all the nurses who come in to you under contract remain for four years?—All the female nurses, and of late the male ones, but I do not like to enforce it with the men, because there are so many fewer avenues open to a man when he goes away at the end of the four years. He has got a training, and it will not be so easy for him to find something else apart from that training. A nurse may possibly get married and cease to have to continue nursing, or may go out into general nursing. Unless a man goes into private nursing he is rather at a loose end.

5503. There is not so much career, I suppose, for male nurses, except in mental hospitals?—That is the way to put it.

5504. Or as attendants to private patients?—That is so.

5505. *Earl Russell*: Is that one reason why you pay the men so much more?—I do not know that it is a reason; the two things are facts. I do not know what the relation between them is.

5506. *Chairman*: Do you find in your experience that you ever have to dismiss a nurse?—Yes, I have dismissed two nurses in the last three years, since 1922.

5507. It would be interesting to know (this is on the topic of discipline) the occasion on which you had to dismiss these nurses?—Perhaps I should say that I, speaking strictly of the constitution of the Retreat, do not dismiss the nurse; I suspend her, and the Committee nominally dismisses the nurse.

5508. We do not want any names but merely the circumstances?—One was for theft, a girl who had previously been dismissed from another institution, and had come in to us concealing that fact, and the second was for immorality.

5509. *Earl Russell*: Neither of them for offences against patients?—Oh, no.

5510. *Chairman*: As regards discipline in your institution, do you ever have complaints from your patients of the treatment they are receiving at the hands of nurses?—You have the usual complaints from one or two of the chronic paranoïd patients, and the patients who resent everything; you always have a few, I think, in every mental hospital. I have very few.

5511. What means of direct access to you have the patients got? Let me put a case to you: it is always better to be concrete. There is an idea abroad apparently that patients sometimes are ill-treated, but are afraid to complain to the higher authorities such as yourself, and that in that way there may be more or less systematic ill-treatment of a patient who has no means of obtaining redress. Now how are you personally brought into contact with your patients? I quite appreciate you have a relatively small number; but how are you brought into personal contact with your patients in your daily work?—My routine is this, that in the morning I come in at half-past nine or ten, and while I am seeing the secretary, and possibly the head engineer, and the head gardener, or doing anything just to settle off in half an hour the machinery of the place for the day, both my assistants come in to see me, and I tell them whether or not I am coming round with them, or which of them I am going round with. I may say to the male side assistant, "I will come round with you this morning," or else I may say to the female assistant the same thing. Occasionally, a thing I detest, but generally on a Monday morning, we have a formal round, and I go round with both of them and the matron, a whole trail of assistants, round the house. But every second day I go round

on one side or the other with one of the assistants. Whatever I do, they do their routine round of the home every morning. As soon as they have finished, if I have not been with them, they come into my room at midday, and we sit down and talk over by name practically every patient, certainly every acute patient. If there is anybody who specially wants to see me, or if there is any particular form of medical treatment that I am going to give, or if there is some patient who I think is distressed and might be comforted by having seen me, I ring up to the appropriate department, and say, "You might ask Mrs. So-and-so to be brought down to my office," or else I run up myself, and have a chat with her in the ward. At 12 o'clock the matron comes in to me, and I discuss with her all the reports she has had from the assistant matrons, and from the sisters in the wards, and any cases of discipline are brought up, and any questions against the nurses. In the afternoons, if I am about the place, I am probably either playing tennis with some of the patients, or playing some of the games or refereeing at one of the hockey matches, or seeing a party go off somewhere or other, but generally being on the spot.

5512. But one figures the case of a patient who is not happy, and thinks the nurse is not kind to her, and wants to see you to put her case before you, and to say that she would like to be in the hands of another nurse. How would that patient get direct access to you?—By simply telling the nurse she wanted to see me.

5513. Supposing the patient felt that that nurse was unkind to her, it would not be an easy thing for the patient to say to the nurse, "I want to see the doctor," and if the nurse said, "What for?" to explain "Because I am not very happy with you." It is not a very easy thing to say that, you know?—It is not for me to ask questions, but do you believe in the hypothetical question which you are putting?

5514. I could conceive it is quite possible?—I can conceive it is quite possible. I can conceive that I am systematically trying to deceive the Commission!

5515. *Earl Russell*: But is the nurse allowed to say "What for?" if the patient asks to see you?—I do not think she is either allowed to or forbidden. She would not dream of doing it. You mean the nurse would hold an inquisition on her own?

5516. Yes?—Of course it is so hard to explain these things to people who are not familiar with a mental hospital.

5517. Some of us are familiar with them, you know?—I am very glad to hear it. Then I give you as my personal opinion that I should not be systematically hoodwinked in such a way. The relations between the matron and the sisters, the sisters and myself, and myself and the patients are such as to put it grotesquely out of the question.

5518. *Chairman*: Your experience has probably been singularly fortunate, and I can well imagine it, with your own qualifications; but what we are really exploring is suggestions that have been made, and apprehensions that are entertained in the public mind, the uninstructed mind, if you please. It has been suggested that it is possible for the visit of the medical superintendent to be known in advance and for matters to be more or less dressed up for his inspection. In your own experience do you think that you could be hoodwinked in that way?—In any of the hospitals at which I have worked it was impossible. I have heard it said that such things are done in large county mental hospitals. My own main ladies' ward has not got even so much as a hanging curtain between it and the front door; you simply walk into it from the front door.

5519. Let me put it quite frankly. One is anxious to see whether there is any risk of tyrannical treatment by nurses of persons who are of unsound mind and not able to protect themselves; whether there are any risks of tyrannical treatment or cruel treatment without the possibility of the patients being able effectively to complain to somebody who would put it right. One wants to see whether there is a

3 December, 1924.]

Dr. HENRY YELLOWLEES, O.B.E., M.D., and
Mrs. CONSTANCE M. R. CROSLAND.

[Continued.]

risk of that, and whether one can supply any additional safeguards to prevent the possibility of its occurrence?—Firstly, I think one has to consider that the patient, while not able to protect himself, has a very good means of letting himself be heard; I mean he would make his plaint pretty noisily. Supposing the nurse ignored his complaint and refused to pass it on, it is just possible that he would be so audible that somebody higher up would hear him.

5520. Is it not possible that if he took such steps he might find himself put under some penalty or sent to a refractory ward, for instance?—Anything is possible. It is quite outside my experience. How low down the nursing staff are you going to presume trustworthiness? The average nurse, I take it, is not to be regarded as above suspicion?

5521. Of course the working of the system depends upon the trustworthiness of the staff, but at the same time it is desirable that there should be a certain check or safeguard upon the staff, particularly upon the members of the staff who have the less high qualifications?—Suppose I say that either I or one of my assistants sees every patient every day, how is that for a perfectly sufficient safeguard against it?

5522. Do you see the patients with the nurse?—With or without the nurse; we do not make any formality about it. Probably we see four or five of the patients and one nurse is there. It was the practice till I came for the nurse to leave the room when the doctor was there, but I stopped it.

5523. *Earl Russell*: Why did you change the practice?—Because when I go in to see a case of pneumonia, I do not expect the nurse who is dealing with the case to walk out of the room and leave me. When I am attending a case of a much more difficult nature, still less do I expect the nurse to walk out of the room and leave me.

5524. You thought it rather a slur upon the nurse?—I did, indeed.

5525. *Chairman*: And also, of course, the nurse can tell you how the patient is getting on?—Certainly.

5526. The nurse keeps the temperature chart and all the other things, and will be able to tell the doctor, as she does in private practice?—Certainly. Many a time a patient in such circumstances has asked, "Doctor, can I say something to you?" and I say, "Certainly. Nurse, you can leave us for a moment."

5527. That seems to be admirable?—I think the best answer to the difficulty is this, that if a medical officer with experience and knowledge sees every patient every day, I do not think any more complete safeguard could be conceived.

5528. One can quite understand in your institution that that is both practicable and desirable, but we need not trouble you with the larger institutions where to see every patient every day would be impossible?—It is very hard, I know.

5529. But in your institution you are in a position of being in personal contact with all your patients?—That is so.

5530. And you think there is no risk in your case of a patient suffering in any way from neglect or ill-treatment by your subordinates without your becoming aware of it?—I believe that to be so. My committee are also in personal relation with the patients; that is perhaps a unique thing. The committee, I think I am right in saying, regard their being on the committee, simply because it is founded by their religious body, as more or less a definite and sacred trust, and they take an extraordinary personal interest in every patient by name in a way that is not very usual.

5531. You have told us of the relationship obtaining in your institution as between the higher members of the staff and the patients. One is also concerned with the relationship between the patients and the outside world. One knows that they have to be detained necessarily on account of the nature of the particular malady, but we are concerned as a Commission with the possibilities of contact, or at least the preservation of some relationship with the outside

world, so that the patients may not feel that they are entirely shut off. Now in your case what opportunities of contact are there, or what opportunities of communication are there between the patients and outside persons altogether; take, for example, their own relatives or the authorities, to whom they may wish to appeal even, if one may conceive it, against the staff of your institution?—They constantly do.

5532. One wants to know what opportunities are available to patients under your charge to come into contact with the outside world. You have mentioned that one of the opportunities is the visiting committee?—Yes.

5533. Do the committee regularly come to your institution?—They come for their official committee meeting; they spend two days every month there, a Monday and a Tuesday. In the interim there are two committee visitors, two directors' visitors, two what we call lady visitors. Each of those are bi-monthly, that is to say, each of these three pairs occurs in the period of two months.

5534. When they visit the institution, do they see the individual patients?—They do precisely as they like; they walk in and they see either me or the matron and I say, "Well now, it is for you to say what you want to see. What would you like to do?" Sometimes they say they would like to go to the laundry and at other times they will like to see the worst ladies or the worst gentlemen we have got. It is simply their own free-will. They then write a report, which I frequently do not even see until it comes before the next committee; they frequently address it to the Chairman, enclosed in an envelope.

5535. Now when these visitors are going round, do the patients have an opportunity of speaking to them personally?—Certainly.

5536. And do they in point of fact chat with them?—Yes, I think so; very frequently.

5537. Will you just tell us about that, Mrs. Crosland? I suppose you go round yourself?—(*Mrs. Crosland*): Yes. I go there every month and I stay a night in the institution; the next morning before the committees begin, I have the keys and I just go where I like. I sit in a corridor or anywhere, and the patients just talk to me as they feel inclined. If any of them want a particularly private talk with me, I go into their rooms or sit with them in a corner of the corridor. Any of them can talk with me at any time. I think to many of them it is a great comfort to have somebody coming from outside and also perhaps somebody not in uniform.

5538. There is a great deal in that, of course. You make them feel as if they were not cut off from ordinary life, so to speak?—That is so. I can bring messages from their friends, and look at the things they are doing, all the handiwork, and so on, and talk to them about all sorts of outside things. A great many of them read the newspapers and are very keenly interested in things that are going on.

5539. Do you find that your colleagues take a personal interest in the cases?—Yes, but I am the only woman who stays a night there, so the other women have not the same opportunity as I have of spending time in the wards.

5540. Do you find that the patients have many complaints to make to you?—Yes, there are a good many.

5541. What class of complaints do they make to you?—I think most of the complaints lately have been of the roughness of some of the young nurses. Sometimes the patients write me letters to my home address and sometimes they send messages when I get to the institution. One of the complaints which worried me a good deal was a complaint of the carrying of a patient to the bath and of dropping her on the way—I was a good deal worried about that. Then I talked it over with the woman doctor and the matron, and I told them I felt I should like to satisfy myself about the complaint. I felt sure that they had seen and misunderstood some of the treatment that had to be given to some of the very resistive patients; so the doctor said she thought I

3 December, 1924.]

Dr. HENRY YELLOWLEES, O.B.E., M.D., and
Mrs. CONSTANCE M. R. CROSLAND.

[Continued.]

had better go and see some of the treatment of some of the worst patients so that I could judge for myself, and Dr. Yellowlees very kindly agreed and made it very easy for me to do so. They did not tell the nurses at all before; I simply went down with the matron. The first case I saw was a poor thing who very much objected to having a bath; she went absolutely wild. As soon as she found she was going to be given one she struggled and kicked and yelled, and they had to roll her in a sheet, and two nurses carried her. She struggled so terribly that they could not help dropping her; I do not see what else they could have done, and in the handling of her, though there were three nurses and a sister dealing with her, she bit deeply the sister's thumb. Yet they told me that when it was proposed to move her into another gallery, the nurses who were used to dealing with her said she was such a nice patient that they did not want her to go and wanted her to be left. She seemed to be a perfectly nice person as long as she was not being given what she considered to be this terrible thing. Another patient was having her finger nails cut, and it took three nurses to hold her down while they cut her finger nails.

5542. When these complaints are made to you about rough treatment, are they complaints by the patients of rough treatment of themselves personally, or of rough treatment they have seen other patients subjected to?—Both. This instance was of the latter type.

5543. This particular lady was not complaining of any treatment she had received herself, but of things she had seen?—The complaint came from other patients who had seen the patient or heard the screams and thought that some terrible cruelty was being inflicted upon the poor creature. The third case was a poor thing having a bath with very sad sores on her flesh which she had made by her own fingers. She was wailing all the time at the cruelty of simply being washed. She could not do with it.

5544. When you get a complaint of that sort made to you by a patient either of something which she has herself experienced or imagined or of something she has seen somebody else subjected to, do you go into it and make inquiry about it?—If it is a perfectly wild letter that comes to me, as some of them are, I feel that perhaps we need not go further into it. I generally go and talk either to the lady doctor or to the matron about the case. If they think it is a case in which I should have a conversation with the patient I am given the opportunity, and I have the patient alone without a nurse there at all; they have perfect freedom to talk to me at any time. (Dr. Yellowlees): May I point out in connection with this matter how beautifully it illustrates just the point you have been asking, and ask you to note that the complaint was of a kind in which there would have been every temptation not to allow it to go further—the complaint of roughness of the nurses. The complaint went right up to Mrs. Crosland, and far from any attempt being made to gloss it over, or to assert that “it is a delusion,” the only right thing was done, namely, “Go and see for yourself what this person has complained of to you.” It is the only thing to do, but I cannot prove to you that I did not carefully coach everybody in their parts, and that I deceived Mrs. Crosland! She does not think so, I do not think so, and I hope you do not. It was most interesting to me, when Mrs. Crosland spoke in my presence to our committee just as she has said to you, because it was very good for them to realise that such a trifle as the cutting of a person's finger nails required four strong people and gave rise to these terrible allegations of cruelty. Had the nails not been cut, the patient's relatives and those about her would have been the first people to complain of the slovenly nurses and the lack of attention. I do not resent the thing much, but I do think it should be fairly seen on both sides.

5545. *Earl Russell*: When a patient, otherwise quiet, makes so much objection to it, is it actually necessary to give a bath? Could you not wash by sponging, or hospital washing in the ordinary way?—I am not quite sure why this particular thing was done, but it is generally done in a bed bath if the patient is not willing to go to a bath.

5546. No doubt there were reasons in this case?—No doubt there were, and frankly I do not remember them at the moment—probably the patient's habits were so terrible.

5547. *Chairman*: We have heard of the activities of the visiting committee. You have other outside visitors who come to your institution, have you not?—Yes.

5548. You have visitations, have you not, from the Board of Control Commissioners?—Yes, twice a year; statutorily, I believe, only once, but in practice twice.

5549. What do they do when they come?—They visit every patient, every part of the place, see all the officials that they wish to see, and give interviews to all patients who desire to interview them.

5550. Do many patients take advantage of that?—Very few. Again I speak from my experience of this particular place and the small number of patients; I daresay, perhaps, two or three patients.

5551. *Mr. Jowitt*: Each time?—Each time—generally the same patients, the two or three are standing figures.

5552. *Chairman*: Do the patients in your institution know of their right to have a private interview with the Commissioners who come?—Certainly; notices are posted up, and I also tell them as we pass.

5553. *Mr. Jowitt*: Do you know beforehand when they are coming?—No, no one knows. I should say that once only, in all the hospitals in which I have been, I had a suggestion made to me by a superintendent somewhere in the vicinity that if I would give him word when the Commissioner was coming, he would give me word. That is the first and only time I have ever heard such a thing even suggested. He was the head of a very small place which was not at all in a satisfactory condition.

5554. *Chairman*: How did you receive that suggestion?—I was not a party to it. The Commissioners are our friends.

5555. Have you any visitors?—There are these groups of people; the directors send a couple of visitors every three months; the committee send two visitors specially every two months, and we have two what we call lady visitors from the directors. We are rather complicated. The Society of Friends sends the strange couples of people, who make reports.

5556. What about the relatives of patients?—I have only one rule about relatives, namely, that anybody may visit any patient at any time.

5557. *Earl Russell*: There is no fixed visiting day?—There is no fixed visiting day, and no fixed visiting hours. I do sometimes draw the line. When we gave forty teas in a week I really had to point out that it was not a private hotel, but that it was a hospital first. I have made no rule otherwise. In about three or four cases in two and a half years I have had on medical grounds to stop a visit. I frequently advise relatives to leave patients alone for a fortnight or three weeks to give them a chance, but my invariable rule is “You can come at any time you like.”

5558. *Chairman*: Where does a relative see the patient?—If the patient is in bed, in the hospital where the patient happens to be, or on the veranda where she happens to be, or in a single room where she happens to be; if a patient is up and about, generally in one of the visitors' rooms.

5559. Would they be there without any third party?—Oh, yes. The nurse brings the patient in, if it is to the visitors' room, and then leaves, and when the visitors have finished they ring a bell, and they ought to wait until the nurse comes back.

3 December, 1924.]

Dr. HENRY YELLOWLEES, O.B.E., M.D., and
Mrs. CONSTANCE M. R. CROSLAND.

[Continued.]

5560. *Mr. Jowitt*: That is another touch with the outside world?—Yes.

5561. *Chairman*: Then there is another method of communication, and that is by correspondence. How do you treat the letters of your patients?—By law I must send unopened any letters which are addressed to the Lord Chancellor, any of the Visitors in Lunacy, the Board of Control or any of its members, or the chairman of the visiting committee, and also to the petitioner—that is the person who signs the request.

5562. Those letters must be sent unopened?—That is so.

5563. What facilities are there for posting letters inside the institution?—In every ward, or in most of the wards, in the acute ones, there is a small box in which patients can put them; these are brought down to the medical office, through which they go.

5564. Is there any notice up in the wards?—In every ward there is a printed notice explaining about letters and visits.

5565. Then as regards letters other than those addressed to official persons, how do you deal with those?—In the average case when the relatives bring the patient I see the relatives and I say "What do you want done about letters?" If they say they can all go, I am content. If they say "Do not let him send letters to so and so" I say "Why?", and if the person gives a reasonable cause for it, I examine those letters addressed to this black list, as I have a right to do. If the letter is in my view likely to be harmful, or it is obviously insane and giving away the unfortunate mental state of the writer, I destroy it.

5566. You exercise your discretion?—I exercise my discretion. In the case of the great majority of patients we do not look at the letters at all. There are some patients who simply write scribble; we know it is no use. I should say the majority of the patients put the names under where the stamp will come. If you know it is a letter from a patient who is sensible you simply tick the letter off, it is stamped, and dispatched without even being read.

5567. On the other hand, some letters are quite irrational?—A large number are quite irrational.

5568. Now I think these, as far as I can recall, are all the means of contact between the patients and the outside world, are they not? Are there any other ways in which they come into contact with the public or with authorities?—Well, Sir, firstly you have to remember that a large number of patients have parole and are perfectly free to go into the town.

5569. Yes; that is a topic we have not heard very much about.

5570. *Earl Russell*: Are they unaccompanied on parole?—Yes.

5571. *Chairman*: Will you tell us about that; we have not heard much about it?—The question of parole is a graded method of testing the patient's adjustment to the outside world. You begin, let us say, with an acute case who is not in touch with his surroundings at all, who is obviously a sick man, and has to be treated in a bed in the acute part of the hospital. Let us say that he recovers. He goes as soon as he is convalescent to another part of the house where there are convalescent persons like himself, and he is encouraged by that very step (I am missing out the details of treatment) in the belief that he is getting better. He probably then gets into further touch with the outside world by going to the various entertainments or concerts or dances which we are constantly organising among ourselves, a lecture or a debate, or possibly he is a chess or draughts player, in which case he will find others like himself only too anxious to give him a game. Then while, perhaps, you are not very sure of him there is a good concert on in York, and he is very fond of music. He says, "Well, doctor, could you arrange for me to go with one of the attendants?" Of course you could, and he goes out and enjoys it. He comes back. Then the question is, "Could not he go out into the grounds himself?" He is fond of gardening; an allotment is given over to him, and he finds he

can work away on his allotment. He is expected to keep his word to be in for meals; and things work in that way. After a while the question is, Cannot he go out himself? Why should he not? If he says he will be back by tea time we have no reason to doubt it, and the best way is to let him see we believe it. He goes out by himself and he comes back. Of course, by this time he realises, unlike a good many people outside, that our chief enthusiasm and aim is to get the man well and away, and he co-operates with us to that end. When he has satisfied us and himself of his ability to go about unaided, to adjust himself to the various demands of life, we tell him that he ought to go. I have given you in essence the gist of the procedure.

5572. It seems that you have patients at the stage at which they are put upon their parole, are allowed to mix with the community, to go out and shop, or to go to the cinema and so on?—That is so.

5573. Do you find in practice they keep their word to come back?—Yes. Of course, you consider carefully before you give it. A bad mistake is not common. I have had two bad mistakes in the 2½ years. I have had one suicide, the result of allowing liberty, and I have had one escape, the result of allowing liberty.

5574. *Earl Russell*: An escape which extended over 14 days, you mean?—That is so; I have only had two escapes in 2½ years. Of course, the front gate is always open for anybody to escape who wants to.

5575. Do you have to warn them against alcohol when they go out?—In certain cases, yes; but surprisingly few; you do not have much trouble with alcohol in that class of case. That is rather curious. I have a figure with regard to the detention of patients. I may be forestalling what you are coming to.

5576. *Chairman*: I was just coming to that topic. We were trying to get a picture of the relationship of the inmate of your institution to the public, the points of contact. Of course that provides, as you appreciate, a very valuable safeguard, that a person should have opportunities of seeing outside persons and of making complaints if he or she so desires. I think we have probably exhausted the means of contact. With regard to letting patients out on parole, I suppose they can go to their relatives?—That is so; and very often the relatives come for a while and try it, and take rooms near York; we spend a large amount of time in finding suitable rooms near the Retreat for the relatives to live in.

5577. Now I think perhaps you might deal with the next topic which you have in your note here. One of the topics which the public are concerned with is the possibility of detention of persons who are sane; that is to say, either the admission of persons who ought not to be admitted, or the continued detention of persons who ought not to be detained. All the patients reach you on a reception order pronounced on petition?—All the certified patients, yes.

5578. All the certified patients who reach you in that way are private patients?—That is so.

5579. You, of course, will receive the documents relating to their cases?—That is so.

5580. How do they actually come to you? Are you asked by the medical practitioner who attends the case to provide accommodation for the patient?—Very often.

5581. Are you communicated with before the patient comes?—Yes. Sometimes I have seen a patient in private or in consultation with another doctor, but I think in the majority of cases the doctor rings up or writes to say that he has a patient who needs mental hospital care. Occasionally the relatives write, generally, I should think, prompted thereto by the doctor, but on the whole it is the medical practitioner.

5582. It is very much like sending a patient to any other nursing home for any ordinary malady. Naturally, the practitioner attending the case will write to you first of all. On accommodation, do you

3 December, 1924.]

Dr. HENRY YELLOWLEES, O.B.E., M.D., and
Mrs. CONSTANCE M. R. CROSLAND.

[Continued.]

find yourself able to overtake all the cases that are offered to you?—Yes, just; it varies, but we manage.

5583. You receive the patient, of whom you may possibly know something beforehand, or may not, as the case may be?—That is so.

5584. Then the documents are made available to you. You examine the documents, I suppose?—That is so.

5585. Do you find that the documents accompanying the reception order are in general satisfactory to your mind as a trained alienist?—As a trained alienist, yes. They satisfy me medically, invariably. They hardly ever satisfy me from the point of view of a correctly filled-up schedule; in fact, they are almost invariably legally, if I may use the phrase, inaccurate.

5586. *Earl Russell*: Imperfect?—Imperfect.

5587. *Chairman*: but on the substantial point at issue one knows that they contain a statement of facts and opinions?—That is so.

5588. By two medical practitioners?—And, what is legally of importance to us, they contain the legal authority that we have to keep the patient, namely, the magistrate's order.

5589. That is your warrant?—That is our warrant.

5590. That is a legal matter which, of course, is of great importance as a safeguard; but from your point of view I should think the contents of the medical certificate are of great importance and interest?—That is so.

5591. Then you have to make a report to the Board of Control within 24 hours of the reception of the patient?—Yes.

5592. Then what is your next step?—In more than two and less than seven days we have to send a summary of the patient's general condition, bodily and mental.

5593. Then you have to make the month-end report?—Yes.

5594. We know all this already, of course, so I will just take it shortly. After that you have to make a report at the end of stated periods?—That is so.

5595. Continuation reports?—That is so.

5596. Now, of the patients who reach you in this way have you had, in your experience, any reason to doubt the propriety of their reception in your institution on the ground of their insanity or sanity?—No, none whatever.

5597. Have you ever had a case as to which you were in some hesitation?—Do you refer to my experience in England?

5598. Yes; will you confine yourself to the Retreat? Of the cases tendered to you there, accompanied by these documents, have you ever upon your examination of the patient had reason to doubt the propriety of the detention of the case?—Yes, I have. To have said "None whatever" was perhaps rather sweeping. I have in this sense, that patients have arrived who I thought might with wisdom have been treated elsewhere. For example, a patient arrives in acute delirium, which one believes will recover in the course of three or four days. The relatives have sufficient money, and it crosses one's mind, "Now this was foolishness." Of course, the person was mentally out of touch with his surroundings, and anybody could have certified him, but it would have been a wise proceeding medically to continue that patient's treatment at home.

5599. That is rather a different type of case; that is the person who for the time being, but in your view only temporarily, is of unsound mind, but the unsound mind is not the concomitant of a settled state of insanity?—No.

5600. That class of case might be dealt with without certification, but the case arrives at your premises certified?—That is so, and that is what I have sometimes objected to.

5601. But that class of case is probably not so troublesome as the class of case where the person is on the border line. No one can define insanity, I suppose you will agree, doctor?—I will agree, yes, for the purposes of this Commission.

5602. I should have thought for all purposes.—It is a legal term, and not a medical one, so I should not try.

5603. Let us be very careful. It is a question of degree, is it not?—I would like to know what is coming, before I answer that question.

5604. What I want to get at is this: Do you not find in your experience that there are cases as to which it is very difficult to decide whether the boundary line between medical unsoundness of mind and medical soundness of mind has been crossed?—Yes.

5605. That always strikes me personally as the class of difficulty that must confront you in administering the laws relating to insanity?—In the cases that arrive certified, my experience has always been that that line has been passed by a very long way.

5606. In fact, may it not be this, as we have reason to believe, that many cases might never have crossed the line if they had been brought to the knowledge of the proper practitioners at an earlier stage?—In general that statement is true.

5607. Therefore is your experience this, that those who do reach you under a reception order have unhappily passed the frontier?—Yes; but you must not regard the frontier as a bourne from which they are not going to return at all.

5608. No, but there is no right in law to detain a person against his will unless he is of unsound mind?—That is so.

5609. What I want to know is this: Whether you have ever felt difficulty as to the legal right of detaining a particular person on the ground that he or she was not of unsound mind?—I do not think so, ever, at the time of admission.

5610. Of course, that may result from the circumstance that as matters stand there is not adequate provision for what I may call preventive treatment, with the result that the cases that are certified have gone so far that they present no difficulty?—That is possible. It is hardly the point you were asking me, is it? Your point is: Are the certified patients that I receive certifiable?

5611. Yes?—The answer is yes.

5612. Now you said your difficulties, if any, arose not at that stage, but at the later stages?—Yes; and how they arise is interesting.

5613. Of course, convalescence is a gradual process?—Yes.

5614. And I do not suppose even the most skilled alienist can fix a moment of time and say: Before that moment of time a case is properly certifiable, and after that moment of time the case has ceased to be certifiable?—I entirely agree with you. I was once rude enough to write that it is only in courts of law that a person is sane on Monday and insane on Tuesday.

5615. But looking at it from the medical point of view, your right to detain being dependent upon the continued unsoundness of mind of the patient, do you tell us that you never have any difficulty in judging when the patient has passed out of the region in which he or she may be legally detained?—No; but in convincing other bodies, yes. May I explain the difficulty?

5616. If you please?—A patient comes in acutely ill, and in my first report, from two to seven days, there is no difficulty. I write a description to the Board of Control of an acute mental person. Within three weeks the patient is weak, exhausted, showing traces of confusion still coming over him every day or two, but obviously very well on the way to recovery, and I have to sit down and write a report at the end of the month justifying to the Board of Control, who have not seen the patient, his continued residence in the hospital. That difficulty is a small one, but it is astonishingly real, because the Board of Control, if the monthly certificate is in the least weak, at once write back, because their function in this regard is to safeguard the very point you raise—

3 December, 1924.]

Dr. HENRY YELLOWLEES, O.B.E., M.D., and
Mrs. CONSTANCE M. R. CROSLAND.

[Continued.]

they at once write back to say "Let us hear more about it," and they frequently enclose a form, and say, "Send us that form filled up in a week or fortnight or in a month." It is difficult, because the patient knows he is getting better, and is only too thankful to remain till he is better. His relatives know it; I know it; but I have got to write out this document, searching my brain for some terrible symptoms to justify the Board of Control saying he is still insane, and is legally detained. That is all right. I do not see how we can avoid that.

5617. *Sir David Drummond*: How do you deal with the case in which you have searched your brain and have not been able to arrive at a reason?—I discharge the patient and let him come in as a voluntary boarder.

5618. *Earl Russell*: Would it be possible to get over the difficulty in some way by using different words on the certificate and having a different kind of certificate in which you said the patient was convalescent, but that it was still desirable that he should have care and treatment?—If there were a certificate of that kind I should frequently use it.

5619. You would adopt it?—I should gladly adopt it.

5620. *Chairman*: But you would still require to have powers of compulsory detention in such a case?—I would not, really. If I had not powers of compulsory detention at this moment, have the Commission any idea of the percentage of patients who would leave?

5621. Tell us about your patients. Supposing you opened the door and you had no power to detain: how many would leave in twenty-four hours?—About a fortnight ago I did a small experiment, which I quite realize has no evidential value, and you could no doubt tear holes in it, but it is of value. I discussed with my colleagues a form of question, and we arrived at this question: "Do you definitely resent your detention here?" We took a morning at random when there were in the building 162 patients. Of those 162 patients, 12 were voluntary boarders, which left us for the purpose of experiment with 150 certified patients. Every one of those patients, whatever his mental condition, was asked this question. The rules I gave to my colleagues were these: If the answer is in the least indicative of resentfulness, that they do definitely resent it, put it down as "Yes," even though it may be said in mischief or in spite, put it down. If the answer is unequivocally "No," put it down as "No." If it is not unequivocally "No," put it down as doubtful. 15 patients (10 per cent.) answered, "Yes," that they resented their detention; 46 patients, that is 31 per cent., gave incoherent answers or doubtful answers, or were silent; 89 patients, or 59 per cent.—more than both the others put together—said unequivocally, "No," they did not resent their detention.

5622. Of course, one does not quite know how far those answers might be dictated by the desire of the patients to please the questioner?—As I said at the beginning, it is of no evidential value whatever. It is also possible that I stood over them with a stick, and applied duress.

5623. I do not suggest it, but you have already warned me not to try and tear holes in it?—No; I said it was possible that you could do so.

5624. *Mr. Jowitt*: I am thinking of the political principle, that you give the other side all the doubts and take the 10 per cent. as your own?—Is it not interesting?

5625. *Chairman*: It is exceedingly interesting.—Of course, the only way of interpreting it is to give me and my assistants a certain amount of credit for being neither scoundrels on the one hand nor dupes on the other, with a certain knowledge of our work, and sympathy with the patients.

5626. Now on this point of the detention of the persons on the way to recovery, as you have said, there is some difficulty in fixing the point of time when they ought to be discharged?—That is so.

5627. But when their recovery is established do you discharge your patients at once?—Certainly.

5628. How are they discharged from your institution; what is the procedure? Of course, the petitioner can always ask for the release, whether recovered or not recovered?—A recovered patient can be discharged by my authority or by the petitioner. Funnily enough, the Board of Control always put down "by authority of the petitioner", but the patient can be discharged by myself or the petitioner.

5629. When you see that a patient is approaching complete recovery, what do you do yourself? Do you notify the petitioner or the relatives?—I have a talk with the relatives generally or write to them and try to satisfy myself as to the future of the patient. In fact, very much more than the public imagine, the difficulty in the discharge of a patient is due to the unwillingness of the relatives to be bothered with the patient; and I write a very large number of letters, in which I have to urge quite strongly upon relatives their responsibilities in the matter. It is all perfectly right and legal, and so on, especially in the case of a patient with regard to whom I cannot swear that he is, strictly speaking, recovered; and the relatives frequently take that attitude. They say, "Doctor, is this patient recovered?" I say, "Well, no she is not, but I think she might very well be tried at home; I think she would do pretty well at home." And they say, "Oh, well, it is not easy at home." And, of course, it is not easy, but the relatives are frequently unwilling to accept one's judgment that the time has come when the patient might be tried.

5630. *Earl Russell*: Do you ever adopt the system of monthly trial?—Yes, frequently. We never put it for a specified time; it can always be renewed; we very very frequently adopt that system.

5631. *Chairman*: In the case of private patients, who may be persons of considerable means, there may be a motive on the part of the relatives for desiring a continued detention that may not operate in the case of pauper patients. I suppose you do have patients with considerable property under your charge?—That is so.

5632. Have you had any experience of cases where you have had reason to suspect that the relatives desired to keep the patients away as long as possible? I am not thinking of the motive that they had difficulty in accommodating them at home; I am thinking of a more sinister idea.—With an unrecovered patient in a way they are perfectly right. You are asking me whether I impute a motive to relatives other than the one they give?

5633. Yes. Of course that is a difficult question to answer?—It is. I know what you mean, and I do not think I can honestly say so. I have come across things which I thought were rather fishy and persons who I do not think were just thrilled to do the very best for their relative. I certainly will not go further than that.

5634. The patient is *ex hypothesi* recovered, and ought to be discharged?—If he is *ex hypothesi* recovered, I would simply say he must go at once.

5635. The case of a person more or less recovered is a person still certifiable, and certified in fact?—If I feel very strongly about it I stretch a point and discharge the patient recovered, and thus force the hand of the relatives, and they have to do it.

5636. Do you attach importance to there being two medical certificates appended to the reception order in the case of the private patients?—I think it is a great comfort to the magistrate and to the public, and I can imagine it being a safeguard to the patient. I do not think it is a great safeguard to the patient.

5637. I think we may say that we are rather impressed with the undesirability of there being a distinction between the machinery of certification for so-called pauper patients and that for private patients?—I think that is very wise.

3 December, 1924.]

Dr. HENRY YELLOWLEES, O.B.E., M.D., and
Mrs. CONSTANCE M. R. CROSLAND.

[Continued.]

5638. And we are considering whether we can make any recommendations upon it. The pauper patient is certified on one medical certificate and must be seen by a justice of the peace. A private patient is certified on two medical certificates and need not be seen originally by the judicial authority, but may call for a visit from the judicial authority within 7 days, as we know?—That is so.

5639. Now if we are to assimilate the procedure in both cases, can you assist us at all with any suggestions? Would one medical certificate in the case of the private patient, coupled with a compulsory seeing of the patient by the judicial authority, be adequate?—I think that the second medical certificate is a much greater safeguard to the patient, if that is what you are anxious to know, than is the seeing by the justice. Of the two I think the second medical certificate is the better safeguard.

5640. What I ventured to put to several of the preceding witnesses was this, that there must be many cases in practice where the unsoundness of mind is so obvious that a second medical certificate might be redundant. Of course it costs money, one has got to remember?—That is so.

5641. What do you say to the idea that where there is any doubt either in the mind of the first medical practitioner or of the justice of the peace, they should have the right to call in a second opinion before certifying?—I do not know if my mind works quickly enough to take in all that at once. I hardly think it would be very satisfactory for the justice of the peace; I think it might be a comfort for the doctor; but it is putting a great deal upon the doctor in any case. It is much happier for the doctor to know he has a colleague with him, and if you give him that right, I think he will exercise it in every case. It is a point that I had not considered but it is very interesting.

5642. If we have to assimilate the procedure in the two classes of cases, which we may have to recommend, one is very anxious to know from a person of practical experience what we should prescribe as the necessary preliminary to certification. It must be adequate and it must be reliable?—Are you concerned with the legal irregularities in the papers? Are you concerned with the fact that the average magistrate will sign papers which are from a technical point of view hopeless and have to be sent back for amendment?

5643. Yes. We have heard a good deal about that from official sources, but I think the question of the adequacy or inadequacy of the filling up of the forms is perhaps not a matter we are on for the moment. It is a question really of what persons are to intervene. In the case of the pauper patient two persons intervene, a justice of the peace and one medical practitioner. In the case of the private patient three persons intervene—the judicial authority, who after all is a justice of the peace, and two medical practitioners. Now if assimilation is to take place, I gather your view is that in all cases two medical opinions would be better?—I would be inclined to add one to the pauper patient.

5644. And you make the point on it, which is perhaps of importance, that in a responsible matter of this sort any professional man prefers to have the assistance of a second opinion, or the comfort of a second opinion?—That is so.

5645. *Earl Russell*: You must remember, of course, that the second certificate has to be made without consultation. He is not supposed to talk it over with the other man?—It is not likely that I forget that; but it is for the purpose of helping each other with responsibility.

Chairman: It is the knowledge that the patient will not be certified unless another confirms his opinion.

5646. *Mr. Jowitt*: It is sharing the responsibility?—Yes.

Mr. Walter Stewart: Before you leave that point, Sir, would you ask the witness what is his view with regard to the provision of Section 31, which provides

that the second certifying doctor should be the patient's ordinary attendant?

5647. *Chairman (To the Witness)*: Tell me about Section 31. It provides that one of the certificates should, where practicable, be under the hand of the usual medical attendant, that is to say, of the attendant who has some knowledge of the case?—That is so.

5648. Now do you think it desirable that that should be used as much as possible?—I do. Of course it is sometimes extraordinarily difficult.

5649. I was just going to say, one can imagine great difficulties practically; in your case probably there is not so much difficulty because the private patient has presumably been in the hands of a practitioner?—From that point of view it is less difficult, but, on the other hand, the private patient has travelled about more; he may have been in other places, and perhaps has been abroad and not in touch with his medical man for a long time, or possibly has gone as a voluntary boarder.

5650. *Earl Russell*: You mean there is a good deal of doubt as to who is his regular medical attendant?—Yes, there is a good deal of doubt.

5651. *Chairman*: Of course in the case of an alien or a lunatic wandering at large he would have no regular medical attendant?—That is so.

5652. May I take it that this section of the Act is of value in this respect, that the medical attendant will be most naturally familiar with the history of the case?—Yes. My opinion of this section is that it is a good section; what it ordains is very wise, but it is essential that it should say "whenever practicable," which it does, because to make it a hard and fast rule would bring about very great inconvenience and hardship at times.

Chairman: I do not know whether I have put the question in the form you wanted it put, Mr. Stewart?

Mr. Walter Stewart: Yes, Sir. I wanted you to call the attention of the witness to that provision which is the real safeguard, as we suggest, namely, that somebody who has had previous knowledge of the case should, wherever possible, be consulted.

Chairman: You observe, of course, that Section 31 relates only to private patients on a reception order following on a petition.

Witness: That is so.

5653. Have you any view as to whether a similar provision should be made with regard to pauper patients? If they have a usual medical attendant, the certificate should be by the usual medical attendant wherever possible? It might be the panel doctor?—I should have thought that such a provision would be wise and right. I do not pretend to know how it would work, but I should have thought it would be very desirable.

5654. It is really recommendatory rather than mandatory. If it contains the words "whenever practicable" it would not safeguard cases where there is no medical attendant?—That is so.

5655. *Earl Russell*: Have you considered the possible objection to the usual medical attendant from this point of view: that he might be extraordinarily reluctant to certify until it was too late, by reason of the fact that he was the usual medical attendant?—I think that that is not an objection, because for better or worse he is the patient's medical attendant, and, presumably, he will know more about the patient than any other physician; and if he happens to be too conservative, that may be a misfortune, but I think the benefit of his knowledge of the patient ought to outweigh it.

5656. And you do not think the patient would suffer by the delay?—I do not think so much as he would probably benefit in other ways.

5657. *Sir David Drummond*: Has it not come under your notice personally that practitioners have actually declined to certify because of their objection with reference to the point that Lord Russell has raised?—Occasionally, not very often, that is so; but I do not quite see how this suggested clause would

3 December, 1924.]

Dr. HENRY YELLOWLEES, O.B.E., M.D., and
Mrs. CONSTANCE M. R. CROSLAND.

[Continued.]

make that matter worse, because if the patient's own medical attendant is going to be reluctant to certify, surely the average strange medical attendant would be equally reluctant, the more so when he heard that the gentleman who knows the patient is not going to certify.

Chairman: Except that the medical practitioner who is the usual attendant is ordinarily a personal friend, and it is therefore a more painful or difficult duty to certify a person who is your friend.

Sir David Drummond: And the fear that he will not be the medical attendant after the recovery of the patient.

5658. *Chairman*: Supposing a patient after leaving the Retreat returns to ordinary life and he knows Doctor So-and-So was the person who put him in, would he not say "I would rather change my doctor now"?—The answer to that is that it simply does not happen in my experience.

5659. *Sir David Drummond*: In your experience?—Yes, I may be wrong.

5660. *Sir Humphry Rolleston*: What, in your opinion, would be the feeling of the public generally, supposing we were to adopt the recommendation that has been suggested, that we should only have one certificate for a private patient. Would they feel that a protection had been removed?—In my opinion they would feel that a protection had been removed.

5661. They would consider it really a retrograde step from that point of view?—I think there would be a good deal of noise made about it.

5662. Even if there was the suggestion that either the one doctor who certified or the justice should have the option of calling in a special individual to give, so to speak, a consulting opinion?—I do not think it would do. If the doctor did not avail himself of the right, he would be in a most invidious position with the unfortunate patient afterwards. "There was this doubt and he did not even take the trouble," says the patient, "to call in another man. The moment he has not got to do it by law, he simply does not do it."

5663. So that if there was that in the background, in practice you think it would come to two certificates still?—I believe so.

5664. *Chairman*: Have you any opinion as to whether one of the practitioners who certifies should be required to have any special qualifications?—Yes. I have no improvements to suggest in that except the improvement of medical education.

5665. That is to say, all round?—Yes, all round.

5666. But do you think public confidence would be increased if one of the medical certificates had to be given by a person specially skilled in mental ailments?—After all, it is the magistrate who says whether the person is insane or not.

5667. But he properly proceeds upon the evidence before him, which is two certificates?—That is so.

5668. Do you think that if one of those certificates were required to be given by a person specially conversant with mental ailments, that would be an advantage and an additional safeguard?—There again it is so hard to say. One gives the public every credit for being completely sincere, but you could use it either way. You could say "There you are, you are going to rope in the insane. You get these terrible mental specialists who see everybody insane and you will not let a plain unprejudiced doctor look at him." On the other hand, the public might say the precise opposite.

5669. Now, on this question of detention, do you find, as a result of your census, that the patients who are most anxious to leave are those who are most unsuitable to leave? Which class of them express their desire to get away?—The paranoiacs—that is the condition known as chronic delusional insanity, which is very much rarer than one would believe from the papers—and a few of the elated patients; certain patients in the condition known as simple mania will give an angry, furious retort, and will say the unpleasant thing. Those are the two classes that are anxious to go.

5670. Now, dealing with quite another topic, we want to know what provision you have for the treatment of patients. You have the establishment, of course, and we have heard about the recreation you provide, and all the rest of it; but from a purely medical point of view, what facilities have you for treatment, to what extent do you need to provide treatment?—You need treatment very much more than people imagine; but you leave aside the social life of the place, the entertainments and so on, failing to realise, before you get any further, that treatment of a very definite order—

5671. I fully realise that the whole life of the place with its home surroundings and the discipline are themselves curative?—That is the idea.

5672. One wants to know, apart from the routine of the place, and so on, are there any specific courses of treatment to which you resort, or are there any particular means of cure?—Practically every patient on admission goes to bed, precisely as he would go in a general hospital.

5673. Or in a nursing home?—Or in a nursing home. He is examined in precisely the same way and his physical condition is duly noted, any physical abnormality or disease is appropriately treated as it would be in a hospital. He is probably treated also, if he has certain symptoms such as sleeplessness or depression, by living outside on the verandah the entire day. Then it is considered whether he is a suitable case for any of the forms of psychological treatment about which we hear so much? The essential point of all these courses or systems of treatment being that they demand the intelligent co-operation of the patient. Is he in a condition to do that? If he is, the patient is taken as the special province of one or other of the assistants, is spoken to and conversed with on suggestion or analytical lines as may be thought right. I happen to have two assistants who are trained and qualified in psychology, as I am myself. The question of glandular therapy, which is perhaps one of the more hopeful and more modern ways of treating mental disease, is also considered, and he is probably put on a course of one of the glandular extracts which are being now experimented with. Of course, when I say "experimented with" I lay myself open to the retort "You experiment with your patients."

5674. *Earl Russell*: You mean thyroid, and others?—Yes, thyroid and others. Then, of course, we have a visiting dentist, and a large body of opinion at the present day, as you know, sets great importance on sources of sepsis, especially in the teeth, and we have these examined as routine by our visiting dentist and anything of that kind done. I am installing a continuous hot-bath treatment, and all these various methods which experience has shown to be of possible use in the treatment of insanity or the bodily symptoms associated with it.

5675. *Chairman*: To what extent do you use drugs?—Just to the extent that I think is required. Do you mean sedative drugs?

5676. Yes. One, of course, knows that sedative drugs are part of the treatment that you must give to certain classes of cases. Do you use them to any large extent?—In the Retreat, as it happens, we use them to a very small extent. For one reason, we find that our open-air treatment is extraordinarily good in the prevention of the sleeplessness for which these drugs are generally used; and, secondly, as it happens, my predecessor, Dr. Bedford Pierce, had a very strong feeling against the use of sedative drugs, and I think his tradition in the matter somewhat lingers.

5677. *Earl Russell*: Do you not have many restless patients?—We have our fair share of acute patients, but of late we have had very few patients of that kind. The last time the Board of Control Commissioner came he paid a surprise midnight visit with me. This is in order to show you the way they go into the matter. The next morning he asked me to let him see all the sedatives used that night and in the last month. On the night that he chose at

3 December, 1924.]

Dr. HENRY YELLOWLEES, O.B.E., M.D., and
Mrs. CONSTANCE M. R. CROSLAND.

[Continued.]

random he notes in his report that he did not happen to hear a single sound, and the whole of the sedatives used were, I think, four drachms of paraldehyde; that is to say, there were two doses of paraldehyde in the 160 cases.

5678. *Mr. Jowitt*: For one night?—For one night, but that may vary, of course.

5679. *Chairman*: It has been suggested that in some instances there is an abuse in the administration of purgatives?—I have never given croton oil to a mental patient since I was born—never once. Is that what you were referring to?

5680. I was not going to refer to that specially, but do you have to administer purgatives to any extent?—It is a very important thing to regulate the bowels of a patient naturally, as in every hospital.

5681. With regard to the issue of drugs, what control have you over them, as medical superintendent? What is the routine for the issue of drugs; who prescribes and who administers?—My assistants prescribe and dispense. The sister in charge of each ward has the ward medicine cupboard with all the things you use. The only person who has a stock of any size is the night superintendent, who has the matron's duty over the whole house at night.

5682. Have you control direct or indirect of all the drugs that are used?—Yes.

5683. Do you know to what extent they are used, to whom they are administered, and when?—I cannot tell you any morning, unless I take the trouble to look, who had been given drugs the night before.

5684. *Earl Russell*: But there is a record kept, I suppose?—Yes, there is a record kept.

5685. *Chairman*: It has been suggested that violent drugs are used as a punitive measure for the purpose of punishing patients. Have you ever experienced that at any part of your career?—I have never experienced it. The nearest I came to it was a practitioner who insisted that the only remedy worth thinking about for delirium tremens was 30 grains of calomel. That was a general practitioner who tried it on sane people, and he was in a mining village in Scotland.

5686. The hardy Scot may possibly survive that treatment, but it does not suggest to me that that doctor was thinking of punishing the effects of delirium tremens, but was thinking of curing them. What one has heard of is that medicine has been used as a punishment?—I cannot imagine any class of physician countenancing drugs of any kind being used as punishment. I cannot understand a physician in charge of a patient with pneumonia giving his patient any drug with any other object than the well-being of that patient; and why the unfortunate physician who treats mental disorder (not that I resent it) should have to defend himself against even the imputation of giving drugs to his patients for other reasons I have never been able to see.

5687. The suggestion has rather been made that in some instances the attendants have done so, not that the medical superintendent has done so?—Of course the only people who have access to drugs are the responsible heads of the wards, or ought to be.

5688. Would the ward sister herself see that any drugs that were issued were given to the patient for whom they were intended?—In a large place she might not; she probably would in our case. She would probably give it to the head nurse or to one of the nurses who was doing the medicines. Of course, there again it is so easy to control these things in a comparatively small place.

5689. In your establishment there is no risk of anything of that sort happening?—Not the slightest.

5690. *Earl Russell*: It is a very common delusion of patients that they are being drugged and that their food is poisoned?—That is so. That is very frequently said.

5691. *Chairman*: That is just one of the difficulties in valuing testimony that comes from these sources—that it may itself be subject to delusions?—Yes, although there is an interesting thing that only a

mental specialist can tell you. It is commonly said that when a patient makes a complaint it is easy and simple to put it down as a delusion. I talked the matter over with my assistants the other day and we were considering our various delusional cases. It was pointed out that there are certain patients whom you or anybody would see at a glance were hopelessly and utterly insane; yet their slightest complaint I would believe, and believe at once. On the other hand, there are patients whose complaints it is right and proper to disregard, not necessarily because of their delusions. Patients' complaints are not most frequently the result of delusions. They are the result of spite and pettiness. The most complaining patient of all is an epileptic. We do not have epileptics at the Retreat. I am speaking on general principles. An epileptic patient very frequently has no delusions at all.

5692. *Earl Russell*: He is simply lying?—He is simply lying. It is simply not the case that even the most insane patient's complaints are turned down by saying "That is a delusion." If one of my assistants came to me and said Mrs. So-and-so complains that the nurse did this but it is a delusion, I think I am right in saying that with regard to the majority of my patients I would view that statement with suspicion. I would say I would like to hear more about that; I would like to go and see her. Of course, the kind of delusion you do get is this: I asked one of my colleagues, when she was writing my census, to write down at random some of the remarks she got in answer to the question: "Do you resent detention here?" The first remark she got was "Don't talk nonsense, Margaret"—Margaret was her Christian name. The second was "No, there is nothing wrong in this place." The third was "Why should I resent it? This place is protecting me; I am more likely to resent having to go." All those patients are insane.

5693. *Chairman*: Then you rather give us this warning, that when it is said that an account given by a patient of some particular occurrence is a delusion, it may not be a delusion; it may be true or it may be malicious intent?—Yes, it may be. It is very often a misinterpreted thing, like the complaint of the patient of whom Mrs. Crosland told you; the patient who heard these noises had misinterpreted the whole thing; she is a very very malicious patient; she has recovered and for the moment she is away. In that mildly elated state she was discharged. She was just contentious; she was interfering, fault-finding, almost intolerable, and hearing these sounds and noises she quite characteristically wrote a report and complained to Mrs. Crosland to the effect that there were tortures going on and so on. That is the kind of complaint that patients make.

5694. Now there is one other matter we have to ask you about, and that is your views as to the treatment of incipient cases and the treatment of cases without certification. You are familiar with the movement in that direction?—Yes.

5695. You cannot have been with Professor Robertson without knowing a good deal about this matter. Would you just give us briefly your views as to the policy which could best be adopted in these matters? First of all, are you in favour of a provisional system under which patients might receive treatment without certification?—Do you know, Sir, it is almost impossible for me to answer you, because the matter is so chaotic. I am not very clear about it in my own mind, and the only way in which it could be fought out, I should think, would be as a result of comparing the results of the various people who have tried experiments in a small way.

5696. We are to have the advantage of hearing what has been done at Maudsley, but I think you may help us on the general policy of it. It is our duty to produce cosmos out of that chaos to which you have referred?—That is so. To begin with, there is no objection whatever at the present moment to treating the uncertified patient anywhere you like.

3 December, 1924.]

Dr. HENRY YELLOWLEES, O.B.E., M.D., and
Mrs. CONSTANCE M. R. CROSLAND.

[Continued.]

5697. You have yourself voluntary patients?—That is a different point.

5698. But it is related in this sense, is it not, that you may have a person, for example, who feels that he or she for the time being is rather upset, but has not yet reached the certifiable limit, who would say, "I should like to go to Dr. Yellowlees' care," and is admitted voluntarily. That person may never reach certification, because of the advantage of being treated at the early stages. That case, if arrangements were not made for voluntary admission, might have to stay out until it became certifiable. We have had cases where they cannot take voluntary boarders, and they have been heartbroken about cases that they have not been able to take?—I do not say it would have been the right thing, but as the law stands there would have been no objection to the voluntary boarder going to a nursing home.

5699. *Earl Russell*: With a chance of a prosecution?—No, excuse me; no chance of prosecution. Why?

5700. *Chairman*: Suppose the patient had gone there on the edge, so to speak, and while there became of unsound mind?—Then there is a chance of a prosecution.

5701. Is the unhappy patient to be thrown out of the nursing home, or is the owner of the nursing home to run the risk of prosecution? It is that sort of thing we want to devise redress for, if we can?—The moment the voluntary boarder begins to show signs of illness, the Board of Control insist that he shall be certified.

5702. Because otherwise you would have no right to detain him, and his going away might be detrimental to his own health and injurious to the public?—That is so.

5703. *Earl Russell*: But that is not the reason they want him to be certified. It is the fear that you would be breaking the law if you kept him there uncertified?—The reason they want him certified is to safeguard me and themselves from breaking the law.

5704. *Chairman*: Supposing the law were re-adjusted on the lines of the Mental Treatment Bill, namely, that voluntary patients could be received and could be detained for a short period of, say, 72 hours, as proposed in the Bill, so as to allow in the case you figure of the necessary steps being taken. If that were done a very large number of people would never reach the certifiable limit at all?—By far the larger number; but it is not so easy as that.

5705. We do not have to handle the practical problems you have to deal with, and we want assistance from you. We do not want to suggest things which are impracticable to persons like yourself?—The fallacies are these: That an early case is necessarily not a certifiable case, and will recover; and that an acute recoverable case can be treated without certification for a short time. Well, the commonest case of all the cases that come in as voluntary boarders is the melancholic; it is probably the commonest form of mental disorder. Now simple melancholics can invariably be induced to come into the place voluntarily. The only reason for having to induce them at all is that they are slow; they object to taking any initiative. Once they have taken the step and have written the request for admission they are perfectly content to remain; they retain their modesty and their dignity and their sensitiveness, unlike many. They are very reasonable indeed, but they have one symptom, the majority of them, namely, a tendency to suicide, which makes them the most difficult patients a mental hospital can possibly have. Now what are you going to do with a person of that type? The patient wants to be there; the patient has come because he or she is afraid that the suicidal impulse or depression will be too much for them; they have come to you to help them. You say to them "Very well, come in; we will do everything that

science knows to avert it, and if it cannot be averted we will see you through." The moment the disease comes for which the patient has sought help he becomes suicidal, and becomes a very real danger to himself, and we have to certify him.

5706. I follow that class of case. Now, let me put another type of case to you. Suppose a case of acute mania, but transitory, a mere incident in an otherwise normal and sane life. We have been told that these acute cases are generally the most curable?—Yes, that is so.

5707. Is it not unfortunate that in order legally to detain that person, who for the time being obviously requires restraint, it should be necessary to certify, when after the lapse of a week or a fortnight he may be susceptible of being restored to ordinary life? Why should that class of person have against them a mark, "This is a person who has been certified as insane"? The question is whether every case should necessarily be certified as a preliminary or as a pre-requisite of any detention?—The case you have mentioned differs from the melancholic case to which I have referred in two points only. They are both recoverable, and both will recover. But your acute case does not realise he is ill; he has no insight; and, secondly, he is not a danger to himself, but he is a nuisance to others; he is tending to be violent and unpleasant; otherwise he is the same.

5708. Take both those cases, with their varying features. Have you any views as to the desirability of some provisional method of dealing with cases like that, which are recoverable, so that, interposed between the onset of disease and certification, there might be a period during which the patient would be under observation and treatment, and might emerge cured without certification at all?—Well, I have often wondered whether it would be possible to give some authority to the relatives of the patient, but I do not know how it could be done. I have no thought-out scheme at all; I have worried about it for years.

5709. *Earl Russell*: Are you not thinking of the better-off patients when you speak of giving the relatives some authority?—Yes.

5710. *Chairman*: Far the larger proportion of cases are essentially not the type you have to deal with?—Of course, you are making a great step at once if you recommend the admission of voluntary boarders to county mental hospitals. At present they cannot go, as you know; but in the last resort the question is inclined to be a financial one, as you indicated at the beginning.

5711. *Earl Russell*: Then the Chairman put to you a further step, besides that, you know. Suppose the justice of the peace, whose business it is to pronounce the detention order, had a suspensory power longer than the present very small number of days, by which he could suspend that order to see if a patient improved under treatment, and yet by a mere flick of the pen could certify him at any moment when it was required?—Without seeing him again?

5712. I do not say that. The whole point is to provide that if the man does recover quickly nobody shall say he was a certified lunatic?—I should think it might be arranged to give a power of that kind to the medical superintendent. Once you could make some safeguard, and convince yourselves and the public that his desire would be to avoid detention as long as possible.

5713. It is not us you have to convince; it is the public?—Exactly.

5714. *Chairman*: There are persons, unhappily, whom people would regard as outside the ordinary pale of humanity, because they are not mentally sound and cannot be cured. On the other hand, there are a great many people in our modern civilised life who have temporary breakdowns of one sort or another, but in many cases nothing more than an illness. It is not a permanent lesion or a permanent degeneracy, but an illness?—That is so.

3 December, 1924.]

Dr. HENRY YELLOWLEES, O.B.E., M.D., and
Mrs. CONSTANCE M. R. CROSLAND.

[Continued.]

5715. What we all feel, and the public feel, too, is that it is unfortunate that there should be attached to those persons, because of what is merely a transitory stage, the kind of stigma which will attach to people who are degenerate, and who do suffer from other manifestations of insanity, and are persons differing from their fellows. We do not want to put all these people into the same category?—Two questions, Sir: Firstly, the permanent degenerate cannot possibly differ more from his fellows than does the acute maniac at the moment; secondly, does the stigma arise from the patient having been certified, or from his having been in an institution which also accommodates the second class of whom you speak?

5716. The public attach more importance to hall marks, and the fact that a person has been convicted, let us say, if I may take a case with which I am more familiar, is obviously a black mark against that person. There it stands; it is something which does not admit of discussion?—That is so.

5717. Similarly it is said that, when a person has been certified, we need not go beyond that: that person was insane, at least for a time, and therefore that person is regarded as to some extent differing from his fellows?—Do you think that stigma would attach if the person had been a voluntary boarder and had recovered without being certified?

(After a short Adjournment.)

5720. *Chairman*: Dr. Yellowlees, there is one figure I think we should have from you which would be useful, namely, the proportion of nurses to patients in your institution—can you give us that?—Yes. For every one nurse there are rather less than two patients—about a patient and three-quarters to each nurse.

5721. That is a very high proportion?—It is a high proportion, and in a sense it is misleading, because it includes a large number of patients who pay for the exclusive services of one or perhaps two nurses, which, of course, tends to raise the average.

5722. Then will you tell us what are the charges made for patients—have you a scale?—There is a scale, which briefly is this: The standard charge is five guineas weekly. Higher rates are charged for private accommodation and special nursing if these are desired. Specially low rates are charged and grants made should the patient be connected with the Society of Friends. That, of course, is because the Retreat is a Quaker institution and was primarily for Quaker patients alone.

5723. Do those terms yield a profit?—They yield in an average year a small profit. Of course, these terms have not been operative long enough to know, but the terms we charge generally yield a small profit on the year's working.

5724. What is done with the surplus?—It is applied, after writing off the usual depreciations and so on, either to improving the place or to decreasing the rates of board paid by patients.

5725. There is no inducement to anyone to make any money out of the undertaking?—None whatever. That is, of course, the characteristic of a registered hospital, and all the registered hospitals do a very large amount of charitable work. For example, our charity, because of our position, is limited to Friends, but our lowest rate for Friends is £1 11s. 6d. a week, that is if we give them what we call our maximum grant. Now £1 11s. 6d. a week is very considerably below the cost of maintenance.

5726. *Earl Russell*: It is not so far off the ordinary pauper rate?—No.

Chairman: I think those are all the questions I desire to ask you. My colleagues will ask you some questions now.

5727. *Miss Madeleine Symons*: Dr. Yellowlees, you do not have any children at the Retreat, do you?—No. There is no definite age at which we do not receive certified patients. I have a girl of 15 just

Chairman: No, I think not.

5718. *Earl Russell*: But then the voluntary boarder system would not do for your acute case; you must have some power to detain him?—Cannot something be done in that way? I wish I could help the Commission more, but it is the most difficult of all the points.

5719. *Sir David Drummond*: You seem to associate in your mind this kind of early treatment with mental hospitals, not with general hospitals. Would you think of it from that point of view?—My view of that is this: I think that the mental hospital ought to be such (and that was the point of my last question to the Chairman) that mere residence in it will not convey a stigma. I have no objection to the general hospital treating the cases of acute insanity if it provides the staff who have gone through the mill of practical experience in treating insanity, and provides the necessary facilities; but I think the mental hospital of the future will be a place where there is every possible facility, and a place to which people will come, and that we shall begin to differentiate at the other end; that we shall remove, not the early recoverable patient from the mental hospital, but I foresee, years ahead, the removal of the chronic, demented, degraded, incurable case.

now; I was most unwilling to have her, but she is the youngest I have had for many a day.

5728. Unwilling because you do not think they ought to be in the same institution as adults?—I think it is most unsuitable.

5729. Do you, from your history of the cases, think that many of them start when they are young, or when they are quite children?—It is, of course, impossible to point to anything and say that this is the cause of insanity, but I think that the inherent instability which is the root cause of a large number of forms of mental disorder has been present from a very early age, if not from birth, and is sometimes manifest in childhood. Especially is that so in the disease which is commonly called dementia præcox, in which I am quite sure that abnormal symptoms can be seen in the childhood of those persons who ultimately become sufferers from it.

5730. I was asking you because in various ways in children's courts, and elsewhere, one comes across a good many children who are not mentally deficient, but are abnormal; and I wondered whether you had any views as to whether anything ought to be done about it, from your experience?—What you say is very true and very regrettable. It is hardly in my own line. I have no definite remedial measures to suggest, and I believe that these children of whom you speak do exist and many of them do later become the subjects of dementia præcox.

5731. I thought it would be interesting if you, or perhaps Mrs. Crosland, could tell us something about the cost of maintenance in the Retreat—perhaps the cost of maintenance and the cost of food separately, if you have those figures?—(*Mrs. Crosland*): You mean the whole maintenance, including the costs of the attendants, and everything?

5732. Yes?—It comes to about four guineas weekly—that is very rough.

5733. *Earl Russell*: Is that without capital charges?—(*Dr. Yellowlees*): Without capital charges, but it includes everything else, the cost of the tradesmen and everything. (*Mrs. Crosland*): The cost of the food alone varies probably between 12s. and 13s. per head per week.

5734. *Chairman*: Do they all have the same dietary—is there a general standard of diet?—(*Dr. Yellowlees*): There are small differences between the diets of patients, male nurses and female nurses, but they are very slight. There is a rather more generous allowance for the male nurses, but within fairly close

3 December, 1924.]

Dr. HENRY YELLOWLEES, O.B.E., M.D., and
Mrs. CONSTANCE M. R. CROSLAND.

[Continued.]

limits they have the same dietary apart from the special cases of sickness. The whole family, by the way, is about rather over 300, although only 170 are patients, that is to say, it is even more than one staff to 1½ patients, if you add in the maids and the extra workers, the plumbers and engineers, and joiners, and so on.

5735. *Earl Russell*: Dr. Yellowlees, you take in such cases as your committee select; you are not bound to take in any case that is offered you in any way, are you?—No. It is not even my committee, because they do not have time. I can personally, acting I take it with their support later on, decide whether or not I will take or will retain a case.

5736. You have a free choice, I mean?—We have a free choice.

5737. Are your cases in fact selected cases?—In fact they are not, with the exception that we do not take patients suffering from epilepsy, and we do not take patients suffering from the grosser forms of mental defect.

5738. No G.P.I. cases?—Oh yes, any number. When I said mental defect I mean congenital defect; we have any number of G.P.I.'s.

5739. Now on that same question I notice you talk in your *précis* about popular fallacies in regard to the grading of patients. I do not think you have developed that yet, have you?—No, except incidentally when we were talking about melancholia. The popular fallacy about the grading of patients is this, that all the recent cases are necessarily recoverable, and will not hurt to be with each other, but would hurt to be beside chronic patients. That is very often the reverse of the truth. There are many chronic patients who appear to be perfectly sane—in fact it is the chronic patients whose insanity it is sometimes difficult to tell—there are many chronic patients who are perfectly decent, quiet, ordinary, well-behaved, very pleasant fellows, and they will not recover. There are many recoverable cases who are most unpleasant, noisy, filthy in their habits, dirty and untidy, and possibly suicidal. Finally there are many cases who although they may be recent you could tell from the beginning are, humanly speaking, unrecoverable and will not recover. Thus you can see that when you talk of having an admission block, purely reserved for the recent recoverable cases, it is not quite so simple as it sounds until these considerations are studied. I can imagine at least four consecutive admissions, each one of whom would be most unsuitable to be put with any of the other three.

5740. When you said popular fallacies you really meant fallacies of the general public?—Yes.

5741. I thought you meant fallacies of other members of the medical profession?—I do not say that some of my professional brethren do not share these fallacies, I am afraid they do. It is quite simple when they consider them, but the public are apt to speak on this point of admission and grading of patients without thinking.

5742. I do not think we have heard very much of your voluntary boarders?—No, there are a very small number resident, but more than half the admissions in any one year are voluntary boarders. We have, roughly speaking, 90 to 100 admissions in the year, say 100 as an average, and of those just on 50 per cent. are voluntary boarders. In the year 1923 the proportion of voluntary boarders was just over 48 per cent. of the total admitted. Why there are so few voluntary boarders of the number resident on any given day is, of course, that the voluntary boarders are naturally of a favourable type as regards recovery. They recover, they go away, and you have always the residual population of chronic incurable cases to swell the number of certified patients.

5743. You mean that given a resident population on any given day of 10 or 20, it would mean that four or five times that number had been in and out during the year?—That is so.

5744. What is your number at the moment of voluntary boarders?—At the present moment there are 12 or 14 voluntary boarders resident in the hospital.

5745. These are not certifiable, or should you say some of them were?—As soon as they are certifiable I ought to certify them, but if I think a case is going to recover I fight it out with the Board of Control and use the law's delays as best I can, and the Board of Control are becoming very much more reasonable in that respect.

5746. I am sure they would, of course, subject to the fact that it is their duty not to break the law?—Quite so; of course we must safeguard the patients themselves.

5747. Do you say that if they become voluntary boarders you exercise no restraint on them when they are in your hospital?—I would need a definition of "restraint" before I could answer that.

5748. You would use pretty strong moral suasion if you thought it was undesirable they should go out?—I should simply tell them they will not, and if they will I should say "Very well, you cannot come back, you will have to go altogether." I tell them that is the essential part of the contract, that they agree to carry out my suggestions for treatment, and my wishes, and if they do not carry out my wishes in the matter I say: "Now this cannot go on. Either I have to have the legal right to do it, or else you cannot stay."

5749. And do you find in most cases that is most effective, that they have the sense to submit?—Yes, I think in almost all cases where it arises, the majority of the voluntary boarder cases that one has to do with are cases which have no particular will in the matter; and that is the point Lord Onslow's Bill would have met to a certain extent. The patient is willing enough to come, and then perhaps gets a little worse and ceases to care, has no volition in the matter. Now it all depends, as you know, on how you put the question to the patient, and the Commissioner of the Board of Control is very strict on the whole. Of course he always sees every voluntary boarder, and asks the question, he never misses. He says, "Do you know you are a voluntary boarder?" "Yes." "Do you want to stay here?" and the patient says, "Oh, yes; it is all right," and if the Commissioner is very thorough, or perhaps not tremendously experienced, or is anxious to make the patient a certified patient, or thinks it wise, then you see how readily you can make a patient in that state say anything.

5750. He is really a person without any reasoned volition?—Yes. I say the Board of Control is getting very much more human in that matter. If they are satisfied that the patient is perfectly content to remain, and is not desirous of leaving, they allow us a pretty fair latitude, which is all to the good of the patient.

5751. Now I want to go back to another subject, and that is the subject of the medical certificate. All your patients, of course, come in with two certificates?—That is so.

5752. Do you find, as a rule, these certificates agree pretty reasonably in their account of the patient's condition and symptoms?—Yes, they give different symptoms, showing a common cause as a rule, or if there is anything striking they probably both have got it.

5753. And do you find that the certificate of the regular medical practitioner is fuller and is able to give you more facts than the other one?—No, I cannot say I have ever seen any difference between the two on the average.

5754. Because *primâ facie* he ought to be able to give you a better and longer history?—He is not asked to give the history, so that it would not come out in that. In subsequent correspondence with him, or from a form we very often send, it does come out.

5755. And from that you get some assistance in treatment?—There is no doubt about that whatever.

5756. Now you think that, although most of the cases are free from doubt, the public would still be alarmed if one medical certificate was all that was

3 December, 1924.]

Dr. HENRY YELLOWLEES, O.B.E., M.D., and
Mrs. CONSTANCE M. R. CROSLAND.

[Continued.]

necessary in all cases?—I believe the public would be alarmed.

5757. You think if any change were made in the way of assimilation, it would be better to go to the expense of getting two certificates in pauper cases rather than one in all cases?—I do.

5758. *Mr. Jowitt*: Would you, Dr. Yellowlees, assimilate the process with regard to the necessity of a personal inspection by a magistrate?—No, personally, I would not; I do not set any particular store by the justice or magistrate visiting the patient.

5759. *Earl Russell*: In either case, or only in the private one?—Personally in either case; but I do believe that the public regard it as a safeguard.

Mr. Jowitt: I think we had evidence from some medical gentlemen that they themselves attach considerable importance to the visit by the magistrate.

Chairman: Yes, that is so.

Mr. Jowitt: You do not agree about that?

Chairman: They like the idea of the intervention of some neutral and unprofessional person.

5760. *Mr. Jowitt*: He comes in as the man in the street?—Does he not fulfil that function by signing the order, and was not the evidence you heard to that effect?

5761. No. I think I am right in this, that in the case of a private patient it is not necessary for the magistrate personally to see the case?—That is so.

5762. In the case of the rate-aided where there is one doctor, the magistrate has to see the case?—Yes.

5763. You would like, would you, rather from the point of view of alleviating the public anxiety, two medical certificates in each case?—Yes, I would.

5764. Then you would be prepared to say that that having been done, it would be unnecessary for the magistrate to see the case?—I would.

5765. And, if I follow you rightly, your reason for that is that, of course, you perhaps think that the man in the street without any technical knowledge cannot form an opinion which is of value?—That is so. I believe that the magistrate forms his opinion, whether he sees the patient or not, upon the written evidence which is presented to him, and I do not think that his examining the patient as well really helps him to form that opinion, although it may comfort him when the patient is obviously grossly insane.

5766. *Earl Russell*: Are you not overlooking the fact that it gives the patient some outside representative of the public to make a protest to if he is, in fact, being wrongly certified?—I was about to say that I believe the safeguards for the patient are so good, in my opinion, that even if this were an additional safeguard, which I question, he can very well do without it. I do not believe that a person who was not certifiably insane could be passed by a magistrate's order, and could reside in a mental hospital, as at present constituted, for a week without the case being raised and looked at.

5767. *Earl Russell*: Yes, but he might not like a week?—I will say a day if you like.

5768. *Mr. Jowitt*: Let us analyse this a little further. Of course one appreciates the advisability of the man in the street being there, if the popular impression is that there is some great conspiracy on foot among the medical profession?—We must have him somewhere.

5769. As an actual judge of sanity, or insanity, do you say this, that the opinion of a man in the street is really worth little or nothing?—In many cases it is quite worthless. In obvious cases it is as good as anybody else's.

5770. In border line cases, anyhow, you say the opinion of the man in the street is really valueless?—I do.

5771. The trained alienist, or the medical man, would be able to appreciate symptoms which, of course, would not be obvious to the eyes of a lay person?—That is so, or not so much symptoms as their significance.

5772. Now I want to ask you another question. You have given us an account of your institution. I may say some of us have heard of it before, and I may take it, may I not, that so far as human institutions can be satisfactory, the circumstances in which your institution is run make for efficiency in every possible way?—We believe so, we think so.

5773. I mean to say you are fortunate in having a very keen and active committee?—That is so.

5774. I will not refer to yourself, but you have an admirable staff?—I have an admirable staff.

5775. Perhaps I may be allowed to say the staff have an admirable head?—Kindly do not.

5776. And you have a very adequate nursing staff, and you have every possible touch with the outside world for your patients?—Yes.

5777. And a sufficiency of money?—Yes, a sufficiency. We are not endowed but we can, it being a concern of the Society of Friends, touch on them for money when we are in a very bad way. At this moment we are building a nurses' home, and an appeal to the general public would have got little or nothing, but the Society of Friends stands by and helps us, so finance does not really distress us.

5778. So that without wanting to blow your own trumpet for a moment you are, you realise, in a much more favourable position than many of these larger asylums who have to deal with a couple of thousand or 2,500 patients?—I do realise it. Of course I have experience of other institutions, not as their head, but I quite realise what you said.

5779. In your case you know personally and see two or three times a week every inmate of your institution?—That is so.

5780. Therefore you are in the closest possible touch with them and see how their maladies are progressing?—That is so.

5781. From your favourable position you have to deal with the question as to whether they have advanced sufficiently to be allowed out, or to be discharged?—I have.

5782. Now obviously the state between the point of malady and the point of recovery, the border line, it is impossible to draw with any precision?—That is so.

5783. Between light and darkness you must have a twilight?—That is so.

5784. And the personal equation must enter largely into a question of whether a patient shall or shall not be discharged?—Yes.

5785. In order to guide you to make up your mind in any case you can go by stages; you can, first of all, try the effect of a visit to a concert, or allowing the patient out to tea with his friends near by, then you can put him on parole?—That is so.

5786. And gradually by degrees see if the patient is or is not trustworthy?—Yes.

5787. And that is the method upon which you proceed before you make up your mind to discharge a patient?—That is so in the great majority of cases.

5788. Does it not occur to you that even for you, with your training and having comparatively few inmates, it would be an appallingly difficult task to make up your mind as to when the border line has been passed, unless you could go by those stages?—Do you mean, if I had not those means of finding out, how else could I find out?

5789. Yes. You have to make up your mind whether a patient can be discharged. You have these facilities for his going to a concert, or tea with his friends, or to stay with anybody, and you are called upon to make up your mind. Has this man recovered, as has he not recovered?—You have, firstly, your experience of similar cases, and, secondly, you have trial and error. One ought to know the circumstances to which one is going to discharge the patient. Very well, try him out in those circumstances, reproduce them as much as you can. However poorly off the patient may be, he is going back to stay with someone presumably; very well, let them try him for a day or a week; or let him go out on

3 December, 1924.]

Dr. HENRY YELLOWLEES, O.B.E., M.D., and
MRS. CONSTANCE M. R. CROSLAND.

[Continued.]

leave of absence and then, if he breaks down when he is out, let him come back.

5790. Now I want to ask you to give us the benefit of your opinion if you will. I want to see if we can devise any methods to make this task rather easier for those in charge of our asylums, where there is bound to be absent that element of personal touch. My impression is that the visiting committee in some cases are apt to be—I do not use the word offensively, a little bit too much under the thumb of the medical superintendent, to lack initiative, so to speak. Is there any other method which you can suggest, the interposition of an independent medical committee, or medical man, to assist the superintendent in coming to a conclusion as to whether a patient may be discharged?—Well, Sir, the point about that is this, that one would have to know, is the superintendent a person who, on the average, is more likely to let them out too soon, or to detain them too long? You speak of the committee being possibly under the thumb of the superintendent, and you speak of the possibility of having some independent person. Is that to be sure that the superintendent has noticed the recovery, or to be sure that the superintendent is not letting them out too soon?

5791. Of course, there is a danger either way; there is a danger to the community at large and to the patient if the patient is let out too soon; but, on the other hand, if the medical superintendent errs the other way there is danger, is there not, of patients, who have been properly certified and who have been kept in an asylum for a considerable time, being retained in the asylum after their sanity has been restored?—If there was the least doubt in such cases when the question is raised, and if the medical superintendent has the least idea in his own mind that the patient is fit to take his place in the world again, the answer is: Try it—and I believe that every medical superintendent works on that line. I do not see how any independent tribunal you could invent would help. To begin with, you would be substituting an independent tribunal for one biased in favour of the patient, if I may say so, which would be a pity; and, secondly, no tribunal would know, unless they cared to get it up with much pains, the history of the case and the circumstances of the patient.

5792. You must not judge the knowledge which a superintendent of a large hospital has of the history of the case from the same point of view as you have in your small home?—Surely every assistant would have a reasonable knowledge of these important factors in connection with the patients under his charge.

5793. But you would agree with me to this extent, would you not—I will not put it any higher than this—that there is a grave danger that persons who have recovered may be detained in asylums unduly long?—I am sorry, Sir, but I cannot agree; I would like to for the sake of broadmindedness, but I cannot do it. I have never experienced it, all our experience has been the other way.

5794. Then you think the danger is of their being discharged too early?—It is not a real danger in any case; it is trouble and expense, but that is the side on which it lies, in my experience, both in Scotland and England. I have read of the point in larger asylums.

5795. I did not hear your early evidence. Have you had experience in dealing with large asylums?—Not what you would call large in England. I have been, in one pauper asylum of 400 beds, the only assistant, and I have been one of several assistants in the Edinburgh Royal, which contains 1,000 beds.

5796. I am asking you to contemplate a harassed man who is dealing with a population that is a good deal too large for him to deal with adequately, and who is called upon to take a responsibility which may be a grave responsibility?—The only case in which it is really a serious responsibility is the question of the convalescent melancholic, and sometimes in a very few cases a man with homicidal ideas and

delusions against his own relatives, but those occur more in the story books than in real life. Apart from these, which are a problem, I cannot see any objection to the superintendent going on the rule, which I believe he does adopt, “When in doubt let it be tried.”

5797. Mr. Snell: I did not hear the early part of your evidence, Doctor, but in the latter part you spoke of drugs being given at nights, sedatives or purgatives, by your deputy. Would those deputies be medical men, or people with medical knowledge?—The drug would have been ordered, of course, by the doctor and given by the night superintendent.

5798. It is not that any person would have access to give them of their own volition?—No; it is precisely the same as is done in a general hospital; the drugs are ordered for the night sister, and she discharges the duty.

5799. In your evidence you said there were many border line cases in which the opinion of the man in the street would be more or less valueless?—I did.

5800. This would apply practically also to the opinion of the lay justice of the peace who would sign a certification order?—That is so.

5801. On the matter of the danger of discharging a patient too soon, you mean it would be dangerous to the patient to return him to the strain of outside life before the composure of his mind had been completed?—It would very possibly invite a recurrence of his illness.

5802. Owing to the outside strain that he might have to face?—Going back to the circumstances in which he had broken down.

5803. Mrs. Mathew: Did I understand you, Dr. Yellowlees, to say that you used suggestion treatment?—I said so. There are very few of the insane who can advisedly be treated by suggestion, but it is a form of treatment with which I have had a great deal to do in other cases, and the application of suggestion to the insane is a very interesting thing. Of course, suggestion was used and is used daily, but was used in mental hospitals long before it was used anywhere else and long before the public had any particular interest in it; but there are still, apart from the obvious suggestions—encouragement and hope which one gives to all patients—only a few mental cases who are amenable to suggestion treatment.

5804. And you have found it useful?—I have found it useful in a very few cases.

5805. Sir Humphry Rolleston: You have never seen any bad results, have you, from suggestion?—Do you refer to suggestion aided with hypnotism?

5806. Either with or without the induction of sleep?—No, I have not; but then I have selected the cases with some care. I can well imagine that, given in unsuitable ways to unsuitable patients, you might have much trouble.

5807. You do not think that you could ever induce crime by suggestion, do you?—No. It is one of the subjects on which I made a certain number of experiments when I wrote a small book on the subject. It is rather a difficult thing to experiment upon, because you have to let the patient into the secret. With the aid of two colleagues, however, who were good about it, I experimented on that matter with the sane. But my view is that you cannot get a crime committed under hypnotic suggestion.

5808. Now it was suggested to you that patients were kept in public asylums unduly?—That is so.

5809. You have no evidence to support that, have you?—None whatever.

5810. That is a suggestion which from a medical point of view you would rather strongly oppose?—As regards my own experience I oppose it. I say it is simply not the case. It may occur in public asylums, and I can imagine it much more likely to occur in a very large institution that was under-staffed, and so on, unless the patient's relatives were sufficiently vocal.

5811. If it occurred then it would be a pure accident. There is no object in retaining a patient?—

3 December, 1924.]

Dr. HENRY YELLOWLEES, O.B.E., M.D., and
Mrs. CONSTANCE M. R. CROSLAND.

[Continued.]

The suggestion that there is any object or motive in doing it is to my mind grotesque.

5812. You have had a great deal of experience with private patients?—I have.

5813. I should like to ask you a question as to the function of the petitioner, whether in a certain proportion of cases the petitioner is not entirely satisfactory; but from the nature of the case someone has to take up that rather unpleasant duty, and he discharges it without very much enthusiasm or without much interest?—That is perfectly correct.

5814. Therefore the petitioner is a source of a certain amount of anxiety to people like yourself?—That is perfectly correct in some cases.

5815. Now how would you view the suggestion that in those instances some kind of official petitioner, analogous perhaps to the Official Receiver, might be appointed?—My only objection to it is that the patient's relatives (dealing with private patients) so very strongly resent as a rule any official interference. The less official interference they can have of course the happier they are. I can see it might be a very good arrangement. Of course I think in the majority of cases the petitioner does his work fairly, but there are cases precisely as you have described.

5816. *Sir Ernest Hiley*: Could you tell me what is your annual percentage of readmissions as compared with those of ordinary county mental hospitals?—I am very sorry that I have not got it in my mind, and I do not think it is in my report.

5817. Could you send it in afterwards?—I should be very glad to; I will do that with pleasure.

5818. *Sir David Drummond*: Dr. Yellowlees, would you tell us what is the distinction between a registered hospital and a private hospital?—I will. The registered hospital is managed by a voluntary committee who have no pecuniary interest in its welfare. A private asylum or licensed house is managed by a man or a company who are directly interested financially in it.

5819. Is that the only difference?—No, that is the essential difference.

5820. I want to know for the sake of the statement going on the notes?—The licensed houses, generally speaking, are, I think, on the whole, smaller; they give more accommodation, many of them, to each patient. Patients who pay very high rates of board generally go to some of the licensed houses; patients who desire a tremendous amount of privacy and have practically the whole of a villa, which is run in connection with a licensed house. They generally have few patients and they are, with few exceptions, perhaps, not run on hospital lines. They are not satisfactory for acute recent cases. I do not say that against them at all, but their type is more of a retired place for a chronic patient. They are under much more stringent inspection and safe-guarding than are the registered hospitals, because of their constitution. They are more frequently visited, for example, by official bodies, and their number is not being added to; no fresh licences are being given. I do not think that the fact of their proprietors being financially interested in them for one moment does affect their treatment of their patients, but the factor is there.

5821. Now do you think that with your knowledge of private licensed and registered hospitals throughout this country, there is sufficient accommodation for private insane patients?—I do not know, Sir, if I have been in England long enough to answer that question wisely. I should have thought that for private patients the accommodation is fairly good, but I really do not pretend to answer that question with wisdom.

5822. You cannot give me a definite answer?—I cannot.

5823. Then if it were considered desirable to expand that accommodation, in what direction would you suggest it should be done?—Well, I think the registered hospital is as near the ideal form as you can

get. I believe in the hospital ideal, and I believe in the absence of any possible financial interest in the prosperity of the place.

5824. You think the extension should be in the direction of the registered hospital?—That, I believe, to be the best we have got.

5825. Now would you expand an opinion you gave, it was to the effect that it was very desirable to have a lady doctor on the staff?—Yes.

5826. Tell me what the advantages are to the hospital and to the patients?—More than half the patients are women, and of those women there are a large number, not all by any means, who prefer to be treated by one of their own sex. More than half of the nursing staff are women, and of those a large number prefer to be treated by one of their own sex.

5827. Do you suggest that the medical superintendent should in many cases be a lady?—Not yet. To a certain extent I would like a few of man's rights left, but I have no doubt that it may come to that. It is one of the difficulties at the present moment that we cannot give her promotion.

5828. You tell me that the treatment of the women patients is in the hands of the lady doctor alone; the male assistant does not see the cases?—Of course he sees them; they work in absolute harmony; one has to relieve the other, which is one of the draw-backs in a way; she has to relieve on the male side and he on the female side when one of them is out.

5829. He sees the female cases?—Certainly. There is a cardinal rule I go on, that whatever else happens or does not happen, I myself, the matron and the senior assistant, who is a man, must know everything about every patient.

5830. And you seriously tell me that women patients prefer to be treated by a woman?—I did not say so; I said that some of them did. A large number of them express no opinion. Of course the Society of Friends has feelings upon that matter, as you no doubt know, and possibly that is one of the reasons why it came in at an early date. This particular subject was discussed by the Conference between the committees and superintendents of asylums and the Board of Control a couple of years ago, and there was a considerable difference of opinion upon it; but it seems, I think, only reasonable, that out of three medical officials one should be a woman, if she is a properly trained woman.

5831. But you still maintain that the head should be a man?—No, I do not; I think in the present state of things it would be rather difficult for the head to be a woman, but I do not think a man has any prescriptive right to being a superintendent of an asylum. I should be sorry for any woman who tried the job.

5832. You referred to the fact that in your experience the certificates were often very inaccurate?—That is so.

5833. Were you referring to the medical certificate or to the magistrate's certificate?—Neither. Mainly to the petitioner having failed to fill in the forms accurately.

5834. The petitioner, not the doctor?—The doctor fills in the things about his patient properly. What a doctor does in a moment of aberration, for example, is to sign a certificate "11th November" instead of "11th June." I have had that happen.

5835. But that would not occur very often, would it?—Almost every certificate I have to return in connection with some part of it, generally the petitioner's part; but the dates are most confusing, and there are technical irregularities of that kind.

5836. As a rule the medical certificates are fairly accurate?—The statements of the patient's symptoms are thoroughly accurate, I have rarely any complaint to make about them.

5837. You are quite satisfied with the form of the certificate, simply a statement of what the individual doctor has seen, and with no reference to the history of the case at all? This is a very important matter from a professional point of view?—I think that I

3 December, 1924.]

Dr. HENRY YELLOWLEES, O.B.E., M.D., and
Mrs. CONSTANCE M. R. CROSLAND.

[Continued.]

could write out a better schedule than the present one easily enough, but I do not know that there is very much to be said against it, except that it might be a little less archaic in its phraseology.

5838. Do you think it is desirable that the doctor's statement should be limited strictly to the statement of what he saw at the time and absolutely independent of history?—Well, that is hardly so. He has two things to do. He must give facts observed by himself, and there is a special place for him to give information obtained from others, and in that place he can surely give any salient features. Of course, the certificate is not a medical report. The certificate is a statement by a medical man to convince a lay person of a certain thing, and it has to be framed with that object in view.

5839. Then you are perfectly satisfied with the certificate?—Yes, if it were a shade easier for the average man to understand. I have no complaint with the form of it.

Mr. Walter Stewart: Would you ask the witness this question, Sir, with regard to the Retreat: Whether there is any special plant or any special appliances to be found there, such as would not be found in an ordinary hospital.

5840. Chairman: Well, Dr. Yellowlees, you have been in various institutions of different types, as we know. You have talked of baths, and so on. Have you appliances in your Retreat that are not to be found in public hospitals, let us say?—No; I do not think we have anything as to which we can lay claim to being unique. My particular method of the continuous bath is an invention, but there are many other methods just as good. We have not got many things that many other places have, of course.

5841. Sir David Drummond: Have you not an institution in Scarborough?—No. We had our holiday home at Scarborough, but, as a matter of fact, our lease of it has run out.

5842. Have you no place of the kind now?—We take a summer house year by year. We have two detached villas in the grounds, and we have a detached house a mile away.

5843. Under what conditions do patients live, either at Scarborough or a mile away?—A mile away they are sent on leave of absence, because the place is not technically "The Retreat," and a Sister is in charge there, and one of my colleagues visits it daily.

5844. Chairman: You cannot say that you have at the Retreat any equipment over and above what one would find in a reasonably modern public hospital?—In a modern hospital, certainly not. We have an absence of padded rooms. We have not certain things which you would find somewhere else.

5845. Mr. Walter Stewart: Could not the witness tell us what is the approximate average duration of residence of the voluntary inmate at the Retreat?—I am afraid I shall have to send that information to the Commission.

Chairman: I should like to have that information, and then we can give it to Mr. Stewart.

Witness: If you please.

Mr. Walter Stewart: Would you ask the witness, Sir, whether he has observed, in connection with Section 31, that very often the petitioner fails to state the reason why the regular medical attendant has not given the second certificate? The section provides that the petitioner should state why that

has not been done. Has the witness observed in any case within his knowledge that there has been that failure on the part of the petitioner?

Chairman: Just one moment. I am looking at the form. Does not the form provide that you must state it?

Mr. Walter Stewart: Yes, that the petitioner must state it if the regular practitioner does not certify.

Witness: There is a special space in the form for it. It is on the medical certificate.

Chairman: I have got the form of medical certificate, which is Form 8.

Mr. Walter Stewart: Section 31 says it shall be part of the petition: "shall be deemed to be part of the petition"; those are the concluding words of the section.

Chairman: The point is, why do not the doctors say so? There does not seem to be any place provided in the form.

Mr. Walter Stewart: No.

Witness: But there is, sir. I cannot recollect whether it is in the medical certificate form or the petition, but it is there in every single case. "The reasons why this petition is not presented by the usual medical attendant are as follows."

Chairman: However, I do not see that Dr. Yellowlees can help us in this. If the form is inadequate, the form must be made adequate.

Mr. Walter Stewart: The question I was asked to put was whether the witness had noticed that there was a failure on the part of a petitioner in any case to explain why the regular medical attendant had not certified, whether he has ever noticed the case of a petition in which there was that failure?

Witness: In every case where that is omitted, and it always appears on the form, though for some reason it does not appear to be here, as in the case of every other irregularity, the Board of Control (to whom we have to send copies of the papers precisely as received) return the papers to us, with red ink requests for emendations.

5846. Chairman: And would that be one of the emendations required by them if the petitioner had failed to state why the regular attendant was not one of the certifiers?—Most certainly. No case ever remains with that question unanswered. The Board of Control sent me back a paper the other day because one of my colleagues had signed himself "Assistant Physician" instead of "Acting Medical Officer," so I can assure you they do not miss the larger question.

5847. Earl Russell: Can you suggest to us any reasonable ground for the provision of 14 days in the matter of an escape? You have had an experience of an escape. Is there any point in that provision of the 14 days?—No; I have often wondered what it was for. I suppose it is to save the trouble of re-certifying, if he was taken back reasonably soon.

5848. Why should it not be a longer period?—You do give him a chance of having recovered in the period. I do not see any use for it.

5849. You would not say that a patient who had been able to maintain himself at large for 14 days was necessarily sane?—No, I would not, by any means.

5850. You cannot think of any reason for that particular provision?—No, I cannot.

5851. Chairman: It is arbitrary?—I think it is arbitrary.

Chairman: We are much indebted to you for the most interesting evidence you have given us.

* See Appendix XVII.

(The Witnesses withdrew.)

Dr. J. G. PORTER PHILLIPS, M.D., F.R.C.P., and Mr. LIONEL L. FAUDEL-PHILLIPS called, and examined.

5852. Chairman: I understand, Dr. Porter Phillips and Mr. Faudel-Phillips, you are both here together to give us evidence in a conjoint form and to supplement each other's statements?—(Dr. Porter Phillips): Yes.

5853. First of all, Dr. Phillips, you are a Doctor of Medicine, and a Fellow of the Royal College of Physicians, and you hold the post of Physician Superintendent to the Bethlem Royal Hospital?—Yes.

3 December, 1924.]

Dr. J. G. PORTER PHILLIPS, M.D., F.R.C.P., and
Mr. LIONEL L. FAUDEL-PHILLIPS.

[Continued.]

5854. And you are Physician for and Lecturer in Mental Diseases at St. Bartholomew's Hospital?—Yes.

5855. And are you Physician to the Hospital for Nervous Diseases (out-patients) and Lecturer to the Royal Free Hospital School of Medicine for Women?—I am.

5856. You have, I think, studied the Terms of Reference to this Royal Commission?—I have.

5857. And are you in a position to place before us your views on one or two of the topics upon which you are specially qualified to speak?—Yes, I hope so.

5858. I think your experience has been obtained as the result of your present position as medical officer of a registered mental hospital, and as a physician to an out-patients' clinic, and also from private consulting practice?—Yes.

5859. And you have made a study, of course, of the literature of this subject as well?—I have.

5860. Has your experience been derived entirely from treatment of private patients as distinguished from rate-aided patients?—That is so.

5861. I think the Commission would like to have your views upon the question of the treatment of voluntary patients without certification?—The voluntary boarder system has been in vogue at Bethlem Hospital I think for the last 40 years, and from careful observations made by my predecessors and by myself, I think we are agreed that it is a system which should be encouraged in many ways.

5862. What is the total population of your institution at Bethlem?—When we are full, 300 patients.

5863. How many of those will one find to be voluntary inmates?—At present nearly 40 per cent. are voluntary patients.

5864. Will you tell us a little of your experience with voluntary patients, and how the system works?—A straightforward voluntary patient of course gives no trouble; he readily makes up his mind; he knows that perhaps he is ill, and he seeks advice, and on the advice perhaps of his own medical practitioner or of his relatives, he is admitted in an easy manner. There are patients, however, who find a difficulty in making up their minds, but on gentle persuasion by their relatives, or on the strong advice of the practitioner, they are induced to apply to the hospital for admission. They have to sign a form which is placed before them, clearly indicating to them their exact position, and the conditions under which they will live at the hospital. Regarding first of all their detention, they know definitely that if they give 24 hours' written notice to the physician superintendent, or his deputy, he or she can leave the hospital. They also know that if there are any complaints (that is also stated on the paper) to make, they have to put them in writing or verbally, so that they may reach the proper quarter. At times we find a difficulty during the first few days. The patient may feel undecided as to whether he should remain or not, but on the whole we have little trouble in legitimately persuading the patient that in his own interest he had better remain. There is no coercion of any kind, and on the whole we find that they are willing to remain.

5865. These patients, of course, would be paying patients?—Not necessarily. A very large percentage of the patients admitted to Bethlem Hospital as private patients are admitted on a free basis, quite 70 per cent. of them are free. (Mr. Faudel-Phillips): It varies very much, but it is safe to say 70 per cent.

5866. Who provides for their maintenance there?—The foundation. It is a charitable foundation. (Dr. Porter Phillips): The difficulty, of course, arises if the patients become mentally unbalanced. Occasionally we find patients who show signs of temporary loss of memory, or confusion, which may clear up in the 24 hours. From our experience we are not keen on taking immediate steps, but we usually give them some limitation as regards time, two or three days; and if the mental condition does not clear up then we have to appeal to the relatives to remove the patient and to take steps to carry out certification, if necessary.

5867. Then the 24 hours is the period which the patient agrees to as a period during which he may be detained, even although he wants to go out—he contracts to that effect?—Yes; we do not carry that out strictly; that is purely a time limit, so that we may get in touch with the relatives.

5868. Yes, because the case one naturally figures is the case of a patient who has come in on a voluntary basis, and then unfortunately the case deteriorates, and the patient wants to go out at once, and you recognise that the case is one where it would not be expedient to allow him out. In such a case you have 24 hours' moratorium, so to speak, and that would enable you to get into touch with the relatives and to get an urgency order?—That is so, but we always like the patient to leave the hospital if he is not too ill, and then be brought back again.

5869. Brought back on a new status, either under an urgency order or an ordinary reception order?—That is so. I think it would have a bad effect on the patient if the patient felt that at first he was admitted as a voluntary patient, and then, because he happened to be showing mental symptoms requiring certification, we had taken advantage of his detention there.

5870. *Chairman*: You want to discriminate between the two periods of his residence?—Yes.

5871. So far as a person is able to enter into this relationship with you, I do not see much difficulty; but there must be many cases where a patient has really no volition and could not properly contract with you to stay for 24 hours, or for any other time. Do you take such cases as voluntary patients?—No, we refuse them.

5872. Then you do not have any of the class of patients contemplated in Lord Onslow's Bill, a patient without volition, for whom the relatives may contract?—Not at present.

5873. Would you regard that as a desirable extension of your present practice?—I certainly think so, yes.

5874. In the case of your voluntary patients, is the proportion of recovery high?—Fairly high, considering the acute character of the illnesses we have to deal with. We have got up to over 50 per cent. recoveries; last year it was slightly less than that.

5875. Does this method of receiving patients on a voluntary basis enable you to treat to recovery a considerable number of cases which are restored to society without certification at all?—Yes.

5876. We are much interested as a Commission in this question of avoiding certification, while at the same time securing for patients the same measure of beneficent treatment. Do you advocate an extension of this system of voluntary residence in institutions?—Yes, most emphatically.

5877. And do you think it would be desirable to extend it to the rate-aided patients in public asylums?—Undoubtedly.

5878. I think on this question of the difference in the position between the private patient on the one hand and the rate-aided patient on the other, you take the view that there is really no reason for discriminating between the treatment of the two classes of cases?—In my opinion, no.

5879. In certification there is, of course, a different code applicable to the two, as we know?—Yes.

5880. If we were to recommend the assimilation of the position of the two classes of patients, what would you regard as the system of certification which should be adopted for all classes?—As I have suggested in my *précis*, I consider, in the first instance, there might be some temporary observation order put into action.

5881. For all cases?—For all cases.

5882. Then the temporary observation order would not have the quality of a certification?—No.

5883. But would be something short of it?—The word "observation" meaning a good deal.

5884. Would it require to be accompanied with some power of control or detention?—Undoubtedly.

3 December, 1924.]

Dr. J. G. PORTER PHILLIPS, M.D., F.R.C.P., and
Mr. LIONEL L. FAUDEL-PHILLIPS.

[Continued.]

5885. But something short of the full strength of a certification order?—Yes.

5886. Now do you contemplate that in that period of observation a certain number of the cases would pass out?—Yes.

5887. And in that way escape certification?—Yes.

5888. Where would you contemplate such persons being kept during this period of observation?—Under the present system the housing question would be rather difficult, because most of the institutions are out of London—the large institutions.

5889. I think we may say we do not very much like the idea of utilising the workhouse as a place of observation. Other suggestions that have been made are that the general hospitals might have a department for the purpose; and another suggestion is that the asylums might have associated with them a department for observation purposes, or I suppose a hospital, such as your own, might have an observation department?—Undoubtedly. I think there are a certain number of cases that might be quite adequately looked after and treated in a general hospital; I do not mean in the general wards, but in a special wing or special ward. I have in my experience been called upon to give an opinion regarding the mental condition of certain patients, and I formed the opinion that the patient might in a few days or a week recover his mental balance, and I have suggested that he should be treated as an ordinary patient, perhaps in a side room. Within the last two or three months I can recall three or four cases in which there was a desire on the part of those responsible in the general hospital to certify. In those particular cases I recommended that they should continue treatment a little longer. In all three cases the patient showed signs of rapid recovery, and two out of the three have completely recovered, and neither of the three cases has been certified. One felt justified in recommending that. I think it is quite within the law to suggest that. The patients perhaps were showing certain mental symptoms, and yet their conduct was not such as to require control or restraint. These early cases may be associated with general or physical illnesses, and I think especially in those cases they should have every opportunity given them to continue in the atmosphere of a general hospital.

5890. One would desire, if possible, of course, to avoid the creation of a new class of institution, if one could avail oneself of existing institutions. The association of the asylums would be avoided if the observation order applied to a ward of a general hospital?—Yes.

5891. Would the advantages of such observation orders include this, that persons would not be deterred by fear of the stigma of certification from going at the early stage, at the outset of their illness?—I certainly think so.

5892. And would you thus perhaps be able to arrest incipient cases more frequently than is now possible, where people put off to the last moment going to the asylum?—Quite so.

5893. So that it would have a double advantage?—Yes.

5894. It would not only avoid certification, but also possibly prevent incipient cases developing?—Yes; and it is not only that, of course. I am in charge of two out-patient mental departments, and one finds there are patients presenting themselves quite readily, quite eager to receive advice and follow out treatment in the early stages; they feel, by coming to a general hospital, fairly safe, and they are not apprehensive, and they seem to have more confidence not only in themselves but in the physician dealing with the case.

5895. It would also enable cases which, while for the moment acute, were merely transitory, to be treated, and again to avoid certification?—Undoubtedly.

5896. Then I think you have views with regard to the certificate itself, and you have a preference which corresponds with what the statute also prefers,

namely, that the medical attendant of the patient himself should be one of the certifying doctors?—Yes, I think that is essential.

5897. The statute provides "wherever possible." Of course it is not always possible?—Not always.

5898. Would you recommend the extension of that to all cases, pauper as well as private?—Yes, to all cases.

5899. Have you anything to say to us on the subject of out-patient clinics?—Yes, I have just touched upon that. One finds a great number of patients who can really receive treatment with benefit in an out-patient clinic. I find that a difficulty in dealing with patients in an out-patient clinic is that very often their trouble arises from their social setting at home, and one finds it extremely difficult to remove that. They come up to the clinic, they are examined, they are given treatment, and I have noticed that they appear to be considerably better even in that short time, in those early stages at any rate, and they go back home feeling (from what I have gathered from evidence) that they have really received benefit by that visit. But as an out-patient clinic is only held once or twice a week they have to wait at home, and wait until perhaps the next visit, it may be a week hence, and during that time many of the militating factors are at work; and all the good that one has done perhaps during the visit is undone during the week; so that I think the social setting of the patient is an all important thing, and that is a difficult question in connection with out-patient clinics.

5900. Of course they have to remain resident in their own homes, with all the concomitant disadvantages. So you find the chances of curative treatment are much enhanced if the patient can be taken away from such surroundings?—I think most of them, if not all, would benefit greatly.

5901. On the other hand, do you find there are cases which can be treated to recovery as out-patients?—Yes; we have a fair number of patients who are treated in the ordinary way, with a weekly visit, and perhaps in the course of two or three months they have completely recovered.

5902. You are, as you have told us, Physician for, and Lecturer in, Mental Diseases at St. Bartholomew's Hospital. To what extent is mental disease dealt with at St. Bartholomew's, which is a general hospital?—We only have the out-patient department definitely dealing with early mental patients; we have no wards there.

5903. When you lecture do you have demonstrations for your students?—Yes.

5904. You take an out-patient case?—We have out-patient cases, yes.

5905. You describe the case?—Yes. We generally have a number of students who attend the out-patients' department and sit there with me, and the salient points and chief features of the case are discussed; in that way there is a kind of demonstration.

5906. Those cases, I suppose, are not certifiable cases, are they?—I should think some of them are, a small percentage, but there are some patients who are definitely certifiable.

5907. Of course, your interest is not the legal interest; you are looking at them from the medical point of view?—Purely from the medical point of view. Some of them are quite unfit to come up regularly to the out-patient department; they ought to be under care and treatment.

5908. Suppose you see a case which is of that character, what do you do? Do you take steps to see that the case is certified and sent to an asylum?—I simply inform the relatives, or the practitioner who is dealing with the case. I usually interview the relatives if they are present, they usually are; and if not, I generally write to the medical practitioner who has been dealing with the case, drawing his attention to the fact that in my opinion the patient is quite unfit to be an out-patient and should receive indoor treatment somewhere.

5909. I take it your ideal is that you would send such a patient who was not able to benefit materially

3 December, 1924.]

Dr. J. G. PORTER PHILLIPS, M.D., F.R.C.P., and
Mr. LIONEL L. FAUDEL-PHILLIPS.

[Continued.]

from out-patient clinic treatment to some intermediate observation ward for a time?—Undoubtedly; that would be an ideal way of dealing with it.

5910. Under some modified order?—Yes.

5911. And a period would thus be interposed in which the patient could be studied further, possibly treated to recovery, or possibly disposed of by detention under a certification order?—Yes.

5912. Do you think the interposition of such a stage would be of great value not only medically, but also from the point of view of the public relationship to mental disease?—Undoubtedly; I think it would provide adequate protection for the patient, which is a great feature at the present time; and before certification was resorted to one could form a very definite opinion, and perhaps in a number of cases certification would not be needed.

5913. Then the only other topics to which you refer are, first of all, the terminology at present used in connection with mental disease: Are you anxious to remove from the terminology of it, so far as the public are concerned, the suggestion of stigma which attaches just now to words like "lunatic" and "asylum"?—Yes. I think they are very unnecessary and very unpleasant, and they do rather hurt the susceptibilities of patients and relatives.

5914. And you would approve of the assimilation of the terminology of this branch of the public service to that of an ordinary hospital as far as possible?—Yes.

5915. Then I think you have some views also on the question of the training of nurses. Perhaps you will tell us a little about your nursing staff at Bethlem?—The nursing world at present is, unfortunately, in an unstable condition, but at Bethlem we have a fairly good staff. With regard to training, they are trained by the sister of the ward, or the charge male nurse, and I think I can safely say that all our charges, that is, the sister on the female side and the charge male nurse on the male side, are individuals of fairly long experience; and the nurses receive the ordinary ward training from them. They also receive instruction from the matron, and, in addition to that, they have a systematic course of lectures and practical instruction by the medical officers. Throughout the whole of the year they are attending classes and demonstrations, and, as you know, they have to pass examinations in order to justify their position.

5916. Do you think that the conditions of service and the remuneration of the nurses at present make the career an attractive one?—I think, comparing it with general nursing, it is fairly favourable.

5917. Do you approve of mental nurses having at some stage of their training some general hospital work?—I strongly advocate it.

5918. Would you put it before or after their period of specialised mental training?—I should think in many ways it might be preferable before and in some ways, one might say, during the training; that is to say, having been appointed to the staff of a mental hospital, at some later period of their training they might go to a general hospital for their general training; in fact, we have done that at Bethlem on certain occasions in order to train a nurse for special duties; we have sent the individual to a general hospital for three to six months, or longer if necessary; six months is about the longest period recently.

5919. Have you, in connection with Bethlem, any library?—Yes, we have, if I may say so, a very well equipped library, and we also have a pathological department.

5920. Is your institution visited by students?—Yes, and qualified practitioners.

5921. I do not propose, subject to what my colleagues may wish, to take you over all the topics we have heard so much of to-day from Dr. Yellowlees as to the general administration of the code, unless you have any special points you wish to bring before us of the difficulties you have experienced in working the code of law.—No, I have listened to Dr.

Yellowlees' evidence this afternoon. I do not think it stimulated me with regard to any new ideas.

5922. Then I think we might take a little evidence from you, Mr. Faudel-Phillips. You are a governor of Bethlem Royal Hospital, are you not?—Yes, I have been for about 20 years, I think.

5923. And your father, Sir George Faudel-Phillips, was a governor from 1888, and president of the hospital from 1897 to 1912?—That is so.

5924. And your grandfather, Sir Benjamin Phillips, was a governor from the year 1857?—That is so.

5925. So that we may take it you have hereditary associations?—There is a long family connection.

5926. There is a Mental Hospitals Association, is there not?—Yes.

5927. And Bethlem Royal Hospital is a member of that Association?—That is so.

5928. Does the Association meet from time to time to consider matters of interest to you?—They do. They meet more frequently than I have attended, but I have been there.

5929. But you are a member?—That is the case of many associations to which we all belong.

5930. I think you were appointed Treasurer of the Hospital in 1920?—That is so.

5931. And in that capacity one of your chief duties is to preside at the weekly meetings of the sub-committee at which petitions for the admission of patients are considered?—That is so.

5932. Are all the persons who are to enter your institution interviewed by you personally?—Yes, by me and, generally speaking, by a certain number of the Committee—the patients before we enter the committee-room, and the relations after we have entered it; that is to say, we go with the doctor, we interview the would-be voluntary boarders, because we make a practice to hear from them whether they wish to remain; we do not coerce them, but we ask them. The doctor informs them who we are, and asks them to say voluntarily whether they wish to remain as voluntary patients or not.

5933. But does this interview which you have with the patients apply to all classes of patients, both voluntary and certified ones?—Yes, that is so.

5934. I should have thought that some of the certified patients would not perhaps be in a position to have an interview?—In those circumstances I always make a practice of seeing the patients who are certified and are in bad health or in bed, or, possibly, in padded rooms. I do not ask the rest of the Committee to go. If they want to they can, but I invariably see every patient myself on admission.

5935. You will have in the case of the certified patients, of course, the reception documents; that is to say, the certificates and the order of the magistrate?—Yes, the doctor has those things.

5936. Do you see those documents yourself?—I always see them on the table every week; they are brought up to the Committee on the admissions.

5937. Do you have complaints from your patients to any extent?—Not to any extent. We do have complaints obviously from people who are unbalanced and who have troubled minds, but, as a matter of fact, we have extraordinarily few.

5938. Do you get your complaints in the form of letters sometimes?—Yes; generally speaking, they are addressed to me personally, or else to the Committee, or the Chairman of the Committee. They are brought to me on Wednesday morning, I read them, and I always make it a rule to interview those patients. Very often patients write in every day or oftener, and I have the privilege of getting the letters through the post, so I get them at home as well as at the hospital; but if the patient is not an habitual letter writer then we go and see him always, after the Committee is disposed of.

5939. Do you see the complaining patient alone?—Any of the Committee who like to go. I see them, and invite any of the rest of the Committee and the doctor to be present at anything they have to say.

5940. In investigating these complaints have you ever found that there was substance in them, and found things that required setting right?—Very

3 December, 1924.]

Dr. J. G. PORTER PHILLIPS, M.D., F.R.C.P., and
Mr. LIONEL L. FAUDEL-PHILLIPS.

[Continued.]

rarely. I have occasionally found a clue, but very, very rarely.

5941. What is the type of complaint—generally?—The general type of complaint is that they want to leave that afternoon or the next day; they have had enough, they are not ill, and they must go home.

5942. They are complaints against being kept there?—Yes.

5943. Have you had any complaints about their treatment or about their food?—I would not like to say that in 20 years I have not known of a complaint, but it is very rare; I cannot recall one at the moment.

5944. The majority of the complaints you receive are against being detained?—Yes, that is the general type of complaint.

5945. When you get a complaint which is not habitual you do see the patient yourself?—Always the same day.

5946. Have you ever found any case in which you have had reason to doubt whether the detention was proper or not, apart from the medical view of the case altogether?—For the last 10 years certainly not. Since I have got accustomed to it, I have never had any doubt in my mind that a patient who has complained has been wrongfully detained.

5947. Do you consult with your medical superintendent with regard to the case?—I always do where possible. If he is not there—and he generally is—I always insist upon the medical superintendent or one of the other doctors being present at the interview. I never will see them alone except in rare cases. I had a case of a man to-day who kept me for 20 minutes; he would not let me go, but that was only to comfort him; he was a man who was very actively mentally ill.

5948. You have seen to-day a patient in your hospital without a doctor at all?—Yes, I did. It is very difficult to say the doctor was not present, because the interview was in a large dining room in which we could be observed.

5949. Could he hear what was being said between you?—Not a word; we could be seen, but not heard.

5950. When you heard this patient's complaints to-day what sort of complaints were they?—He has a Russian name, but he spoke in a mixture of German and Hebrew. I am acquainted with German, but my knowledge of Hebrew is very small, and it was very difficult. One of the complaints was that the doctors were trying to poison him, and that he could not take the medicine which they gave. I think I subsequently learned that he had had a sleeping draught last night; but, at any rate, he could not take the medicine they were offering him, because they were trying to poison him. That is a very common delusion. Then he said he had some differences of opinion with his son who had put him into Bethlem, because he was neither ill nor mad, for reasons which were not very clear. I think they must have been in Hebrew; but they were not very clear. The result of it all was that he must be taken out to-night, because if he were not removed he would go mad. That took about 20 minutes, and then I had had enough.

5951. There is no doubt about his mental condition?—No, none at all.

5952. It is interesting to us to know that in your institution even a patient so obviously deranged is entitled to have an interview with you alone and does have it?—Yes, he is entitled to it, I think.

5953. Are you in favour of the system of voluntary patients?—Very much.

5954. You have had a long experience of your institution. Will you tell us, speaking not so much from the medical point of view but from the administrative point of view, whether the system works well?—I think it works perfectly really, so perfectly that we have constantly cases of certified patients who become decertified and remain in the hospital as voluntary boarders. I do not think you can have a higher testimony than that.

5955. That is the sort of case Dr. Phillips has just been telling us about: the patient who recovers

partially, and then chooses to remain on?—Yes, of his volition.

5956. Do you think that the admission of voluntary patients to Bethlem may go some way to remove the association of hopelessness that is apt to characterise an asylum in the public mind?—I think so definitely, because there are obviously very many cases which come in and clear up. I am not a doctor, but I can say I have had experience of them. As voluntary patients they come in free and go out free, without any sort of stigma of certification.

5957. Of course we cannot but realise that there is a certain legacy of unfortunate association still lingering round the mental hospital of all classes. We are much concerned to assist in removing that so far as possible, and in removing the cause for it so far as possible. Do you think that not only a system of voluntary patients, but also, possibly, a system of observation of patients who were under a qualified control, might further assist that process, so as to reduce the number of persons actually certified in asylums or in registered hospitals?—Undoubtedly.

5958. Do you view with favour any system which would reduce the actual number of certifications?—I do.

5959. Speaking again as a person very conversant with this world with which we are dealing, do you think that the stigma of certification is still an actual real thing in the public mind?—I think so, undoubtedly. Not only do I think that, but I can give it you in a curious form. The word "Bedlam." Bethlem is very little known, curiously enough, except among people of the medical profession, and the word "Bedlam" is still a very potent factor and a very great drawback to the tremendous work our hospital does.

5960. The name of your institution in that corrupted form has passed into the English language, and suggests a place of disordered and unruly inhabitants?—Yes, a place of madness—of people who are mad.

5961. And, therefore, association in these matters may be a very potent social factor which it is very desirable to avoid as far as possible?—Very.

5962. On the patients leaving, do you ask them to express their opinion of how they have been treated?—No, I never ask them, but I wish them good-bye, and in 99 cases out of 100 they thank the staff, the doctors, and incidentally, the Committee, for what has been done for them.

5963. Is that statement volunteered to you before or after the effective discharge has been granted?—After the effective discharge has been granted. They do not come in to wish us good-bye until that has happened.

5964. Because it has been suggested that persons who have not yet been discharged might desire to conciliate the person who had power to discharge them, by saying pleasant things?—I would say this, that very often patients are actually discharged before they can leave the hospital; they may have to remain in the hospital for a week before a home can be found for them.

5965. But the discharge is effective?—Yes. We do not wish them an absolute good-bye until they have received their discharge.

5966. And, moreover, you do not solicit testimonials from them?—Never.

5967. Merely on parting they often express their appreciation?—Yes.

5968. *Sir Humphry Rolleston*: Do you think it would be possible to modify and to extend the system of voluntary boarders, so that when a person came in he might say, "I wish to come in, and I wish now to bind myself to stay and to be detained for a period to be decided by you." I mean now they can leave in 24 hours?—(*Dr. Porter Phillips*): I think it would be a great help.

5969. Do you think it would be practicable?—I presume so.

5970. You would be able to judge whether that person was sufficiently sensible to justify you in

3 December, 1924.]

Dr. J. G. PORTER PHILLIPS, M.D., F.R.C.P., and
Mr. LIONEL L. FAUDEL-PHILLIPS.

[Continued.]

deciding as regards his freedom?—I certainly think so.

5971. In that way they would avoid the slur of certification?—Yes. For instance, a patient who has come in as a voluntary patient and later on is certified, on recovery has at times expressed this view to me: "I wish I could have remained as a voluntary patient. I came in as a voluntary patient originally, and now I have been certified."

5972. Has the possibility of such a plan been discussed and put aside?—Not to my knowledge.

5973. But you would think it was quite reasonable?—Quite reasonable and practicable.

5974. There was one point with regard to teaching I would like to put right. You do not wish to leave the impression that all the teaching you gave was limited to the out-patients?—Not at all; they come to the hospital.

5975. And you also have post graduates at Bethlem?—Yes.

5976. In connection with your clinic at St. Bartholomew's, have you anything in the way of social service, or anything that can be included under the auspices of the new Society of Mental Hygiene? Do you have people who go into their homes?—I am

hoping that will come about; it is a thing I am very interested in. It is being started in one or two hospitals, and I am hoping that St. Bartholomew's will follow suit.

5977. Or lead?—Yes.

5978. I have only one other question, and that is this: You are in favour, are you not, when you are having two medical certificates, of the second one being given by a man who has rather an expert knowledge. That is quite practicable in London, but it would be rather difficult in some of the remote parts of the country?—I have thought of that; it would be rather difficult.

5979. But it would be an advantage to have an expert man for a particular district?—Yes.

5980. *Sir David Drummond*: Dr. Phillips, do you think the accommodation for private patients throughout this country is sufficient?—That is rather a difficult question, Sir. I presume so.

5981. You think it is?—Most of the institutions I know have certain vacancies for private patients. That is the only means by which I could judge.

Chairman: Thank you very much; we are much indebted to you both.

(The Witnesses withdrew.)

(Adjourned to Tuesday, December 16th, at 10.30 a.m.)

5, OLD PALACE YARD,
WESTMINSTER, S.W.1.

ELEVENTH DAY.

Tuesday, 16th December, 1924.

MEMBERS PRESENT:

THE RT. HON. H. P. MACMILLAN, K.C. (*in the Chair*).

THE EARL RUSSELL.

SIR HUMPHRY ROLLESTON, BART., K.C.B., M.D.

SIR ERNEST HILEY, K.B.E.

MR. NATHANIEL MICKLEM, K.C.

MR. H. SNELL, M.P.

MRS. C. J. MATHEW.

MISS MADELEINE SYMONS.

MR. P. BARTER (*Secretary*).

MR. W. FAIRLEY (*Assistant Secretary*).

The Rev. P. S. G. PROPERT, Mr. R. A. LEACH, Mr. JAMES H. FORD, and Mr. J. W. FLINT, J.P., called and examined.

5982. *Chairman*: We have this morning before us representatives of the Association of Poor Law Unions, who are to give us some evidence on matters with which they are specially familiar. The evidence which they have to give us to some extent overlaps, and I am going to suggest that we might ask Mr. Propert, in the first instance, to give us his evidence. The other gentlemen who are present will hear what he says, and if they have anything to add, they might give us their personal experience, but we do not want of course to duplicate the evidence. Mr. Propert, you are, I think, President of the Association of Poor Law Unions?—I am.

5983. You have been a member of that Association since it was established, and a member of the Council of the Association for 18 years?—Yes.

5984. You have also been Chairman of the Fulham Board of Guardians for over 25 years?—Yes, since 1900. I have been elected 25 or 26 times.

5985. We should like you to assist us this morning with your views on the existing legislation in so far as it affects your duties as Poor Law authorities. I think you are brought into contact with the Lunacy administration through the Lunacy Act of 1890, which has various sections in which the Poor Law authorities are referred to?—Yes.

16 December, 1924.] Rev. P. S. G. PROPERT, Mr. R. A. LEACH, Mr. JAMES H. FORD, and [Continued.
Mr. J. W. FLINT, J.P.]

5986. I think in particular the sections are sections 13, 14, 16, 20, 21, and 24?—Yes, those are the chief sections. I should like to say, Mr. Chairman, that I am really giving evidence as an ordinary guardian; I do not claim to have very great technical knowledge or legal knowledge of the subject. Mr. Leach, who is on my left, will deal chiefly with the matters which have come up from time to time, views from the guardians which have come to the Association; he has evidence largely on those points which have come before the Association. He is clerk to the Rochdale Union, and Mr. Ford is clerk to the Leeds Union. Mr. Flint is a member of the Sheffield Board of Guardians, and also a justice. I might say, in answer to your statement, that my experience as a guardian during the past 30 years suggests to me that, as a whole, the Lunacy law in relation to our work as guardians is working smoothly, and I would say satisfactorily. During the whole of that time (I speak now as a guardian) no serious complaints have come to us as guardians. Of course, there have been matters of detail, but during the whole of that time it is very remarkable that nothing in the nature of serious complaints has come before my Board, with regard to the relieving officer; he is working, of course, independently of us under the Acts, and the work has gone on, as I say, very smoothly. I think the absence of friction indicates that, generally speaking (I am not going into details of administration), in Fulham the whole thing has gone smoothly and satisfactorily.

5987. Have you not found the rather complicated provisions of the Act a little embarrassing sometimes?—So far as we are concerned, I think I have attached to my *précis* some letters and papers which indicate the details upon which we have had from time to time difficulties.

5988. We have been a little struck as a Commission with the complexity of the Statute as regards the different methods in which you are brought into contact with cases?—That may be so.

5989. And I conceive from those letters that legal questions have to some extent embarrassed you?—I am not now putting forward medical views. I have a great many opinions, and I have expressed some of them with regard to certification, the necessity for uniformity, and I think the power or the lack of power, of the justice to remand—things of that sort. I can give a number of opinions, but I am giving now evidence as a guardian, and I say from the point of view of the Board we have had very little friction indeed.

5990. That is what we want to get.—Yes, as a Board we have had very little trouble, if any.

5991. At the same time we are concerned with the legal code which exists at the moment.—My co-witnesses will give a good deal of evidence upon that point. I do not wish to pose as a legal or medical authority.

5992. But, after all, the law is handed out to us as citizens to administer, and what one wants to know is whether you have found the existing code, from the administrative point of view, in any way lacking in clearness or in precision?—I should not say so. The large majority of our cases are dealt with in Fulham under Section 20 of the Act. I suppose other witnesses will probably say they have dealt under other sections, but we have dealt almost entirely under Section 20. The relieving officer receives information; he visits the case; if in his opinion there is an element of urgency about it, he brings it to the workhouse, and then within three days a justice is called in; and it appears to me that there is a very short time there by implication. It seems to me the justice must certify or discharge the patient. Of course, he can suspend under another section—he can delay the case, but that gives no power to remand, and we have found a difficulty here.

5993. That relates to a matter we have been considering—the desirability of having a period during which investigation and observation may take place?—Yes. I think there is certainly a need for delaying and further investigation, and further observation,

and we do use the other sections of the Act which give us power to suspend the order, but there appears to be no power to remand. You can delay and you can suspend. The other day I went in to see a patient, and I found on the order the magistrate had written in the margin, "I remand this case." Very often there is an infringement of the Act, because they feel there should be further observation than that which is given under the various sections of the Act.

5994. You are aware probably that in the case of private patients it is open to the judicial authority to adjourn a case for 14 days for further investigation?—Yes.

5995. Would you welcome a similar provision with regard to rate-aided cases?—Certainly I should. I think there should be, as far as possible, uniformity, and I think that, if there was an extended time for observation and treatment, fewer people would be sent to asylums. I think that is quite possible. That is rather a medical opinion, but that has come out in my experience.

5996. I shall not trouble you with the rather technical legal points to which those letters relate. I have studied them myself, and my colleagues have also, but it is not an appropriate topic for discussion here?—No. I see you have had evidence upon that point before too.

5997. We have, but your letters are certainly very useful in that respect.—May I say that on one occasion a man was brought in to our observation wards, and the magistrate was in doubt about the case. I think he rather had views—I do not quite know what view the medical officer took—but the justice refused to certify in that case, brought up in one of those letters; so they discharged the man, and he went home and cut his throat. That was a case in which the magistrate felt: "Well, I must certify, or discharge," and he discharged him, and that brought up one of those letters which I have attached to my *précis*—this man was discharged by the magistrate. The magistrate refused to certify, or to detain him in the workhouse, and he was discharged, and went home and cut his throat. That was one of the occasions when I say the working of the law was brought up for discussion by our Board.

5998. I would like your view on quite a general topic. We are rather struck with the extent to which the Poor Law administration is brought into contact with Lunacy administration, and the machinery of the Poor Law is utilised. There is some feeling—I do not know how far it is well founded—that that is rather an unfortunate association, and that persons who hitherto have not come under your charge in any way, artisans, or respectable working people, by the mere misfortune of becoming mentally afflicted find themselves brought into the Poor Law atmosphere, which is to some of them distressing. Have you any general view upon that?—Yes, I think I have. I cannot say that that has come out very much in Fulham. Our observation wards are quite distinct buildings. I am in London, and therefore I am not giving evidence from a country point of view. In London these observation wards are really little hospitals. I think there are nine beds in each, male and female, and they are placed under the infirmary; we have transferred them to our infirmary, so we treat our people who come in as sick people. Being under the infirmary they have trained nurses, they have medical attention every day. On that point I think this has interested me: let us suppose the matter was separated altogether from Poor Law administration and became known as part of the lunacy laws. I think that it would mark the patient much more than under the present circumstances. For instance, our ambulance goes down a street to-day—no one knows whose it is; it is not distinguished in any way; the neighbours in London see that an officer has gone into a house in a street, they do not know exactly why he has gone there. The patient is taken away; he becomes better and he comes back again, or he may be taken to the

16 December, 1924.] Rev. P. S. G. PROPERT, Mr. R. A. LEACH, Mr. JAMES H. FORD, and [Continued.
Mr. J. W. FLINT, J.P.]

asylum, but he is not branded there and then; they do not know that it is a question of lunacy. We know the public are very afraid of mental disease and, I think, under the present circumstances there is less likelihood for the public to take up that position; it becomes part of the general administration and is not separate and distinct.

5999. There are, of course, two quite different stigmas, if I may so call them, there is the stigma of certification, that a person has become of unsound mind, and there is also rather a social stigma—the stigma of having had to be relieved by the rates; and it has struck us that by the utilisation of the Poor Law machinery a person who becomes mentally sick becomes for the time being pauperised—let us use the word, while a patient who suffers from an infectious disease, or any ordinary ailment, and goes to an ordinary general hospital, does not suffer that disadvantage?—Quite.

6000. One appreciates that you must have some institution to which you can take patients?—Yes.

6001. And your institutions have been utilised for that purpose?—Yes.

6002. But in consequence of utilising them, as they are provided out of public funds, the patients then become to that extent rate-aided?—Yes. What I regret is that the Poor Law is becoming so tremendously popular—it is becoming extremely popular. Since the Representation of the People Act there is no disqualification. Our hospitals are becoming remarkable institutions, and the people have votes. I am a guardian of 30 years' standing, and I belong to the strict school. I have been in favour of legal relief. When I began there were distinct disqualifications, and there was the stigma; that is passing away, and the Poor Law has become extremely popular and in fact public aid is generally becoming popular.

6003. I do not know that we desire to encourage that?—Exactly, that has been my view.

6004. It is a slightly different aspect of it that I am considering, a class of person to whom rate aid is distasteful—who is independent?—I am sorry to say that there are very few people to whom it is distasteful; it is passing away, I assure you. I live among the people; I have lived in a congested area for 40 years, and I say that this feeling of the stigma is passing away.

6005. I am not at all sure that in the public interest it is desirable that it should pass away?—Look at the hundreds and thousands of able-bodied workmen who come to the Poor Law without hesitation. We spent £36,000,000 in the year before last largely in relieving able-bodied workmen. They have come by their thousands, for instance, the ex-soldiers; one would have thought the ex-service man would have felt it, but these come. We have dealt with 300,000 persons, ex-service men and their dependents in the past year. I am simply giving evidence, I am not expressing now preconceived opinions at all, I am giving what I have felt from living among the people, and I believe, looking back 30 years, that the Poor Law is not so unpopular as it was, and really there is no ground for the stigma in these days.

6006. I appreciate that point of view, but I am not sure that it is in the public interest that reliance upon public money should be encouraged. What one is rather thinking of is this, that there is an implication, in a resort to the rates, of destitution—that is the accepted word?—Yes.

6007. And even in the case of the able-bodied whom you relieve that right to be relieved depends upon their being destitute?—But Mr. Adrian, formerly the legal adviser of the Local Government Board, has given a very wide definition of the term "destitution" which does not mean that people may be without means, but that they may be destitute of the particular thing which is necessary either to their existence or to their physical well-being.

6008. Again, if I may press my point a little, it is this: that persons, who are not destitute in any sense of the term while they are in possession of their senses, have to find their way, if they become mentally

afflicted, to asylums through the medium of the Poor Law. It is that point which I want to emphasise rather.—There is an escape from that position by dealing with a case under Section 13, the non-pauper class, and I think Mr. Leach will have something to say about that.

6009. In that case you must be satisfied that the lunatic is not under proper care and control, or is being cruelly treated?—That is so, but I think one may assume, in the first instance, that the person is not a pauper, and proceed under that clause.

6010. You have been fortunate, of course, in London owing to the more perfect administration that you have here?—I should not like to say here that London is really more perfect.

6011. It has larger resources, shall we say?—The resources are better.

6012. You are able to take your mental cases really into a hospital, as you call it, rather than into a Poor Law institution. Although it is a Poor Law institution in law, it is in character and administration more akin to a hospital?—That is so.

6013. And you are enabled to treat your patients in a period of transition, so to speak, as if they were in a general hospital?—Yes; that is my evidence.

6014. But, owing to the circumstance that it is a Poor Law institution all the same, they must for the time being be treated, as we know, under the Act as persons who have been relieved at the expense of the public, and therefore from that aspect are rate-aided patients?—That is so.

6015. Unless, of course, you use Section 13?—Yes, and there is the escape; you may assume at first that the case is non-pauper, and it is not treated as a pauper case unless it is so ascertained—for instance, by calling in the medical officer.

6016. Calling in a medical officer? "A person who is visited by a medical officer of the union, at the expense of the union, is, for the purposes of this section, to be deemed to be in receipt of relief." That is Section 18.—Yes, that would be so. Of course, the guardians can recover the cost afterwards if it is found the patient can pay.

6017. Of course, cases which are for the moment treated as pauper cases pass into an asylum, and then it is one of your duties, is it not, to find out whether they have means?—Yes.

6018. If you find that after all the patient has sufficient means for his maintenance in the asylum you recover from his relatives?—Always.

6019. And in that case provision is made for the transfer of the patient to a private category?—Yes, always.

6020. Now take that case. It seems to me rather an interesting case—a person who has sufficient means for his own maintenance. He is brought to you, you know nothing of him at all; he passes into your hands, and is ultimately certified; shortly afterwards it is discovered that he is a person of adequate means, and he then becomes a private patient. But en route he has passed through a stage in which he has become a rate-aided patient, and he could never afterwards say that he has not been a pauper?—For the time being, yes. You would have to do this in any case, you would have to ascertain the means; and it is found that a great many of the cases that come in ought, to my mind, to be non-pauper, but they have no objection to receiving a certain portion of the cost which is necessary for their maintenance. I have not found (I am giving evidence as a guardian) among quite important people socially in a sense, not wealthy of course, but I have not found in Fulham in the whole course of my 30 years that anyone has ever come to me and said, "I very much object to the fact that I have been treated as a pauper." That is my evidence, and that is quite correct. Many people have come to me and rather suggested they would like to receive help.

6021. But we have had a great deal of evidence that the word "pauper" is an unhappy word.—Yes, we all agree; in fact we have had that up at the Association over and over again—nomenclature. There is a regular school of thought now in our country who

16 December, 1924.] Rev. P. S. G. PROPERT, Mr. R. A. LEACH, Mr. JAMES H. FORD, and [Continued.
Mr. J. W. FLINT, J.P.]

wish to smooth down everything absolutely, and we are getting all kinds of suggestions; in fact, we shall have to go into the question of nomenclature. They wish to replace old words which have their meaning. Of course words, like coins, go out of currency. I believe they objected, in the first instance, to the word "poor," and somebody suggested the French form would be better, and they introduced "pauper." Now "pauper" has become unpopular. "Lunatic" was quite a proper word at one time, but has got out of currency; people do not like it. Now they are asking for a change. I think my colleagues will give evidence that we often use the term "mental hospital patient," and so on, but in our actual documents we have to use legal words, because the Act uses them, and therefore the word "lunatic" stops, because it is in the Act. But we suggest changes; we are not opposed to that in the least. "lunatic asylum" becoming "mental hospital," or "pauper" becoming "rate-aided."

6022. We are not going to enter upon those large topics of sociology just now. What I am rather concerned with is this, that there is no particular harm in calling a thing by its own name, if it deserves its own name; but there are cases in which the name, let us say, of a pauper, is, through the machinery of the law, attached to persons who do not deserve it. That is the point I am concerned with for the moment, and the invocation of the machinery of the Poor Law, excellent machinery for the purpose, and indeed the ordinary machinery to hand, has had the consequence, which some people seem to resent, of associating this form of illness with pauperisation. —Yes, I know the school very well.

6023. And one has to consider among other things whether it is possible to dissociate the two ideas, possibly in nomenclature, and possibly to some extent in administration, and treat the mentally afflicted person very much as you would treat a patient who is suffering from an infectious disease, and who now has to be notified and taken to an infectious diseases hospital—in short, treat the lunacy administration as a branch of the public service rather than as a Poor Law incident. It is a point one is rather interested in; it is a large question of administration?—Yes, I quite appreciate that view, but my evidence does not support the idea that there is a tremendous objection to the present machinery.

6024. And it may well be, as you say, that there is less reluctance now to be associated with Poor Law administration than was formerly the case. We hope it does not mean that the independence of the nation is being sapped?—It does certainly.

6025. I wanted to have your view as to whether you found in experience that people are unhappy at this association with the Poor Law as an episode in their lives?—My evidence is negative on that point; I do not want to say anything more than that.

6026. Now I see that you have a view, which I think most people share, that it is desirable to assimilate the treatment of mental illness as much as possible to the treatment of other forms of illness?—Yes, I regard it as sickness. I think my colleagues will give evidence upon that point too. I am speaking as a guardian.

6027. Meeting the people?—Yes. These gentlemen are technical experts much more than I am.

6028. And you would favour, would you, any expedients whereby that aspect of treating this affliction could be developed?—Yes, I think there is room for some variation in the present law on that point.

6029. To get the element of detention or incarceration, as far as possible, eliminated and the aspect of treatment emphasised?—Yes, quite, I agree with that entirely. We have tried to do that in Fulham, but we have found the law was against us.

6030. We are here, of course, to consider possible amendments of the law; but do you find that by having a separate infirmary at Fulham with what one may call a hospital atmosphere, you are enabled,

although it is technically Poor Law treatment and treatment of alleged lunatics, to give your administration rather the aspect of medical than of legal treatment?—Yes, we do, and we have made every effort to emphasise that aspect of it.

6031. One other matter I think you allude to—we have really touched on it already—as you know the code for certification of pauper patients and non-pauper patients is different?—Yes, quite.

6032. You would be in favour, I take it, of assimilating the two methods?—Yes. I am not so keen myself upon the number of doctors, whether it is one, two, or three, but I think whatever is agreed upon that should be uniform. I think the liberty and the freedom and the protection of the subject, and the protection of the community should come in exactly the same in both cases, because, after all, these interferences are really for the protection not only of a particular individual but of the public.

6033. I do not think any of us appreciate why there should be more precautions in the case of one class of person than in another, because the liberty of the subject is as important in the eye of the law whether it is a duke or a pauper, or a millionaire or a person on a weekly wage?—Yes. I think that was due to the fact that that was not so much appreciated a few years ago, in the old days.

6034. What, of course, may have had something to do with it is, that in the case of the private patient often there is much more property involved?—Exactly. There may be interests at work there which do not come in so much with the poorer man, but I think the question of liberty and protection is equally important.

6035. I think I may say we should all agree with that aspect of it and, of course, the medical certificate is the evidence upon which the subject is deprived of his liberty?—Yes.

6036. The medical certificate is the evidence adduced to the certifying authority, and one has to consider, if there is to be assimilation of the two cases, the private case and the pauper case, what would be an adequate precaution for all cases?—Quite so. Of course the justice appears to me to come in to protect the public; he represents the public, and as far as I can see, of course I am not an expert, no one can be detained in a Poor Law institution for more than 14 days without a justice's order.

6037. Of course he represents the public interest?—Yes; he is there to see that the public interests are protected.

6038. You suggest that the examination of lunatics or alleged lunatics should be more formal?—I do. I have rather varied my opinion.

6039. I was wondering what you meant exactly by that?—I have varied my opinion. There have been cases, I have no doubt, in the country sometimes where people are examined in bed, and are taken to the house of the justice, and so on. I should like to vary my view upon that.

6040. What is your reconsidered view upon that?—I think now that in dealing with people whose minds are out of order perhaps less formality is better than too much formality; the atmosphere of a Court and that sort of thing, might perhaps from a medical point of view be prejudicial. My evidence on that point has varied, because when I consulted one of the relieving officers I got the idea of more formality rather from him, but I happened to meet a highly qualified medical man the other day, and I mentioned this point, and he pointed out that every formal process where the mind is a little unhinged might perhaps have a bad effect rather than a good effect.

6041. We have two things to reconcile, we have to see that every proper precaution is taken to prevent improper certification or detention, and at the same time to see that those steps are not such as themselves to bring about the very thing we want to avoid, namely, the mental illness?—Quite so.

6042. Do you think the avoidance of the forensic element is desirable?—Yes, I think so. If we could get treatment without certification sometimes it

16 December, 1924.] Rev. P. S. G. PROPERT, Mr. R. A. LEACH, Mr. JAMES H. FORD, and [Continued.
Mr. J. W. FLINT, J.P.]

would be an important distinct advantage from a medical point of view; that is my opinion. I think that treatment without certification, and without all this Court business, might be an advantage. I agree with you.

6043. We have, of course, always to keep clearly before us this, that you cannot interfere with the liberty of the subject without some sanction, as we call it?—Exactly.

6044. And it is to accommodate those two ideas that is really our problem?—Exactly.

6045. Some people have thought that the forensic element is too conspicuous, and that people feel as if they had done something wrong if they are brought before a justice?—Exactly.

6046. One wants to get rid of that idea, because you are not taken before a justice when you have pneumonia. At the same time, when you have pneumonia you do not find yourself deprived of your liberty?—There should be a sufficient formality at the same time to safeguard.

6047. Now just one other question, and then we will go to your colleagues, who will tell us of the more technical matters. In your experience, have you formed any idea as to the desirability of having two medical certificates in all cases?—Yes, I have formed some opinions upon that; that is rather a matter which has come up before the Association.

6048. Then shall I ask that of the other witnesses?—Yes, I think Mr. Leach will deal with that, although I am rather against having two always.

6049. One idea which did occur to us was that as the great majority of the cases are straight, simple cases, it might be unnecessary from the point of view of public expense to have two opinions?—Certainly.

6050. But, on the other hand, that in a case where there was any dubiety, the class of case where you would ask for a remand, if a remand was open to you, there might be two?—Yes, I have felt with regard to that point that a good deal depends upon the character of the qualifications of the doctor. A man, I feel, should be qualified for this work, although, of course, every man is qualified, but I think there is a particular experience necessary in this work of certification.

6051. You will appreciate we hear views on both sides of almost every question, and some people think that the alienist, or expert, is undesirable, and that it is better to have the ordinary general practitioner?—Yes; you will hear evidence on that point from my colleagues.

6052. Then I think we have taken from you the general view, and we are obliged to you, and I will keep these letters?—Please do.

6053. I think perhaps we might take Mr. Leach, who has given us a more elaborate and technical *précis*, as our next witness. Mr. Leach, you are second Vice-President of the Association of Poor Law Unions of England and Wales?—Yes.

6054. Just tell us a little about your Association, first of all. What is it?—The Association of Poor Law Unions of England and Wales is an Association set up by Statute under which any and all members of Boards of Guardians may be members for the furtherance of their own administration, and for obtaining amendment where they find in administration any matter of law is not sufficient.

6055. It is a conference, really, of experts?—Yes, certainly, it is a conference of the chosen representative of members of boards and of their corporations.

6056. Do you meet from time to time?—There is an annual meeting, and there is a Council that meets frequently with its committees, the Parliamentary Committee and the General Purposes Committee, and it issues annually a very fine report (*handing in the same*).

6057. *Earl Russell*: How are they chosen? By a general meeting of all the people, of all the unions, or what?—No; each board elects its own representatives, who are limited to two; they may be two guardians, or they may be a guardian and the

clerk. (*Mr. Propert*): The great point is, it is a constituent assembly—that is, the members of it are members of boards of guardians.

6058. *Chairman*: And I see it is your province to consider legislation that is passing at the time, and to make suggestions upon it, and also to consider the Poor Law administration, and to confer with each other, exchange experience, and so on?—(*Mr. Leach*): That is so. I think at the annual meeting, there are nearly a thousand representatives. (*Mr. Propert*): There are 590 boards of guardians who are members of the association, out of about 630. (*Mr. Leach*): Yes; their population aggregates to 35,000,000—in fact all boards, excepting a very few small rural unions, are in membership. There is all the difference between this and a conference. There are statutory Poor Law conferences set up under a statute specially, but this is an association, distinct from conferences, to insure the betterment of the administration of the law where an amendment of the law is desired. This Association comes to conclusions; it passes resolutions, it takes steps, determines its way, as distinct from a Poor Law conference which may meet together for the purpose of discussing a particular problem and separates without anything being done.

6059. I see you are a statutory body founded under 61 and 62 Victoria, chapter 19, and therefore you have a status?—Yes.

6060. But so far as the lunacy administration is concerned that will be one only of the many topics you will have to consider?—Yes.

6061. And I see in this particular report you have put in that that subject was under your consideration, among many others?—Yes.

6062. Now you, I think, in addition to holding office in the Association, are Clerk to the Guardians of the Rochdale Union, and have been so since 1886?—Yes.

6063. And you are also a barrister-at-law?—Yes.

6064. We should be glad to have from you your observations upon any topics which you think it would be useful for the Commission to consider in their general survey in the matter of certification, detention, and care which we have under consideration. Perhaps we might take the subjects you speak on in the order in which you have put them before us. Your first point, if I may say so, is perhaps hardly germane to our enquiry, the question of the inadequacy of the statistics. You want further information, I understand, in the annual reports of the Board of Control?—I think more complete information (that is why I mention it) would strengthen the demand for dealing with cases of certification without the order. However, if the Commission think it is not germane to their enquiry, perhaps I had better leave it.

6065. I think it is a little remote from our enquiry, except that I can see the bearing which you refer to, that at present there is no means of knowing how many cases have been dismissed, and you think that that would show that many cases are brought forward without being really certifiable cases. They are brought up for examination, and the present system is efficient to this extent, that it discards the cases which are not certifiable?—Yes. For instance, speaking about Poor Law infirmaries, the medical officer under Section 24 of the Act, may, when he finds a person has got a mental breakdown, and has to be under care as such, use his own certificate for 14 days.

6066. Yes, but he has got to certify that the person is insane?—Yes, but before the end of that 14 days the person may be free, he may reclass the person again as a sane person. I mention that as indicating that probably if as much was known as might be known by obtaining fuller statistics, it would strengthen the demand which is becoming very strong amongst the guardians and outside, that there should be some way of dealing with a case of mental breakdown without dealing with it under the Lunacy Act, if there is any likelihood that in the

16 December, 1924.] Rev. P. S. G. PROPERT, Mr. R. A. LEACH, Mr. JAMES H. FORD, and [Continued.
Mr. J. W. FLINT, J.P.]

course of a few days, or a few weeks, the patient may have recovered his sanity.

6067. It would illustrate the number of cases which are of a transitory character, and therefore might be treated without certification—that is your point?—Yes.

6068. We have that in mind.—On that matter, if I may say so, I was looking at the statistics for the mental hospitals in Lancashire—there are five. I noticed that last year, 1923, admissions numbered 3,087, and where they were sent to the asylum under a justice's order 10 per cent. were discharged as recovered within six months, and 8 per cent. discharged as recovered within three months.

6069. And the further statistics which you wish would show that a considerable number of the cases brought up had really recovered within a shorter time still?—Yes, and yet they have to be dealt with and certified under the Lunacy Acts by a medical officer as persons of unsound mind to be kept in the hospital.

6070. Take the 14 days' case: A person might recover in 10 days, and, if the illness were of so transitory a character as that, you think that certification should be avoided?—I think so.

6071. I follow your point. We might just get on the note the additional statistics which you think might illustrate that. You think it would be desirable that the number of persons dealt with in England and Wales under the Lunacy Acts as alleged lunatics, where the proceedings are abortive from one cause or another should be recorded?—Yes. If I may put it in this way—I know the Commissioners have got to report ultimately on this matter, and I do not suggest that these statistics can have a permanent place annually in the records, but I thought—excuse me if I am making a suggestion that I ought not to do—but I thought if the Commission obtained these statistics, say, for a year or more back, under all the heads that I have given, the Commission itself might be assisted in ultimately framing its recommendations. The Royal Commission on the Poor Law and Relief of Distress did obtain a special return for 12 months of all classes of chargeable persons dealt with by the guardians, to assist them in coming to what they thought they should ultimately have to recommend, so that if the Commission are going to consider or suggest that there may be a way of dealing with mental breakdown, on the lines of the Bill of two years ago, they might find, if they have a special return of that sort, very much support for the recommendation. I do not know whether I have put it rightly, but that is my view.

6072. You think that is a source of information to which we might reasonably resort in connection with this topic?—Yes, I think so, without giving them a permanent place in the annual returns.

6073. Shall we just take the other points on which you think we might obtain information? You suggest, in the second place, the number of alleged lunatics removed to Poor Law institutions in England, under Section 20, until the case can be dealt with by a justice. Next you suggest we might get figures as to the number of persons removed, or temporarily detained in Poor Law institutions by orders under Section 21, subsection (2)—these are known as the 14-day orders?—Yes.

6074. And on the expiration of the 14 days they are set free, or sooner?—Yes.

6075. Then you think the number of persons detained for not more than 14 days in the Poor Law institution on the sole certificate of the medical officer under Section 24 (1) might throw light upon the subject?—Yes.

6076. And as to what befell these patients?—Yes.

6077. And lastly you refer to the number of lunatics, in respect of whom a summary reception order may be made, allowed by the justices under Section 22 to be taken charge of by a relation or friends?—Yes.

6078. Your view is that information from these sources would strengthen the case for some reform of the law in the direction of the treatment of transitory cases without certification?—Yes, that is my point.

6079. Then in the next place, we have the subject of the method of certification. Now you have not only had practical experience, but you are also a member of the legal profession. Have you found the existing code difficult to work in the matter of certification, and the precautions prescribed?—Yes.

6080. I am putting it quite colloquially, if I may say so; and, reading the important sections with which you are concerned, it seems to me that the programme that is laid down for the official to work to is rather complicated?—It is.

6081. It is not so precise as it might be in a matter of so great importance. I have no doubt that it is to some extent the survival of earlier systems which have been carried forward, but personally I always feel that when a code is handed down to officials for administration, the programme of the code, so to speak, and the steps to be taken, should be set out with great precision and clearness. I think we have all felt from our study of those sections, and the varying views we have heard and the extraordinary variety of practice under those sections, that the programme cannot be so precise as it should be. Have you experienced that yourself in working it?—In 1901 the statement of the case was put before Mr. Macmorran on behalf of the Poor Law Officers' Association as to when the relieving officer should deal with a case under Section 13, and when he should deal with it under Section 14. Mr. Longbottom, the Clerk at Halifax at that time, put before the Yorkshire Officers' Association that relieving officers in taking as many cases as they were doing under Section 14, were too readily classing these alleged lunatics as paupers, which was a mistake, and that if a person had had no relief until the case was reported as a case of alleged lunacy, if they had had no relief at all from the Guardians, it should be dealt with under Section 13.

6082. And so avoid the Poor Law association?—There is a Poor Law association, the Poor Law machinery is still used, because you have got to have either the relieving officer or the constable, or the overseer, under Section 13.

6083. True, but he is not a pauper, and then he may be sent to an institution to which, if a pauper, he might have been sent?—As soon as he gets there he is classed as a pauper, unless he is re-classed on the private side, so that the Poor Law machinery, or the police machinery, is still there in dealing with a case before the justice. After the case gets into the asylum, or the hospital, then they go down as pauper cases, or rate-aided cases. I have Mr. Macmorran's opinion here—may I hand it in?

6084. I should like to read it very much if you will be good enough to hand it in?—There is the statement of the case. (*Handing in the same.*)

6085. It does seem to be a little difficult to know under which section to proceed. The classification of mentally afflicted persons is peculiar. There is in Section 13 the classification of the person who "is deemed a lunatic and is not under proper care and control, or is cruelly treated or neglected"?—Yes.

6086. And then you have the next class of person, a person who is a pauper resident, and who is deemed to be a lunatic, and a proper person to be sent to an asylum; and then we have the person who, whether he is a pauper or not, is wandering at large?—Yes.

6087. It is a little difficult, I should imagine, in administration to know the category to which to relegate your case?—You will find in Rochdale we deal with all cases, unless they are in receipt of relief at the time the case is reported, under Section 13. I think I am right in saying (you will take some statistics that Mr. Flint has put in) that the great majority of their cases are dealt with under Section 14. At Manchester and at Liverpool they have supplied me with statistics—there are, in those

16 December, 1924.] Rev. P. S. G. PROPERT, Mr. R. A. LEACH, Mr. JAMES H. FORD, and [Continued.
Mr. J. W. FLINT, J.P.]

two cities together, something like 2,000 mental cases a year. I believe the great majority, as I think Mr. Ford will admit for Leeds, are dealt with under Section 14, although they are not in receipt of relief except in a medical sense before the case is reported as a case of lunacy. I think it of great importance that the person, whoever he is, should have, if he is an alleged lunatic and is brought before a justice, all the precautions, and all the safeguards, and all the protection that is given under Section 13.

Earl Russell: As the Chairman has just pointed out to you, you cannot deal with a lunatic under Section 13 without making one of two reflections on his relations—either he is cruelly treated, or is not under proper care and control—that is what the statute binds you to.

Chairman: I do not know whether not being under proper care is a reflection.

Witness: One's own experience is this, that the persons generally dealt with under Section 13 are persons whose friends and relatives are very kind and humane, but the case is such that in their own home, while there is no actual destitution in the sense of there being shortage of food, or "destitution" within Mr. Adrian's meaning, they may not be under proper care and control. As a matter of fact, it is the friends and relatives who come and tell you that they are not under proper care and control—their own doctor says the alleged lunatics are not under proper care and control.

6088. But does the diversity of practice to which you have alluded not rather suggest to you that the code is a little indefinite in its guidance?—I think it is too awkward altogether.

6089. At the same time one must recognise that it was founded on a recognition of different types of cases. The class whom you have in your mind, let us say the persons who become mentally afflicted in their own home, form one class of case. Then there is the class of case of the lunatic wandering at large. Somebody out in the street here suddenly has an onset of insanity, and something has to be done immediately. The difficulty is that there is no place to take such a person to at once except either a police office or a workhouse—these are the only two institutions that are available for his immediate reception?—They would not keep him in the police office.

6090. A constable might take him to the police office to see the sergeant in charge, and would be told at once to pass him on to the workhouse?—Yes, under Section 20.

6091. But that class of case is a case by itself, and not so frequent, I suppose, as the ordinary case of illness overtaking a patient in his own home?—It is surprising, the great majority are taken under Section 20 first, a very small percentage of the persons dealt with under Section 13 are taken from their own home to the asylum.

6092. They pass through this intervening stage?—The doctor advises the relatives to have them taken away at once, the officer is called in, and they are taken away under Section 20; except a very small percentage. The Lunacy Commissioners, now the Board of Control, some time ago in their Annual Report laid emphasis upon the advisability of getting the patients taken direct from their home. What can you do? The doctor comes, the relatives say, "We cannot look after them. You must get them away," and the officer goes, and he finds that under the conditions of Section 20 for the safety and welfare of the patient he ought to be put under care and control temporarily. I think Mr. Ford will bear me out, and Mr. Flint too?—(*Mr. Ford:* Not entirely. (*Mr. Leach:* That shows a difference at once, but I think you will find in this return I suggest that the vast majority were taken under Section 20 before they were taken to the asylum or mental hospital, although there may be cases dealt with under Section 13.

6093. *Chairman:* Have you to arrange in practice with the asylum before you get a patient sent there?—Yes.

6094. I am thinking of the time that is required. One wants to look at these things practically. Then take a case where this unhappy misfortune has befallen a home, let it be either the head of the house, or one of the members of the family who suddenly becomes uncontrollably insane. Something has to be done at once. You say there was a feeling that it was desirable, if possible, to have those patients taken direct to an asylum?—Yes.

6095. Can that be done in practice?—In practice it cannot be done, because you have got to ascertain whether there is room in the asylum where you are going to take the patient. In Lancashire the chief administrative officer for the Asylums Board is at Preston. There are five asylums in the county. You have got to ring up or telegraph to the administrative officer at Preston to find which asylum of the five you may take this patient to. (*Mr. Ford:* Might I suggest that that question is taken as applying to Lancashire?

6096. (*Chairman:* Yes. Let me take this as an illustration. Does this intervening period in the workhouse or the workhouse infirmary really serve three purposes—first of all, it secures immediate care and supervision of the patient?—(*Mr. Leach:* Yes.

6097. Secondly, it enables the justice of the peace to be invoked, and to come to the infirmary for the purpose of seeing the patient, and there pronouncing upon him, with the assistance of the medical opinion; and, in the third place, it gives you time to make arrangements, if the case has to be certified, for its reception in an asylum?—Yes; if he is dealt with under Section 13, the justice does not necessarily need to see the patient. If he finds that he may make an order he may say, "Instead of making a summary order for the asylum I will make a 14 days' order."

6098. Perhaps I should have added that—there is a fourth advantage in that it enables the case to be reviewed in suitable surroundings with considered medical opinion, and the outcome of it may be that the case is retained in the infirmary under a 14 days' order, and may ultimately never reach an asylum at all?—Or be set a liberty.

6099. Whereas if a case is taken direct from the home of the patient, no other place but the asylum is available?—That is so. Of course, I do not see really in the big boroughs, where they have their own asylum, why Section 20 should not be extended to the borough asylum, just in the same way as with a private case under the provision for dealing with private cases, you may get them in the asylum before a detention order is actually made. (*Mr. Propert:* Must the asylum be mentioned in the order?

Chairman: Yes.

6100. *Earl Russell:* A great many superintendents very much regret not getting them at once; they think a patient suffers in this intermediate stage?—(*Mr. Leach:* Yes.

6101. *Chairman:* There is that difficulty, that you may not have in the Poor Law infirmary the same facilities for treatment, or the same skilled care of the case that you would get in an asylum. You cannot, of course, provide the same equipment?—You may not have the same equipment, but, as a matter of fact, you may have quite a high standard, if not a higher standard, of nursing. That has always struck me, that the bulk of nurses in mental hospitals are not fully trained nurses.

6102. You mean in general nursing?—Not fully trained in general nursing.

6103. In mental hospitals the nurses were not in practice trained in general nursing?—They have not got the full certificate of general training. It rather seems to me the position is this, that you insist on a higher standard in your hospitals for the nursing of the sane than you have any guarantee of as regards the nursing of the insane; I should have thought if there was to be any difference it ought to be the other way about.

6104. We have had some evidence already with regard to the desirability of nurses in mental hospitals

16 December, 1924.] Rev. P. S. G. PROPERT, Mr. R. A. LEACH, Mr. JAMES H. FORD, and [Continued.
Mr. J. W. FLINT, J.P.

having training in general hospitals at some stage of their training, at any rate before they are put in responsible charge of wards. You approve of that, do you?—I do most certainly. At the same time, if I may say so, I have been in the Poor Law service for over 50 years as clerk and assistant; during that 50 years I have been going to asylums with the guardians under the section referred to, and I am bound to say that always on my visits I have found the greatest care and humane treatment and kindness has been manifested by the staff to all the patients there. Still there is that fact. I have always felt that you have not the highly skilled nursing, you have not got the nurse with a general training in your mental hospital that you get in other hospitals.

6105. You are familiar with the provisions of the Nurses Registration Act of 1919?—Yes.

6106. The register there has to contain a general part, and then there is a supplementary part containing the names of nurses dealing with mental diseases. There is a special qualification?—Yes. I attach a great deal of importance, first of all, to the general training.

6107. Now take the nurses in your workhouse infirmary—have they any special qualification for dealing with mental cases?—If we have a sick case—of course you may have a mental case which is healthy, apart from mental breakdown—if we have a sick case, during the time they are there we have them dealt with by the general trained nurses—under the matron of the hospital.

6108. But do you have nurses specially trained in mental disease?—In our place?

6109. Yes?—No. We have some of the attendants who have got the certificate of the Medico-Psychological Society—not all of them, but some of them.

6110. Then these are nurses of a special qualification?—Yes.

6111. Now on the question of the safeguards under the existing lunacy law, I see that your Association has considered the question of the desirability of two medical certificates in every case. Will you just tell us how you stand now upon that subject?—The resolution of the Association was that one doctor with the justice is sufficient. My own personal view is that there ought to be at least the safeguard that is given under the latest legislation touching other mental defectives; and I attach a great deal of importance not only to there being two medical men, but that one medical practitioner should be a medical practitioner who is approved for this matter either by the Board of Control, or as under the Mental Deficiency Act by the local authority.

6112. You think he should be a specialist, do you?—I do. I have given a case where there were six medical men called in.

6113. Yes, I read that case with much interest. There was a great diversity of medical opinion in that case?—Yes. My own feeling is that there should have been a trained alienist, or a brain specialist; I have not a word to say against a general practitioner, but I do not think there would have been all that trouble if, in the first place, there had been a trained brain specialist called to the assistance of the justice.

6114. That view, I think, is shared by many. There is another view, you know, that the alienist is apt to think us all insane. You know the popular idea that a person who is always dealing with these cases is too ready to certify?—Yes. Still I think there ought to be two, and that one ought to be specially qualified. During the war young men came out of medical schools with four years' training. They were at once dealing with and certifying cases of alleged lunacy for the purpose of reception orders.

6115. Look at it for a moment administratively. There is this difficulty, of course, that these cases often arise suddenly, and have to be dealt with at once. Could you always have at hand, particularly in rural districts, the necessary specially qualified man? I can see that in London and in large centres possibly such a person, or a deputy, could be obtained

always, but is it practicable, do you think, all over the country?—My idea many years ago was that there should be districts for this purpose, larger than unions, an aggregation of unions. You would be able to get your specialist to hand probably within three days, or within six days. The opinion is worth waiting for, especially if the drawback is that if you do not get it you may get a person certified and put under detention as a lunatic who ought not to be so. I always think there is a great protection in one sense inside the asylum, because if the medical officers found there a person who was not insane they would make representations to the Board of Control, and get the discharge at once; but the great thing is to save people from being certified and placed under order as lunatics.

6116. Then we take it, do we, that you regard it as a desirable improvement on the existing legislation that if there is to be only one certifying doctor he should be selected for special qualifications in that matter, or, if there are to be two, that one of them should have those qualifications?—Yes, as is laid down in the Mental Deficiency Act.

6117. Then, I think, your Association has considered the question of dealing with cases without certification?—Yes.

6118. Of course you are aware of the terms of Lord Onslow's Bill which was introduced into the House of Lords?—Yes. The annual meeting of the Association in 1923 adopted the Council's recommendations as regards that particular provision in the Bill.

6119. The resolution there was a general resolution viewing with alarm the increase of insanity, and urging the Government, or the Minister of Health, to take up the question and devise measures for prevention and possible cure; but I do not think that resolution dealt specifically with the point we are interested in for the moment, of dealing with incipient or transitory cases, without certification?—Yes, we have done that. Legislation for the temporary treatment of mental disorder without certification under Clause 4 of the Mental Treatment Bill has the strong approval of the Association of Poor Law Unions: (Resolution of the annual meeting in 1923 adopting the Council's recommendation in the matter). I can put the resolution in.

6120. Clause 4 of the Bill you have just mentioned provides for the temporary treatment of mental disorder without certification, and contemplates the reception of a patient into an institution for a period, which is not to exceed six months, for treatment, and provides for methods for obtaining the consent of the patient to his treatment. The thing that strikes one as the practical difficulty (I do not know whether you have any view upon it or not) is this, that certification, of course, has for its object the giving of control, power to detain; it is the preliminary to the power to detain. If you have no certification the corollary is you have no power to detain. If you have no power to detain, may you not find it difficult to deal with a voluntary case where the patient does not want to remain in the institution, and where it may be a symptom of the ailment itself that the patient wants to get away. Do you favour any less stringent form of certification—something which would enable the medical superintendent of the institution to detain the patient for a limited period without certification?—Yes, without certification under the Lunacy Act, certainly. He has that power now in the case of an infectious disease, in the case of a delirium tremens, under the Poor Law Acts.

6121. Could you give us a reference to the power to detain an infectious case. I know you have to notify infectious diseases?—I think it is in the book I have handed up.

6122. Would you look at it. I should like to know what power you have to detain infectious cases?—If the medical officer finds a case that comes within that provision he can detain under his own certificate until the next meeting of the board of guardians, who go into the case then as to whether he should be further detained.

16 December, 1924.] Rev. P. S. G. PROPERT, Mr. R. A. LEACH, Mr. JAMES H. FORD, and [Continued.
Mr. J. W. FLINT, J.P.]

6123. Is that in the case of an infectious disease?—Yes, or a case of delirium tremens.

6124. If you will hand in a reference later it will do?—So that in a case like that if the man wants to go home, he is told, "No, you have got to be cared for; you cannot have your liberty; you have got to stop here until the guardians meet"; and that is a certificate which he gives under the Poor Law provisions, and I do not see why that provision should not be adopted in lieu of Section 24 (1) of the Lunacy Act.

6125. Are you aware that under the Mental Treatment Bill there is a period of 72 hours' notice provided, which seems to contemplate this, that a person who has gone into an institution for treatment voluntarily, uncertified, cannot leave without 72 hours' notice. Now 72 hours, of course, would give time for certification of a case, if certification then became necessary, would it not?—If certification were wanted, yes.

6126. It does seem necessary, does it not, that there should be some provision enabling the superintendent of such an institution to exercise control, though not necessarily the full control which you have under certification, if some control over the patient is necessary in his own interest?—I think so.

6127. Do you think that would be achieved by providing that such patients should not be allowed to leave without a certain period of notice such as is proposed in the Bill?—I certainly do; that is my own view. Sometimes a doctor has got to think for his patient.

6128. Then you deal in your *précis* at considerable length with a topic which is rather outside our purview, namely, "the participation of representatives of boards of guardians in the management of county and borough hospitals"—that is a topic I could imagine which is partly political, and perhaps not very much to our address. But will you tell us this: Have you any suggestion to make on the subject of the visitation of patients by guardians? At present I take it the guardians have the right to visit any institution in which patients of theirs are housed?—Yes.

6129. They have, however, no legal duty to do so as the law stands—they have the right to go?—No. The Board of Control attach great importance to their doing so.

6130. Perfectly. We have been concerned in our enquiries with what I may call the possibilities of contact between the patient in an institution and the outside world, an important safeguard in our view. Do you attach importance to the guardians, who are outside persons, having access to patients in institutions?—Yes, I think they should have, most certainly. Of course, apart from the visiting committee it would serve the purpose of management and outside contact as well.

6131. I see your point, but it has been suggested that it is perhaps desirable that the patient should be visited by two classes of persons, firstly, the visiting committee, who have their official duties and who are bound to visit; and secondly, the guardians, who have the right, though not the obligation, to visit, thus bringing the patients into contact with yet another outside interest. It has been suggested that the visits by guardians, or indeed by visiting committees, are apt to be perfunctory. Have you taken part in any visits yourself?—Yes, any number.

6132. What have you done as a guardian visiting an institution in which patients of yours are housed?—I have visited as a clerk. I have not the privilege of being a guardian.

6133. Do you go with the guardians?—Yes.

6134. You have been at plenty of such visits?—Any number.

6135. I would like very much to hear from you what your guardians really do when you are with them?—First of all, I supply the guardians with a list of the patients in the institution.

6136. Who come from their district and for whom they are responsible?—Yes, and of their residences before admission to the asylum. That has the advantage of drawing the attention of the individual members of the deputation to patients particularly from their own parish.

6137. Are the guardians specially selected for the visit, or do they volunteer to visit?—They are selected by the board and divided into sections. They have a spring visit and an autumn visit; they go to the five asylums; there would be about six sections. At one time they only went annually. The district auditor thought the deputation very big and he surcharged the expenses; he cut them down to the number he thought ought to go. The Local Government Board upheld the surcharge, but remitted it in the exercise of their equitable jurisdiction; so the guardians said: "Well, we will see our patients, but instead of going once a year we will go twice"—which meant that the deputations were cut down. Quite as much money was spent as previously, but it had the advantage of a half-yearly visit. My practice is this. I give them this list; they see the patients; very often patients have been there some time, chronic harmless patients who want to be sent to the workhouse, and where that is so, especially if the guardians have got a decent mental hospital, as we mostly have, the guardians are very careful to ascertain whether that can be done, and they generally go into it. If it is not a case of that sort or a case of recent admission, they are very careful to ascertain from the medical officer whether there is any likelihood of the case being discharged recovered within a reasonable time, and all this information that they get and which they bring home is very comforting to the relatives and friends. I attach very great importance to the guardians visiting their own cases at least once a half-year; I think 12 months is too long.

6138. *Earl Russell*: Are these visits made with or without notice to the asylum?—Where you get a large number of patients in an asylum it is for the convenience of the medical superintendent there to send in the night before and say you want to see your patients the next morning; because if you do not do that you may find that in some of these large asylums—at Prestwich there are over 2,000 patients and a large estate—it may take them a considerable time to get the patients together. Of course we have a right to go without any notice at all.

6139. *Chairman*: Are the asylums in which your patients are housed large asylums?—Yes, Lancaster at the end of last year had 2,485 patients, Prestwich 2,680, Rainhill 2,094, Whittingham 2,762 and Winwick 1,578. They are all large asylums, and they are pretty well full. As regards what I am going to express now, if I may—it is a layman's opinion—I always think that new cases ought to be sent, in the first instance, to hospitals where there is not this large aggregation of patients, although notwithstanding that, as I have already mentioned, there is a recovery of 8 per cent. of the cases admitted within three months of admission to the asylum.

6140. *Mr. Micklem*: A further 10 per cent. within the six months?—No, that includes the 8 per cent.

6141. *Chairman*: There is, as you know, a question of policy as to the size of asylums—the best size to have. You have, apparently, experience of large asylums. Have you found that your patients seem to suffer in any way from the fact that they were in such large institutions?—No, I do not know that that is so. If an alienist found I ought to be put under control and they put me in a place where there are 2,000 or 3,000 patients, that would probably set up an added depression.

6142. Yes, it is like so many of the other questions—there are two sides to it. The larger institution, we are assured, permits of better classification?—And as a rule commands, probably, a higher grade official at the head.

6143. And also, of course, will be enabled to have fuller equipment—I mean laboratories for pathological work, and so on. It is a balancing of con-

16 December, 1924.] Rev. P. S. G. PROPERT, Mr. R. A. LEACH, Mr. JAMES H. FORD, and [Continued.
Mr. J. W. FLINT, J.P.]

siderations of course, as in so many of these matters. You have alluded to one matter which struck me as interesting. You find that a number of patients in the asylum would like to get back to the workhouse, that is to say, those who have been inmates of the workhouse and are moved to asylums would wish to get back sometimes?—Yes.

6144. Is that a common experience?—Yes, that is my experience, and it will be borne out by my colleagues.

6145. There is a provision in the statute for the transfer of patients from asylums to workhouses?—Yes, it is Section 25.

6146. Can you tell us why that is not taken more advantage of?—It is in the hands of the asylum authorities whether they are to come under Section 25; the guardians have no control over that. I venture to say that if the hospital is a large hospital and there is a very large amount of accommodation, unless there is pressure for accommodation they are more likely not to use Section 25.

6147. But we have heard evidence that the asylums have about reached the limit of their capacity just now, and it seems to me that some relief for that might be found by the transfer to the workhouses of cases from asylums, that is to say, old people or chronic cases, at present occupying beds in the asylums. If the patients themselves desire it, as you have told us many of them do, do not you think it would be proper to avail ourselves of that provision?—Certainly. In my own union we had a contract with Prestwich for over 20 years, under which we took a number of patients under Section 26.

6148. That provides for an arrangement being made?—Yes, and in that case they are kept on the books of the asylum.

6149. But are housed in the workhouse?—Yes, and they are under inspection by the asylum medical officer. Of course, in the case of a contract like that, the Board of Control have to make special rules, which become part of the contract.

6150. Has that contract come to an end?—Yes, because the pressure at the asylum ceased; we got a new asylum at Winwick. That bears out the point that the use of Section 25 is largely in the hands—it is in fact entirely in the hands—of the asylum people.

6151. Let me put this to you: We have to take a large view of this matter from the point of view of what can be done with the financial resources of the country at the moment. The erection of new asylums is, of course, a costly matter, is it not?—Yes.

6152. Particularly with the modern ideas of asylum accommodation?—Yes.

6153. On the other hand, is it not the case that many of the mental wards of workhouse infirmaries are at the present moment only half full?—Yes.

6154. Does it not occur to you that if there were some saving effected by transferring patients from highly-equipped asylums, patients who desired it, to workhouse infirmaries which are not at present fully occupied, you might in that way be able to effect some economies and possibly be able to improve the asylums for those who could benefit from them; I mean, one wants to take a large view of the whole situation. Is that sound, do you think?—I think it is sound. I think it ought to be coupled with the condition that if they are taken over, which is not the case at present, there ought to be the same aid to the guardians towards the cost of maintenance as there is now in the case of an asylum, where the old four-shilling grant obtains. It is stabilised for the time being; but as soon as ever you transfer them under Section 25 that grant is lost; although when you bring the same patients in by a contract under Section 26, although those patients belong to the same union, you get the grant in that way.

6155. At present when a patient is sent from your union to an asylum the union remains responsible for

that patient and pays whatever may be the establishment charge per head?—Yes.

6156. Towards the relief of your rates you get four shillings per head from the grant in aid?—Yes.

6157. You would therefore have to defray the balance yourself?—Yes.

6158. I should have thought that as the maintenance in a workhouse infirmary is less than the rate per head in an asylum?—No, not always. (Mr. Ford): Not in the larger ones. (Mr. Leach): The reason for that is this: Take the 2,000 patients here, you get a great many of those patients who are able to do work in the different departments, but the class of patients that you bring in under Section 25 or Section 26 are chronic helpless persons who need greater care.

6159. Now, tell me this: Is the reason why there are relatively few of those transfers under Section 25 this, that if you have them in your own hands in the workhouse infirmary there is no grant for them?—There is no grant.

6160. Is not that a deterrent?—That is one. If there is pressure on the local authority under the Lunacy Act, if there is a shortage of asylum accommodation, they will make use of Section 25 for all they are worth, and Section 26, but if there is not pressure, well, they will not do it. The only case you get back under Section 25 is the case of a harmless patient who wants to come home, or where, as often as not, the relatives and friends want a patient to come to the workhouse because they are too poor to pay the cost of visiting him elsewhere.

6161. If you get your patients back under Section 26, that is, under an arrangement, the patients remain certified and under the asylum charge. Do you get a grant in such a case?—What you do is this: The asylum pay you your charge, and the union which has to meet the charge for the asylum (the patients are still on the asylum books) is getting the grant. It is a roundabout way of doing it. For instance, we have this case within my own experience. You brought a case under Section 25; you bore the whole cost of maintenance; there is no grant. But there were some of my union cases while that contract was running which belonged to Rochdale; they were boarded out from the asylum as asylum patients in the Rochdale workhouse. We paid the asylum their charges, that patient being on their books; we got our grant towards that charge, and they were paying our charges on account rendered. That is to say, you could get nothing under Section 25, but you can manage to get something under Section 26.

6162. What one would like to know is this, whether there is any deterrent, due to the grant in aid, to the utilisation of Sections 25 and 26?—I do not think so in these days, but it is a matter of fact that the original purpose of the four-shilling grant was to get guardians to send their old chronic cases to the asylum, and it has been a very costly grant because it has meant the erection of large mental hospitals for a class of case that might have been kept at home.

6163. You are touching there upon a large question of policy which I think is interesting. The asylum with its equipment is naturally directed, or ought to be directed, to the cure of patients?—Yes.

6164. There are a large number of cases, are there not, which are recognised and must be recognised, as incurable?—Yes. I received notice of a case this week—the death of a patient who had been there since 1885. We have cases of patients who have been in the asylum for 40 or 50 or a longer number of years.

6165. And those cases might just as well have been in your workhouse, so far as their prospects of recovery were concerned, or any benefit they could get from treatment in an asylum?—Yes. Of course they were probably rightly sent to the asylum in the first instance, but they may as well after long detention have been back, if they are harmless and chronic, in the Poor Law institution. They are sent back where there is pressure, but not where there is not.

16 December, 1924.] Rev. P. S. G. PROPERT, Mr. R. A. LEACH, Mr. JAMES H. FORD, and [Continued.
Mr. J. W. FLINT, J.P.

6166. But what is of much interest to us is the fact that many of them, as you told us, would wish to get back to the workhouse?—Yes, to see their friends. I have got the reports here. There are five medical superintendents of mental hospitals in Lancashire. In my reading from time to time—I have read a lot in years gone by—great complaints have been made by superintendents of mental hospitals of relatives and friends dropping off visiting patients after they have been there a while, and the medical superintendents have spoken of it as rather a lamentable and regrettable thing, because the patients are out of touch with their relatives.

6167. The relatives cease to take an interest in them and possibly they may not be able to afford the expense of paying the visits. Therefore the patients feel they would be in closer touch with their relatives if they were in the workhouse of their own union, where their people would come and see them?—Yes.

6168. Suppose one of your patients in your asylum says, "I want to get back to the workhouse where I would see my own people," what do you do?—I have had a case within the last fortnight where the relatives came and asked that their brother might be brought back to Rochdale.

6169. What do you do in that case?—We write to the medical superintendent and ask if there is any reason why this request cannot be carried out. If it is a very old case, as it is in this instance, they discharge him to the workhouse.

6170. Then you got him back?—Yes. That is where you make a request, but if there is no pressure in the asylum, you do not get them back, except you ask for them.

6171. But the value of the guardians' visits is in this respect: If the guardian who comes from the locality and knows about the people sees the patient and the patient makes that request, then the guardians can take action?—Yes, we do, and make the request; but if it comes in between the visits, if we get an application of that sort, we always write direct; at any rate, that is my practice.

6172. I am selecting some of the topics which you have brought before us because others of them are not within our province. There is one topic you referred to about which we have heard a little, that is the clothing of patients in asylums. I see you have a view upon that subject?—Yes. I do not want to bring this out before the Commission more than I should, but some years ago, not many years ago, I addressed one of the large Poor Law Conferences on the matter of treatment in Poor Law institutions. One of the things I argued was that although a person was charged on the guardians in a Poor Law institution, if he had his own clothing he should be allowed to wear it, or if his friends could supply him, he should be allowed to have his own clothing, and in my visitation of asylums I have found that in some places they let the patients wear their own clothing. But, generally speaking, in Lancashire the case is that when the officer delivers a patient at the asylum they bundle up the patient's clothes and send them back with him. I think that to take a man or woman out of their own clothing simply because they are in an institution, granted the clothing is decent clothing, is very hurtful and sets up a very hurtful de-classing feeling. Generally, I have put that in my statement. I know no good reason against it. There is a growing practice in Poor Law institutions of letting patients and the inmates wear their own clothing, and in our case if the friends want to do the laundry for the patients at home we let them do it.

6173. Is there any difficulty in getting their clothes renewed?—Not in a large number of cases, but, as Mr. Ford says, there are patients who are destructive. I think that simply because a person is chargeable to the rates in any institution, it is a wrong thing to take him or her out of his or her clothing if the clothing is decent and can be renewed. I see that the Board of Control mention that in their Report of this year.

6174. Yes, the subject is quite before us. Then you have an observation on the subject of inquests. You think that the guardians interested in any particular patient should have a notification?—Yes, that has been before the Association several times, and it is only right that it should be so.

6175. But you would like some regulation on the subject?—I think there ought to be a regulation. It should be done probably in the case of a person dying immediately after admission, where there are some fractures, where the officer who removed might be sent for; but, in the view of the Association, where death takes place the guardians ought to have an opportunity, on notice to the clerk, to attend the inquest. If a person dies in a Poor Law institution, and there is an inquest, the master of the institution has got right away to give notice to the clerk.

6176. Now you, I think, share the view that has been expressed by Mr. Propert on the subject of nomenclature?—Yes. But I do not know whether the term "mental hospital" is not worse than "asylum."

6177. I am afraid it is difficult to neutralise the effect of words, or the associations which they gather round them?—If you take the expression "hospital" under the definition clause of the Lunacy Act—a registered hospital—it does not say that they shall be "mental hospitals"; they are hospitals in which mental cases may be put. They do not put "mental" before "hospital."

6178. That is the statutory definition, of course, for the purpose of the Act. It is an institution wherein lunatics are received.—Yes, but I certainly would not put "mental" before "hospital"; I do not see why it should be so.

6179. Of course, one knows that there are specialised hospitals for other things; you see them all over London—"hospital for epileptics," "hospital for cancer," "hospital for skin diseases," and various types of hospitals for particular maladies.—Yes. I do not know whether it is a good practice. I do not care what it is, a hospital is a hospital, and it ought not to have any dressings, either before or after; it should be simply left "hospital."

6180. Then you have furnished us with a letter which you have received from your special relieving officer. You have a specially designated relieving officer who performs the functions under the Act?—Yes.

6181. I have read it with interest. You have also given us a very large table of statistics.—I thought perhaps it might be of some assistance to the Commission.

6182. Yes, they are very interesting. They show the way in which in practice patients come before you and are dealt with?—I might have added, if I may, the number of cases during the same time which have been dealt with by the medical officer of the workhouse and who, by the end of the 14 days, have been re-classed as sane patients (*handing in document*).

6183. There is one thing which interests me in your schedules. The first table you have compiled gives us the number of persons who were not in receipt of Poor Law relief when first dealt with as lunatics?—That is so.

6184. That emphasises the point that quite a substantial number of the persons who are dealt with as lunatics had no relation to the Poor Law at all before their malady afflicted them?—That is so.

6185. In your case this covers the period from 1st April, 1923, to 30th September, 1924. I find that no less than 48 of the cases you dealt with during that period had not been paupers in any sense of the term at the time of their affliction?—That is so.

6186. But became recipients of Poor Law relief by the circumstance of their being afflicted?—Yes.

6187. There are 48 of those?—Yes.

6188. Then the next group you give is those who were in receipt of Poor Law relief when they were overtaken by their malady?—Yes.

6189. I find that you have 28 cases of those?—Yes.

16 December, 1924.] Rev. P. S. G. PROPERT, Mr. R. A. LEACH, Mr. JAMES H. FORD, and [Continued.
Mr. J. W. FLINT, J.P.]

6190. Were these actual inmates of your workhouse or persons in receipt of outdoor relief at the time they became afflicted?—They were persons found inside the institution sick, excepting one; there is only one who had out-relief.

6191. What is your third category? Your third category is called "Poor Law Institution Cases"?—That is what we call the permanent class. The medical officer gives his certificate for 14 days as a proper person to remain; then he gets it supported by another certificate under Section 24, and then the justices make an order. They are really chronic, harmless cases—more of the imbecile class.

6192. Of that class you give us 14 cases during that period?—Yes.

6193. So that the bulk of the persons whom you have dealt with over the period in question were persons who at the time of their affliction were not in any way in receipt of relief at all, but became chargeable through the circumstance of their being afflicted?—That is so. The reason that I have taken 18 months is that that happens to be the period that this officer has held his office.

6194. Then I think, Mr. Leach, those are all the matters, subject to what my colleagues may ask you, that I should like to bring out from you?—If you please.

6195. Then, Mr. Ford, you are Clerk to the Guardians of Leeds?—Yes, I have been for 28 years and have been 45 years in Leeds union altogether.

6196. You, of course, have been sitting here while we have been discussing matters with Mr. ProPERT and Mr. Leach. Have you any further contribution to make to our enlightenment?—I do not think so. I think you have covered all the ground I have set out in my *précis*, except that I should like to emphasise the necessity of some provision for the border line cases. I happen, perhaps, to be different from other Clerks, as almost every day in the week I am consulted by somebody, most frequently with regard to the very early cases. There is reluctance on the part of persons to take any step unless matters become aggravated.

6197. To what do you attribute that?—The fear that if they even call in their own medical man—I am speaking now of personal friends and people who come to me repeatedly, who are so afraid if they call in a doctor—their brother, or daughter, or whoever it may be, will go to an asylum. There is not the same objection, though there is still an objection, to their being moved, at all events temporarily, to our own institution. May I point out that our infirmary has had separate blocks, called until recently imbecile blocks, since the infirmary was separated from the workhouse in management in 1872. The whole of these have been under the medical superintendent. Our present medical superintendent has been with us for over 40 years, and he has possibly had a greater experience in examining lunatics than certainly any man in our part of the country. It is difficult to suggest what should be done, because I am not an expert from the medical point of view, but I have said in my *précis* that I fail to see why in the early stages there should be such a definite distinction between the treatment of a person who is mentally sick and a person who is physically sick. We do have cases in our own infirmary that are certainly unstable at the time they are admitted.

6198. Let us pause there for a moment. It is the consequence or the concomitant of the particular class of ailments we are dealing with that some interference with liberty is necessary?—I agree. Later on. When the malady has become pronounced, I have nothing further to suggest, but the sooner the case is dealt with in remedial institutions the better, but not institutions where there is accommodation for an enormous number of people of unstable mind. I should like to see separation made again between them and the old chronic cases. We have cases in the imbecile wards for years and years as happy as they can be, and those people are often happier than

people in full possession of their faculties. I, like Mr. Leach, have visited asylums with the guardians for the last 30 years until perhaps the last year or two, when other matters have kept me from visiting, and it has been a common experience that the patients have recognised the guardians and have appealed in the most strenuous terms, "Let us come back to the institution," and we get some of them back, but only on request.

6199. But recurring to the topic you started with for a moment, you are anxious to see a development of the treatment of incipient cases without what one might call the menace of certification?—I agree.

6200. If it can be achieved?—I agree.

6201. As you know, that is a part of our reference. We have to consider that under the second head of the remit to the Commission?—Quite.

6202. One of the practical difficulties that, I think, does press upon us, and has pressed upon all people who have had to consider the problem, is just this: that the incipient case at any moment may become a pronounced case?—Quite.

6203. Therefore some form of control, possibly short of the full control which is given by certification, may be necessary for a temporary period, a provisional period, in such incipient cases?—Quite.

6204. Would you be apprehensive that any form of control or detention against the will of the patient might operate as a deterrent, such as exists just now, in resorting to doctors?—To some extent. As far as the detention was lightened so I think the fear would vanish. May I give you a case in point? I had a close relative of my own who had a certain brain attack. I sat up with him for three or four nights continuously. He switched off from physical convulsions to mental delusions. I asked the doctor who was attending him was he likely to recover his mental balance afterwards. The doctor said it was impossible to say, but there was no place to which that relative of mine could be sent for a short period. He is perfectly well now and going about his business. The probability was that his physical side might become better, but the mental side might be bad for some little time, and the only alternative was an infirmary or an asylum.

6205. What did you do in that case?—In that case, fortunately, he got better in his home, but I would just like to point out that in his position it would have been almost fatal to have certified him as a lunatic. Since then he has retired, but he had a year or two more to work.

6206. *Earl Russell*: Would it have been equally fatal for him to have gone as a voluntary boarder to an asylum?—Yes, to an asylum.

6207. I meant a private asylum?—I am leaving out Poor Law infirmaries, but even Poor Law infirmaries might be a place of refuge. Some persons would not care to place themselves under voluntary confinement for a time, but there are a considerable number who would be very glad to do so, and who have no more connection with the Poor Law in the ordinary sense than a millionaire has. I think there should be something between the two.

6208. You suggest a ward of a general hospital?—I think so. I have taken a great personal interest in these cases in our own institution. I know so many cases which have been caused by some physical ailment. I have seen cases in which with care in our own infirmary wards the physical disability has been removed, and the mental disability has followed suit, and they have gone away.

6209. *Chairman*: There is a difficulty there, is there not, in this respect: Take the case of a friend of one's own, a relative in your case, who suddenly becomes afflicted in that way. You naturally want him to get the best possible treatment, and at the same time you want to avoid the disastrous consequences of certification?—Quite.

6210. If he were taken to a general hospital, if the case were a violent case or a noisy case, as these transitory cases often are, would not you have a pretty bad upset of the ordinary hospital régime?—No, I do

16 December, 1924.] Rev. P. S. G. PROPERT, Mr. R. A. LEACH, Mr. JAMES H. FORD, and [Continued.
Mr. J. W. FLINT, J.P.]

not think so, any more than in the case of delirium in typhoid fever and other acute fevers; they have to deal with those cases.

6211. That answers that side of it, but what about the facilities for treatment? Do you consider that a patient taken to a general hospital would have the same opportunities for specialised treatment as you can get in a mental hospital?—No, but you must remember that I am speaking of incipient cases only.

Sir Humphry Rolleston: Would you ask the witness, Mr. Chairman, if he would expand a little the physical disabilities he was speaking of as complicating the mental disabilities? Of course nobody would dream of certifying a patient with typhoid fever who had got delirium, but I think it would be useful if the witness would say if the physical disabilities were not accompanied by some mental disturbance which might be certified.

Witness: Might I just correct a statement? I have known a case of typhoid delirium and insanity at Leeds. I am not a medical man. I am speaking again from what my own medical superintendent told me. There are certain diseases which frequently cause a man to be for some considerable time certainly mentally unbalanced; I do not mean delirium for a day or two, but there are acute internal diseases, for instance, I believe, that do at times cause an inflammatory state of the brain, and for a considerable time a man is mentally unbalanced; puerperal cases, for instance, in the case of a woman. I could ascertain what cases there are from the gentleman who has given me the information.

6212. *Chairman:* Your idea then seems to be that just as at present people send their relatives to a fever hospital, which is provided in most towns nowadays, without any social stigma attaching to it whatever, so also they should be able to send their cases of mental disturbance to a similar general hospital or a special ward of a hospital?—Quite. I am not entirely cutting out the Poor Law hospital. I do not agree that there is any stigma in association with the Poor Law.

6213. I can imagine that you gentlemen do not feel that at all, but the public has to be reckoned with in the matter?—I agree. I point out—I do not want to debate this matter very long—the great distinction that is drawn in our union. The infirmary has been separated from the workhouse; it is in the same curtilage, but the administration is entirely different. In the first place, the applicants draw a very great distinction. If you tell a man there is an order for the institution he says, "What do you mean; that is the workhouse." Sometimes there is the case of a man who is convalescent who is not fit to go back to his home and he is told he will be transferred to the workhouse. He says, "I am not going to be made a pauper." He does not understand any legal distinctions but he makes a distinction. I could give you cases of people of very considerable eminence in Leeds who have asked if their own relatives could be taken care of in our institution and they would pay the full cost. There is no other association of any kind. I find no objection whatever is made to going into a Poor Law infirmary, though there is the greatest objection to going into a workhouse.

6214. You draw a distinction between the workhouse and the infirmary which, although it is really a Poor Law institution, has become associated with the idea of a hospital rather than a place where destitute persons are detained?—What I say is that the public draw that distinction. (*Mr. ProPERT:* The Metropolitan Asylums Board are under the Poor Law. (*Mr. Ford:* We are hoping to have an Order very soon from the Ministry of Health in which provision is definitely made, but our arrangement for taking in private cases is tacitly agreed to. There is no law for it, but we do it, in a Poor Law infirmary, cutting out the ordinary machinery. I am speaking now of ordinary cases.

6215. You mean ordinary sick cases?—Yes, in the infirmary. I was just dwelling on the point that

the stigma has gone, whatever may exist with regard to the workhouse.

6216. You have your medical staff there?—We have four resident medical officers there.

6217. And the public of your district have come to regard that as just one of the hospitals of the district?—We are linked up with the Leeds Infirmary. We have classes for the students. The Poor Law infirmaries have the beginning and end of disease which the general hospitals will not look at. Cancer cases come to us to die. They are like the chronic lunatics we have been speaking of.

6218. Do you have incipient mental cases uncertified?—Yes, not a large number, but we should like to have a still larger number of cases who could be persuaded to come to us. In some cases they are drafted to the ordinary imbecile wards, and in some cases they go back home. We have a visiting magistrate—and the one who does much of our work has a special qualification—he has been a district medical officer for many years, he has been Chairman of the Board of Guardians, he is a barrister and is senior magistrate and is a doctor—I may say we are very fortunate in Leeds in that the majority of our infirmary cases are managed by a medical superintendent who has 40 years' experience, but even there the magistrate occasionally turns down cases because he is not satisfied that the certificate is strong enough. The majority of the cases are taken under Section 14.

6219. Then, I think, Mr. Flint might tell us if he has anything to add. Mr. Flint, you are a Justice of the Peace and Chairman of the Sheffield Board of Guardians. I think you have been a member of the Sheffield Board of Guardians for 24 years, and you have held the office of Chairman of the Board for the past nine years, and were Vice-Chairman for eight years previously?—Yes.

6220. You have had, as Chairman of the House Committee of your Board, the care of the mental wards of the Firvale Institution?—Yes.

6221. Where you have accommodation for male and female cases—225 in all?—Yes.

6222. I think you have taken a great interest in that institution?—Yes, I have.

6223. We do not want to have matters repeated on our notes. You can tell us if you have anything to put before us by way of supplement to what has been said by the gentlemen who have preceded you?—Generally, I may say that I agree with the evidence of my colleagues, and I ought to say, I think, that I am not here to-day as a representative of the Sheffield Board, or because I am Chairman or hold office, but I am one of the representatives of the Poor Law Unions Association along with my colleagues; therefore, to some extent perhaps, my personal opinions are in abeyance.

6224. Yes?—I should like to emphasise what has been said (I do not want to do so at any length) in regard to the cases for certification remaining under observation for a longer period. I mentioned, I think, in my *précis* my experience in dealing with these cases, and you will see that I have certified a very large number of cases. Practically I certify all the cases in the Sheffield Union.

6225. I am very much struck with that. I notice that out of 2,587 patients dealt with in the period 1916 to 1924 you personally dealt with no less than 2,377?—That was so.

6226. So that you seem practically to do all the work?—I have seen as many as 10 cases in one day; they were not all certified, I am thankful to say, but you have got it before you.

6227. As an illustration of the statistics that I think Mr. Leach thought to be desirable, out of the total of 2,587 patients dealt with in your district in the period 1916 to 1924, 370 appear to have been discharged—that is to say, no order made?—That is right.

6228. And of those in your own experience, 2,377, 341 were discharged without any order made?—Yes.

6229. That illustrates Mr. Leach's point that quite a substantial number of cases occur upon which it is not found necessary to pronounce an order at

16 December, 1924.] Rev. P. S. G. PROPERT, Mr. R. A. LEACH, Mr. JAMES H. FORD, and [Continued.
Mr. J. W. FLINT, J.P.]

all?—Yes, that is so. I think it is only fair to observe, if I may say so, that that is only a small percentage of the total number, and I think it does emphasise the fact that considerable care is taken by the relieving officers, and by the examining doctors, and the magistrates, in dealing with the cases.

6230. Perhaps I am under a misapprehension. Does "patients discharged" mean patients that have been discharged after certification?—No, before.

6231. Without an order made?—Yes, without an order made.

6232. I notice that you resort in Sheffield chiefly to Section 14?—We do.

6233. Because out of your own cases of 2,377 patients dealt with, you certified 1,559 under Section 14?—Yes.

6234. And only 98 under Section 13?—Yes.

6235. And 379 under Section 24 in the period in question?—Yes.

6236. While of the total of 2,587 in your district, 1,663 were certified under Section 14, 131 under Section 13, and 423 under Section 24?—Yes.

6237. So that Section 14 seems to be the section under which you operate in Sheffield?—That is our custom, and I think it is the custom in Leeds. I believe it is the general custom really.

6238. Now it appears that at Firvale your accommodation is by no means fully utilised?—No.

6239. You have apparently 99 beds in the male block and only 53 occupants at present?—The point in regard to that is—and I should like to say I agree entirely with what has been said—that there is a great deal of available accommodation in Poor Law institutions which might be utilised for this purpose for taking cases from asylums. In our case we have admirable buildings which are not half occupied, and we have some empty blocks; we are already utilising them in one case for mental defectives under the local authority. We have a large number of mental defectives.

6240. You have already given us the figures for the male mental block; in the female mental block I see you have 125 beds, and only 65 are occupied at present?—We are expecting 50 cases from the Grimsby Union; we have arranged to take those, but we have empty blocks which could be utilised for this purpose, quite admirable blocks. They are empty, because, like many other workhouses, I think they are not fully occupied with the ordinary class of inmates. We have considerable accommodation that we could make use of, although we are, as I have said, taking mental defectives from the local authority; and we also have one block occupied with tubercular cases under the local health authority. We are utilising the buildings as far as possible, but there are other blocks which we could utilise for this particular purpose without any difficulty whatever.

6241. Then you would favour the policy of the return of cases from the asylums to the workhouses?—Yes; I think that would relieve the asylums' accommodation to a very large extent.

6242. I think these are all the questions that occur to me to ask you, unless you have anything to add?—I make some reference to the certification of children and their accommodation; my colleagues have not made any reference to that. It may seem a little exceptional perhaps, but I have always felt that certifying children as lunatics has been the most painful part of my duty as a magistrate. This is

(After a short adjournment.)

6249. Mr. N. Micklem: There appears to be a different practice in different unions as to certifying. In your union, Mr. Leach, you say the practice is to certify generally under Section 13 of the Act?—(Mr. Leach): If the alleged lunatic has not been in receipt of relief at the time.

6250. Section 13 only applies to a case where a man is not a pauper?—That is so.

perhaps apart from the Poor Law side, but taking the two together, of course, experience may be useful; it always seems to me to be very regrettable that these cases of young people should be sent to an asylum, which is a mixed asylum for adults mostly, and that there should be no special or proper provisions for dealing with these particular cases. You will notice in some information I got from the Clerk to the West Riding Asylums Board that they admit practically that there is no special provision made for these cases, but there is an intimation there that the policy of the Board of Control is that such cases should not be certified as lunatics, but should be certified under the Mental Deficiency Act. That is obviously impossible, in my view. I spoke to the medical man who examines the great number of the cases in lunacy in our union with regard to this matter, and I pointed out to him the letter that I had received in regard to it; and he was very much puzzled that it should be suggested to him, as a medical man examining mental cases, that he should certify a lunacy case as a case of mental defect. He asked: What did I suggest he should do in the matter; so I said, "Well, it seems to me it is altogether contrary, in the first place, to the Lunacy Act that that should be done," and I said, "Of course it is a case for you as an expert—I am not an expert, I am simply a layman, and you must use your own judgment"; but it seems to me it is rather a curious suggestion that these cases should be certified as mental defectives.

6243. But one knows that the Mental Deficiency Act deals primarily with the class of case that is congenital, that is to say, the incurable case?—Yes.

6244. And, of course, children who suffer from imbecility, and so on, can be dealt with under it; but are you thinking of the case of a young person under 16 who is really for the time being of unsound mind who simply goes off his or her head as anybody else may—is it that class of case you have in mind?—Yes, I think so.

6245. What is your proposal as to how they should be dealt with? Is there any difference in their case from that of an adult lunatic?—There are a number of cases which have been certified as lunacy cases, lunatics, and I should take it that those cases could not be sent to an institution for the reception of mental defectives.

6246. There seems to be some difficulty about that?—I have had a good deal to do with the Mental Deficiency Act, as I have pointed out in my *précis*, and, as a matter of fact, I attend under that Act as a specially appointed magistrate to examine the cases from time to time.

6247. What is your proposal as to young people who become of unsound mind, but who are not congenitally so?—I suggest there should be special provision made for them.

6248. Do you mean a special institution, or a special ward, or what?—I do not suggest that a special institution should be built entirely for that purpose, but that there should be separate accommodation, that they should not be placed in mixed institutions with the adults, and that separate provision should be made for them. I think it will be generally agreed that there has been a great outcry with regard to children remaining in workhouses, ordinary cases; therefore I think these cases should not be placed with adults in mixed institutions. They are the most pathetic cases we have to deal with.

6251. Then Section 14 deals with the pauper case?—Yes. It may so easily make a person a pauper for the purpose of proceeding, by sending the district medical officer to see the case—that is sufficient. It is thought by some to take the case out of Section 13 and put it under Section 14.

6252. It would be rather a question of caprice on the part of the union?—I do not say that; it is a

16 December, 1924.] REV. P. S. G. PROPERT, MR. R. A. LEACH, MR. JAMES H. FORD, and [Continued.
Mr. J. W. FLINT, J.P.

different view. I have put in the opinion of Mr. Alexander Macmorran.

6253. That opinion deals with this point, does it?—The very point.

6254. Very well. May I just ask you this: I understand that you think that possibly the present safeguards in regard to certification are hardly sufficient—you would require in every case of certification two certificates, one of them by a specialist?—Yes. I adopt what was done under the Mental Deficiency Act. Mind you, I think with my colleagues that a long way should be gone to deal with an alleged mental case without bringing him under certification, but once it is determined that that proceeding has to be taken, I say that the latest safeguards enacted under the Legislature are laid down under the Mental Deficiency Act, which largely follow the lines of dealing with private cases under the Lunacy Act—i.e., there are two medical men.

6255. You have had a very long experience of these cases—have you come across cases that in your judgment have been wrongly certified?—No, I will not say that. First of all, it would not be for me to take objection to a medical man as to the facts or the grounds on which he certifies—I mean classes of facts, the one ascertained by himself, and the other communicated by others. But there have been cases, of course, before the Courts where it has been alleged that they have not been properly certified. We had a case at Rochdale many years ago, a woman named F.F. I think it was. The officer reported this case to me. She had not had relief, and we got the district officer in. The ground of her insanity was a charge that she had made against a resident in the town, who said she was a lunatic. As it came to me, I said, "Well, on the face of it it is quite possible, not at all improbable, that that may be so; you had better deal with this case under Section 13." She was dealt with under Section 13.

6256. That is to say, you got a second certificate?—Yes, and she was sent to the asylum. She was in Lancaster asylum for over two years, and she got discharged as "not improved," and she set up an action against one of the medical men who gave a certificate on the ground that his certificate did not disclose sufficient facts of insanity to warrant the justice in making the order. The case was tried at the Manchester Assizes; it went on for several days, and ultimately the medical man against whom the action was taken felt that probably in the long run, from a financial point of view, he had better make terms, and the terms were made.

6257. But those certificates must have been examined by the Board of Control in the usual way, must they not?—Yes. It is quite a notorious case. I am only giving you an instance where an action was taken 12 months after. Then you have had the recent case, of course.

6258. Exactly the same thing might have happened under your scheme. There were two certificates in that case?—There were two certificates in this case, but neither of the certifying practitioners was a brain expert, and that is why I advocate the adoption of the provision under the Mental Deficiency Act, which requires that one of the two medical men should be a person either approved by the local authority or by the Board of Control—I say, by preference, by the Board of Control.

6259. Thank you. Now may I ask Mr. Flint one question on his figures. I see that you give us the summary of the patients dealt with during the period commencing 11th January, 1916, and ending the 31st October, 1924. Let me just take one year, if I may, 1924. In your case in 1924 nine were certified under Section 13—that is, as non-paupers?—(Mr. Flint): Yes.

6260. And 179 as paupers?—Yes.

6261. Now how do you determine whether a man is a pauper, or is not a pauper for your purpose?—In many cases we are approached by the relatives of

the person. The relieving officer is approached because that is the simplest and most convenient way of dealing with the case, and in certain cases they are people in a position to pay the charges and costs.

6262. In that case you classified them as non-paupers?—Yes, obviously, although they are dealt with by our officers, because that is the machinery most convenient to deal with the case, but they are obviously non-pauper cases.

6263. In those cases, of course, there are two certificates in every instance?—That is so.

6264. In the 179 pauper cases there would be only one certificate?—Quite right.

6265. How do you ascertain whether they are paupers? I appreciate you can find out that they are able to maintain themselves, and that they are non-paupers. When do you classify them as non-paupers? They have not been beforehand on the rates, have they?—No, they are only classified here as paupers because they are not dealt with under the 13th Section, and they only contribute part of the cost, some of them not at all, so they are obviously pauper cases. (Mr. Propert): A pauper is a person who is either wholly or partially chargeable to the rates.

6266. But up to the time they are certified they have not been chargeable to the rates, and therefore *prima facie* they would come under Section 13 and not under Section 14?—(Mr. Flint): No. We deal with all the cases, unless they are brought to our notice, as cases under the 13th Section, that is private cases.

6267. Now I want to ask you one question as to the patients discharged in that year. There were 81—a very large number—of those 179 patients discharged, and I think you told the Chairman that they were discharged before certification?—Yes, but after they had been seen.

6268. Now all of those must have been brought before you, must they not?—They were, all of them.

6269. Did you refuse to certify them?—No, the medical officer refused. Might I say that the medical officer who certifies our cases is what my friend Mr. Leach would call a specialist. He certifies the whole of the cases. He is appointed jointly by the justices to do this work, and where he is doubtful about certifying a case, in order that it may be detained he writes a note to the resident medical officer, and I sign it, asking him to consider detaining the case, putting it on a 14 days' order. We do that in order to carry out what we have been suggesting this morning, that more complete observation should take place before a case is certified. A large proportion of those cases are ultimately discharged and not certified.

6270. They were all cases, were they, in which the relieving officer, or certain other officials, thought there was presence of unsound mind?—Yes, he took steps with that in view, and brought them there for observation.

6271. It seems strange that there should be such a very large number that he thought it necessary to bring in either for the public interest, or for the welfare of the persons themselves?—I think if you look at this table in this particular year the number discharged is unduly large comparatively with the other years.

6272. It is pretty large?—I do not know the actual reason of that, but you see you have only 23 discharged in 1918 out of 170, whereas in the case that you mention there are 81 out of 179.

6273. Yes, but, on the other hand, in the first year there are 52 out of 157?—That is so, yes. I do not want to say that we are different from other unions in the way in which we deal with these cases, but we have a certifying medical man who is very careful indeed.

6274. Those cases would be usually discharged because he had declined a certificate, not because you, as a justice, refused to make the order?—No. I have refused on certain occasions, but really I am always placed in the position of putting my opinion against medical experts, and, of course, one hesitates to take that step.

16 December, 1924.] Rev. P. S. G. PROPERT, Mr. R. A. LEACH, Mr. JAMES H. FORD, and [Continued.
Mr. J. W. FLINT, J.P.]

6275. *Mrs. Mathew*: I wanted to ask Mr. Flint about paragraph 9 of his *précis*, "special mental nursery homes"—is there any such thing?—The Chairman asked me something about that this morning. What I suggest is that there should be special provision. I put it in this way in order to call attention to it, because I do think it is important that young people of tender age when they are certified should not be placed in wards where there are mixed cases, that is to say, adults generally. There are special institutions for boys. I visited one such at Stanley Hall, Wakefield, but there what they call boys range from about 10 to 30 or 40 I found; they are very bad cases indeed, shocking cases. But there are many cases which are not so bad as those that I saw there, and I think there should be special provision made for them so that wards should be set apart particularly for their care and treatment. It is pointed out in the reply I have sent in from the Clerk to the West Riding Asylums Board that the adult patients are rather glad to have these cases in the wards, because they are of interest, and they take a personal interest in them; but, on the other hand, one cannot help feeling that the effect of these adult lunatics upon the children must be very bad.

6276. And children are mixed now with adults, are they?—That is so.

6277. In many cases?—I think in most cases; I do not think there is any special provision made at all.

6278. Then I wanted to ask Mr. Ford, is it because of the better nursing in the general hospitals that he would use them for mental cases?—(*Mr. Ford*): I do not suggest there is better nursing in general hospitals; I would suggest in my own hospital there is quite as good nursing as in the Leeds general infirmary. Of the whole of our nurses who have put in for their certificates, 100 per cent. have passed; that is as near perfection as you can get, and our scale is one to five patients. You cannot get much above that in a general hospital. I was only suggesting the general hospital for the class that are not of the pauper class. I do not think there would be the same objection in going to a general hospital as going to a Poor Law infirmary, although they would rather come to the Poor Law infirmary than go to an asylum. With regard to the Section 13 cases, there is no reason why we should have them if there is any other body to take charge of them, but at present there is not.

6279. There you suggest the general hospital?—I know general hospitals are overcrowded, but I am speaking of what might take place in the future as a matter of improvement.

6280. *Sir Humphry Rolleston*: Mr. Leach, you rather gave the impression that you thought with regard to the nurses who were looking after the insane, it was more important that they should have a good general training such as a hospital nurse gets than that they should have a special training. Did you mean that?—(*Mr. Leach*): No, I meant take the other as a post-graduate course, the special training; they should have the three years' training as general nurses first.

6281. Do you think that you would favour an alteration of the law on the following lines, namely, that a patient who felt that his mind was beginning to shake should voluntarily go to a mental hospital and say that he wished to come in, and that he consented in his present state of mind to bind himself to remain for a certain period, to be determined by the medical officer perhaps in some cases, and that on that voluntary desire he should be detained, even although it may appear to be against his will in the future?—I should say that; but I should also make provision for taking cases against their will without certification, up to a certain point. I have known a patient who has been discharged from an asylum recovered (we had a case like that in Rochdale) who some time after felt that her mind was giving way, and went back to the asylum and asked to be admitted; they took

her in and got her certified after admission, but in that case, of course, she had to be dealt with again as a lunatic; but she had that sanity to go straight away to the asylum and ask for admission, and she was admitted; but they could not keep her there without the ordinary certification and justice's order.

6282. But it would be rather dangerous, would it not, to detain a person without putting them under certificate?—Of course in a lot of these cases where a mental breakdown occurs, a sickness, an illness, or bodily ailment has preceded it; they are not of sufficient mentality at the time to express any wish about the matter.

6283. Has it ever happened in your experience (this is another matter) that three guardians have discharged an insane patient from the infirmary without the concurrence of the medical officer, or even against his advice?—No—not three guardians; guardians have power under the Lunacy Act to discharge any person who is detained as a lunatic although there may be a justice's order.

6284. *Chairman*: It is under Section 81: "The guardians of the union to which a workhouse belongs may make an order for the discharge of any lunatic detained therein." That is the guardians as a whole. Then the three members of the visiting committee may discharge—?—I say the guardians.

6285. Not three guardians?—No, the guardians as a board. That is only in the case of a patient in the workhouse. I take it, it was that class of case to which the question related—have the guardians at any time discharged such a person (under a doctor's certificate or justice's order) in opposition to the advice of the medical officer?

6286. *Sir Humphry Rolleston*: That is the question?—I have never known it. They have power to do so, but I have never known it done, in fact it is not an uncommon thing in the case of a person who is detained in a workhouse under Section 24, or it may be under a 14 days' order, for their friends and relatives to come to the guardians and ask them to be discharged to their care and custody; but I have never known my Board to order such a discharge in opposition to the opinion of their medical officer, and they are very careful always not to let the persons go, excepting there is a good home for them to go to.

6287. Mr. Ford, do you think that, generally speaking, the Poor Law infirmaries are good places for the treatment of more or less acute cases of insanity?—(*Mr. Ford*): No, I should not say acute cases.

6288. Then you drew a distinction; you said there ought not to be a hard and fast line between mental illness and physical illness?—Quite.

6289. And you rather drew the analogy and said there was not very much difference between the treatment of infectious diseases and other diseases?—Quite.

6290. Do you think that is a true analogy?—The analogy I was attempting to draw was with regard to the point that in one case you must deal with a person either as a pauper or a non-pauper; that does not obtain with regard to the treatment of infectious diseases; they are treated in an institution that is maintained from the rates; but there is no question as to whether a person before admission is a pauper or non-pauper, nor should there be in the case of a lunatic.

6291. A point has been raised (it is not my point) as to what you would think if the suggestion were made that the Poor Law infirmaries should be abolished, so far as regards the treatment of the insane?—My reply would be, I should like to be informed what it is suggested should take their place. They are an absolute necessity at the present time, whether public feeling is in favour of that or not.

6292. It has also been suggested that they should be abolished as regards their present function, and that they should be reconstituted under the name of hospitals for mental debility, for the reception of patients not under certificates?—Quite apart from my capacity as Clerk to the Poor Law Guardians, I

16 December, 1924.] Rev. P. S. G. PROPERT, Mr. R. A. LEACH, Mr. JAMES H. FORD, and [Continued.
Mr. J. W. FLINT, J.P.]

should be glad to see any change I have suggested brought about.

6293. Then you would have to have the institutions occupied by all these people with senile debility?—Yes. In the Leeds Union at all events, the four unions in the city of Leeds, we have enough lunatics to run an asylum ourselves. My own Board is paying £60,000 a year. I see nearly every medical certificate that is given, the grounds given convince the magistrate and convince the Visiting Commissioners afterwards; but as indicating insanity observed either by the medical man or communicated to him by friends some are remarkably thin. A question was asked of my colleague that was not put to me. I cannot give any present cases, but if my long experience may allow me to go back 20 years, I can give you many instances where cases were certified as lunatics who never were lunatics; I say that advisedly, and there is correspondence with the Lunacy Commissioners to prove what I say. The black list cases were sent to an asylum. We wrote to the Ministry of Health and to the Local Government Board, but there was no effective remedy. The medical man certifies; the magistrate says, "I am not bound to accept the certificate, but what can I do in place of it?"

6294. But they could be discharged, could they not?—They were discharged very promptly, but they had been in an asylum as lunatics in the meantime.

6295. *Sir Ernest Hiley*: Mr. Ford, have you got out any figures corresponding to Mr. Flint's figures for the Leeds Union?—No, but I shall be very glad to send them in if I may.

6296. Has Mr. Leach got anything for the Rochdale Union which gives the number of discharges?—(*Mr. Leach*): Yes; I thought I had given very full information on that point.

Sir Ernest Hiley: If the Chairman has it I will not ask you anything more.

Chairman: I do not know that they are the same figures that you want.

6297. *Sir Ernest Hiley*: I was rather curious to know whether the proportion of patients discharged in these other two unions was anything like the high figure for the Sheffield Union?—(*Mr. Propert*): Roughly speaking, in Fulham they are about half. Would you like the figures from Fulham?

6298. If you please?—(*Mr. Ford*): I should like to forward them from Leeds, too.

6299. *Chairman*: If you gentlemen would concert your figures on a comparable basis it would be helpful. If you get figures for different stretches of time, and so on, they will not compare. You might arrange among yourselves to take a couple of years and give us the result. That would be what Sir Ernest would like.—(*Mr. Leach*): In my case I have given the history in every case.

6300. That is rather too elaborate.—(*Mr. Ford*): Something on the line of Mr. Flint's figures?

6301. Yes.—(*Mr. Leach*): I can get them for Manchester and Liverpool too.

6302. *Chairman*: I think Mr. Flint's way of arranging the figures is very useful.—(*Mr. Ford*): If you please, Sir.

6303. *Sir Ernest Hiley*: Mr. Flint, I suppose there is no mistake about the figures you gave us for 1924—your own personal figures? They show 64 patients discharged by you out of 232 presented to you?—(*Mr. Flint*): In 1924?

6304. In 1924—that means that in one case out of every four the relieving officer was wrong?—I confess I do not understand those figures, because, generally speaking, if you take the average of patients discharged, 341 out of 2377—

6305. That is about 12 per cent.?—Yes.

6306. But this year it seems to have been particularly bad?—Yes. These figures were given to me by the officer who was responsible for dealing with these cases, and I take them to be correct, but there

may be some misapprehension. I do not understand it.

Chairman: I think, Mr. Flint, it is not very satisfactory to leave the figures as they are; my colleague, Mr. Micklem, was also in doubt about it. Do you think you are quite right in saying that the patients discharged are patients upon whom the justice has made no order, although they have been presented to him for consideration? I doubt if it can be so many as that.

Sir Ernest Hiley: I am dealing with Mr. Flint's own cases, and I understand that these "Patients discharged," the numbers in that column, meant to him cases which he had refused to certify.

6307. *Chairman*: Do you think it is so?—No, I do not. My experience is that about 12 per cent. is the usual.

6308. What does "Patients discharged" at the head of that column mean? Does it mean patients presented to you for consideration, or patients who, after certification, have been discharged later on? What you had better do to help us is to ask Mr. Hill, who compiled this, what he meant by that column headed "Patients discharged."—Yes; I will get further information upon that point and send it on.

Mr. Stewart: Mr. Chairman, would you put a question to Mr. Ford arising out of an answer he gave with regard to the disinclination of people to send incipient cases to asylums?—Is Mr. Ford in a position to tell the members of the Commission what is the reason for the horror which seems to be felt by people with regard to sending those near and dear to them to asylums?

6309. *Chairman*: I will put the question, but I think it has been asked of a good many people?—(*Mr. Ford*): I do not think I can give any answer to that. It is not a suggestion of ill-treatment; it is only fear of an asylum; there is a stigma which attaches to a person through life who at one time has been a lunatic, and people dread that stigma being attached to anybody dear to them.

Mr. Stewart: This being a public enquiry might I ask for direction on this point: A number of figures have been supplied to the members of the Commission which I, for one, of course, have not access to. Will any facility be granted to me, as representing the Society for Lunacy Reform, to obtain access to those figures. This evidence, I assume, is evidence given in public. For instance, the table which Mr. Flint supplied to the Commission—one would very much like if it were permissible to have those figures.

Chairman: Some of the tables will ultimately be selected by us for publication, and will be appended to the evidence. On the other hand, for example, to give you the table that we have been examining this gentleman about, which has just appeared to be inaccurate in one of its headings, would be misleading.

Mr. Stewart: I meant when corrected—it is part of the evidence, I take it, before the Commission and therefore hypothetically available to the public; but if it is put in the form in which it is put here, it is not really available to the public.

Chairman: I will tell you exactly how I feel about that. We have been supplied with a great many figures, some of which have no bearing upon the topic we are to consider, and you will understand I have tried to select relevant figures. These are the figures which will appear on the note. A lot of the tables are not always material, and I have always tried to select figures which are of importance.

Mr. Stewart: I quite appreciate that, but if there is a figure which is of real importance to our case—

Chairman: Ask me for it, and you shall have it.

Mr. Stewart: I am much obliged. That percentage of discharge without certification is peculiarly interesting to the Association I represent.

Chairman: When we get this table corrected I shall be quite happy to give you the figures for any year you want of the number of patients dealt with by this particular gentleman, and the number who were

* See Appendix XVIII.

16 December, 1924.]

Dr. F. H. EDWARDS.

[Continued.]

discharged without certification, or after certification. If there is any figure of that sort you wish, let me know.

Mr. Stewart: I am much obliged, Sir.

Chairman: Thank you, gentlemen, very much for your attendance here to-day.

(The Witnesses withdrew.)

Dr. F. H. EDWARDS, M.D., called and examined.

Witness: May I hand in this letter, Sir? I promised a patient that it should be put in. It is rather relevant to something we heard just now. (Handing in a letter.)

6310. *Chairman:* Dr. Edwards, are you Medical Superintendent of Camberwell House?—I am.

6311. Where is Camberwell House?—It is within the Metropolitan area, in South London.

6312. How long have you been Medical Superintendent of that establishment?—Rather over a quarter of a century.

6313. Camberwell House belongs to the category of licensed houses, does it not?—It does.

6314. Licensed houses are dealt with, are they not, specially in the lunacy code?—They are.

6315. I see you have been good enough to furnish us with an historical résumé of the position. I think you might give us shortly an outline of the history of the licensed house in this country, if you will just summarise the first two or three paragraphs of your *précis*?—Would you like me to read it as it stands?

6316. If you please—the first two or three paragraphs, to put the matter historically?—To summarise it, I think I should say that licensed houses did not come into legal existence till the year 1774. That was really the first legislation which dealt with the insane in any kind of way, excepting an Act which was passed in the reign of George II and which dealt with the apprehension and the detention of people who were dangerous—that was purely a judicial procedure; there was no question of medical examination at all. Such people were apparently invariably confined in gaols. However, at the time of the Act of 1774 there were unquestionably a very large number of insane people in the country, and they were at that time, with very few exceptions (fewer exceptions than those I mention in my *précis*) confined to what subsequently became the licensed houses, which were then spoken of, of course, as private asylums. A large number were, however, in the poorhouses, and a good many were in gaol. The Act of 1774 really was brought about owing to an inquiry by a Committee of the House which disclosed a very grave condition generally through the country as to the care of the insane; and it laid down at least this, that houses that were to receive the insane must be licensed by law, and that people must not be received except they were received under a medical certificate.

6317. Was that the first inception of medical certification?—Yes, that was so. At that time, of course, there was no judicial order; indeed, as far as private patients were concerned, there was no judicial order at all until the Act of 1890. Prior to that, patients were admitted on an order which was given by a member of the laity—by a relative or friend—supported by two medical certificates.

6318. Without the intervention of a public functionary?—Without any public functionary intervening. Prior to the year 1811 there were, in fact, no certificates required at all in the case of a poor patient—a pauper. These people were received and detained in licensed houses without any formality whatever, and the only protection they got was the fear that they might subsequently take action for illegal detention; they had that power, and of course the Habeas Corpus Act was in existence.

6319. Apparently when one looks at the matter historically the anxiety in the early days was directed much more to the property of persons who were insane than to their person?—Entirely so. That goes back to the reign of Edward I.

6320. But as regards the legal code relating to the care of the person, it is interesting to note that the medical certificate in the case of the private patient

who went to a licensed house was introduced in 1774, and in the case of the pauper patient in 1811. Up to that time the patient could be detained without any medical certificate, and was protected only by the common law and the Habeas Corpus Act?—Yes, that is so.

6321. We need not take the later history, which we know, I think; but looking at the particular class of institution with which you are associated, the licensed house, one is struck with this, that both the number of the houses and the number of patients under treatment in licensed houses have been progressively diminishing?—That is so. I think there is a very clear reason for that, as far as the numbers are concerned. The function of the licensed house was very largely that of receiving pauper patients under contract. There was no public asylum before the early part of last century. It is only within comparatively recent years that many of the large boroughs have provided themselves with mental hospitals. Prior to that, it was the case that the various outlying boroughs would enter into contracts with licensed houses for the reception of their patients. At the time when I was first associated with Camberwell House it was in fact a house primarily for the reception of pauper patients. We had at that time some 250 patients from the Borough of Hastings alone; all the patients from Hastings were received there under contract. They were taken in those days at 16s. a week. Then in London there were four other large houses of this character, all of them receiving only, or almost only, pauper patients.

6322. May I just put to you one or two figures I have taken out which show exactly what you have said. In 1847, which was the start of the new régime under the Commissioners appointed in 1845, you will remember, there were 141 licensed houses?—Yes.

6323. And they had 6,629 inhabitants?—Those are not my figures, are they?

6324. No, they are the Lunacy Commissioners' figures for 1847. 6,629 inmates, of whom 3,996 were paupers, while in 1914 there were only 68 licensed houses with 3,493 inmates, of whom only 638 were paupers. So that apparently, historically, the position has been this, that in 1847 there were more pauper than private patients in licensed houses, whereas in 1914 there were far more private than pauper?—Yes. The reason for that, of course, was this, that at that date two, if not three, of the large licensed houses had disappeared, those that took pauper patients; but if you take a date, say 1900, you would find the number of pauper patients was largely in excess of the number mentioned there.

6325. The last figures I have are for January, 1923. and there were 56 licensed houses with 2,606 inmates. Are there any pauper inmates still?—No, none.

6326. So these would all be private patients?—Yes.

6327. I had not understood why it was that the pauper patients had originally been in licensed houses and had now left. Formerly the method adopted was for the local authorities to send their pauper patients to licensed houses before they had provided county and borough asylums of their own?—Yes.

6328. The result is therefore that the licensed houses have been very steadily diminishing in number?—Rapidly; practically at the rate of one a year; but speaking generally those represent very small licensed houses.

6329. I would like to put a question which would probably have been asked by Sir David Drummond, had he been with us to-day, on the subject of the existence of a sufficient number of places to which private patients may be sent in this country. Have

16 December, 1924.]

Dr. F. H. EDWARDS.

[Continued.]

you any view on that matter?—Yes; I take the view that there is an unquestionable need to extend accommodation, inasmuch as at the present time there are certain areas of England which have no such accommodation at all. I personally have to admit patients from all parts. Perhaps you have noticed the figures I have given you of my own admissions in my *précis*. May I read the paragraph which deals with it?

6330. If you please?—"There undoubtedly exists, in a considerable section of the population, a demand for the treatment of the insane in other than public institutions. As evidence of this, it may be stated, quoting the statistics in the Blue Book recently published by the Board of Control, that, for the year 1923, there were admitted into one of the metropolitan licensed houses 247 private patients, as against 115, the largest number admitted into any registered mental hospital, and 112, the largest number admitted into any county or borough mental hospital. The aggregate admission of private patients for 1923 was licensed houses 1,312, registered hospitals 598, county and borough mental hospitals 1,190, and single care 189."

6331. Now what do you infer from that? Do you infer that there is not sufficient provision made in this country for the private class of patient?—There is grave inconvenience. Of course, there is a section of people who prefer public management; there is a section of people who prefer private management. It is a matter of the mentality of sections of the population. America has its licensed houses under some name or another, and every country in Europe has them; and it is to my mind an exceedingly inconvenient thing that people who live in Wales should have to send their patients to London to have them nursed. That constantly happens; not a month goes by but I have to admit patients from some district in Wales, because they desire to place the patient in some private hospital.

6332. Rather than in what one might call the private department of a public institution?—Rather than in the private department of a public institution. The chairman of the committee of one of the best known of the Welsh mental hospitals, whose name I cannot mention for obvious reasons, applied to me last week to take a near relative of his who had had to be placed in a great hurry in the county mental hospital.

6333. The licensed houses therefore are now the only places in which patients are taken for payment; private patients only are taken, and those are all patients who pay for their maintenance?—Oh, no, Sir; the registered hospitals take private patients.

6334. But all the patients in a hospital do not pay?—Exclusively, do you mean?

6335. Yes. What I want to elicit is the special feature of your institution. First it is private, and secondly every patient is a paying guest?—Yes; and that would apply to the majority of the registered hospitals, too.

6336. There is this distinction, that in the case of the licensed houses the institution is carried on for gain, that is to say, in the sense that it is not merely like a charity that pays its way, but it is a place carried on like a hotel?—It is not a charity.

6337. Whereas the registered hospital, on the other hand, is a charity, and contains both persons who pay and those who cannot pay, and the one to some extent helps the other, with the advantage of the endowment?—Yes.

6338. But yours is a nursing home or a hotel, if one may so put it?—Yes.

6339. And you say that caters for a certain demand that exists in the community?—I think these figures show it.

6340. Yes, it is quite interesting. The number, of course, is diminishing steadily, as you say?—The number of licensed houses is diminishing, for this reason, that primarily a licensed house was started by some medical man who was probably interested in the care and treatment of the insane, and in due

course he built up a certain connection; he built up a certain hospital, as we might call it now, and subsequently died; he left the property he had to his children, who very likely had comparatively little interest in the work, and consequently the place, instead of being of any particular value in the treatment of patients, became of little value, and so it tended to disappear; in other words, if a place were not efficiently and well controlled it would tend to disappear. Where smaller licensed houses within recent years have lost the owner by death, they generally have been allowed to die, because they have no monetary value; there is no transferable value in them at all.

6341. And therefore they lapse, do they?—They would lapse.

6342. As regards their distribution throughout the country, it seems to be more or less haphazard—it is accidental?—Yes, and it is, unfortunately, at the present time so restricted by the law dealing with the licences that a house situated in a comparatively small borough, which might once have been a country borough and has now become a sort of town, cannot be moved beyond the confines of that borough because it is going under another licensing authority.

6343. There are metropolitan licensed houses which are licensed directly by the Commissioners of the Board of Control?—Yes.

6344. And there are provincial houses which are licensed by the local justices?—Yes.

6345. The proportions of the two do not seem to maintain any fixed ratio at all; that is to say, at 1st January, 1923, there were 19 metropolitan licensed houses and 37 provincial licensed houses, while in 1914 there were 23 metropolitan and 45 provincial?—Yes.

6346. The numbers apparently vary, but always on the down scale?—Yes.

6347. Now you are aware, are you not, that in 1890, or rather the inquiry which preceded the legislation of 1890, there were two views on the subject of licensed houses. One view was that they were not required, and that they should be abolished?—Yes.

6348. The other view was that they served a useful purpose and should be continued, but should not be increased in number?—Yes.

6349. It is interesting to note that they have diminished in number by a process of time since then. I should gather from your evidence that you think they still play a useful part?—I cannot question it; my own work tells me it.

6350. And useful, perhaps, just because they meet the demand of a particular class of the community?—There always must be a class of the community that neither want to have charitable aid given to them nor do they want to place themselves under the eye of a public authority.

6351. But if there be a substantial demand for this class of institution, can you account for the numbers diminishing so much, apart from the fact that there are no longer pauper patients in them; even since pauper patients have been in them the number has still dwindled? Demand usually creates supply.—It depends entirely. I tried to make it clear just now that in a certain place which is, shall we say, well managed, there would be no question of lack of patients—rather the reverse; there is a difficulty in accommodating the patients. But when a place ceases to have a medical man, perhaps, at its head, he having by death fallen out, or disappeared, and the place is left more or less, as smaller places may be, without even a resident doctor, it becomes known to the general public, to the doctors who send such patients, as a place where it is not very helpful to send a patient from the standpoint of treatment.

6352. I think that possibly the prejudice, if there were a prejudice, on the subject of the licensed houses was due to the fact that it was thought there was more liability to improper detention there than in the more public institutions, and that they were the sort of place in which designing relatives might put away their more or less ailing relations?—Yes.

16 December, 1924.]

Dr. F. H. EDWARDS.

[Continued.]

6353. Would you tell us what are the precautions which exist for safeguarding against such occurrences in licensed houses? We have heard a good deal of evidence about other places. In licensed houses what is the touch maintained between your patients and the outside world?—They differ in no circumstances or way from the conditions in the registered hospitals—the conditions under which patients are admitted, the right to see judicial authorities, the right to have private interviews with Commissioners, all these things are exactly similar in the case of a licensed house to the conditions one finds in the registered hospital. One does not want to go over ground which you must have dealt with frequently before, but the bogey of illegal detention, of course, quite obviously connotes conspiracy between doctors (for illegal admission), magistrate, superintendent, and visiting Commissioner; and of course in the metropolitan licensed house we stand in a very different position even from the registered hospitals that lie outside the London area, because we are visited eight times a year by the Commissioners: six times to see all patients, and twice to see the new patients particularly. Every patient who is in residence has to be seen; every patient has to have his name ticked off in a book; in other words, the Commissioner has to satisfy himself that each case he sees every six weeks throughout the year is a proper person for detention.

6354. May I suggest this also to you: the licensed houses are all very much smaller than the public institutions, are they not? What is the largest licensed house?—The largest licensed house is licensed for 672 patients.

6355. That is much smaller than the great public asylums; and are many of them much smaller than that?—Much smaller; some of them go down to even four patients.

6356. I was thinking of the efficiency of the visits and the possibility of direct contact between the visiting Commissioner and the patient?—May I describe the visit of the Commissioner, or two Commissioners?

6357. If you please. When they come to your own house, what happens?—It would mean they would come about 10 o'clock in the morning.

6358. Do they tell you before that they are coming?—No; without warning they come; one has no idea when they are coming; they start going round where they will, deciding they will start at this point or that point, even going first of all to the stores or the kitchens. They carry a book with the name of every patient in, and a short note as to the nature of the patient's disease. They spend the whole day, usually till six o'clock, and they come the following day; they finish their inspection probably at six o'clock the following day. That means that to see perhaps 380 patients they spend certainly 12 or 14 hours, and as of course a large number of patients are habitually mentally ill, it follows that the rest have ample opportunity of discussing matters with the Commissioners.

6359. Do they take advantage of it?—A certain number invariably do, but they are nearly always people who are suffering from chronic brain disorder and have fixed ideas, perhaps, of persecution; and although such patients time after time ask for an interview, I have never known a case where the Commissioners have refused to give a private interview, that is to say, not seeing them in the house in which they are, but taking them to my private office and seeing them apart from myself, although such cases are perfectly well known to the Commissioners and although their delusions have existed possibly for years. Patients who are progressing satisfactorily do not ask to see the Commissioners privately. It is a certain small section. It is unquestionably good for them that they should see the Commissioners and realise that they get a hearing.

6360. Are you not also subject to visitation by visitors who are appointed by the local justices?—No; that only applies to the licensed houses in the country, outside the metropolitan area.

6361. Then you are not subject to that. We shall have some evidence by gentlemen who are in charge of provincial houses, later. In your case the visitation is entirely by the Commissioners?—Entirely, excepting, if I may add, at fairly regular intervals the Lord Chancellor's visitors also come, dealing, of course, primarily with the estates of patients, but also satisfying themselves that the patients are comfortable.

6362. Have you some patients who have been so found by inquisition?—A very large number under Section 116, and a very considerable section of those are placed by the Master on the visitors' list. The visitor pays always two statutory visits a year, during which he sees all the patients on his list under Section 116.

6363. Your patients, being all private, would to a large extent be persons of some means?—Yes. Then, as happened yesterday, Lord Sandhurst, one of the visitors, came down in the evening to see a special patient for whom some special form of treatment has been advocated. He paid a special visit, and these special visits are paid very, very frequently by a visitor.

6364. What facilities have you for relatives seeing the patients?—Relatives can, of course, visit at any time. Visiting normally takes place every day between half-past two and half-past four, but of course one cannot make hard and fast rules, because people come from the country, and that sort of thing. They go into every part of the house; there is no part from which the visitors are excluded, even where the acute patients are nursed.

6365. Then you have the same rule in licensed houses, that all letters addressed to certain public officials must be forwarded unopened?—Yes, under the Act of Parliament.

6366. And is that right or privilege made known to your patients in any way?—It is placed on the wall in every house. In every separate division there is a little printed notice in a frame, telling them that they have that right, also explaining certain other rights that they have. That is exposed so that every patient may see it.

6367. Will you allow me to put an entirely supposititious case, Doctor? Suppose that there was a patient in your institution—you will not regard me as offensive if I put it in this way—who was a very good paying patient, and whose relatives were also very anxious to have him kept there. You can figure the case; it is more the case of the novelist, but I put it to you for the purpose of asking you what means such a person would have of obtaining redress, of getting out, in short? What would be his points of contact? You have told us of the visits of the Commissioners. The relatives we must put out of account in this case, because they are in the conspiracy. We must put you out of it, because we have supposed that you are in it?—Yes, I am in it.

6368. What chance does that person have? What are his means of communication? Is he confined to the interview with the visiting Commissioner and to correspondence?—If a position of that sort arose, such a person having the use of his faculties—

6369. We must assume that, because it is *ex hypothesi* a sane person?—Yes, and consequently a person, who would have the ordinary common-sense the average man in the street is supposed to have, would probably get letters out without knowledge of the superintendent or his staff; that, of course, would be a very easy thing indeed, because it is a thing that even now does happen.

6370. Of course, you are assuming for the moment that your conspiracy went so deep that you intercepted the letters addressed to public officials. I am not assuming you were as wicked as that?—But I am; I am shutting out every means. There is no means at all, except that I should find it exceedingly difficult to keep the wealthy patient out of touch with other patients, or the nursing staff. Sooner or later some member of the nursing staff or one of the patients would go out on parole—10 per cent, do so go out—and that would mean it is quite certain that

16 December, 1924.]

Dr. F. H. EDWARDS.

[Continued.]

letters would begin to get posted, which I, with all my ingenuity, had no power to stop. I can quite conceive in that way the person would get into touch with the outside world.

6371. But the visit of the Commissioner, I should think, was of importance. Does the Commissioner actually see each individual patient?—Each individual patient. The Commissioner has a book with the names of the patients, and as the Commissioner goes round he takes his pencil out and ticks them off. In many cases in the London licensed houses the Commissioners individually know such cases as are chronic; if they see them so many times a year, they must; but in each case they tick off the name of each patient, and subsequently check their book against the names that they have, and then they check them against the numbers which are submitted to them.

6372. A mere arithmetical checking, so to speak, "All present and correct," is not of much use?—Quite.

6373. It is not so much a question of seeing that the people are there as to have them given an opportunity of speaking to the Commissioners?—It is not a question of giving them an opportunity of speaking to them. The Commissioners individually speak to every patient. They do not walk through a ward and say, "I have now given all the people in this ward the opportunity of speaking to me," but they go up to each case; they would not take so many hours inspecting if it were not for that fact.

6374. Let me again put to you a sinister suggestion, if I may. Is it not possible that a patient may be deterred from complaining because of the possible consequences of doing so?—I could imagine that, if a patient were living under some iron régime in which terrorism were the treatment, such a condition might arise. It can only be a conjecture on my part that such a thing might happen.

6375. I am putting these questions to you because one is anxious to allay rather than to arouse suspicion?—I know.

6376. Of course, I have this difficulty, that the assumption in a case of wrongful detention must be that the person is sane?—Yes.

6377. Because if the patient is not sane then he is not being wrongfully detained; but if the patient is sane one would naturally imagine that, being in possession of his wits, he would not be likely to be deterred from making his complaints known, or would not be disabled from making his complaints known outside?—That is so.

6378. Of course, there may be a class of case that is feeble, but not insane?—Yes.

6379. That might be the class of case more exposed to danger?—There is, of course, that class, the class that have virtually no initiative, and who would, perhaps, in any state or walk of life, whether they were in a hospital or whether they were not, take all things without complaint; one knows the type, of course, perfectly. Complaints as to illegal detention are the commonest form of complaint one has to hear.

6380. That has a certain popular vogue, if one may so put it?—Although I am the detaining authority, in a sense—the Act gives me power to detain certain people—nevertheless, the complainant speaks to me, complaining of the detention, which he always applies to some other person; they do not put it upon the doctor. The reasonable person does not complain; the person who is progressing normally and is going to recover does not complain about illegal detention.

6381. Of course, we are dealing with a subject which has not got definite edges—I mean, insanity is not a subject of mathematical ascertainment; it is a matter of opinion?—Purely.

6382. In dealing with such cases it must be inevitable that there are patients who are being detained against their wish and as to whom opinion might differ with regard to whether a case was a proper one for legal detention or not. That must occur?—Unquestionably; but one such case a year, perhaps, comes to my knowledge.

6383. What one is concerned with is to see that that class of case should be well safeguarded. Have you any suggestions to make for our consideration as to whether the existing protections are sufficient, or whether they should be in any way tightened up or added to?—I think, to start with, I would say that that type of case, as a class, as far as I am personally concerned, would not be nursed as certified patients at all; such patients would be nursed as voluntary patients, and a very large number of patients are so nursed.

6384. In your institution how many voluntary patients do you have?—I had under care last year altogether 78 patients voluntarily. My total admissions last year were just over 300. Of those, 78 were voluntary cases. A person suffering from a distinctly mild form of mental disorder would not be treated as a certified case, probably, in any institution if it were possible to treat him as a voluntary patient. It very commonly happens that a patient may be admitted to Camberwell House as a certified patient who in a month has been transferred to the voluntary boarder class.

6385. Is that because they have recovered?—Because their condition is such that they have improved up to a point when it is felt it is better for them themselves that they should be treated as voluntary patients.

6386. Without the sense of restriction?—Yes, exactly. Perhaps I might show you the form which I employ (*handing in a form*). I hand you that because there is no statutory form.

6387. I see the form says this—the public may be interested in it: "I herewith make application to be received at Camberwell House as a voluntary boarder for treatment, having first read the appended notice." Then the notice is: "Camberwell House is a private hospital for the care and treatment of people suffering from nervous or mental illnesses. Boarders are received on their own application. They are entitled to leave at any time, after giving to the Medical Superintendent twenty-four hours' notice in writing of their intention to do so, but, whilst in the institution, they must undertake to conform to the rules and regulations." Then there is appended a medical certificate by a doctor, saying that the patient is suitable for admission to your house?—Yes.

6388. *Earl Russell*: That is really your own form?—My own form entirely.

6389. *Chairman*: And this is what you send in to the Board of Control?—Yes. There is a notice of admission, which goes after the admission of the patient, but that form has to be sent to the Board of Control, and that is a matter which I rather object to, the intolerable delay which is necessary at present under the Act before being able to admit a person who comes to you in great need and in great urgency. You may have to say, "I am sorry, I cannot take you; you will have to wait two days while I get this permission." That is how the Act is at present.

6390. Yes. Now is one of your suggestions that the admission of voluntary patients should not be clogged by such a condition?—I think there should be no objection to any person voluntarily entering themselves as voluntary patients in any hospital for mental disorder. I would not in any way lessen the conditions which apply subsequently, in so far as the notice to the Board of Control, or whichever authority it may be, and the sending of a statement as to the mental state of the patient, is concerned. I think those things should be always on record; but I feel that patients should have the power—in fact I may say I have broken the law in this matter,—I have taken people who have arrived perhaps late at night, in some cases from great distances; people who probably have formerly been under care and who come and apply to be taken in. I say, "Very well, you can come in for to-night or for a couple of days, until I am able to get sanction." It is, of course, unfortunate to do things which are irregular, if one can regularise them.

16 December, 1924.]

Dr. F. H. EDWARDS.

[Continued.]

6391. You do, however, do you not, recognise the appropriateness of the Board of Control or some responsible authority being notified of the admission of such patients?—Oh, yes.

6392. Otherwise one can see, of course, that there would be no safeguard at all?—Oh, yes.

6393. Would you advocate the extension of the voluntary system to the public asylums also?—Unquestionably, yes.

6394. It might be useful if you were to give us any suggestions you have to make specially applicable to the system of licensing houses which at present obtains. I think you have some views to advocate on that topic, have you not?—The present system of licensing is that in the counties of London and Middlesex and in certain scattered hamlets in Surrey, which seem to have been picked out because they had small licensed houses in them, the Commissioners were given the power to licence. The area is very limited; it is something like seven miles.

6395. *Sir Ernest Hiley*: Is the licence for the house, or for the proprietor?—The licence is for the house, but certain people are called licensees, one of whom must be a resident.

Chairman: You will find that in Section 211, *Sir Ernest*.

Witness: If the house is licensed for over 100 patients there must be a resident medical man. If below 100, a medical man must visit as the Board directs. Of course, such a staff would be ridiculous now. At Camberwell House we have six paid medical officers. The work at the present day could not be done in the sort of way it was done a century ago. Licences are granted on the first Wednesday in each February, and certain licensees have to attend; they have to make certain payments, which are fixed by Statute, and the licence is then granted for the succeeding 13 months. Now outside the London area the justices at quarter sessions and at any quarter sessions have the power to grant licences. Consequently, there are numerous licensing authorities. Wherever there happens to be only one licensed house, in that particular area you have to have a special licensing bench, a special licensing meeting for that purpose. I feel very strongly that the question of the supervision and control of the licensed houses all over the country should be in one hand. I mention that the Ministry of Health should be the licensing authority, that branch of the Ministry of Health which is especially concerned with the treatment of mental disorder, that is, the Board of Control, or whatever name they may be called by, and that these licences should be issued from the one central authority after the Board of Control are satisfied as to the propriety of the methods of treatment which can be applied in that particular place.

6396. Would you continue the visitation of the licensed houses by the magistrates?—That, at present, throws an intolerable strain upon the Commissioners. One feels that the Commissioners are very numerically weak at the present time, and so much so that even the London licensed houses, which were formerly visited four times a year by two Commissioners, are invariably visited by only one Commissioner now. The legal and the medical Commissioners came together, and although naturally the majority of the patients liked to see the medical Commissioner, there are sections who regard their case merely from the legal standpoint; therefore the legal Commissioner was of more comfort to them. So that I think, at present, until the Board is strengthened, or some other form of medical visitor is appointed, the magistrates would have to carry out the visitation. Of course, after all, for the provincial visiting the magistrates are accompanied by a medical visitor; that medical visitor becomes in time a man expert in the knowledge of mental disorders, and capable, perhaps not to the same extent as a member of the Board of Control would be, but to a large extent, of forming an independent and proper opinion of the condition of a mental patient.

6397. *Earl Russell*: Have not the Commissioners some power in the country of appointing Deputy Commissioners?—Yes, they have the power of appointing what are known as visitors—inspectors.

6398. *Chairman*: They have only two, I think?—Only two inspectors, and they, of course, are properly employed under the Mental Deficiency Act. It was to relieve the Commissioners largely of the extra duties placed upon them by the Mental Deficiency Act, but the strength of the Commissioners at present is, of course, totally inadequate, when one realises what the strength of the Commission was in 1845, with something less than 20,000 patients to care for, and now over 130,000, and the mentally deficient as well.

6399. I gather that you do attach importance to a supervising central authority?—I think it is essential. I think that wherever detention is carried out, whether it is in a private house or in an institution, one must have compulsory inspection. I speak advisedly, because I have on many occasions acted for the Lord Chancellor in examining houses where patients were supposed to be detained as lunatics, and one has realised that out of ignorance or from other causes patients have not received, in certain cases, the form of treatment which should have been applied. They were detained without formality, without legality, and one realised therefore how necessary inspection is in all forms of mental disorder where detention is involved.

6400. Then you have some view as to the transference of licences; you think that that should be facilitated?—The position is that there are certain licensed houses situated at the present time within the area of the licensing authority that might serve a very much better purpose if they were moved to more congenial surroundings, more particularly the small licences, licences for a small number of patients, which could serve a very useful purpose if the patients could go down to seaside places or into the country, and there is a very obvious and real necessity for it. At the present time I get applications from all kinds of sources, from medical men and others, "Can you recommend a mental hospital at the seaside?" Well, I know of only three at the present time, a convalescent home which is attached to Camberwell House, a convalescent home which is attached to Holloway Sanatorium, and a convalescent home attached to St. Andrew's Hospital, Northampton. I know of no other. It has always seemed to me that both for the county mental hospital and also any other form of mental hospital there should be an opportunity of sending patients when they reach a certain stage of convalescence to seaside homes.

6401. A seaside home or a convalescent home treated as part of your licensed premises?—It is not recognised by law, but it is nevertheless visited twice a year by a member of the Board of Control. That is outside his statutory duty, but he does it.

6402. Now all the patients who are at the seaside and convalescent, let us say, are still certified patients, I take it?—Either certified or voluntary boarders.

6403. But let us take a certified case as being a case under the arm of the law for the moment. Do you send them down to this seaside place?—I send them down, but in order to send them down I have to apply to the Board of Control for what is known as leave of absence.

6404. *Earl Russell*: Theoretically they are not in your licensed house?—They are not in the licensed house; they are out on leave. But what does very often happen is that frequently there is an urgent case in Brighton itself, for instance. They say, "Here, you have a mental hospital in the borough," and you say, "We cannot send a patient into it." It seems very ridiculous, and I think the Board of Control themselves have taken that view, because they submitted in their 66th Report the question to Counsel, and the Law Officers of the Crown decided that it was not legal to permit the entry of either certified patients or voluntary patients into convalescent homes.

16 December, 1924.]

Dr. F. H. EDWARDS.

[Continued.]

6405. *Chairman*: It was not a licensed house, it was not a registered hospital, and therefore it was none of the known places of detention?—That is so.

6406. You think that really covers all the special matters relating to your type of house, do you?—If I might take paragraph 5, Sir?

6407. If you please?—Paragraph 5 I feel very strongly on, because one does realise the present extremely unfortunate position that medical men are placed in who desire to take and treat patients in their own care. There are many such, and there are many such men who are recognised by us as being skilled and specially trained and adapted for the treatment of patients of the private class, specially in private care; and yet what so frequently happens is that the patient is sent to such a doctor who may have a half-a-dozen patients in his house, and in the process of recovery the patient gets a little worse; he may just pass over that border line; then that terrible Section 315 looms over the doctor, and he has to send his patient away into some mental hospital and he cannot continue the treatment of the patient.

6408. That is because he would be held to be detaining for gain an insane person?—As he would be, but that is why to my mind there should be a possibility of extending the power to take patients who are of unsound mind into the houses of people who may be specially approved, and into houses specially approved for the purpose, without necessarily founding a large number of private asylums about the country. But I am sure that for the public weal, for the public benefit, it would be an advantage to many men who are now treating such patients in fear and trembling because they know how near they sail to the law. I have had to visit such, and I know the conditions of anxiety they are under if patients show symptoms which may be construed even into being symptoms of unsoundness of mind, and I know the fear of subsequent visitation and prosecution or of a tragedy happening, a suicide or something of the sort happening. There are many such houses within my knowledge that I know are admirably conducted and where patients are receiving individual skill and care from men who are really experts in their subject.

6409. Of course, it might find a place in any scheme which contemplated the treatment of patients, particularly of incipient cases, without certification and under some provisional method of detention?—The Mental Treatment Bill, as it was presented originally, made no provision for the care of such patients in medical men's houses.

6410. No, it did not. One has also knowledge of course that in the case of nursing homes, places to which people resort sometimes when they have a breakdown, the same problem must arise there. Apart from the cases where a doctor will take in one or two patients, the doctor who is running, as many doctors do, a nursing home, must have the same embarrassment you speak of?—I would not exclude the nursing home so long as the qualifications of the person keeping the home were satisfactory and sufficient.

6411. One's real anxiety is to give the best chance to the patient, consistently with the due preservation of his legal status?—Yes, so long as inspection follows the power of detention, it seems to me to be the only thing.

6412. Then you rely, do you, on inspection as a safeguard?—The greatest safeguard. Of course people so often (I am speaking now rather of the nursing home) will apply methods of treatment in ignorance which might be prevented where there were skilled inspection and skilled advice available.

6413. Then the system of inspection in your view is not only valuable as securing what you may call the legal rights of patients against unlawful detention, but also as securing for them the advantage of greater experience in the treatment of the cases?—I am sure of that, or we should not have the Medical Commissioners you see.

6414. Tell me this; in your own institution of course you will have both male and female nurses, will you not?—We nurse the entire place with female nurses,

men and women patients. I have certain orderlies who assist in the matter of bathing in the case of certain patients, for 20 years I have done so; I lay no claim for inventing the system; I borrowed it from Scotland. I saw it in Scotland and I brought it down. Of course it was an enormous help during the war; when every man had to go, I had no difficulties. When superintendents up and down the country used to come and say, "How did you manage?" I said, "Turn out your male staff and put in your female staff." Of course it is an extreme error to think that male patients who have got mental disorder are not amenable to the care of women nurses. A man who is sick understands a woman who is a nurse. Apart from that the woman has the instinct of nursing. Some few men have, but very few. Also there is the distinct sense of resentment that so many male patients have at any form of coercion that might have to be applied to them being applied by a man, whereas they can understand the female nurse and her uniform as a person who must be obeyed. I personally have had no trouble after 22 years of specially nursing insane men with female nurses. Even in the war when the very worst cases were nursed—and of course I had a great many acute and difficult cases—even then I had a charge sister with two female nurses working under her. Our male assistants were entirely subordinate to the female staff. In the other four divisions there is no man ever admitted into a ward except for such purposes as shaving and bathing patients.

6415. And you find the psychological influence of that excellent?—Excellent.

6416. Without beating about the bush, are there not a good many cases of mental derangement which are associated with exceedingly unpleasant sexual symptoms, and so on?—I have talked to women engaged in general nursing and also engaged in general hospitals. I have spoken to women who were thrown during a great part of the war into contact with many types of patients, and they said they had had less in the nature of insult and unpleasantness or vicious suggestion from the insane than they had had from the sane. I do not think that, speaking generally, one finds, except in a very small percentage of one's male patients, obvious vicious habits.

6417. Take another class of case, take the acute case. Have you not a number of cases of patients to deal with, whose restraint requires really a very strong man to carry it out?—It might be that the male assistant would have to be called in, but whatever was done to that patient would be done under the supervision of the sister of the ward or her deputy. The great thing is to have a woman, a female nurse, in charge, but as I say, I have five divisions altogether where male patients are nursed, and in only one of those is there any regular permanent service given by a male orderly. In the other four divisions they may visit for the purpose of bathing and shaving, but they have no power of interference; there is no call to them to interfere in any way with the patients.

6418. Do you think it due to the particular character of your institution and the type of patient you have there that it has been so successful?—I think perhaps the social class of the patients may have some bearing upon it. It may be, but I should not like to say. After all, the experiment had to be carried out very largely during the war in the county hospitals. I visited the hospital of one of the witnesses whom you have had before you, Dr. Wolseley Lewis, last year, and I was very much struck to see how many really difficult turbulent cases were being controlled there by female nurses. The fact is that those who have tried it never go back, unless they have to go back for reasons such as are stated there.

6419. Of course one can understand the moral value of the woman's influence and that a man might perhaps try to behave better because it was a woman?—Unquestionably that is so.

16 December, 1924.]

Dr. F. H. EDWARDS.

[Continued.]

6420. And you have taken advantage of that natural instinct between the sexes?—Entirely, and it is a very true and very real thing.

6421. *Mr. Micklem*: Dr. Edwards, I understand you to suggest that in the case of these licensed houses there is no saleable value attached to the house?—I should imagine not. I have heard of one or two where the owner died, and they have simply shut up and gone.

6422. But I suppose there is a certain goodwill, if the licence runs with the premises, which would attach to the licence and which could be handed on?—Yes. I never heard of one being sold, however.

6423. But some of the licensed houses have run for many years?—Yes, I know the case of one. A medical man came to me recently; he said he thought that his health was not very good, and that the quieter life of a mental hospital would suit him. He told me that he had been offered a very beautiful house with very nice gardens, the house was furnished, on the condition that he paid £600 a year. If there were no licence attached at all I should imagine a furnished house of that size would be £600 a year.

6424. But I suppose one house would be convenient as a nursing home or as an asylum, and at the same value convenient as a dwelling-house?—The Commissioners have always very strongly deprecated any financial association between the licence which they grant, and which can be withdrawn each year, and the sale of such premises. I cannot say that such things have not been done, but they are not within my knowledge.

6425. But how generally does a licensed house pass from the possession of one person to another?—It passes from father to son. There is one in the County of Kent, I think, of which the fifth or sixth generation is now in charge.

6426. How does the licence run? Does it run to allow the patients to be either certificated patients or voluntary patients?—Yes.

6427. In the case of voluntary patients do the rules of visitation and notice to the Commissioners, and so on, apply?—Yes, exactly in the same way. Every voluntary boarder has to be produced if he is on the premises to be seen by the visiting Commissioner, who has to satisfy himself about him. The detention of a person who is a voluntary boarder and who is also of unsound mind, if the law were strictly interpreted, would render the licensee subject to prosecution under Section 315.

6428. The section is a little bit ambiguous, is it not?—Yes, but strictly you are detaining a person who is of unsound mind not within the provisions of the Act.

6429. It says, "Takes charge of, receives to board or lodge in an unlicensed house"?—Yes, but would you continue the section?

6430. The whole thing seems to be summed up in "in an unlicensed house." "Every person who, except under the provisions of this Act, receives or detains a lunatic, or alleged lunatic, in an institution for lunatics, or for payment takes charge of receives to board or lodge, or detains a lunatic or alleged lunatic in an unlicensed house."—Yes, but the first part that you read was as to detaining a lunatic or alleged lunatic in an institution for lunatics.

6431. It is ambiguous?—It is stated in Archbold's Lunacy that if a voluntary boarder becomes insane and is detained, the proprietor is liable to penalties. I have only to say I have treated patients as voluntary boarders; I have fed them artificially; I have done all such things that one might do to a certified patient, but I am sure I have broken Section 315 over and over again.

6432. But are many of these persons who are in your home uncertificated at all events persons of unsound mind?—A certain number of them are.

6433. May I take it that the majority of them are?—No, more than 50 per cent. are people in whom, I think, no medical man could detect any indications of insanity.

6434. A considerable proportion of them are?—Yes.

6435. Do you say that in the case of all those people you are breaking the law every day?—No. It is only in the case of a small section who definitely become insane, where I recognise their insanity, although it may be acute, is going to be transitory.

6436. I do not feel myself that in those cases you are doing anything that is illegal, because you have your licence, and under your licence you are allowed to take those who are certificated and those who are uncertificated.—I think the first part makes it clear. Archbold in his references to it specifically mentions the admission of a boarder who is insane.

6437. *Earl Russell*: Of course you keep on using the word "detention," but theoretically you do not detain a man?—Oh, yes, you detain a boarder. When you take a boarder, it is clearly understood that that boarder places himself in your care absolutely, and you have power of detention subject to the patient having the power of giving you 24 hours' notice. They are detained for 24 hours.

6438. In the same way as when a boy is at school he must keep the hours?—Yes, exactly.

6439. *Mr. Micklem*: Your view is that Section 315 ought to be amended, even in the case of homes like your own?—Yes, I do think so.

6440. *Miss Madeleine Symons*: Could you tell us, Dr. Edwards, have you had any cases who, when they came to you and you had them under observation, you felt ought not be kept and were not certifiable—I do not mean people who have recovered?—I have never actually admitted a patient that I have had to discharge, a patient who was not insane on admission. I have frequently had to discharge a patient in seven days, cases of puerperal insanity occasionally, people who get well in seven days and have to be discharged within that period. I should feel very loth to discharge a patient who was properly committed under two medical certificates and a magistrate's order on my own opinion until I had detained them for certainly seven days; it would be setting up my opinion against two other medical men and the justice, and, of course, the petitioner. But in 30 years' experience I have had 8,000 cases, and I never remember a case which I felt actually on admission was not insane.

6441. Could you tell us about the nurses; do they all have some general hospital training as well as mental training?—I think there is no greater mistake than to send a woman to train first of all in a general hospital and then to have her come to a mental hospital. I cannot say why it is, but the two attitudes of mind of the woman who is prepared to nurse the insane and the woman who desires to nurse the sick are quite different; they are different types of women. I am speaking, of course, very generally, and there are brilliant exceptions, but the hospital nurse rarely makes a good mental nurse. Whether the mental nurse makes a good hospital nurse, subsequently, I do not know, but the experiment of trying to train the hospital nurse as a mental nurse is not, as a rule, in my opinion, a successful experiment. I do not think, either, that it is necessary, because, after all, our probationers come at the age of 21, or any age over 21. They come and they train for three years; they pass the preliminary examination at the end of the year, and at the end of three years they pass the final examination and have sufficient instruction in general nursing. Take a hospital like Camberwell House; there is scarcely a week when there is not some major operation performed. Each nurse in her turn passes through the more purely hospital division. The handbook—the nurses have to study is composed of one-third of ordinary physical training. The first thing a nurse has to learn when she joins the staff is physiology, elementary anatomy, and of course ordinary first-aid, the way to take a temperature, and that sort of thing. It is unnecessary to have a highly technical education in general nursing and general surgery in order to become a good mental nurse. In some ways they are a different type of

16 December, 1924.]

Dr. F. H. EDWARDS.

[Continued.]

woman who take it up. The trouble I am afraid of is that, if there is to be any attempt to introduce general nurses into mental hospitals, I doubt much whether the nurses will like the rule that they have all got to become members of a trade union. At present the hospitals have managed to avoid that, but I gather that in the greater part of the country the mental nurses have to become trade unionists. It never seems to fit in very well with nursing, but I suppose I am getting old.

6442. *Chairman*: Do you think it is desirable that mental nurses who have started as probationers in institutions for mental illness should have a post-graduate stage, as we call it, in a general hospital?—I do not think it is essential in any way. I think it is an advantage, of course, for any nurse to have a general knowledge of all things.

6443. We are told that general hospitals have interposed great difficulties in the way of mental nurses who desired to have a year or two's experience with them?—Yes, I know.

6444. Is that the case?—At my old hospital, Guy's, there was a half-hearted attempt to change over the nurses for short periods with Bethlem Hospital 30 years ago. I do not think it was ever a success.

6445. Why not—do you know?—I think for the reason I give, that if a woman is interested in general nursing she probably hates the worry and anxiety of mental nursing.

6446. *Earl Russell*: You have got 380 patients altogether, did you say, Dr. Edwards?—Yes, rather more.

6447. About what number of those are certainly irrecquerable—chronic?—Not a large proportion—under 100.

6448. As to those, of course they really want no treatment except keeping them well physically, feeding them properly and making them as happy as you can?—That is so.

6449. That leaves you freer to devote yourself to the more hopeful cases?—Yes.

6450. And those, I suppose, are a remnant of admissions over many years?—That is so, yes. Taking the direct admissions last year, there were 210 certified patients who were admitted directly to Camberwell House, and of those 108 were discharged either on recovery or relieved within 12 months. That is rather more than half, you see.

6451. *Mr. Snell*: Dr. Edwards, I think you said that you had six regular paid resident doctors?—I said four are resident and two are visiting. One is a pathologist. There is no point in having a resident pathologist. The other one is the medical officer who looks after the patients in the convalescent house. I exclude, of course, the surgeon who visits each week.

6452. You have four resident doctors?—Yes, four.

6453. I was not quite clear when you mentioned that you had 380 patients whether those were all who passed through in a year or were always resident?—Always resident. I suppose about 600 or 700 pass through in a year.

6454. Is it your opinion that four doctors can do all that is necessary for 380 patients?—Yes, because if you take 100 off 380 you come down to 280. The amount of actual definite treatment from day to day is not very great. Drug treatment in many cases is unnecessary. Take the ordinary routine; a patient is admitted in the ordinary way, put to bed and examined by a doctor. Then within two or three days, if it seems desirable, blood is taken and we get the pathological report; the dentist visits and examines the teeth. It is just the routine of a general hospital in every way, and a certain percentage of such patients are very much better with no drugs at all.

6455. That is to say, your doctors are more or less there to give attention to the variations rather than to the ordinary treatment?—Actually a general line of treatment is laid down on consultation in every acute case.

6456. What is the proportion of nurses that you need for that number of patients?—There are 85

nurses on the staff to-day. Of course at one time the nurses in mental hospitals were called upon to do all sorts of work; I think they cleaned the floors when I knew it first. All the actual domestic work now, of course, is taken off them, because we have a staff of ward maids who do the actual physical work, so that such nurses as there are on the staff are entirely for the care of the patients.

6457. I should like to pursue the point you made about female nurses just one step further. What about the cases that are really violent cases?—The comparative number of patients who are really violent I should say—and I am, of course, rather giving guess-work figures now—is perhaps 3 per cent.

6458. You find that a woman's influence is more composing than a man's strength, is that it?—When I first received an appointment in a mental hospital, from time to time there were regrettable incidents; there were such things as fractured ribs that were unaccounted for; generally the patient had slipped and fallen on the side of the bath. I can say that no such regrettable incident or accident has occurred since female nurses have had charge of male patients.

6459. They do not slip on the bath?—No.

6460. *Chairman*: But you have just told us that the bath is in charge of the male attendants?—The really infirm male patients have everything done for them by nurses, as they would have in a hospital.

6461. The bath that is given in bed to a patient is given by a nurse to a male patient just the same as to a female patient?—Yes, exactly as in a hospital.

6462. *Sir Humphry Rolleston*: Does a fracture of a rib necessarily show that any violence has taken place?—No. I have taken in my hand the bone of a patient with general paralysis and it has broken.

6463. *Mr. Snell*: I find it difficult to put this question, but I am sure you will not misunderstand what I mean. There is a feeling in the mind of the public that in private hospitals, which are not run primarily for public service but as proprietary institutions, there comes a point where the medical proprietor's interest in his establishment may conflict with his duty to his patients. How is that provided against?—*I am fortunately not a medical proprietor. I fancy that one has to look at this rather from a peculiar standpoint. You have got a small number of hospitals, such as Camberwell House and Peckham House, which are really big places run on hospital lines in which the entire medical management is vested entirely in the hands of doctors who are not proprietors in any sense but who are paid officials; they have no more financial interest than the superintendent of a county or borough mental hospital. You have those on the one hand and that type of place is carrying out the functions of any other hospital. The ultimate destination of any surplus profit is a matter in some cases for a financial board or such proprietary interests which may lie behind, but there could be no interference by such a body as long as the present Board of Control exists. There is an understanding which I have always found between the Board of Control and the superintendents, such as myself. If there is anything I wanted or anything I thought wanted altering, it would be done. If I could not get it done it would be done by pressure put on the financial body by the Board of Control. But the other places are in a different category. They are small homes; they provide comfortable places where people can live; they are suitable particularly for chronic forms of mental disorder. They are not, excepting in the rarest cases, at all suitable for the reception of patients who are acutely mentally ill; in fact, many such smaller homes would refuse to take a patient who was acutely insane.

6464. I do not know that I have quite got the point that I wanted. The Chairman and other members of the Commission will correct me if I am wrong, but I believe it is a legal maxim that where a man's duty and his interest conflict he is in a very

* Since giving evidence, Dr. Edwards has modified this reply in the manner indicated in Appendix XIX.

16 December, 1924.]

Dr. F. H. EDWARDS.

[Continued.]

difficult position. I feel that there possibly might be such occasions in regard to private hospitals, and I am trying to find out how in such cases, if they exist, the patients and the public can be protected?—That is the detention of a sane person?

6465. Yes, where a person has been ill, perhaps certified, and then is restored to health?—I think perhaps my reply shows that it would hardly affect me in my particular work—but you are presuming you have got a small mental hospital in which you have a medical proprietor whose financial interest might tend to clash with his duty to his patients. You are bound in this world to trust certain people to do their duty. We might, of course, quite as well say that an ordinary doctor who treats us when we are ill is purposely keeping us ill in order to run up a bill against us when we are well.

Chairman: It has even been said about lawyers that they foment litigation.

6466. *Mr. Snell:* There is only one other question I would like to put to you, and it is in regard to the dietary and amenities of these private hospitals. One public complaint against them is that though patients pay on a scale which should ensure a good dietary, the proprietors of establishments tend more and more to pare down the comfort until it becomes almost below the standard of living?—Of course, if that happened, I can quite understand that the place would not last very long, because the patients would complain and their relatives would move them somewhere else where they were better fed.

6467. Are the places available so numerous that there is any very great choice in the matter?—Yes. Speaking rather generally, the large licensed houses receive patients at rates which are lower in the ordinary way than even the registered hospitals charge; but they charge at rates which are nevertheless higher than the county mental hospitals charge generally. There is no secret about the charges that are made at Camberwell House; they are printed in bold type for all who want to know. The ordinary charge for ordinary patients is 3½ guineas a week. In the case of people acutely mentally ill, and during such time as they are acutely ill, they pay five guineas a week.

6468. Are the dietary scales subject to examination?—Yes. We have in the kitchens—fortunately new kitchens were built just before the war—nine cooks engaged. If you would like the dietary scales which are regularly sent round submitted to the Commission, I should be very glad to get them for you, because a permanent record is kept of every meal.

6469. *Mrs. Mathew:* Dr. Edwards, I should like to know what the nurses at Camberwell House receive in the way of payment?—The probationer gets £36 in her first year; she gets £39 in her second year, and if she remains a junior, that is to say, until she gets promotion, she gets £42 in her third year. If she becomes a sister she starts at £65 and goes to £100. They, of course, receive their uniform and all found.

Sir Humphry Rolleston: I have got no question to ask Doctor Edwards, but I should like, if I might, to say how valuable his evidence has been and how excellently it has been given.

Chairman: I am sure we all concur in that view.

6470. *Sir Ernest Hiley:* Just one question, Doctor, with reference to the voluntary boarder who gives an undertaking to stay for 24 hours. Supposing he

breaks that condition and goes away, you cannot bring him back, can you?—I could bring him back within 24 hours, but as a matter of expediency I should not do so, unless I had reason to think he was going to hurt himself or others.

6471. Really the undertaking to stay is of no value?—The patient undertakes to stay for an indefinite period, subject to his giving 24 hours' notice.

6472. *Earl Russell:* Still I think you are mistaken in saying you can bring him back?—I could refuse to let him go out.

Earl Russell: I do not think you could bring him back.

Sir Ernest Hiley: If he takes himself off I do not see how you could.

Mr. Walter Stewart: Would you ask the Witness, Sir, how in the case of a limited liability corporation the functions of the statute are applied? We have not had any evidence with regard to that matter.

Chairman: That seems to me to be rather a legal question.

Witness: I think I can answer it. That, Sir, has nothing whatever to do with the licensed premises. It is merely a financial arrangement whereby the finance of the business may be managed; it has nothing to do with the licensee.

6473. *Chairman:* It must be an individual?—Yes.

6474. *Mr. Walter Stewart:* Have the board of directors the right to dismiss the medical superintendent?—It would depend upon whether the superintendent was engaged by them or not.

6475. One wants to see what is the control by the members of the Board of Control of the business side of the concern?—None at all.

Earl Russell: Except in the annual licensing.

6476. *Chairman:* They could refuse to licence if they were dissatisfied?—Yes, undoubtedly.

Mr. Walter Stewart: Could the witness, through you, Sir, tell us how many of the 78 voluntary boarders who were admitted were certified before they went out?

6477. *Chairman:* How many became certifiable and were certified, Doctor?—I could not answer that question offhand, but some were. This is purely guesswork, but perhaps 15 per cent.

6478. *Mr. Walter Stewart:* Would the witness regard the control of such an institution as his own by the Ministry of Health with favour or otherwise?—The answer is that we are already managed by the Ministry of Health.

Chairman: You mean through the Board of Control, I suppose, Mr. Stewart.

Mr. Walter Stewart: I meant a direct independent control.

Chairman: You mean independently of the Board of Control.

Mr. Walter Stewart: Eliminating the Board of Control, yes.

Chairman: The Ministry would have to do it through some department or other. Do you mean direct control by the Ministry?

Mr. Walter Stewart: Yes, as in the case of an ordinary hospital.

6479. *Chairman:* Have you any view upon that point, Doctor?—It would simply be calling it by another name, I take it.

Chairman: I think I have brought out the point raised in the letter you handed to me. (*Handing letter to Witness.*)

Witness: I am very much obliged.

Chairman: Thank you very much, Dr. Edwards.

(*The Witness withdrew.*)

(*Adjourned to to-morrow at 10.30 o'clock.*)

5, OLD PALACE YARD,
WESTMINSTER, S.W.1,

TWELFTH DAY.

Wednesday, 17th December, 1924.

MEMBERS PRESENT :

THE RT. HON. H. P. MACMILLAN, K.C. (*in the Chair*).

THE EARL RUSSELL.

SIR HUMPHRY ROLLESTON, BART., K.C.B., M.D.

SIR ERNEST HILEY, K.B.E.

MR. NATHANIEL MICKLEM, K.C.

MR. W. A. JOWITT, K.C.

MR. H. SNELL, M.P.

MRS. C. J. MATHEW.

MISS MADELEINE SYMONS.

MR. P. BARTER, (*Secretary*).

MR. W. FAIRLEY (*Assistant Secretary*).

Sir CECIL CHUBB, Bart., LL.B., called and examined.

6480. *Chairman*: Sir Cecil, you are proprietor of the Old Manor, Salisbury?—Yes.

6481. Is the Old Manor a licensed house for the reception of patients under the Lunacy Acts?—Yes.

6482. It would be interesting to us to have from you a short account of your institution?—It is the largest licensed house in the country. It is licensed for the reception of 672 patients. It is also one of the oldest, having existed for 111 years. The first admission we have on the books was on the 25th January, 1813. During this time it has admitted, apart from voluntary boarders, some 15,000 patients. The institution has been on more than one occasion, I might say, of great help to the country. Some 60 years ago there was a grave lack of accommodation for the criminal patients of England, and they were housed in this institution whilst Broadmoor was being built. Since that time we have received large numbers of patients from the county asylums, as Dr. Edwards told you yesterday, relieving a grave want of room there; and during the war the Board of Control found 25,000 beds for the wounded in the institutions round about London and other places, leading to a great congestion in the other institutions, and there again I helped the country in taking some hundreds.

6483. Has your experience been such as we were told of yesterday, that formerly your institution took in pauper patients, but that that practice has ceased?—Yes, it has now. Some two years ago, as there was an increasing demand for the care and treatment of patients who could only afford moderate fees, I reconstituted it in that I finally gave up the practice of taking patients from public authorities. At the present moment I might say I am assisting the Government by taking 150 ex-service patients who were the victims of the strain and stress of the war; I took those from the Ministry of Pensions, they are on a private basis. The institution is situated in the City of Salisbury, and it stands upon some 40 acres. It is about five minutes walk from the station. It consists of separate houses, the number being about 19, which is a great advantage, of course, in the classification of patients. The number of patients to-day is 501, 18 of whom are voluntary boarders.

6484. How many men and how many women?—About equal numbers. Of course, with regard to myself, I am not a medical man.

6485. I was just going to ask you what your exact personal relation to the establishment is. You are described as the proprietor of it; what does that mean?—I am in the position practically of a committee of management. I have really under the Act no *locus standi*, I am only the proprietor. I am a licensee jointly with my medical superintendent.

6486. Are you the actual owner of the premises, that is to say, of the land and houses?—Yes. It is a little company.

6487. Is it a private limited company?—Yes; I formed it at the beginning of this year.

6488. What is the name of the company?—The Old Manor, Salisbury, Limited.

6489. Would you tell us a little of the history of the property. I do not wish to ask anything that is private, but did you acquire it by purchase, or by succession?—Practically by succession. My predecessor held the asylum on a mortgage, and we were the mortgagees. It was really a friendly foreclosure in a way, because the place was not paying, and they were very glad to get rid of it.

6490. When was that?—In 1910.

6491. So you have been 14 years there?—14 years at this work.

6492. You have incorporated this company, I have no doubt, for convenience of management?—Yes.

6493. It is a private company. Who are the directors of it?—Myself, my wife, and my brother-in-law.

6494. Just a family concern?—Yes.

6495. And the shareholders—just yourselves again?—Just ourselves again, and one or two outside, the number, I think, being five.

6496. You, yourself, are identified as the chief person interested in the concern?—Yes; I am there about three or four days a week on the average.

6497. We will come to the question of the licensing in a moment, but you and your present medical superintendent hold the licence jointly?—Yes.

6498. Perhaps I might just ask this question: How long has your present medical superintendent been there?—About two years now.

17 December, 1924.]

Sir CECIL CHUBB, Bart., LL.B.

[Continued.]

6499. Has he special qualifications in psychiatry?—Yes, he was the chief medical officer for some 14 years at St. Andrew's, Northampton, one of the registered hospitals.

6500. How is he appointed—is he a direct employee of the company?—I appointed him, with the approval of the Board of Control.

6501. Then he is the direct employee of the company; his employer in law and to whom he would look is this company?—Yes.

6502. Is he remunerated by salary?—He is, yes.

6503. And the Old Manor is one of those places falling into the second category of licensed houses, those not within the immediate jurisdiction of the Board of Control?—Yes. As you know, it is licensed from year to year by the Licensing Justices of Salisbury. It somewhat differs from the licensed houses in London; they are licensed by the Board of Control.

6504. Those are within the immediate jurisdiction of the Board of Control?—Yes. We have six visits a year, as they do. They have six visits from the members of the Board of Control, and we have two visits from them, and four visits from the licensing committee.

6505. As regards the licensing, you derive your licence from the justices?—Yes. The justices, you know, appoint a medical visitor. I should like to mention that here, because one of his duties is that, within 30 days of the admission of a patient, he has to visit the patient and make a report as to his fitness for detention. It is a safeguard in the Act against a sane person being unduly detained.

6506. We might just turn for a moment to the visitation arrangements. We shall find them in Section 191 and the following sections of the Act of 1890. There is the provision that your house "may at any time, by day or night, be visited by any one or more of the Commissioners." Then your institution comes under Sub-section 3 of that section whereby "every licensed house not within the immediate jurisdiction of the Commissioners shall be visited twice a year by not less than two Commissioners, of whom one shall be a medical practitioner, and one a barrister"?—Yes.

6507. So you are subject to visitation twice a year by two Commissioners, and then in addition to that provision is made for visitation of your institution by justices?—Yes.

6508. First of all, as regards the Commissioners, at present are you visited by two Commissioners or by one?—Two now.

6509. For a time I think it was one?—Yes.

6510. The system of two Commissioners visiting you has been restored, has it?—Yes.

6511. One of them a doctor, and the other a barrister?—Yes.

6512. These visits are twice a year; have you any notion when they are coming?—Not the slightest.

6513. They just appear?—Yes, they just appear.

6514. Will you tell us what they do when they come?—I think, as Dr. Edwards explained to you yesterday, they do exactly as they think fit.

6515. We need not duplicate the evidence?—They see every patient and they give private interviews to every patient who wants one.

6516. We are very concerned to see that the visitation system is made effective, because, as you know, there have been complaints, I do not know whether they are well-founded or not, that visitation is apt to become perfunctory, and that patients do not get the opportunities they would like of really putting their case before this outside authority. One is very anxious to see, if there is any foundation for that grievance, that it should be removed. In your own experience, do you find that the patients really do get a chance of speaking to the Commissioners?—Yes, certainly.

6517. You appreciate the point I am making. What one is anxious to have is this: that the patient should feel here is someone he can really talk to, and also, if possible, talk without the shadow, so to speak, of the authorities to whom he is presently

subjected. That is the idea, of course, and that is the conception of the visit. Do your patients, in fact, have private talks with the Commissioners?—Yes; they give private interviews to a good many. I think last time there were 12 or 14 interviewed.

6518. At private interviews?—At private interviews.

6519. What do you mean by a private interview?—It is held in the room where the Commissioners are by themselves, none of the staff of the asylum being present. Then, of course, they call in the medical superintendent to answer any serious allegations that may be made.

6520. You tell us that on recent visits as many as a dozen interviews have been given to individual patients, in a room without the presence of anyone representing the institution?—Yes, and that applies to the magistrates as well when they visit.

6521. So that at least, so far as your institution is concerned, an opportunity is given?—Yes.

6522. I suppose there are cases in which, when an interview is asked for, it would really be useless?—Quite so—many cases—and it is usually the same patient that asks for an interview. The convalescent patients do not bother. I must tell you that we have in the Old Manor 109 ladies and gentlemen who go into the town and country unattended every day, on liberty. It is a great record, I think that; no registered hospital or borough asylum can show such a record, and I say that because the patients then have plenty of opportunity of speaking to outside people.

6523. That keeps your institution in touch with the outside world?—Yes. We take risks about that kind of thing—we do, perhaps.

6524. It is very satisfactory to hear what you do with regard to visits. The Commissioners see every patient, and then do they go over the premises?—Yes, they go everywhere.

6525. And they look at the diet?—Diet, and the buildings, and they recommend certain things to be done, and so on.

6526. Of course, in the case of persons in your institution no trouble will arise as regards clothing; I suppose they have their own clothing?—Not the ex-service patients; I supply them with clothing.

6527. But the ordinary patients will have their own clothing?—Of course; they do their own shopping, and buy it in the town mostly.

6528. Except in cases where they are destructive of their clothing, and there you have to deal with them specially?—Yes.

6529. But in the ordinary case a patient entering your institution naturally keeps his or her own clothing?—Yes.

6530. Will you tell us about the hours of rising and going to bed, because we have heard something about that in some of the institutions. Have you a programme for the day?—We have not a set programme. Some of my patients sit up to ten, eleven, and sometimes twelve, playing bridge, and so on. We have no set programme. In some wards you must have, where they are refractory patients.

6531. Tell us about them. Where you have to have a disciplinary time table what is that time table?—They usually go to bed about 7 to 8 o'clock, those patients.

6532. And when do they get up?—About half-past seven to eight in the morning. You see with difficult patients you have to have some little routine of that kind. Each of the patients has to be undressed by the nurse, and that takes time if she has 10 or 12 patients to put to bed, and some voluntarily go to bed much earlier.

6533. It seems rather a long time to be in bed without food, does it not?—I think it is a part of the treatment; I think the more rest they get the better, especially patients suffering from acute melancholia; rest is advocated.

6534. Do you not think that the interval is rather long between meals? I suppose they have dinner in the evening—or is it supper?—Yes.

17 December, 1924.]

Sir CECIL CHUBB, Bart., LL.B.

[Continued.]

6535. Supper which is before seven, and breakfast about eight?—We do not get many complaints of that.

6536. Now as regards the visitation by the justices under Section 193, which I have before me, there is provision again for visitation of your house by visitors appointed by the justices, again at any time, day or night, so that you may have an entirely unexpected visit at any time?—Yes.

6537. Then there is provision that there shall be stated visits, not stated in point of time, but obligatory visits four times a year by not less than two of the visitors, of whom one shall be a medical practitioner, and twice a year by one or more of the visitors; that means that you get six visits, I suppose, does it?—In practice that is not so; we get four visits from the justices; but the medical visitor is there, I suppose, two or three times a week.

6538. Now in the case of the justices do they carry out the same kind of inspection as the Commissioners?—Yes, with the exception, of course, that they do not do it quite so thoroughly as the Commissioners.

6539. And they are more familiar with the institution, because they are there more frequently?—Yes, and they walk through each ward and give private interviews to patients, and talk to them if they are asked to.

6540. With regard to the medical practitioner who must be one of the visitors, is he an entirely outside and independent person?—Quite so, yes.

6541. Is he selected by the justices themselves?—Yes, he is selected by them.

6542. Do you find that the patients frequently want to talk to that outside doctor?—Very often, yes, but they rather talk to the Chairman. He is rather a nice man and very popular, and he is pleasant, and so on.

6543. But the doctor is always at hand if they wish to see an independent medical man?—Yes.

6544. Does the independent medical man have interviews with them sometimes?—Yes.

6545. There are very full instructions given as to what is to be done, both by the visiting Commissioners and the justices, in Section 194, what they are to do on their visits, and so on. Have you any suggestions to make with regard to further instructions to them, or do you think the present instructions are adequate?—I think they are quite adequate; in fact, as regards the Act of 1890—I do not see in my experience how it is going to be improved upon; it is a very wonderful Act.

6546. So far as the licensed houses are concerned?—It is a bit hard on us.

6547. It may be a little rigorous, but at the same time the provisions seem clear; you do not find difficulty in working to those provisions?—Not a bit.

6548. Then there is provision made for the entering of the reports and the results of the investigation which are available, and you are under obligation to show every part of the premises?—Yes.

6549. There is a special injunction, I observe in Section 197, to any of the Commissioners who visit a licensed house licensed by justices, not licensed by themselves, to "carefully consider and give special attention to the state of mind of any patient, as to the propriety of whose detention there is a doubt, or as to whose sanity their attention is specially called, and shall, if the state of mind of such patient is considered doubtful, and the propriety of his detention requires further consideration make and sign a minute thereof in the patients' book." It would be interesting to know if you have had any instances of that?—Yes, many. Friends write to the Commissioners and ask them to give a special interview to one of their friends. They have those in a book when they come down, and they see them and go into the question of sanity with the doctor, as to whether the patient is convalescing or not.

6550. Do they then after their investigation make a minute in the patients' book of their visit?—Yes, they do, in the patients' book.

6551. Do these special inquiries, directed to a particular patient, arise in practice generally from relatives or friends?—Yes, generally, and of course it

may be a case that the Commissioners have drawn special attention to before, on their previous visit; then they would see him again to see if he had improved still further.

6552. As a result of such inquiries into special cases, have you had any large number of discharges?—No, not very many. Some few we have sent away on leave of absence, on trial for health. That is what generally happens in the case which you are considering now.

6553. You give them an experimental period of leave?—Yes.

6554. But as the result of such inquiries, in your experience in the last 14 years, have you had any cases in which the Commissioners have been satisfied that the person was a sane person who should not have been detained?—Never; not one.

6555. That has not resulted from any of the inquiries?—No.

6556. Although there have been a number of such inquiries?—Quite so.

6557. On the other hand, you tell us that in some of the cases it has been thought desirable to give leave of absence as an experiment?—As an experiment, yes.

6558. In consequence of that experiment, have a certain number of patients effected recovery?—A certain number have not returned, but a great number have.

6559. Apart from a special inquiry such as is referred to here, do you use your power of giving leave of absence of your own initiative?—Frequently, yes.

6560. Do you find that a useful provision at the stage of convalescence?—Very useful indeed; of course it gives the patient time to realise his responsibilities of life; after being in an institution for some months, naturally he is a little unused to the outside world.

6561. The transition must be difficult?—A little difficult for the patient.

6562. And while he is on leave you have a hold on him, and he is certified?—He is still under certificate. Of course in a recent case, as you know, there was much confusion of thought as to leave of absence on trial for health, and the learned judge took the view that a patient on leave of absence was really decertified, and that the medical superintendent should go and get him back if he were to come back. If you have 10 or 12 patients away on leave of absence, your medical superintendent would be careering up and down the country the whole time and bringing these people back; which I should deprecate very strongly, because a medical superintendent is not a policeman to go and bring the people back to the asylum. You want the patient to have great confidence in his medical superintendent.

6563. Now the patient on leave, as you have pointed out, is still under certification, therefore you are still in a sense detaining him—I mean you still have control over him?—Yes.

6564. While he is away, no question would arise with regard to any of your patients, who are all private patients, as to maintenance. Presumably he will be sent back to his home?—Quite so, yes.

6565. Suppose the trial is unsuccessful; suppose he felt himself unfitted to cope with the world again, and the experiment has really failed, what happens in such a case?—The friends bring him back. They write to us, as a rule, and tell us he has not improved, that in fact he has got much worse, and will we receive him back? Of course we do; he is still on our books.

6566. But whose duty is it to bring him back?—I think it is the duty of the friends myself.

6567. You may, of course, get a medical certificate from the personal medical attendant of the patient who is seeing him when he is on leave?—Yes, we always like that, but usually the friends know, naturally.

6568. Let us assume the leave is expiring; you have not heard any report about the patient on

17 December, 1924.]

Sir CECIL CHUBB, Bart., LL.B.

[Continued.]

leave, you may get a medical certificate that he has recovered?—Quite so, then he is discharged from the books.

6569. Do you allow his case to lapse, so to speak?—He is actually discharged.

6570. Do you see him again, or, rather, does your medical superintendent see him again?—Perhaps they come to the asylum just to see him personally.

6571. But he may not come back to the asylum at all?—Oh no.

6572. The leave may end in two ways, it may end either in the patient having unfortunately to come back because he has not recovered, or in simply passing into the general population again as recovered?—Yes.

6573. Suppose the period of leave has expired, he has not come back, and you have no word of him. How do you treat the case then?—Discharge him. We write to the friends naturally, we always do that; and if they say the patient is very much better, then we discharge him practically as recovered.

6574. But suppose he has not recovered and is not discharged?—Then we extend the leave.

6575. Is he not treated as a person who has escaped at the expiry of the period of leave?—No, we can extend the leave, as you know.

6576. *Earl Russell*: Do I understand that you extend it without any real information about him, either from the friends or the doctor?—We get information at the end of the leave from the friends about him, and then if he is very much better we can advise the friends whether we shall discharge him as recovered, or whether we shall extend the leave; we do which they like.

6577. You have no case in which you do not hear at all?—No, very seldom.

6578. What would you do if you did not hear at all?—If we could not get hold of the patient, of course he is discharged.

6579. *Chairman*: Automatically?—Automatically.

6580. He is really an escape in that case, is he not?—Yes.

6581. Because he is still under your charge, and you have lost him? That really is the position, is it not?—Yes, that has happened.

6582. And does the period of 14 days run from the expiry of the period of leave in such a case?—Yes.

6583. Have you 14 days after the expiry of the leave in which you can bring him back?—In which we can recapture him if we want him; we never do.

6584. *Earl Russell*: You never send out your attendants to fetch a patient back?—Not under those conditions. We had a case a few months ago; he was a man who had means of his own, and his leave expired, my medical superintendent went to see him—he asked him to—and when he had got there he had gone, and of course we had no other course but to discharge him within the 14 days.

6585. *Chairman*: It seems a little indefinite at that stage, if one may say so. I quite appreciate the arrangement. A patient goes out on leave for a stated period and is still under your control, in this sense that he can be brought back without re-certification?—Yes.

6586. You treat the responsibility then as being with the relatives?—Yes.

6587. Just as the responsibility for originally bringing him under your charge was with the relatives, and the power to discharge from your institution is with the relatives all the time, so you regard the duty to bring him back, if he has not recovered, as reposing in the relatives also; that seems to be the scheme of the thing?—That is the practice.

6588. We are not dealing with pauper patients, we are dealing with patients who have been introduced into your institution through a reception order obtained by relatives?—By petition.

6589. And these relatives are persons with an obligation to visit the patient while with you, and they also have the right to obtain the discharge, whether the patient is recovered or not?—Yes

6590. So that you regard the case as one in which you have given the patient temporary leave of absence to rejoin his friends, and you treat his friends or relatives as the persons who are responsible during that period?—Quite so.

6591. Then if he comes back at the end, he simply resumes his place in the life of your institution?—Yes.

6592. It being the responsibility of the relatives to bring him back again?—Yes.

6593. Then if, on the other hand, he does not recover, you expect to receive a report from the relatives?—Yes, or from their doctor.

6594. Then there is a third case, that a person simply goes away on leave, and you hear nothing more at all, and that you tell us is a rare case?—A rare case. I cannot extend the leave, because I have no request to do so.

6595. On the expiry of the term of leave if you have heard nothing, and if the patient does not turn up, then you proceed to discharge?—We have that 14 days, and then we proceed to discharge him.

6596. But you do not regard yourselves as having any duty to recover him, or to take active steps to recover him.

6597. *Earl Russell*: If his release is a danger to the public, you regard the responsibility for that as resting on the petitioner and not upon you?—Yes.

6598. *Chairman*: It is quite consistent with the position of a private patient?—Yes. Of course that section about the escape of a patient and recapture did not contemplate this case which we are considering now.

6599. You might develop that a little, because it is rather an interesting chapter of the law, the treatment of the escaped lunatic?—The question of escape is the escape of a man who is really mentally bad.

6600. Rather than the case of a person out on probation?—Yes. I do not think when that section was drafted that was contemplated in the least.

6601. You have, I observe, a suggestion to make on the subject of this provision?—It is only to get an extension of time; that section should either be cut out altogether, or the time made longer.

6602. It is Section 85?—Yes.

6603. That is the provision dealing with escape and recapture?—Yes. You see you may have a patient escape who has homicidal tendencies; at the time of his escape he may be fairly lucid, and I think it would be a great danger to the public if that man were not recaptured.

6604. Oh, clearly?—And therefore why 14 days?

6605. We have 28 days in Scotland, you know; I do not know why there should be that difference?—They thought the same, perhaps, as I do. You have many things in the Scottish law I believe that would be an improvement on ours, especially about the specially appointed justice.

6606. One does not very much like the language of escape and recapture, which heads this series of sections; it does suggest the idea of incarceration, which is the element one is so anxious to eliminate from this code of law?—Quite so; it really looks as if they were criminals.

6607. Yes, the language is unduly threatening. What it really means is this that a person who is mentally ill at the time, really as an incident of his illness has gone out, just as a person might in delirium arise from his bed and walk out, it is in itself a symptom of the ailment?—Yes; I often get ladies and gentlemen who go home and I get a wire to say: "We are home to-night, and will be back to-morrow"; they have perhaps some irresistible impulse to go home and see their friends.

6608. However the whole provision seems inapplicable, a little arbitrary so far as it relates to the particular case of a patient out on leave. You would like us to consider that aspect of the case, and what is to happen at the expiry of the term?—Yes; I think the onus should be on his friends either to ask us to extend the leave or discharge him.

6609. My attention is drawn to Section 55, subsection (8) which deals with this case: "If a person

17 December, 1924.]

Sir CECIL CHUBB, Bart., LL.B.

[Continued.]

allowed to be absent on trial for any period does not return at the expiration thereof"—that is the person we are thinking of?—Yes.

6610. "And a medical certificate certifying that his detention as a lunatic is no longer necessary is not sent to the visitors of the asylum or the manager of the hospital or house, he may at any time within 14 days after the expiration of the period of trial be retaken as in the case of an escape." That is permissive, you observe, there is no obligation. It does not say "shall be captured," it is merely that you may retake him?—Yes.

6611. In practice you do not retake him—is that it?—That is the practice.

6612. Of course, Lord Russell's point arises. Suppose you know that this person, although sufficiently recovered to be allowed out on leave, is a person who ought to be under some care or control and he has just disappeared, is he left at large, so to speak?—We strongly advise the friends what to do.

6613. In fact, you use the friends as the vehicle of the control while he is out of your establishment?—Or the doctor or his medical attendant.

6614. *Earl Russell*: Have you known cases of a single man of sufficient property who does not happen to have friends and relations to look after him?—Yes.

6615. Who would you deal with in that case?—With himself.

6616. *Chairman*: Of course, there always has to be somebody who is responsible, because the petitioner must be a relative, or some person who is interested in the case and who must explain why it is not a relative who is applying?—Quite so.

6617. Then there is provision in the statute for the substitution of some person for the petitioner if the petitioner is remiss in any way in attending to the case; so there is always in the eye of the law some person who is known to you, and who stands in the position of the petitioner?—Yes. If we can get at no one else it is the person who made the last payment, and he can demand his discharge in the same way as the petitioner.

6618. *Earl Russell*: That may be a solicitor in Lincoln's Inn; you do not expect him to run after a patient?—It often is a solicitor.

6619. *Chairman*: What happens in that case? You can hardly hand the patient out on leave to the solicitor, can you? I mean *ex hypothesi* he has not really got any family circle.—What the solicitor would do in that case, if we recommend the patient to go on leave of absence is, he would get someone to take charge of that patient.

6620. He would get an attendant for him?—Perhaps an attendant, or in some little private home, whatever he considers best.

6621. And would no doubt arrange for medical attendance?—No doubt he would. Of course, that is really not my business.

6622. No, but it is interesting to us to see what happens to the person. You have this responsibility for him that he is still a person on your books, still certified, and with regard to him the legislature has given you power to recapture him if you have no medical certificate of his recovery?—Yes, and also if he commits suicide, it is suicide in the asylum.

6623. For which you would be responsible?—Yes.

6624. May one take it that the class of person who is so bereft of family support and surroundings is rare?—Very rare indeed; there are always some friends about. Of course, many patients have receivers.

6625. That is for their property?—Yes, and, of course, they act in the position of a petitioner very often; very often the petitioner is the receiver.

6626. Have you any patients who are so found by inquisition?—I think one or two, yes.

6627. And they are visited, of course, by the Lord Chancellor's Visitors?—Yes.

6628. And do the Lord Chancellor's Visitors also visit those patients in whose case a receiver has been

appointed?—I do not think they do. It is the official solicitor I look to in that case.

6629. In the case of your institution, of course, all the patients will have some means?—Oh, yes, or their friends. Some have not. I have got some there who pay nothing, one or two. I am doing charitable work as well as the registered hospital.

6630. Some cases are taken either on special terms or gratuitously?—Yes.

6631. But that is a pure piece of philanthropy?—Yes, I feel for some people. They want to come to my institution, and if they do not come to me they must go to a rate-aided institution. Perhaps you would like to know about my fees?

6632. Yes, we might.—The average fees paid in my institution are £2 14s. 9d.—that is the average for the whole of my patients. There are 357 people who pay less, or up to two and a half guineas a week. For that sum I have to find doctors, nurses, attendants, and every necessary of life, and in 40 per cent. of those cases I have to find clothing, so mine is a very low paying institution in a way.

6633. I was going to say I wonder how you manage to budget on that basis?—I am supplying a demand in the country for these patients there is no doubt, and the patients are very grateful for the treatment they get with me for those fees.

6634. What is the maximum fee you charge?—Yesterday I was rather amused about what you call the good-paying patients. That does not arise with me. I have two paying fairly high fees, and they have their special nurses and attendants, but the average is £2 14s. 9d., and 357 at £2 12s. 6d. or under, so you see I have very few high paying patients. Some pay five guineas, some four and some three, but those are very few in number.

6635. Your budget must be rather difficult, I should think, if you have to pay considerable rates and taxes. You are not a charity, and therefore you are not exempt from rating and taxing in any shape or form?—The registered hospitals charge much higher fees than I do, and of course they are in a way charitable. I suppose out of my total number there are 100 paying two guineas, some paying less, and one or two paying nothing.

6636. I should be surprised to hear that your Company pays any dividend?—Oh yes. Of course I run with the institution farms on which I grow most of the produce, the potatoes and the vegetables, and milk, eggs and poultry, and so on.

6637. You are able to market your surplus?—I am my own market. I am my own middleman.

6638. As we know now that is a very important thing?—That is why perhaps I can do it more cheaply than anyone else.

6639. Have you any surplus in the way of produce you can market outside the institution?—Wheat, of course. I used to have my own mill and I ground my own wheat; I have given that up now.

6640. You work this market garden and farm in association with the institution?—Yes, and many of my patients go out to work in the gardens.

6641. How much land have you associated with the Manor?—At the present time it is 350 acres, but I have just bought another place which is 1,100 acres, so I shall have a bigger farm, and I may revert then to my old practice of growing my own wheat for flour.

6642. That, of course, would enable you to get a large amount of your produce without any middleman's profits?—At cost price, yes.

6643. You have your dairy, I suppose, and supply yourself with milk?—Yes; I do sell surplus milk. When you have 70 or 80 cows, of course you do not want all the milk.

6644. In this connection you might tell us what is the number of your staff. You have got a medical superintendent?—I have four on the medical staff, and all those are engaged with the mental condition of the patients. I am the manager as regards food supply. In many institutions the medical superin-

17 December, 1924.]

Sir CECIL CHUBB, Bart., LL.B.

[Continued.]

tendent is really engaged in administrative work. One of my doctors is a lady doctor.

6645. So you have three men and one lady doctor?—Yes.

6646. What nursing staff have you?—We have about 60 staff—I am not including ward maids; there are 24 male and 36 female nurses; it varies round those numbers. And, of course, you must look upon my outside staff as more or less attendants, because they take patients into the garden, and the patients engage in carpentry and other work.

6647. *Earl Russell*: That is a thing I am rather interested in—you have patients whom you can allow to use sharp tools with safety?—Yes. We have to be careful in choosing those patients, naturally.

6648. And also careful that the tools do not get missed?—Oh yes. Of course to-day with 109 people allowed to go into the town they can buy things they want; we have to take certain risks to-day to cure our cases.

6649. Do the men shave themselves with ordinary razors?—Some do, those that we know; we have patients who have been there a very long time. I had a patient die not long ago who had been in the institution 61 years, and there is one now, a dear old man, who has been there 50 years.

6650. *Chairman*: Will you tell us a little about the conditions of your staff, because that also has some relation to our inquiry, of course—the efficiency of the staff, the prospects of the nurses and the attractiveness of the profession are subjects on which we should like to hear you?—We have lectures weekly, given by the doctor to the nurses for the Medico-Psychological examination.

6651. Do your nurses all go in for the examination?—Not all of them; they have not perhaps the ability to take that examination, because the Medico-Psychological final examination is a very difficult examination indeed, and some of my best nurses could not pass it, some nurses I would not be without, and I would not discharge them on account of their having no Medico-Psychological certificate.

6652. There are people who work exceedingly well but who are very bad at examinations, as we all know?—Quite so. I am sure one of my best nurses would never pass an examination; she would pass the first part of the examination, but not that second part where you have to go into the question of enzymes and all these wonderful things which they give in examination papers to-day.

6653. What about the remuneration of your staff?—It is about the same as other institutions, you know. The probationary nurses start at somewhere about £30, and they work up to £60 and £70.

6654. Do they all live in?—Yes, in the institution.

6655. The whole of the staff?—Yes.

6656. Are none of your men married?—One or two of the night attendants are married—of course they live out; I had forgotten that for the moment.

6657. Have you any views as to the desirability of mental nurses having, either before or after their period in a mental hospital, some training in general hospital work?—That is really a medical question.

6658. If it is not really within your province we will not trouble you with it?—I should not like to express a view upon it.

6659. It is really more within the medical superintendent's province and we have some evidence about it already. It is just a question whether facilities should not be provided for nurses having general experience as well as specialised experience. I quite see that is not perhaps within your province?—Of course they get a good deal of general experience in an institution such as mine, because we have many physical ailments as well as mental, naturally.

6660. And very often a mental disturbance may be associated with some physical ailment?—Yes, especially in cases of general paralysis of the insane, and that sort of thing.

6661. It would therefore be desirable that nurses who have charge of the mental cases should also have some experience in general nursing?—Yes.

6662. One must remember that in mental institutions there is a certain amount of ordinary illness as well as the special illness for which the patients are confined?—And much more really, owing to the mental state of the patient.

6663. Therefore one must not assume that mental nurses are engaged solely in mental nursing, but they also have general experience inside the institution?—Yes.

6664. Have you in your institution provision for what one may call the medical, as apart from the mental treatment of cases?—You mean as regards consulting?

6665. Yes?—Yes, I have a consulting surgeon.

6666. Does he frequently visit?—If he is asked for the purpose of diagnosis.

6667. Suppose, for example, a patient in your institution showed symptoms of appendicitis and an operation was indicated, have you an operating theatre, or what provision have you for operations?—We have a room we use as an operating theatre, and I generally get our consulting surgeon to come and do the operation, because he is doing perhaps 200 or 300 a year, and I like him to do it because he does it quickly and expeditiously; and, as you can understand, an asylum doctor has not the chance of having that practice.

6668. What provision have you for attention to the teeth of the patients?—We have a visiting dentist.

6669. How are those persons whom you call in, the consulting surgeon or the dentist, remunerated—by fees charged to the patients?—Yes, I tell them that I will get the fees I can for them from the patient, as most of my patients are not very well off; they cannot afford a high fee for an operation, so sometimes an operation is done for as low as five guineas. I make that arrangement with my consulting surgeon.

6670. And you would have one at Salisbury, no doubt?—Yes, a very good one.

6671. I see you have considered the general question of policy as to the differentiation between the private patient and the pauper patient, and you have a view to express upon that?—Yes.

6672. What is your feeling on that subject?—My feeling is that the rate-aided patient should have the same advantage as the private patient of two medical certificates. As you know in the rate-aided form there is no petition, one medical certificate, but the justice signing the reception order must personally see the patient; whereas in the case of a private patient there must be a petition and two medical certificates; but the magistrate giving the order need not see the patient.

6673. Although there is a right to the patient to be informed within 24 hours of his reception that he may within seven days see a judicial authority?—Yes; we have to give the patient notice within 24 hours, and give him a form of request whereby he can exercise his right, but that is a real farce, I think.

6674. *Earl Russell*: Do you find in practice that patients come in without the justice having seen them?—Yes; I have something to say upon that later.

6675. *Chairman*: Then you are in favour, I take it, of an assimilation between the two cases?—I think they should be made uniform, because it is possible now, as you see, to get a patient into a licensed house on the rate-aided form, that is by one medical certificate.

6676. How is that done?—In this way: he can be sent to a public asylum; then the friends say, "We will have him transferred to the private class by giving notice." Then under Section 59 he can be sent on to me by transfer.

6677. So, in effect, he reaches you on the machinery of the Poor Law?—Yes; it is a point which, in regard to making the practice uniform, it would be wise to consider.

17 December, 1924.]

Sir CECIL CHUBB, Bart., LL.B.

[Continued.]

6678. We have been impressed by the divergent methods by which persons reach institutions for the insane, and it is undesirable that the methods should be so diverse, if they could be brought to a basis of uniformity. On the question of the double certification we must, of course, have some regard to the question of expense?—You must have, yes.

6679. And it may not be so important in the case of the private patient, but in the case of the rate-aided patient one has to consider that the second certificate means a doubling of the cost?—It is very important to my mind, because if you are going to give a reception order, and you are going to take away his liberty, I think he should have the advantage of certificates by two medical men. The two separately may not give the certificate.

6680. We are all at one upon this that there is no reason why one class of person should require two medical certificates and another class of person should require one, but we are concerned to consider whether two medical certificates are necessary in all cases; and this had occurred to some of us as being the possible solution; that there are many cases as to which there can be little or no dubiety, but where any doubt was entertained, either by the single doctor or by the judicial authority or justice, then either the medical practitioner, or the certifying authority should be entitled to call in a second or, if you please, any number of opinions, if the case was one of difficulty. Whether that would meet the point or not it is difficult to say. It has the drawback that it would leave it to the discretion of the single doctor, or of the certifying authority, to decide whether it was a difficult case or not?—Yes. Of course the rate-aided patient has a great advantage over the private patient really; the magistrate has personally to see him.

6681. I notice that you attach much importance to that?—I do, yes.

6682. It seems, again, an odd anomaly that in the case of the rate-aided patient he should have the better of it, because he must be seen by a certifying justice, whereas the private patient never need be seen by a representative of the public?—Quite so.

6683. Let us have your views on that topic?—If the magistrate who gives the order has not seen the patient he says so at the bottom of the form. It is our duty then in the asylum to give the notice of the right whereby the patient can demand to see a judicial authority, and a form of request whereby he can exercise that right. Of course, if you get a patient in a state of acute mania, or a very depressed melancholic patient, he does not take any notice of the form.

6684. I should also have thought that it was exceedingly inexpedient to bother a patient in his first days in an institution with notices?—Yes; he says: "Take the thing away."

6685. Then you have to go through certain formalities?—Yes, and it has to be a different judicial authority.

6686. It is all done under Section 8. In 24 hours the matter requires your attention, because you have in 24 hours to make up your mind whether he is a patient who ought to receive a notice in writing or not; is that your problem?—He must receive it. If he has not seen a judicial authority we always give them the notice.

6687. But notice this, Sir Cecil: "The patient shall have the right to be taken before or visited by a judicial authority, other than the judicial authority who made the order, unless the medical officer of the institution, or in the case of a single patient, his medical attendant, within 24 hours after reception, in a certificate signed and sent to the Commissioners, states that the exercise of such right would be prejudicial to the patient"?—That is in the case of a very acutely maniacal patient.

6688. Still one has to see what are the stages to which your attention is directed by the statute, and the first topic is: is this a patient to whom it would be prejudicial to give such notification? The medical

superintendent must address himself to that question first of all. Having first decided he is a person who could receive a notice, then the manager of the institution must within 24 hours give a notice, and then again the patient has to be told that he has got seven days after his reception in which to make up his mind. He ought to be considering about his recovery by that time, but this is put to him, whether or not he is going to exercise his right. Then if he does so declare, you have got to go through, or the manager has got to go through, certain procedure giving notice to the judicial authority?—Giving notice to the clerk to the visiting justices, who then brings up a judicial authority to see the patient.

6689. It does seem rather odd that a person who has *ex hypothesi* been certified, and must therefore at least be a person of disturbed mind if not completely insane, has to be addressing himself in the first seven days to the question of how he is to deal with a notice, which has been served upon him by the manager of the institution at which he has arrived?—That would be avoided if the judicial authority saw the patient.

6690. Therefore, would it be better if it were made obligatory in every case for the person who is responsible on behalf of the public himself to see the patient?—I have got that recommendation here. The reception order can be made either by a County Court judge or a stipendiary magistrate, or the judicial authority appointed under the Act. The County Court judges and stipendiary magistrates, in view of their position, are men competent to give this authority, in my opinion, but that does not necessarily apply to the specially appointed justice. There are many thousands of these officials in the country, as you know, to-day, and to the best of their knowledge and ability they have performed their duties well, but a lot of these men are people engaged in business, and they have not the time to look up the complicated sections of the Act dealing with procedure on petition, which they ought to do, and they cannot properly digest all the information contained in the papers; and many of them do not know whether they are justices specially appointed or not. Surely, if a judicial order is the essential element in the detention of a patient, the man making it should be at least competent to know his duties. I think you will agree with me.

6691. Certainly.—And, of course, if he does not see the patient then the patient has that right to demand to see a judicial authority. Then supposing one comes up, he makes a report to the Board of Control; the Board of Control has to give effect to his report; that is, if the judicial authority says that this patient is, in his opinion, not insane, I think the Board of Control have to discharge that patient.

6692. The Act provides that the Commissioners shall take such steps as may be necessary to give effect to the report?—It has occurred that where a patient has gone out on a justice's report (not in my time I might say) he has committed suicide within two or three days, and that shows that the judicial authority, in my opinion, should be a man who not only knows a little about the Lunacy Act, but he should be a medical man who has some knowledge of mental disorders.

6693. Pause a moment there, Sir Cecil, remember the first part of your suggestion. We appreciate that he should be a person conversant with the Acts; but surely it is not desirable that he should be a medical man, because he is a person who is to proceed upon medical evidence which is adduced to him. Is it desirable that the justice himself should have his own professional equipment?—There are many doctors who are justices.

6694. I should have thought it was desirable there should not be a third doctor in the matter, but there should be rather a person, I will not say not affected by medical predispositions of any sort, but simply representing the judicial element, and who would proceed upon the evidence of the medical practitioner?—Yes, and I think the patient ought to be seen by the justice; he is giving the order for reception.

17 December, 1924.]

Sir CECIL CHUBB, Bart., LL.B.

[Continued.]

6695. It was the addendum to your observation that I was venturing to question, the desirability of the justice himself being a doctor?—Perhaps I want to make it too safe for the patient. What the public object to is certification, of course.

6696. Improper certification?—Yes, improper certification, and I think we should use every means in our power to see that the certification is proper.

6697. Surely. The only comment I would make is that I do not, as at present advised, think it would be judicious that the judicial authority should have a medical qualification, because I think it is much better that he should have a legal qualification, and be able to weigh the evidence of other persons in the shape of the medical certificates?—Yes, I think those should be read very carefully.

6698. *Earl Russell*: If you appreciate the point the Chairman is making, he wants the justice to act as a judge and not as a witness?—Of course the judicial order is not in a sense a proper judicial order, is it? Because after the justice has given the order the friends of the patient can tear it up, and they need not bring the patient to the asylum at all. Therefore it is an authorisation to us to receive the patient.

6699. *Chairman*: That is perfectly true. Still it is judicial in this sense that the judicial authority in the case of the private patient is the representative of the outside public?—Yes.

6700. He is the person who is the vehicle, so to speak, of the view of the public upon the case, and we have had evidence from people who do this work that they occasionally do not accept the medical evidence before them on the certificates; they have seen the patient and they say: "We want more information"—so that it is not entirely a formality?—No, it is not a formality.

6701. You would like it to be much less of a formality by requiring the justice or the judicial authority actually to see the patient as a layman as distinct from a doctor, to consider the case on its merits with the assistance of the information derived from the medical certificate, and with the right to call for the doctor to explain it to him?—That is what I should like to see.

6702. Of course, in Scotland it is done by the sheriff, who is a professional man?—Yes, and the order is really a judicial order in the proper sense there.

6703. One has to remember that the whole judicial system of Scotland is rather different; the justice of the peace does not function in Scotland to anything like the same extent as he does in England. We are really dealing with a different system?—Of course, often in getting certificates, as you know in practice the justice says, "Well, am I right in signing this?" You cannot expect them to know the complicated sections of the Act and to go through all these papers.

6704. *Earl Russell*: Are they not advised by their clerk when they are engaged on this duty?—No. Of course, my point in bringing that up is to make the reception of the patient, I might say, rather difficult. The receiving institution has nothing whatever to do with obtaining the reception order.

6705. *Chairman*: No; that has all preceded the arrival of the patient at your institution. You are for the moment criticising the preliminaries of reception?—Yes.

6706. You are criticising it from the point of view of the adequacy of the machinery?—Yes.

6707. And that is, of course, a matter with which we are deeply concerned, because we are concerned with the safeguards against improper detention. We should like to know whether in point of fact you have found that the present method, whether good or bad, has resulted in persons being brought into your institution who should never have been there; because the proof of the pudding is in the eating of it, and one would like to know whether the system has resulted in persons arriving at your institution with an authorisation for their

reception who, in your view as a layman like ourselves, should not have been there. Has that case ever occurred?—It has once or twice; my doctors have refused to receive a patient. It may have been a mistake in diagnosis. For instance, you get a patient with delirium tremens, and a practitioner might mix it up with insanity for the time.

6708. But I would like to pursue that topic for a moment. You say on one or two occasions your medical superintendent has been of opinion that the case was not appropriate?—Not my present medical superintendent: I am speaking of the one I had before; he asked me to go and see a patient with him because he had doubts, and, of course, we did not receive the patient.

6709. Not at all?—No. He was alcoholic—I mean he showed it. That happens at times, of course.

6710. But suppose a person arrives with due authorisation, and the reception order is addressed to your institution. Are you not bound to receive him?—I do not think so.

6711. I would have thought you would have received him, and then taken advantage of the various provisions which are contained in the Act for bringing about his discharge?—Yes—tell the friends, "You had better take him home and nurse him."

6712. That is to say, really he is discharged?—Really, yes.

6713. Of course, one has to remember this, that these states of mind may be very transitory?—Very.

6714. Therefore the medical practitioners who have examined the patient and certified his insanity may have seen the patient at a time when all would agree he was insane?—Quite so; that does happen very often.

6715. But when the patient arrives at your institution possibly two or three days after the patient has been seen by the medical practitioner, he may have recovered his balance and you may say the man is perfectly sane. That is no reflection on the issuing of the certificate?—No; I do not wish to make the least reflection on the doctor's certificate. He gives a certificate at the time he sees the patient, and no doubt the patient is really insane.

6716. That is not a reflection on the existing code, because the certification was perfectly proper, but it was spent in this sense, that the patient had recovered, and discharge is the proper remedy for that?—Yes, but with regard to that reception order, I think the person signing it should be a competent man, and should personally see the patient. I want to insist on that.

6717. The seeing of the patient could be readily achieved by making that obligatory. Then the mental competency of the justice or judge is a matter which no man can control?—No, but do not you think he should get into contact with the doctor, and not rely solely upon the medical certificate? We must remember we are taking away the man's liberty in a way.

6718. That is what we fully recognise.—It is only a suggestion on my part.

6719. But in the two or three cases to which you have alluded in the past experience of your institution, where the propriety of the detention of a patient has arisen at the outset, could you tell us whether these were cases where there should never have been certification at all, or cases in which certification may have been justifiable but the patient had recovered? Could you tell us which category the cases fall into?—I have never had one as regards private patients. The case I quoted you was a rate-aided case from a certain borough.

6720. I do not want to be critical of your suggestions; but if that was a rate-aided case, then the only case you can recall which has occasioned you doubt is a case where the justice saw the patient?—Yes, it is odd.

6721. Does it not rather reflect upon your suggestion?—No, I do not think so; it is a matter of principle.

17 December, 1924.]

Sir CECIL CHUBB, Bart., LL.B.

[Continued.]

6722. Of course, one recognises this, that it may be desirable to have safeguards which may be superfluous, if they are none the less reassuring to the public, if one may so put it?—Yes.

6723. I think that takes us through the first group of your suggestions?—With the exception of the urgency order.

6724. What have you to say with regard to the urgency order which at present may be granted?—Lord Halsbury in *re Cathcart's* case in 1893, 1 Chancery, 475, laid down there that the urgency order should be used only where instant intervention is required. As you know, Section 11 is the urgency order. Under the section an urgency order can be granted where it is expedient, or in the public interest, that a person be detained. It can be signed before or after the medical certificate. It remains in force for seven days—and it must have subjoined a statement of particulars.

6725. I think the theory of that is that the reception order is a more leisurely procedure, and something may have to be done at once, and this procedure may take place either independently of or co-incidentally with the reception order proceedings?—Yes. These are the judge's words: "An urgency order is what its very name indicates. The safeguards for personal freedom, which the legislature had provided, were obviously considered inappropriate to cases where instant intervention was required, either for the sake of the alleged lunatic, or for the sake of the public; and accordingly exceptional privileges were made for such a contingency." But now in practice I think the great value of Section 11 is minimised by a too frequent use of the urgency order. It may be that it is very difficult to obtain a specially appointed justice and two medical certificates perhaps in country districts, and therefore resort is had to this, and it frequently happens that we get patients in on urgency orders on that account.

6726. What is your criticism of that procedure? What is wrong with that?—I have never known a case come in on an urgency order that would not, if they had had the time, have got the proper certificates; I must say that.

6727. *Earl Russell*: Do you say that they had the time?—You take a man in a country village—it is a difficult matter to get two medical certificates.

6728. *Chairman*: Does not that rather suggest the utility of the urgency order; that in cases where the more deliberate procedure cannot be resorted to because the facilities are not available, there should be some method in the interests of the patient of getting immediate control of him through such an urgency order. I do not quite appreciate, if I may say so, the criticism upon it, that it has to be resorted to where people cannot get all the formalities necessary for a reception order?—Then, of course, that is not the object of the section, is it?

6729. I see, you are really saying that it is being put to a purpose other than the purpose which Lord Halsbury thought it was designed to meet?—Yes, I think so; that is my only criticism on that.

6730. You have, I see, a suggestion that in place of the urgency order there should be a provisional order of short duration?—Yes, where there is no certificate, not to certify the patient; a provisional order of three days, which could be extended.

6731. Of course, that trenches upon a very much larger matter which we have under consideration, and that is the provision of a period of observation which should intervene between the case first coming to the notice of the authorities, and ultimate certification, or discharge, as the case may be. We have had a considerable amount of evidence already and shall have more, no doubt, upon that topic. Would you be disposed to favour such a system whereby patients should be for a time under observation with a limited control by a provisional certificate of some sort, pending a complete diagnosis of their case?—I should very much agree to that.

6732. Do you find in your own experience that many of your patients recover within a short period of their admission?—It is according to the class of case.

6733. Perhaps you might help us there; it is of interest to us. A period of time for observation may have to be suggested. That might be to some extent controlled in our minds by the time which in the experience of persons like yourself short cases take to recover. Have you any statistics which would tell us the periods of detention in your institution?—I have no statistics; only a general idea, of course.

6734. Let me put it to you quite colloquially: How many of your patients stay more than a month? How many go out within a month?—Not many.

6735. There are some cases?—Some, yes.

6736. Recovered within the month?—Recovered, yes, but very few. It is not sufficient time, of course, to give a case; a case of acute mania should have 16 weeks' treatment. We find after 16 weeks that the patient is very much better—practically recovered.

6737. But you do have some cases actually which are discharged recovered within a month of their reception?—We have had those cases, but they are few.

6738. Still even the few cases must be considered?—Yes.

6739. In such a case, therefore, if the patient had been under treatment for a month under some provisional arrangement, the result in that case would be that he would never have been certified at all?—Quite so, and that would be the great value of that.

6740. Then you have some observations on the discharge of patients. Will you tell us what you can on that subject?—Of course, you know the sections, viz., 49 and 72 to 83. Section 49 is a provision for any person to apply to have patients examined by two medical practitioners, and the Board of Control may order discharge, but they have a discretion under that section.

6741. Is any use made of that section?—It has been used in one case.

6742. What happened in that case as the result of the two medical practitioners' examination?—The lady was sent on trial.

6743. And ultimately discharged?—And ultimately discharged, but I might say before that took place her discharge was under consideration independently of that.

6744. Then Sections 72 to 83.—Section 72 gives the petitioner the right to demand the patient's discharge. Section 73 deals with the rate-aided patients, the authority liable for their maintenance. Section 74 gives a restriction on discharge.

6745. The barring certificate?—Yes, and then two members of the Board of Control can discharge, and three visitors of the asylum can discharge.

6746. But you may take it we know the system. What I was rather concerned with was to know whether you have any comments or criticisms to make upon the Act?—Except to say that from the foregoing, one can see that the illegal detention of a patient or an undue detention of a sane person is an impracticability.

6747. Your conclusion is that the existing code adequately safeguards the patients in the matter of discharge?—Quite so. There are so many people who can discharge them. Then there are the letter writing facilities they all have, which you went into yesterday.

6748. May I take it that your evidence and your experience, although you are not a medical man, on the administrative side, coincides with the evidence we had yesterday?—Yes, to a great degree. Speaking of the recoveries, I might say here that my recovery rate is pretty good.

6749. Could you give it us in a percentage to admissions?—Yes, I could. In the year 1923 the total percentage of recoveries, that is as compared with direct admissions—

17 December, 1924.]

Sir CECIL CHUBB, Bart., LL.B.

[Continued.]

6750. That is to say, eliminating transfers?—Yes, of course, those are generally of a chronic nature; the percentage was 31·64. I worked out my average discharges for 10 years, 1914 to 1923, and the percentage came to 37 per cent., nearly 40 per cent. of recoveries from the direct admissions.

6751. That is very good?—It is.

6752. Have you any statistics as to re-admissions, recurring cases?—I have not got them here, but, of course, we do get recurring cases.

6753. There is only one other matter I wish to ask you about, and that is the reception of the voluntary patient; we are much interested in that aspect?—Undoubtedly. I do not like receiving voluntary boarders for this reason: I think a voluntary boarder is in one of two categories, he is either an incipient case of insanity which should be treated on different lines—I think there should be institutions in this country for incipient cases, and those would be the institutions for those people to go to—or if he is not an incipient case he is generally certifiable. I do not like the practice of receiving voluntary boarders, and then getting them certified.

6754. What is the objection to that?—The patient can say to you afterwards, "Yes, you got me here as a voluntary boarder, and you certify me and detain me." It is not a nice thing.

6755. It is noticeable in the code that your class of institution, the licensed house, is the one with regard to which there is express power to receive voluntary patients. As regards the registered hospital it seems to be left to some extent to implication. But if you look at Section 229 express provision is made for the case of patients desirous of voluntarily submitting to treatment?—Yes, and I think if we go on with the receiving of voluntary boarders I must put apart a special villa or house for such patients where they can be treated really as incipient cases.

6756. Your view seems to me to be that this provision with regard to voluntary patients might be superseded by, or merged in, some more general provision for the treatment of incipient patients without certification?—Yes.

6757. Have you studied the provisions of Lord Onslow's Mental Treatment Bill?—No.

6758. As you know generally no doubt, an attempt at legislation was made there to deal with the case of persons voluntarily submitting to treatment?—As you know, if we have a voluntary boarder, and the Board of Control visits us, and if that patient has no volition, that is, he is not competent to sign the form for admission at that time, then we are ordered to certify that patient. We always then write to the friends and say that the Commissioners insist on a certification—what are their wishes—and very often the boarder is sent home because the friends will not have him certified, naturally so.

6759. *Earl Russell*: Tell me what you mean by "insist"? If you refused to do it, would they proceed against you under Section 315—is that what you are afraid of? You say the Commissioners insist on your certifying?—They insist on our certifying or discharging, because he is not a person capable of being a voluntary boarder.

6760. And there is no provision for anyone else to give consent, you mean?—Yes.

6761. *Chairman*: You first of all put forward an objection which I may call a sentimental but none the less important objection, that the voluntary boarder may be deterred from going to your institution by the suggestion that if you go there as a voluntary boarder you will find yourself certified sooner or later; and that you think would be a deterrent to persons from entering the portals of your institution. That is quite an important point to keep in mind, but let us look at it also from the administrative point of view. Do you find any embarrassment in having in your institution two classes of patients, one class of patient over whom you have complete control and whose destiny for the moment is in your hands, and another class who

are in the position of saying, "We are here as guests, and we can go when we please, and we shall go now if we want"? Do you find any embarrassment administratively from the two classes being under the one roof?—Not so much, because we put the voluntary boarders with our very best class of patients.

6762. Being a voluntary boarder one must assume he is not a violent case?—Yes, but since that recent case we have had many more applications for voluntary boarders, simply because doctors will not certify, I suppose.

6763. We have, of course, to consider, and we shall hear evidence later on the question of the perhaps not unnatural reluctance of medical practitioners to certify, but has that had actually any effect on the number of persons applying for admission as voluntary boarders?—Yes, I used to have two voluntary boarders; now there are 18, and I could receive many more.

6764. That is an interesting consequence of the case?—Yes, I always ask on the 'phone, for my doctors do, whether the case is really certifiable.

6765. Is that increase all consequent upon this recent case?—Yes, I had a doctor the other morning tell me on the 'phone that he would not certify a case for £20,000.

6766. Of course that is exceedingly unfortunate, if the existing state of the law is such as to deter doctors from certifying cases which ought to be certified?—Quite so.

6767. And has the consequence of that been in your experience that patients are reaching you under the guise of voluntary patients who would normally have reached you as certified patients?—Quite so, and I do not like the practice of having a patient certified in the institution, although perhaps it is advisable for him to be so.

6768. You do not want it associated with your institution, as I can understand. Again this objection would appear to be surmountable by the idea of the provisional period or observation period which should intervene before final certification?—Yes; that is a great point, I think.

6769. We have had impressive evidence upon that subject already, and it would seem we must add the difficulties with which you are confronted. But suppose now such a reform were instituted, is there not in your view still room and useful room, for the voluntary boarder? Take the class of person who possibly would never reach certification, who, on the other hand, is desirous of obtaining, shall we say, the shelter and the repose and the treatment which you can afford him, and in that way may possibly avoid altogether any ultimate catastrophe. Is it not rather desirable that that class of person should be catered for?—Yes, under certain conditions.

6770. And where can he be better catered for than in institutions such as yours?—Of course the question there is what is a voluntary boarder? What is his mental state? I have two or three ladies who are voluntary boarders who know all about themselves and why they are there. If you asked them to go home they would not go; they prefer to be with me. Under those circumstances I think the voluntary boarder system is all right, but to-day after a recent case we are getting patients who are not desirable as voluntary boarders.

6771. That seems to me to indicate an abuse of the voluntary system rather than an attack upon the voluntary system as properly administered?—Yes, perhaps so.

6772. A person, for example, who may feel that he or she is temporarily unstable and desires the shelter of an institution for a time, but who may not even be an incipient case in the technical sense of the term, should have the advantage?—Those cases I should take at once, naturally, so long as the man reads the form for a voluntary boarder, the same as you were handed yesterday, and so long as he

17 December, 1924.]

Sir CECIL CHUBB, Bart., LL.B.

[Continued.]

knows what he is signing, and also knows that he can leave by giving 24 hours' notice to the medical superintendent.

6773. That is the typical voluntary boarder?—That is the typical one, yes. We have 18 now, and they are very nice people indeed and give us no bother.

6774. Your criticism is rather against the voluntary system being used as a substitute for the more regular system?—It is really. It is not that I want to increase the number of insane people. I want to have a safeguard.

6775. *Earl Russell*: Would you also be against it in the case of rate-aided institutions for old chronic cases which are quite harmless?—No, I would agree there, strongly, because those institutions have, no doubt, certain wards where the patients would be very happy and contented.

6776. *Chairman*: Do you have classification to any extent in your institution?—Yes, a good deal of classification, because we have a number of different houses where we can classify them.

6777. And no doubt you would approve of classification as far as possible?—As much as is possible.

6778. Is there anything in the point that classification may be carried too far? Suppose you classify out all the melancholic cases, so to speak, and congregate them all in one of your detached villas, I should imagine it would be a most depressing place?—Yes, most undesirable; we do not classify to that great extent.

6779. What is the principle of your classification; what guides you in arranging the residences of your patients?—Whether a patient is destructive or violent or perhaps the language is rather undesirable, and so on; that is one classification.

6780. Are they all put together?—Not all of them.

6781. Then I should say the last state would be worse than the first if you had an institution entirely composed of raving maniacs?—But you must understand that these cases are recurrent, and although they may be in a refractory ward one month, the next three months they are in the very best ladies' wards, and quite quiet and go out into the town.

6782. Do you find any trouble in letting patients out on short leave to the town?—We very seldom find any trouble whatever. Of course they do their own shopping.

6783. Do they go alone?—No, generally in twos. I encourage that, because it gives a patient a little responsibility to look after another; that is why we can get so many out.

6784. Are they selected for that privilege?—Yes. They are really patients who are either of a chronic nature of long standing or convalescent patients, patients who are really getting better.

6785. You speak of them shopping, and so on; have they pocket money with them?—Yes, they have money, and they can drive very hard bargains, I am given to understand, in the town.

6786. Then do you find that that contact with the outer world is in itself a help towards recovering mental balance?—Yes, I do; and also it is a great help in doing away with much of the inevitable monotony in an institution. I think that system of allowing them to go into the town and country unattended should be extended as much as possible.

6787. You want, I suppose, to reproduce in your institution, as far as may be, the ordinary normal life of a citizen, subject only to that measure of control which is necessary in the interests of the patients?—That has been my object the whole time.

6788. You provide outdoor occupation, I suppose, for some of your patients?—Yes, in the gardens, a little carpentry, painting, and so on.

6789. I suppose some of them will have hobbies?—Yes.

6790. And with regard to recreation, do you provide for entertainments?—We have an entertainment room, of course; it is, I suppose, the largest room in Salisbury; we have weekly dances and entertainments. I have installed an up-to-date cinema so

that they can have cinematograph shows. Of course we have our chapel where they have four services a week, two Sunday services and two weekday services. There are the billiard rooms and they play cards, tennis, badminton and so on.

6791. Then, finally, do you find that the relatives of patients under your charge take an interest in them? They are, as you know, under an obligation to visit?—Yes, or someone appointed by them.

6792. Is that done in practice?—It is generally, but not in all cases.

6793. Do you find that some people are neglected by their relatives?—No, not neglected at all. If a patient has been there 50 years, all his friends are dead, probably. For instance, I have got patients now, paid for by the Army authorities, who have no friends. I have a captain there, of course I get his money from the Army authorities; he has no friends except ourselves; we are his friends.

6794. Now take those who have relatives: Have they facilities for visiting?—Yes.

6795. Do they come about the place much?—Yes, every day they can come. I do not encourage visiting on Sunday, because of course there are the chapel services and the nurses want a little time, but if anyone does come on Sunday they can always see the patients.

6796. *Mr. Micklem*: Sir Cecil, I see in your *précis* you refer to the question of the insecurity of tenure of licensed houses. Are you referring there to the question whether the licence will be renewed?—Yes. As you know there has been much adverse criticism of the licensed house in times past. Before the Act of 1890 was passed there was a determined attempt to do away with these licensed houses, and since that time people have felt rather insecure. I do not suppose we are perhaps as insecure as we think we are, but you can quite understand licensees being rather nervous of sinking capital moneys in their institutions with a feeling of insecurity; that is to say, that much of the money spent on these buildings, being of a special character of course, would be mere waste if the licence should happen not to be renewed.

6797. Is your suggestion that it might be advisable to grant the licences for a longer period?—Yes, I do suggest that. Why not give us a certificate of incorporation under the Lunacy Act, that certificate to remain in force so long as, in the opinion of the Ministry of Health through the Board of Control, the place is well and properly conducted? It would make our position much better. I have spent some £50,000 or £60,000 on my institution since I have been there. I am now negotiating for a house at Bournemouth for holidays for my patients which will cost me perhaps £20,000 or £30,000. I mean all those capital sums mean something. Under the Act of 1890 anyone interested in a licence could not become a member of the Board of Control; therefore the licensed house has never had a spokesman on the Board of Control yet; registered hospitals have, but not the licensed houses.

6798. *Chairman*: Of course, one knows the principle of that; pecuniary interest is the disabling factor?—Yes.

6799. One can appreciate your point that insecurity of tenure naturally discourages you from expenditure which might otherwise be beneficial?—Quite so.

6800. *Earl Russell*: You are now in exactly the position of a public-house before the Balfour Act?—Yes. In a recent case learned counsel, in order to create an atmosphere, took us back to the Middle Ages and spoke about mad-houses and keepers. Well, doctors and attendants and others object to being called keepers; we are not keepers. The public read these things and they do not understand the institution.

Chairman: I think we appreciate that.

6801. *Mr. Micklem*: One other point with regard to the visitors that you have: Are they always members of the Bench—justices?—Yes, they are chosen out of their body.

17 December, 1924.]

Sir CECIL CHUBB, Bart., LL.B.

[Continued.]

6802. And part of their body is selected year by year?—Selected year by year to visit the institution.

6803. Should you say that their inspections are fully and properly conducted?—Yes, I think they are. They go through the whole place and the patients can see them and talk to them.

6804. Are they your only visitors? You have the Commissioners twice a year?—Yes.

6805. Then the justices?—Yes, the justices; and then, of course, the Lord Chancellor's Visitor comes down at times; he comes to see special patients, but he generally has a look round. Then we have visits from different people as a matter of interest, people who would like to see an asylum, for instance.

6806. Do you think the magistrates who are appointed have the capacity to carry out the inspection properly?—Yes, I do; and they know the place so well.

6807. You seem to doubt the competency of magistrates to consider the certificates of a doctor in the case of certification, but you have no doubt of their competency, I suppose, as inspectors?—They are not inspectors in the ordinary sense that they come round and find fault and that sort of thing, you know. They know the place.

6808. Their duties are very fully set out in Section 194?—I think they all realise their duties.

6809. They never appoint anybody except of their own number—no outside visitor?—No, no outside visitors, except the medical visitors, of course.

6810. Do they in fact make entries in the books of what they have seen?—Yes, they make entries and also of any private interviews they have given and whether they consider anyone has improved or otherwise.

6811. Would the magistrates when they make their visitation actually see all the patients in your place?—Perhaps not, because some of them would be out walking and some would be engaged on work.

6812. Would they make a point of seeing all the persons that were on the premises?—Not every one; they would not make that point; they would not have a book and check up the numbers.

6813. *Chairman*: You observe that their instruction is to see every patient; that is sub-clause (b)?—Yes.

6814. *Mr. Mickle*: That would be almost impossible, I suppose?—It would be, really.

6815. I see they have to make a note, not only of the number of patients under restraint, but the reasons therefor; they have to enter it in a book at the time. That strikes me as being rather an impossible condition?—We have no patients under restraint, so that does not arise. We have no form of restraint whatever. That is one of the traditions of the place.

6816. *Chairman*: "Restraint," of course, is a technical term in this matter; it means mechanical restraint?—Yes.

6817. *Miss Madeleine Symons*: Sir Cecil, you told us that you were in favour of extending the two medical certificates to rate-aided patients?—Yes.

6818. Do you think that one of those certificates should be by a doctor with specialist knowledge in mental disorders, or are you quite satisfied with the present position?—It would be better for one to have specialist knowledge, but I do not think it would be possible to get him for all rate-aided cases. Of course, it would be better to have a specialist, but it would be difficult in country districts and also in some big towns. I think one of the two men should be the patient's medical attendant, as in the case, of course, of a private patient. One of the certificates given is by the usual medical attendant, and, if it is not so given, the reason has to be stated in the certificate.

6819. But about the other point you do not feel very strongly and you think there might be difficulty?—I think there might be difficulty in getting a man well versed in mental disorders, because such men are so few, unfortunately. Of

course, every doctor knows a good deal about mental disorders, naturally, but he is not what one may call a specialist.

6820. Then you told us that there was a good deal of latitude with regard to hours in your institution?—Yes.

6821. I think it would be interesting if you could tell us how you arrange the hours of your nursing staff?—They are on duty most of the day, you know; they get off at times; they arrange it among themselves a good deal. I have no relays like they have in the big county asylums.

6822. How many hours a week do they work?—About eight hours a day, perhaps more sometimes, sometimes less. They get their leave; two or three times a week they get leave to go out into the town on visits. That is more a question for my medical superintendent—the details of the leave.

6823. Then could you give us any idea of the cost of food per head per week?—I am afraid I could not. I have not gone into that matter—the actual cost of maintenance. Naturally, a good deal of what are called profits have to go back into the institution to keep it up to date, and so on.

6824. I was only thinking that the actual cost of food would be rather interesting for the purpose of comparison?—I am sorry, but I have not got it.

6825. *Mr. Snell*: Sir Cecil, I was not quite clear about what you meant when you said that patients might desire to have interviews with the Commissioners, but these were not granted in all cases?—No. I think you must have misunderstood me.

6826. *Chairman*: I do not think Sir Cecil said that?—All patients who desire an interview get it.

6827. *Mr. Snell*: That was an earlier statement. A later statement appeared to me to be that there were some cases that were fairly well known and if they made requests for interviews, those requests were not always acceded to?—They are always acceded to.

6828. I am glad to have that cleared up?—I do not say the interview would last quite so long if they had had 20 previous interviews with the Commissioners; they do not last quite so long as a first interview.

Chairman: Sir Cecil did say that people who asked for interviews were very often the same people over and over again. That rather left in one's mind the impression that if they did ask over and over again they ceased to get an interview.

Witness: They always get an interview.

6829. *Mr. Snell*: Then with regard to the case you mentioned of the learned judge in a recent case appearing to hold that leave of absence during a period really de-certified a patient, how would that theory operate if it were made effective? Would it not really tend to restrict the amount of leave given?—It would, I think.

6830. The authorities would be afraid?—Because it would mean having the patient re-certified.

6831. I want just to ask one question about the doctors. You have three male and one female doctor, I understand?—Yes.

6832. Are all those mental doctors, or is one of them what one might call an experienced general practitioner?—They are all mental doctors. The lady doctor is a newly qualified doctor, and therefore she is really a general practitioner; they have all been general practitioners.

6833. We must assume that the mental doctor is to some extent a general practitioner?—Yes.

6834. On the point of voluntary boarders, are they all actually suffering, or are they just fearful of suffering when they come to you?—Both, I consider. Some are afraid of getting a breakdown and some, of course, are suffering from a breakdown.

6835. There is no tendency to use the institution just as a fairly cheap boarding-house, is there?—No. I do not want it looked at in that light, although it is.

6836. They are all people who ought to live there?—Yes.

17 December, 1924.]

Sir CECIL CHUBB, Bart., LL.B.

[Continued.]

6837. But in the case of an aged person who was not any longer mentally strong and had a little money, would a person of that kind be received as a voluntary boarder?—Yes, if so requested.

6838. Then there was the point of patients going into town to shop, and so on. Do they at all shrink from going shopping and appearing to advertise themselves?—Not a bit. No one knows they are patients, you know; why should they? Certain shopkeepers do, because the patients give the address of the institution.

6839. *Chairman*: I was going to say that they may have things sent home to the institution?—Yes, they do. Sometimes we have to stop ladies ordering so much because they overrun their income.

6840. *Mr. Snell*: There is no shrinking on the part of the patient. You do not, as it were, push him into the town?—No. They all ask for that privilege of parole.

6841. Just one last question. Have there been transfers of ex-soldiers from the pauper class owing to the altered rule of the late Government?—Yes, I have got 150.

6842. 150 have already been transferred?—Yes, they were not paupers when they came to us.

6843. But they may have been treated previously?—They had previously been treated in other institutions and two or three times over; in fact, you might look upon many of them as being really chronic cases.

6844. *Mrs. Mathew*: Were the ex-service patients being treated in rate-aided institutions before that?—Yes, in many of the rate-aided institutions, and they have come to me on a private basis; I treat them as private patients.

6845. With regard to the interview between the justice and the doctor, I am afraid I did not quite catch your meaning on that point. Do you attach much value to an interview between the certifying justice and the certifying doctor?—I think it would give the certifying justice some idea of the responsibility which he was assuming in making the reception order. My point was that the reception order is granted rather too freely, I think. That is my only point.

6846. Have you any views as to observation without certification? What length of time would you suggest, or would you leave that to your medical superintendent?—I would, yes, but of course that would depend a great deal upon the class of the case. It is such a difficult thing to define incipient insanity. The cases we get sent to us of course are not incipient in any way; as a rule they are very badly mentally afflicted at the time, otherwise the reception order would not have been given.

6847. Have you children in your institution?—No, no children.

6848. You never have them?—When I used to take public patients I had one or two children.

6849. About what age were they?—I think one was about 14 and the other 16.

6850. *Sir Humphry Rolleston*: You said, Sir Cecil, that the recent action which has been brought had made doctors very loth to put themselves in danger of having to pay damages, and so on?—I think doctors find that, yes.

6851. That, I suppose, might act deleteriously to the interests of the general population, by making it difficult to get people under any kind of control before they had gone so far that curative measures do not have a proper chance?—That is a question really for the doctors, is it not? I know it is tending that way by the number of applications we get to receive voluntary boarders.

6852. The remedy with regard to the position that doctors are being put in is that the justice should be put in some position of responsibility, as is the doctor?—It is a curious thing that if anyone is sued after a patient has recovered it is the doctor, and not the magistrate who gave the reception order; he is never called as a co-defendant with the doctor in any case I have ever known.

6853. *Chairman*: I would like before you leave us just to take up one answer you gave to Mrs.

Mathew. You expressed the view that reception orders were granted too freely. Do you say that as a criticism of the code as it stands, or do you say from your own experience that you have found persons reaching your institution who should not have been certified; because the two things are different, you know? There may be a theoretical criticism of the code or you may say "My own experience has shown me that people are being certified who ought not to be." Now which is it?—It is neither really.

6854. If it is neither, what is the third point?—I think the point was that these reception orders are signed and the person signing them does not go into the medical certificate sufficiently, nor does he know the clauses of the Act relating to the reception of a patient. That is the only point.

6855. The reason why I am taking it up again is that this is a very important matter, and what I want to get at is this: Have you yourself had any experience of the working of this part of the code? I thought the patients had all passed through that stage before they reached you?—Yes, I am only criticising the order for reception.

6856. If I may put the question without offence, how do you know that the justices are not sufficiently familiar with the code, or how do you know they do not take sufficiently into account the contents of the medical certificate. Is that surmise or founded upon actual experience?—Upon actual experience, because we have often to get patients certified at the institution, and then, of course, my clerk takes the papers to the justice, who is asked to sign.

6857. We are much concerned with the actual experience of the people who have seen the thing working. Your experience of how certification takes place is derived from those cases which, having reached you as voluntary patients, have become certified in your hands?—Yes.

6858. And in those cases have you yourself seen the process of certification being carried out?—No, but I know of it, of course. I have never taken papers myself; my clerk has. The justices are a little concerned about it; they say, "Am I right in signing it?" My clerk points out to them, "There are the medical certificates; you had better read those," and on those certificates the justice gives the reception order. Therefore, the onus of certification comes wholly on the doctor.

6859. It is a case, of course, of a person who has a statutory duty to perform, as a Judge has, on affidavits of two doctors?—Yes.

6860. Do you think the safeguard would be increased by the doctors being personally called to support or to explain their affidavits? You would be putting a very considerable burden on the doctors?—No, not to explain. My recommendation was that the justice signing the order should personally see the patient, as another safeguard to reception.

6861. That can be readily given effect to, I think, but the further suggestion you made was that the affidavits of the doctors should be, so to speak, supported by their personal presence. Do you regard that as of importance?—No, not as of great importance. You see in the certificate it says "facts indicating insanity."

6862. There are two classes of facts; those he has observed himself and those he has ascertained from others?—I think a statement of the facts showing why you advise the making of a reception order would be much better than facts indicating insanity.

6863. Of course, as you know, those certificates come under observation within a short period by the Board of Control, and if they are found to be imperfect in any way they are sent back?—Yes. I only mentioned that in passing.

Mr. Cremllyn (representing the National Society for Lunacy Reform): May I put a question through you, Sir? With regard to the voluntary boarder, would you ask Sir Cecil whether he stated that he had only two voluntary boarders until the Harnett case, and that, as a result of the Harnett case, they had increased, I think he said, to 18?

17 December, 1924.]

Sir CECIL CHUBB, Bart., LL.B.

[Continued.]

6864. *Chairman*: Is that so, Sir Cecil?—There has been a tendency to increase since I reconstituted the institution and made it a purely private place.

6865. Is that unrelated to the Harnett case?—It is unrelated; but since the Harnett case we have found some few more. It may be a coincidence.

6866. It may be *post hoc* but not *propter hoc*?—Yes.

6867. It would be interesting to know to what extent there had been a change since the Harnett case. Have you got the actual statistics? We will not say what the causation is, but can you tell us how many were in your institution before that decision and how many there are now of this class? You must have the means of telling us that.

Mr. Cremllyn: I am quite sure Sir Cecil wants to be fair, but in the Report of the Board of Control it appears that in October, 1923—that is before the Harnett case—he had 20, and to-day he has 18.

6868. *Chairman*: Well, Sir Cecil, what do you say to those figures?—We may have 28, you know, because voluntary boarders come and go. You cannot tell from the number on any one specified day.

Chairman: What page is that, Mr. Cremllyn?

Mr. Cremllyn: It is page 339 of the 10th Annual Report.

Chairman: Of course, we must take the date. I see this is a report of the entries in your books on the 26th October, 1923?

Witness: Yes.

6869. At that time there were on your books 7 males and 13 females as voluntary boarders—that is 20 in all. Can you tell us what the date of the Harnett case was?

Mr. Cremllyn: In March of this year, Sir.

6870. *Chairman (to the Witness)*: You told us you had 18 just now?—Yes, and, of course, that may be reduced in a week to 10. You cannot take the number on any specified date to indicate the applications that we have for voluntary boarders. They can go when they like.

6871. Surely, this point is rather destroyed if, in point of fact, before the Harnett case you had as many as 20, and now you may have as few as 18?—I do not think so.

6872. Unless you have more applications?—The number of voluntary boarders at one specified date compared with another is no criterion of the admission of voluntary boarders throughout the year.

6873. I follow that taking a particular date will not help you, but you gave us to understand that you had about two in your institution before the Harnett case, and about 18 is what we would find since. Is that so?—Yes, about 18; sometimes it is more and sometimes less.

6874. If I had gone there on the 26th October, 1923, I would have found 20?—Yes.

6875. Do you say that was an accidentally large number?—Yes, I think so.

6876. I think we had better bring this to a point. It is not fair to ask you for figures on recollection. Would you be good enough to furnish us with the number of voluntary patients in your institution for two years back, at quarterly intervals or something of that sort, the actual numbers?—Yes, I will let you have those *figures.

6877. That would give us a year before the Harnett case; we have not had a complete year since, but you could bring it down to date. You may start on the 1st January, 1923, and give us, say, at quarterly intervals, the numbers to be found in your institution to date?—Yes.

Mr. Cremllyn: I do not want to stress the point.

6878. *Chairman*: I think it is a useful contribution, because this Report, if I may say so, is inconsistent with the figures given. We are very much concerned with the effect of this case upon the certifying of patients, because that is one of the reasons why we have been appointed. Your evidence struck us as being rather remarkable, that this case was

tending to increase the number of voluntary patients, and we must check your figures with what appears in the Report?—Yes. There was one little point I should like to mention about that case with regard to the continuation order. As you know, the reception order remains in force for a year, after which it has to be continued. There was some confusion of thought in that case regarding the continuation order. The learned Judge, as you know, looked upon that as a mere act of legal machinery.

6879. Yet it is a re-certification?—Yes, it is a re-certification of the patient.

Earl Russell: That is what the House of Lords is going to try.

Chairman: We must not comment in public upon a case which is still pending.

Witness: I am sorry; I had forgotten that.

Mr. Cremllyn: If I am not trespassing too much, may I put just one or two more questions?

Chairman: Certainly.

Mr. Cremllyn: Sir Cecil said that if he was to take voluntary patients he would like to have a separate lodge for them. Would you ask him, Sir, whether his reason for that is that he thinks that if anybody had incipient lunacy or was on the border line, they might be affected by mixing with the other patients?

6880. *Chairman*: What do think of that, Sir Cecil? Should voluntary incipient cases really be treated apart from others, and if so, why?—Of course, that is really a medical question, is it not, but I think the incipient cases should be treated apart from the ordinary inmates of the institution.

Chairman: You are quite right to say that it is rather a medical question. (*To Mr. Cremllyn*): We have two medical gentlemen coming to-day who will deal with licensed houses. May we put the question to them?

Mr. Cremllyn: If you please, Sir. Perhaps you would be good enough to ask this question, which is not a medical question. Did I understand Sir Cecil to say that, as a fact, in the institution he knows so well the Commissioners did actually see every patient?

Witness: Except those, of course, absent on leave or on trial.

6881. *Chairman*: With regard to visiting justices, you rather indicated that they did not and could not see every patient?—No, unless we had all the patients lined up for them to count them up, and so on. They have the opportunity to see every patient.

6882. But is there a distinction between what we may call the thoroughness of the justices' visit and the Commissioners' visit?—Yes, the Commissioners of the Board of Control are more thorough because they have every patient's name in a book and opposite the name his mental symptoms; and they see every patient, but that is no part of the visiting justices' duty; they are not mental experts.

6883. But part of their statutory duty is to see every patient. We gather from you, however, that the justices are less thorough in their examination than the Commissioners?—Of course, you are dealing with my licensed house, which is a very big one. No doubt, in small places where there are about 30 or 50 patients they do see every one, but my patients are in the gardens and in the workshops and everywhere.

6884. We prefer to take your own experience and the result of that seems to be this, that if you have a large institution beyond a certain number of patients it is at least difficult for the justices, who are persons giving their services for nothing, to visit every patient and so fulfil the statutory obligation incumbent upon them. You say that is a difficulty?—It is a difficulty.

Mr. Cremllyn: The only point was this: I understood Sir Cecil to say, in answer to one of the members of the Commission, Sir, that it was impossible for the Commissioners to see everyone.

* See Appendix XX.

17 December, 1924.]

Sir CECIL CHUBB, Bart., LL.B.

[Continued.]

6885. *Chairman*: I think not. Will you clear that up though, Sir Cecil? I thought Mr. Snell brought out that the Commissioners did in point of fact see everyone?—The Commissioners put in their report that they have seen every patient.

6886. It is not what they put in their report, it is what they do?—They do see every patient.

Mr. Cremllyn: Perhaps you would put this question, Sir. How long do the Commissioners spend at his place? There are 600 patients there; how long do the Commissioners stay?

Witness: There are 500 patients. The Commissioners are there two days.

6887. *Chairman*: How long on each day?—From 10 in the morning to sometimes 6 and 7 at night.

Chairman: I think we have got the information now.

Mr. Cremllyn: One other point with reference to staff. I understood that 65 was the staff to 600 odd patients.

Witness: 500 patients.

Mr. Cremllyn: How many of those staff are engaged on the 300 acres outside the institution—I mean there is a farm of 300 acres?

Witness: None of that number.

Mr. Cremllyn: Does Sir Cecil know that in the public hospitals the staffs are much larger than that—in many of them. Take "The Retreat," at York, for instance—157 patients, 65 staff.

Witness: I might answer that question in this way: The average cost of maintenance in "The Retreat" at York is £5 9s. 3d. a week. My average takings per patient are £2 14s. 6d. only. I should

(The Witness withdrew.)

(After a short adjournment.)

Dr. FRANK FAWSETT, M.B., called and examined.

6892. *Chairman*: Dr. Frank Fawsett, you are a medical practitioner with the qualification of Bachelor of Medicine?—Bachelor of Medicine and Bachelor of Surgery, the usual degrees.

6893. And are you a medical visitor to licensed houses appointed under Section 177 of the Lunacy Act?—Yes.

6894. Does that section require the justices of every county and quarter sessions borough not within the immediate jurisdiction of the Commissioners, whether there is a licensed house within the county or not, to appoint three or more justices, and also one or more medical practitioners, to act as visitors of licensed houses within their county or borough?—Yes.

6895. And you are, I understand, a gentleman who has been selected for appointment as a medical practitioner to act as visitor of licensed houses, within what district?—The East Sussex district.

6896. When were you first appointed as such?—In 1891.

6897. Then you have had 33 years' experience?—Yes.

6898. Have you been regularly re-appointed?—Every year.

6899. Will you tell us what are your duties as visitor?—I have to pay visits quarterly, or, more accurately, four times a year with the visiting justices. I also have to pay special visits at the expiration of a month after a patient recently certified has been received into one of the licensed houses.

6900. In the area for which you are appointed how many licensed houses are there?—Three.

6901. Is your appointment limited to visiting those licensed houses within the area?—Yes.

6902. So that the three licensed houses you refer to are the three you visit?—That is so.

6903. Might we have their names?—Ticehurst House, St. George's Retreat, Periteau House, Winchelsea.

6904. Will you tell us what the size of these houses is?—Ticehurst House is licensed for 92 patients, of whom 43 are males and 49 females. St. George's Retreat is licensed for 75, all females. Periteau House is a small place, only licensed for five.

like to say this also, that the patients in the "Old Manor" are treated just as kindly and just as well as those in "The Retreat" at York, and my recovery rate is just as high, if not higher.

6888. *Chairman*: The proportions vary in different institutions, as we know?—Of course they do, and in my institution the patients are more or less of a chronic nature. I do not get the recent admissions that you get in a London asylum.

6889. The number of attendants will have to depend to some extent upon the class of cases you may have. For some cases you may require three attendants to one patient?—Quite, and one attendant or nurse could perhaps manage 20 patients, according to the nature of the case.

Mr. Cremllyn: I understood that Sir Cecil told us that the recovery rate of his patients was 37 per cent.

Witness: That is so.

Mr. Cremllyn: If they are chronic, that is rather high.

Witness: It is, but I took it on the direct admissions. When you are getting the recovery rate out, you see on the Board of Control Report, page 7, the recovery rate is based on the direct admissions.

6890. *Chairman*: It all depends upon what your percentage is based. It is not the percentage of the actual residents in the institution; it is on the numbers admitted?—Yes.

6891. You will send us the figures about the voluntary patients, will you?—Yes, certainly.

Chairman: Thank you, we are very much obliged to you.

6905. Now with regard to the four visits which you have to pay every year with the visiting justices, will you tell us what you actually do?—When we get to the place, we first have all certificates and papers connected with every patient who has been admitted since our last visit.

6906. Are the visits announced beforehand?—No.

6907. You receive all the papers relating to the admissions since your last visit?—Yes, both recently certified and transferred patients.

6908. Then what do you do?—We examine all those papers, read the certificates and the reception orders, or the orders for transfer, and we have also produced a list giving every patient in the establishment. That list is in the form of a book, arranged alphabetically, a, b, c, and so on, and opposite the names are four columns for the four visits. Before going round, we also have the register of admissions, one of the books, to see the entries of the new patients, and see that they have been entered in the list of patients. I then take the book myself, the list of patients, and we go round the establishment, seeing each patient as we come to them. As each patient is seen I tick them off, a, b, c, d, first, second, third, or fourth visit. Every patient has the opportunity of making any complaint; any patient who wishes it is given a private interview, everyone without exception. When we have been round all the establishment, or the various villas connected with it, I then take the list and go through it with the medical officer, if he is there, or the responsible person who has gone round with us. Of course, there are a few whom I have not ticked off, they have got to account for them—absent on leave, absence on trial, or out for the day; of course, those we cannot see, but with the exception of those, we see every patient in residence.

6909. You are familiar, I suppose, with the programme of inspection, which is laid down in Section 194, for visitors?—Yes, the various things we have to do.

6910. I think these things are not expressed really in the sense of obligation; it is expressed rather in the language of powers, "The visitors at every visit

17 December, 1924.]

Dr. FRANK FAWSETT, M.B.

[Continued.]

to a licensed house which they are by this Act required to make shall" (it is obligatory) do the following things, and they may at any other visit do the following things?—Any of them. I think there is a qualification, is there not?

6911. May at any other visit do all or any of the following things?—All or any.

6912. It is rather curiously expressed?—It is complicated—shall do all or any.

6913. *Mr. Micklem*: Any one or more of the visitors may do all or any?—They shall at the four visits do any or all.

6914. *Chairman*: Yes, I think it is so; at the four stated visits you must do those things; at any other visit you may?—Yes, that is so; there is not a necessity to do them all—"shall do any or all of them," I think, is the expression.

6915. Yes. It is rather curious to enact an obligation to do all or any, because I do not quite understand how you can be obliged to do everything and, at the same time, obliged to do something. It is curiously expressed. However, it is an indication generally of what your duties are?—Yes.

6916. One of the most important is sub-clause (b), "See every patient," and you have told us that you yourself, when you go round, are furnished with a list, and you see that every patient is accounted for?—Yes.

6917. Now, apart from the mere enumeration of patients, and verification of their being there, what use is your visit put to by the patients?—If they wish to make a complaint, it is heard. Of course, we get, of necessity, a certain number of complaints from those who are insane, as a result of their delusions; a man may say that he is kept awake by wireless, or tortured by wires attached to his ceiling, and various things which are obviously questions of delusional insanity. Of actual serious complaints of ill-treatment I have only known two in the whole of those 33 years. Those were investigated by the magistrates at the time, and they came to the conclusion that they were unfounded in both cases.

6918. First of all, how did the complaints come to your knowledge in these instances?—In the first case the medical officer told us of it beforehand, that the complaint had been made.

6919. To whom did the complaint relate—I mean did it concern one of the nurses?—Yes.

6920. A male nurse?—In that case it was a female nurse; in both cases they were female complainants.

6921. How did the case come to the knowledge of the medical superintendent, and so to your knowledge?—The patient had complained to him, I believe—it is many years ago.

6922. And did the visiting justices, including yourself as the medical visitor, investigate the case on the spot?—They heard everybody who had any knowledge of the matter.

6923. And what was your conclusion in each case?—The conclusion was that there was no foundation for it.

6924. And what was the conclusion based on?—On the evidence and statements of those whose evidence they had.

6925. Did you see the patient who had made the complaint?—Oh, yes.

6926. What was the nature of the complaint or of the two complaints, rather?—Merely rough usage. It is over 20 years ago; I cannot recall the details, but it was only rough usage.

6927. It is significant that you have not had any case of such complaints for 20 years?—Yes.

6928. You are dealing in the three institutions under your immediate care with relatively small establishments?—Yes.

6929. One of them a very small one?—Yes.

6930. In that case, it will be possible, I suppose, within a comparatively short time to see every one of the patients?—Yes.

6931. We had evidence this morning that in larger institutions it was difficult for the justices visiting

to see on every occasion every patient. That may well be, may it not?—With anything like 500, of course, it would take a long time.

6932. But in the relatively small institutions under your care you find it possible to see every patient on every visit?—Oh, yes.

6933. Do you find that you yourself through your special qualifications, your professional qualifications, are sought after by the patients for interviews, I mean in contradistinction to the other justices, who are laymen?—No, I do not think I could quite say that. Of course, some patients say, "Come, doctor, I want to have a talk with you," and the other visitors do not go into the room with me, but it is nothing more than that simply one happens to be a medical man, and the others are not.

6934. I should have thought perhaps the patients might have wished specially to see a doctor rather than a layman; have you not found that in your experience?—No. I think if they wished to make a complaint they would rather have everybody there. In fact, I have got in mind one or two who made complaints which entirely arose from their own delusions, who would not begin until they had every visitor in the room; they would go outside and see if anybody was there.

6935. To collect the audience?—Yes, exactly.

6936. Are opportunities given to patients to see any of the visitors alone, in private?—Any patient can see them alone in private if they wish to.

6937. Do many take advantage of that?—No.

6938. Have you yourself on your recent visits had any private interviews with any patients?—At these regular visits do you mean?

6939. Yes.—Yes, there would be two or three at each of the larger places who would desire a private interview with the visitors—I do not mean myself alone, I mean the visitors together.

6940. I am asking you just to recall what you are doing in your routine work. Have you recently had actual requests for private interviews at any of your recent visits?—Yes.

6941. Were these given?—Yes.

6942. What was the subject matter of the interviews in the recent cases you have had?—Mainly their desire to be released.

6943. Complaining of their detention?—Complaining of their detention.

6944. How did you set about investigating their complaints?—As a rule let them talk.

6945. And what was the result of letting them talk?—They showed themselves to be of unsound mind by their own talk, convicted out of their own mouths, as one may say.

6946. Were you satisfied in each case on the question of their detention?—Certainly.

6947. In your long experience of 33 years can you recall any case in which you personally have been dissatisfied in the case of any patient with his detention?—I have never known a patient detained whom I myself thought fit for discharge. I am excluding those of course for whose discharge arrangements were being made, but I have never known a patient detained in any of those establishments whom I considered fit for discharge.

6948. Of course, you realise that you are one of the means provided by statute whereby the inmates of such an institution may be kept in contact with the outer world, and may have opportunities of making known any complaints to the outer world?—Yes.

6949. And during your long period of office, no doubt you have had many complaints by patients that they were being wrongfully detained?—Yes.

6950. And have investigated many cases?—Yes.

6951. Are we to take it as the result of that experience that there has not been even one case in which you thought that the patient ought not to have been detained?—That is so.

6952. And may one take it also that in your approach to these cases you have no interest in the detention of the patient?—None whatever.

17 December, 1924.]

Dr. FRANK FAWSETT, M.B.

[Continued.]

6953. And do you realise that in the performance of your duties you have to consider especially this risk, shall we call it, of a person being unlawfully detained?—Quite.

6954. And is your attention directed to that specially?—Yes.

6955. It is satisfactory to know that in your experience it is so. Will you next tell us what you do on your special visits, the second category of visits?—I have not mentioned that we have to make a report.

6956. Perhaps we should take that—you are required at the conclusion of your visit to make a full report?—There are two books, the visitors' book and the patients' book; in the visitors' book the report is of a general nature, the number of patients admitted, discharged, either relieved, cured or otherwise, or not relieved, number of deaths, if any, number of those who have undergone either seclusion or mechanical restraint since our last visit, and anything we may desire to say with regard to the general health of the patients, if there has been an epidemic of influenza, or anything of the kind, any remarks with regard to the condition of the buildings, or any alterations which have been made—just a general report on the whole of the buildings themselves, and the general condition of the patients. In the patients' book we enter the names of all those admitted, and we have to put down, if they have not already been specially visited, an expression of opinion as to whether they are or are not fit persons for detention. We enter the names of all those who have been discharged, all those who have died, if any, the names of all those who have been restrained, if any, or secluded, if any, and the names of all on leave or out whom we have not seen.

6957. Just pause there a moment. One of the things you may enter in the patients' book consists of the observations you may think fit to make as to the state of mind of any patient?—Yes.

6958. Now in practice do you at the conclusion of your visit make observations on the state of mind of patients in this book?—Not invariably.

6959. There is no obligation?—There is no obligation. If a patient has improved and is about to be discharged, we should probably make a note of the thing, that so-and-so has very much improved and will be discharged shortly.

6960. But you have not had occasion to enter any observations on cases as cases which were, in your opinion, in such a state of mind that they ought not to be detained?—No.

6961. That has not arisen in your experience?—No.

6962. We know about these books that have to be kept. Do you think they serve a useful purpose?—They are records.

6963. Yes, and I was going to suggest this to you, that possibly they may serve a useful purpose, because when a person has got to report upon a visit in writing, if I may so put it, it keeps him up to the mark in making the visit?—I did not mean those two books, the visitors' and the patients' books; I thought you meant the various other books.

6964. No, I was thinking for the moment of these two books?—I think they should be kept, clearly.

6965. And they also have the advantage, have they not, of directing your attention to the matters which you ought to consider?—Yes.

6966. And they give a responsible character to your visit?—Yes.

6967. They are, of course, open to the Commissioners, the representatives of the Board of Control, who come round and can see all those books?—Yes, and copies of the report in the visitors' and the patients' books have to be sent to the Board of Control and to the clerk to the visitors. That has to be done by the licensee within 48 hours of the entry.

6968. So that if anything has attracted the notice of the medical visitor, or the visiting justices, it reaches, and must reach, the eye of the responsible central authority?—Yes, it must.

6969. Who in turn can institute special enquiries if they wish?—Yes.

6970. I think we might pass now to the special visits. What are those special visits?—At the expiration of a month from the time of admission of a patient under recent certificates (not transfers)—

6971. Direct admissions?—Yes,—the medical officer has to send to the clerk to the visitors a statement of the mental and physical condition of the patient at the end of the month. A copy of that is at once sent to me with a statement whether that patient has been seen by the Board of Control, by the visitors, or by myself. If the patient has been seen I take no action. If a patient has not been seen, I visit within 24 hours, if possible, but always within 48 hours, for the special purpose of seeing that one patient. I usually give notice of my visits in order that one may not miss the patient altogether. When I get to the place I see all the papers on which he or she was admitted, the reception order, the certificates, the statement of particulars, and so on, and then I have an interview with the patient, which is usually private. Of course, I would not interview privately an acute maniac or an acutely suicidal case, but apart from those I have a private interview as long as is necessary to convince myself that the patient is—I have always found that he is—a fit person to remain there.

6972. That is a very important visit, is it not, because it is the first visit paid to the patient by a representative of the outside world?—That is the first; but the Commissioners or the visitors may be the first to visit.

6973. But if they have not preceded you then this is the first occasion on which a patient is in contact with some person outside the institution, and outside the certifying authority?—Unless he or she has seen a justice after admission, not having been seen before.

6974. You have told us how you proceed. Again, do you conceive yourself at that stage to be charged with the duty of seeing whether this person who is in this institution is, or is not, a proper person to be there?—Yes, that is the object of it.

6975. You must have passed in review a great many cases on such special visits?—Yes, I could not say how many, but there must be a great many.

6976. And have you in any case had any doubt as to the propriety of the particular patient's detention?—No, not that they had not been properly detained, but, of course, I have come across cases who have practically recovered in that month, and who were shortly going to be discharged.

6977. One does not want to be hypercritical, but just at that point, you are examining a patient of course in the state in which he is at the time of your examination, and you say that some of the cases appear to you to be on the way to recovery?—Yes.

6978. It is a little difficult for you, is it not, to reconstitute the position, and judge whether they were originally certifiable or not?—One takes the certificates, but if the patient admits that the certificates, or the statements made in the certificates, were true, well, that is sufficient, you see.

6979. One knows it is not an infrequent incident of the admission that the patient conceives himself or herself to be wrongfully detained and wrongfully restrained. Have you at any of these interviews had patients who were complaining that they were being kept and ought to be let out?—At the first interview?

6980. Yes.—I cannot recall one, at the first interview.

6981. On the other hand, at later stages when you have seen them you have had many complaints of that sort?—Yes, but the complaints have come from people who have been there for years and years, or from transfers.

6982. I am not judging of the quality of the complaint, but I mean complaints have been made?—Yes.

6983. But you do not recall any person at that stage, at this special visit, having complained that they should not be there?—I cannot recall any.

17 December, 1924.]

Dr. FRANK FAWSETT, M.B.

[Continued.]

6984. On the other hand, you have had numerous complaints from patients at a later stage saying that they ought not to be detained?—Yes, numerous. The proportion, however, of those complaining to the total number of patients is small.

6985. But you have repetitions of complaints from the same person?—Yes, from the same person—that is right.

6986. In those cases in which the patient is evidently already on the way to recovery do you take any particular step as a result of your special visit?—The report is entered in the book that they are so, and likely shortly to leave, and a copy of that report of course goes to the Board of Control.

6987. So that attention is directed to the case, and the Board of Control are in a position to know that this patient is one who is about to recover, and are therefore enabled to make inquiries; I mean their attention is directed to the case, and they would inquire?—Yes, their attention would be directed to it.

6988. Have you any suggestions to make for our consideration, Dr. Fawsett, in this matter of the visitation of licensed houses? We are anxious to consider the adequacy of the existing precautions, the question whether any additional means of preserving contact between patients inside with independent authorities outside should be afforded. From your long experience have you any comments or criticisms to make, any points to which you wish to draw our attention?—No. These places are visited four times a year, and twice by the Commissioners—that is six times in the course of the year.

6989. I think that most of us who have any particular form of work to do know whether we have satisfaction in our work, whether we feel we are able to perform a duty, and have the means of doing it to our satisfaction. Do you find that under the existing powers you possess, and with the duties as they are defined, you can serve your purpose of preserving the contact between the patient and the outside world?—I think so, Sir.

6990. Mr. Micklem: Just one question, Dr. Fawsett. When you made your special visits at the end of a month you have the report, have you, of the medical officer in charge before you?—Yes.

6991. And before you see the patient?—Yes.

6992. You are quite familiar with the circumstances of the patient before you get to him?—Yes, I have seen that, and all the papers connected with the case, the certificates and everything.

6993. Miss Madeleine Symons: You have told us, Dr. Fawsett, that you have never in your long experience come across a case in which you felt that the patient was being improperly detained. Leaving aside any question of improper detention, have you ever come across a case, or any cases, where from your experience you would have been inclined either to let the patient out on trial, or to think that they were rather further recovered than seemed to be the view of the institution where they were detained?—No. My experience is that the medical officers in charge are rather proud of getting their patients well, and are willing to get them out on trial as soon as they can.

6994. There never really have been any cases in which you wished to initiate leave of absence on trial?—No. I should like to say that perfectly clearly, that the medical officers in my experience are proud of their recoveries.

6995. Chairman: There is a certain competition in discharge rates—I mean the statistics are all given?—They may be, Sir, I did not know.

6996. Mr. Snell: Dr. Fawsett, would you mind telling me when these visits are made how many persons make the visit at one time in addition to yourself?—Well, it would vary, you see. The quorum is one magistrate and a medical visitor. There must be those to make the visit count as one of the four. I might have four or five justices—of course, at Periteau only one other, it is quite a small house;

there might be more occasionally, but mostly at Periteau House one.

6997. So that there may be half a dozen persons visiting at one time, including yourself?—Yes.

6998. Now I gathered, as you say in your *précis*, that private interviews are given whenever requested. I should like to find out, just because I have never seen this happen, what steps have to be taken by a patient to get this private interview. Six persons are presumably going through a ward, and a patient must step out from the ranks, shall we say, during this procession through a ward, and in the presence of the doctor of the institution, or the managing director, or whoever he may be, the patient must say he wants to see you, or the visiting committee, alone. Is that what happens?—No. You see these patients are not in wards; in most cases the patients are in their private rooms.

6999. They would be alone so far as the patient is concerned?—The patients mostly have got their own rooms, or four or five in one room.

7000. But the other side would remain—there would be six persons, with the possible addition of the managing director and the resident doctor, making eight; the patient would have to say in the midst of those eight persons that he wanted to see you, or someone else, alone?—No; I frequently put the question, "Would you like to say anything?" I have often heard a medical officer himself say to a patient, "Would you like to have an interview with any of the visitors?" Personally, I speak to every one, shake hands with those who will shake hands—some will not.

7001. But you would not go privately into a man's room and talk to him and ask what he wanted to see you about; the initiative would have to come from him?—Not of necessity I very often say to a patient, "Would you like to see us alone?"

7002. You are aware, of course, that amongst ex-patients there is a fairly general denial of the claim that each person is given adequate opportunities to make these complaints?—Of course, I can only answer for the institutions I visit. I do not think one could say there is the least difficulty there.

7003. Might we take it as your view from your evidence that the difficulties facing a patient desiring a private interview increase in proportion as the size of the institution increases, because of the lack of time of the visiting committee?—I do not know that I am entitled to say that; I am not entitled to criticise other people.

7004. I am not asking for that. My point is, that a visiting committee, going through a place which had 50 patients, would be able to give more attention to individual cases than if the institution had 500 cases?—Of course, the numbers are very wide apart, 50 and 500—one is ten times as much as the other.

7005. Would you say that the facilities are as great for a patient to obtain a private interview in a large establishment as in a small one?—I have no knowledge beyond those of mine, and I am not entitled to speak beyond my experience.

7006. I am afraid I must not press you upon that point, but in your evidence you said, "We let patients talk," and they more or less reveal that the complaint that they are detained is due to the sickness for which they are being treated?—I do not mean to say I do not ask questions, but I let them talk first.

7007. Might it not happen that while a person might have delusions, he might be quite normal in regard to complaints affecting himself?—I am not quite sure that I follow you.

7008. A man might have delusions about any theory of life, or the universe or the nation, or anything else, and yet he might be clear that he was not receiving proper treatment?—Yes.

7009. It does not follow, that is to say, that a person if he has got delusions on one thing has delusions about everything?—Oh, no.

7010. Then I just want to ask this further question: Do you, as a medical visitor, actually give an

17 December, 1924.]

Dr. FRANK FAWSETT, M.B.

[Continued.]

independent examination in the case of a patient who you suspect is on the way to recovery? Do you, as a doctor, at all diagnose the position of a patient in regard to his illness, or do you just receive complaints as to administrative matters?—No; one would talk to every patient there in turn. I mean one does not just say "How do you do; good-bye."

7011. But I thought the purpose of these visits was to see that no person was being detained longer than there was any need for his being detained?—Yes.

7012. What I am trying to find out is, whether any diagnosis of the state of a patient takes place other than that given by the resident medical officer?—Yes. I should talk to him myself, certainly. Sometimes a medical officer may say, "I wish you would look at this patient particularly, because we think he is getting on. What do you think?"

7013. Do you personally go into questions of dietary scales and satisfy yourself that the accommodation and nursing provided is adequate?—No, we do not do dietary. In those places there is no question of the patients getting sufficient and good food—not at those three places.

7014. Not in regard to those you visit?—No; there is no question about that.

7015. Mrs. Mathew: Are you an alienist, Dr. Fawcett?—No.

7016. Chairman: Just one point with regard to the large institutions as contrasted with the smaller institutions and the facility of communication with visitors. Of course, one can see, as Mr. Snell brought out, that the larger the area of inspection the less intense the inspection can be, that is obvious to one; but is it not the case that in all institutions, whatever be their size, all the patients are entitled to write to members of the visiting committee, and their letters must be forwarded unopened?—That is so.

7017. I have in mind Section 41 of the Act. Therefore, although all the patients at the time of the visit might perhaps find difficulty in establishing contact with the visitors, they are all entitled to send letters to the visitors at any time?—Yes.

7018. Which must be forwarded, under a severe penalty, unopened?—Yes.

7019. And if a letter is received from any particular patient by the visitors, do the visitors make a point of seeing that person if the letter discloses any ground for enquiry?—Before their next visit, do you mean?

7020. Yes. I am assuming a letter has come from a patient in an institution complaining, let us say, of wrongful detention, or bad treatment, or something of that sort: Would such a case be taken up by the visitors when they next went to the institution?—Yes, it would be taken up then. I cannot say it would be taken up before.

7021. What I am concerned with is the question of whether persons can establish contact with some independent authority. It appears to me that even in the largest institutions through the medium of correspondence the attention of the visitors may be directed to particular cases to be investigated on the next visit?—Yes, certainly.

7022. Do you personally, in fact, get any letters from your institutions?—Now and again, but mostly they are unintelligible.

7023. Do they reach you unopened?—Oh, yes.

7024. Then in each of the three institutions with which you are concerned do you find the statutory notices posted up, which are required under Section 42, that they can write, and so on?—Yes, that is so.

7025. The right to have letters forwarded unopened, the right of every private patient to request a personal and private interview with a visitor at any visit?—Yes.

7026. And do you see these notices when you go there?—Yes. I cannot say that I notice them every time, but I notice that they are there.

7027. You know that you have power to give directions as to where these notices are to be posted?—Yes.

7028. And that not to post them up is a serious offence under the statute?—That is so.

Mr. Cremlyn: May I just put one or two questions through you, Sir? As regards Ticehurst, that Dr. Fawcett has been at, is it the fact that there are there 92 patients and 98 on the staff?

7029. Chairman (to the Witness): Can you tell us the staff and the patients there?—Some years ago, I believe there were 99, including the chaplain and the huntsman. They used to have a private pack of beagles; I think there were 99 at that time. That includes the attendants and the people in the kitchen.

7030. The whole staff?—Yes.

7031. And how many patients?—92.

Chairman: That is about your figure, Mr. Cremlyn.

Mr. Cremlyn: I am taking the Board of Control figures for the year 1923, the last report.

Chairman: What is the point, if I may ask?

Mr. Cremlyn: Only as regards the number of staff, adequacy of staff; that this place is particularly well staffed.

Chairman: I mean if you have all these statistics in a blue book, what is the use of getting them from the witness, if I may suggest?

Mr. Cremlyn: With very great respect, there was some evidence this morning as to the amount of staff that was necessary.

Chairman: Any facts that are contained in the Report will be accepted by us.

Mr. Cremlyn: If you please. May I put this matter to the doctor, with your permission? I want to put a name. The doctor has said that no complaints were made to him during the 33 years; he collects no complaints, except two for rough usage.

Chairman: That is right.

Mr. Cremlyn: May I, Sir, with your permission, ask Dr. Fawcett if he recollects that name (*Handing a name written on paper to the Chairman*). Under the section of special visits he said there were no complaints at all.

Chairman: I follow. Of course, he is speaking of complaints addressed to himself personally?

Mr. Cremlyn: Yes.

7032. Chairman: This is quite a proper question to put, I think. It is suggested that a particular person has made a complaint to you.—At a special visit?

Mr. Cremlyn: The very important visit you spoke of, the first time.

7033. Chairman: On one of those occasions when you are seeing a patient for the first time, a special visit to a patient who has been admitted; and you remember I asked you a question whether any of them had complained of wrongful detention on that occasion, and you said you had not recalled any case.—I do not think you said ill-treatment.

7034. Improper detention; you said you could not recall any such case.—Yes.

7035. I am asked to put to you the name of a person who was, I take it, a patient in Ticehurst. (*Handing the paper to the witness.*) The patient I take it is named on that piece of paper, and did at a special visit complain to you personally.

Mr. Cremlyn: He complained that he was being detained, and that he was perfectly sane.

7036. Chairman (to the witness): First of all, do you recall such a person?—I do not recall the name. How many years ago?

7037. Mr. Cremlyn: About eight years ago. Of course, it was a very celebrated case, because the man escaped and was found sane.—I think there must be some mistake.

Chairman: So that we cannot carry it further, if he does not remember.

Mr. Cremlyn: I put it on my responsibility that that man did escape from that place and was found sane on escape, and my point is that he complained to Dr. Fawcett. Dr. Fawcett may have forgotten it, of course.

17 December, 1924.]

DR. FRANK FAWSETT, M.B.

[Continued.]

Witness: Yes, I cannot recall the name, or the fact that a person escaped from there at the time. I cannot recall it in the least.

Chairman: However, we have served the purpose that is desired, that the case should be put to you in case you could recall the circumstances.

Mr. Crenlyn: May I put this point, Sir? You know, Sir, where the sergeant who accompanies the officer in the Army walks round the men and says, "Any complaints?" It is not encouraging for the man who makes any complaints. I want you to put it, Sir, whether there is any danger of anything of that sort happening, in Dr. Fawsett's experience; if any of these patients do complain about rough usage or treatment by the staff.

7038. *Chairman:* I am desired to put to you a question which really seems to me to come to this:

(The Witness withdrew.)

Sir JAMES BARR, C.B.E., D.L., M.D., F.R.C.P., called and examined.

7040. *Chairman:* Sir James, are you a medical visitor appointed under Section 177 of the Lunacy Act of 1890?—I am.

7041. For which county or borough is it?—For Tue Brook Asylum, in the County of Lancaster, the Borough of Liverpool.

7042. How many licensed houses are there in the area?—There are three in that area. I am only medical visitor to Tue Brook Asylum. I am consulting physician at the Haydock Lodge Asylum. Of course, my position at Haydock Lodge is purely consultative; it is not an official position there, but I make regular visits there for consultations.

7043. That is not a visit in your capacity as a visitor under Section 177?—No.

7044. In your official capacity as visitor how many institutions do you visit?—One.

7045. What is the name of it, do you say?—Tue Brook Asylum. That is just outside Liverpool; it is in the borough of Liverpool, but is on the outskirts.

7046. How long have you acted as visitor?—Forty years.

7047. Therefore, you have been a visitor during the whole period of the operation of the Act of 1890?—Yes.

7048. You have been in the room, I think, Sir James, during the examination of the preceding witness?—Part of the time.

7049. We do not want to cover the same ground twice in our evidence, but we should like to have from you a short account of your experience as a visitor, directing attention particularly to its efficacy as a safeguard against the undue detention of patients. Will you just tell us your experience?—My experience has been very favourable, because the medical superintendent, or the medical proprietor, has always been very anxious for the recovery of his patients as much as possible; therefore, he has always taken every suggestion which I have got to make, not merely with regard to the treatment of patients, but as to their detention.

7050. May we regard you as an expert alienist?—I do not know whether I would call myself an expert or not. I have seen a good many cases.

7051. If you are engaged in a consultative capacity at Haydock, as I understand you are, I assume you are a specialist?—Well, I see a great many cases, but I do not like to call myself an expert witness.

Sir Humphry Rolleston: One might say he does not confine his expert knowledge to that branch.

7052. *Chairman:* Yes. (To the witness): Will you just tell us about your experience with the staff of the licensed house you visit?—Well, I think the patients are all exceedingly well looked after. I do not recollect that I have had a complaint for years about diet; everyone seems to be exceedingly satisfied about the diet. I have had no complaints against any of the attendants. The chief one you get sometimes is that the patients think they are

whether there is any risk of the patients being deterred from making complaints to the visitors by fear of the consequences, that is to say, that it might be the worse for them if they complained. Now is there any danger of a patient being afraid to make complaints, because of the possibility of the nurses, or indeed the superintendent, visiting them upon him?—Not in the case of any of those three places that I visit, certainly not.

7039. Have you found that complaints were made frequently to you?—No, complaints are not frequent; there is always a small percentage who have got complaints, mostly of the same kind, to make, not with regard to ill-treatment, but with regard to their various conditions.

Chairman: Thank you, we are much obliged to you, Dr. Fawsett.

wrongfully detained, that they are quite sane, and that their friends should be in the asylums themselves; they think that the person who signed the certificate is the person who should have been locked up, and as a rule those patients who make the complaint are generally pretty bad cases. You get more complaints from undoubted cases of insanity than you do from those who are beginning to recover.

7053. When you receive a complaint by a person that he is being improperly detained, what action do you take?—I always have a private conversation with them and listen to all their complaints, and listen to everything they have got to say, and I am generally pretty well acquainted with the nature of any delusion which they have; and consequently as I begin to burrow round, I raise some question which leaves no doubt in my mind as to whether they are sane or insane. In the vast majority of those cases that make complaints there is no great difficulty in finding out that they are proper cases for detention.

7054. Is there any case in your 40 years' experience where a patient has complained that he was being improperly detained, and where, as a result of a private interview such as you have described, you were convinced that he was improperly detained?—Well, no. There are cases that I would discuss afterwards with the medical superintendent. Where you begin to think a patient is recovering and might be trusted out, in those cases I recommend that they be let out on trial, but sometimes they are not as favourable as you think they are. For example, I made a mistake myself not long ago; I thought a man was then recovering, and that he ought to be soon let out. I paid a second visit very soon afterwards, and undoubtedly then there was no question about it—he was not fit to be let out. This was a case where the medical superintendent and myself rather differed on the point. He thought it would be a great mistake to let him out, and I came to the same conclusion after the second visit. The mistake was mine—not that of the medical superintendent.

7055. You were disposed to recommend that the patient should be discharged?—Yes.

7056. The medical superintendent had his doubts?—Yes, and on another visit I quite agreed with him.

7057. You see, one of the important purposes of your visit is to satisfy the public anxiety that persons are not being detained improperly?—Yes.

7058. Have you that in view when you go to your institution, that that is one of your duties?—Yes, certainly.

7059. You have, of course, no interest at all to have patients detained?—None whatever.

7060. Are we to take it that in your long experience you have not found one case of a patient in a licensed house, with which you are familiar, who ought not to have been detained?—Yes, that is my experience. There may have been a little difference

17 December, 1924.]

Sir JAMES BARR, C.B.E., D.L., M.D., F.R.C.P.

[Continued.]

as to the time when a patient should have been let out.

7061. Naturally, there must be a certain margin of opinion on a question of convalescence?—Yes, and there is a question as to whether the friends will take the responsibility of taking them out. If you think the patient is not dangerous to himself or herself, or to the public at large, and if the friends will take the responsibility of looking after them, then I think in a good many cases they can be discharged—at least, let out on trial, and that frequently happens.

7062. Does the stage at which a patient can be released with safety to himself and the public depend to some extent upon the circumstances to which he is to be restored?—Yes.

7063. If the circumstances to which he is to be restored are circumstances in which he will still have a certain amount of shelter and protection and assistance, can you with more satisfaction and comfort to yourselves direct discharge at an earlier stage?—Yes, at an earlier stage if you know that the friends are anxious to look after him, and are anxious to have the patient home. If you know the circumstances are such that they will look carefully after the patient, then you can let him go at an earlier stage.

7064. And does that to some extent influence the question of granting leave of absence?—Oh, yes.

7065. Do you attach value to the provision that a patient may be let out for a time on trial?—Yes, I do.

7066. Is that particularly valuable at the convalescent stage?—I think it is a very important provision that the patient can be let out, and then, if matters are not satisfactory, he can be returned again without a complete discharge.

7067. Have you voluntary boarders in the institution?—Yes.

7068. Many?—No, about half-a-dozen.

7069. Have you found any tendency in the voluntary boarders to increase of late?—Not very much of late. I think they ought to be encouraged. I am very strongly in favour of encouraging voluntary boarders, because if they can come in without a certificate they will probably come in at an earlier stage of the illness.

7070. Have you found that patients are deterred from coming into an institution by the formalities of certification, indeed, by the dread of certification, and so postpone their arrival until the disease has got advanced?—Yes; I think I give in my *précis* of evidence a case of that kind.

7071. I think you might just refer now, so that we may have it on the note, to the instance you have in mind where a simplified voluntary system would have been of advantage?—I think at the present time one thing you have got to guard against is that the patients' friends frequently persuade them to come in as voluntary boarders when they are really not voluntary boarders; they have got the better of them, and have got them to sign the form, and I say not infrequently patients are persuaded to enter asylums as voluntary boarders, and the relatives and medical attendants are thus relieved of the duty of having the patients certified. Many of the patients are induced to enter under false pretences; they are told that they are going to a nursing home or a home of rest, and will be able to leave when they like. Some of the cases are found to be undoubtedly insane, or even suicidal, and have afterwards to be certified. One such case was recently admitted to Tue Brook; two days afterwards he was found hiding behind a bush with an open razor in his hand. He was then certified. Patients who come in under such duress are really not voluntary, and when they find that they have been deceived they are apt to wish to leave immediately. There is another class of patients who would readily go into a mental hospital or asylum if there were less formality about their admission. Recently during the visit of Dr. Bond at Tue Brook a man voluntarily sought admission, but when he found that his application would have to be approved

by two justices he at once refused to enter under such conditions—he simply went away. When he found he could not come in there and then, and when he found the superintendent required to have the signature of two justices, he refused to come in.

7072. Of course, you realise that you must have some safeguarding formalities with regard to voluntary boarders?—Well, what I say in my *précis* is that I think the voluntary principle should be encouraged, and any person willing to enter a mental home for treatment should be admitted—that is my own view of the case—on his own application, and more especially so if he presented a letter from his medical attendant stating his condition. This would be a guarantee of privacy, and under such conditions patients would as readily go into a mental hospital as they now do to a nursing home. In the latter case patients are frequently deterred by the expense, but in asylums they are deterred by the publicity and stigma of insanity.

7073. Yes, one appreciates the undesirability of formalities interposed in the way of patients who want to go and have the advantage of treatment in an institution without certification, but you must recognise, Sir James, at the same time that there must be some safeguards for such cases. Do you think that the requirement of intimation to the Board of Control as the central supervising body is a sufficient protection?—The only thing is if a man has got an idea of coming into a home for rest, if he is not able to go in there and then, if there are a lot of formalities to be gone through, you would require to let him come at once, and notify the Board of Control or anyone else you like afterwards.

7074. I recognise the undesirability of worrying the patient with formalities, but I am thinking of the formalities necessary for the protection of the patient?—Yes.

7075. That would be secured, would it, in your opinion, by the Board of Control being informed?—Or the medical visitors, or the ordinary justices. If the patient could come in, then the superintendent could notify immediately afterwards—notify as many as you like—the Board of Control or the clerk to the medical visitors, and he would be seen almost immediately afterwards.

7076. We have evidence to this effect, that patients were deterred from going in as voluntary patients because a voluntary patient had on occasions subsequently to be certified, owing to the case probably becoming worse; and it was a deterrent therefore to the patients to go into such an institution on the voluntary basis, lest they should shortly find themselves in on the compulsory basis. What do you say with regard to that?—There might be that possibility about it, but I think most of those cases should have been certified. Most of the cases that come in and require immediate certification afterwards are not voluntary boarders. Their friends have persuaded them to come in as voluntary boarders. It has not been voluntary on their part. Those cases which require certification afterwards are not, in my opinion, truly voluntary boarders.

7077. Does it not depend upon the stage at which they enter the institution? May the case not become a pronounced and certifiable case later on?—Yes; that is quite possible, but I think a great many of the cases if they were taken in early would recover. I think you would increase your recoveries if they were admitted earlier.

7078. Then you would be in favour of any expedient that encouraged people at the very onset of mental trouble to go to some place for treatment?—I would.

7079. The methods available, as far as one can judge, would be, first of all, a clinic at which outdoor patients could be received and treated?—Yes, you could have that; certainly that would be an advantage.

7080. Then you would have beds in the ward in which patients could be under observation, with some provisional method of detention?—Yes.

7081. So that ultimately the asylum properly so-called would contain only the persons who had been

17 December, 1924.]

Sir JAMES BARR, C.B.E., D.L., M.D., F.R.C.P.

[Continued.]

diagnosed as requiring asylum treatment and compulsory detention under law?—Yes. Of course, that would limit your scope for the voluntary patients, if you did not allow them to come into an asylum. If you merely sent them to a home you would have to establish new homes; for example, in Liverpool we have not got any home of that kind. That might be done all right in London, but I should think in the provinces it might be a difficult matter to find mental homes of the description which you suggest.

7082. It has been suggested that you might work the voluntary system in co-operation with the county and borough asylums. As you know at present they cannot take in voluntary patients.—That is so.

7083. That there might be provision made for their taking voluntary patients?—Yes.

7084. That might work quite well, might it not, alongside the conception of some provisional method of dealing with patients?—The only thing is the county asylums are all very large, and the majority of them are away from the big centres of population, so that I think myself to encourage voluntary patients in association with smaller asylums would be an advantage. You might have them at the larger asylums if you like, but my own feeling would be that facilities would be more available for that class of patient at the smaller places.

7085. You approve of the voluntary patient, but you think many of the voluntary patients are truly involuntary patients, because they do not know what is happening to them?—Yes. That is not due to the asylum, that is due to the people outside.

7086. But then let us see where we are. Do you think it would be more desirable that these people should be certified, with all that that means, rather than that they should have a little deception practised upon them so as to avoid certification?—I do; I think the patients who come in under duress would be far better certified, and the majority of those cases of whom I speak are certifiable.

7087. One looks at it from the point of view of sentiment. It seems a little brutal to say to a person, "You are going to be taken off to an asylum." It would seem to me you might well say to a person, "I think you should go to a home where you will have a rest, where you will find it very comfortable, and you will probably get better." You may say that is deceit, but the effect of it may be helpful.—When I was speaking, I was speaking of the extreme cases, undoubtedly certifiable cases.

7088. Let us consider for a moment the place that the voluntary patient ought to have in the system. It seems to me it has an advantage in this way, that certification and its stigma may be avoided altogether because the case may never become certifiable?—Yes.

7089. Secondly, it may put at the disposal of patients the advantages of institutional treatment without their being deterred from going by the fear of certification, and thus they may go at an earlier stage and so, possibly, secure a cure which might not otherwise be obtained?—Yes, I quite agree with you, but then, of course, you are dealing with cases where the patient has a certain amount of will which he is capable of exercising.

7090. I think that is the essence of the voluntary patient, if I may say so. You would rather see nothing but voluntary patients and certified patients in institutions?—I would, as far as possible, encourage the patients who have no objection to the deception so far as you speak of it, but when you are deceiving a patient that is truly certifiable, and perhaps a dangerous patient, then I think it is a mistake.

Chairman: That would seem to be right.

7091. *Earl Russell:* And you would be opposed to the provision in Lord Onslow's Bill by which, if the patient had no will, some other person could give their consent to his being a voluntary boarder?—Yes, if the patient was not dangerous to himself or to others.

7092. *Chairman:* Lord Russell's point is that, under Lord Onslow's Bill, if a person has not a volition

of his own, the volition of somebody else, who has charge of him, may be substituted?—Yes.

7093. Take the case of a minor—there the guardian's consent operates in place of the minor's own consent?—Yes.

7094. Do you approve of that substituted consent?—Yes, I would.

7095. In the case of a person who could not give it.

7096. *Earl Russell:* And would you be opposed to the relation or friend giving consent in the case of adults who had no volition?—No, always provided, of course, they were neither a danger to themselves nor to the public at large.

7097. *Chairman:* Would not that rather trespass upon your argument that it is undesirable to detain a person in an institution who ought to be certified while remaining uncertified?—If anything for the protection, not merely of the patient but of the asylum, if you have got any risk of suicide, for example; when a patient is fully certified his position is more fully recognised, and that he is a danger to himself.

7098. Then you have a view, I think, upon the provision that a patient, who has not been seen by a judicial authority before admission, has now a right, as we know, to be seen by another judicial authority after admission?—Yes.

7099. Do you share the views that have been expressed to us that that is a futile provision?—I do.

7100. And you take the view that the judicial authority, like the justice, ought to see the patient?—They ought to see the patient. If you are dealing with a maniacal patient, what is the use of telling him that he can see a justice?

7101. It does seem rather an idle ceremony, does it not?—Yes. If you are dealing with a case of melancholia, if you commence to tell him that he can see a justice, he begins to think something is wrong, and he gets more depressed. I think the justice ought to see them, any way. There is no use in telling them they can see a justice. I think either a justice or the visitors should see them pretty soon after admission, any way.

7102. Are you in favour of the assimilation of the case of the pauper and the private patient? At present the pauper has the advantage that the certifying magistrate must see the patient?—Yes.

7103. Whereas in the case of the private patient the judicial authority need not see the patient?—Yes. I think it would be better for the judicial authority to see the patient, rather than to be telling the patient afterwards that he can see the judicial authority.

7104. It is difficult to understand why that should have been arranged on this principle. Then, *per contra*, the pauper comes off worst in the matter of the number of certificates. The pauper may be detained on one medical certificate, while the private patient has two medical certificates?—Yes.

7105. Have you any view to offer us upon that?—I do not think there is any great advantage in the two; if the patient is being frequently visited afterwards, I do not think there is any advantage in the two.

7106. But is not the first detention of the patient a very critical stage?—Well, the more difficult you make it for the patient to get into the asylum the worse it is for the patient.

7107. Of course, every one who has to deal with this branch of administration recognises that you have balancing considerations at almost every stage. On the one hand the importance of preserving the liberty of the subject, and, on the other hand, of seeing that as many patients who would benefit by treatment can get it?—Yes.

7108. I gather you do not attach so much importance to two medical certificates as a safeguard at the beginning?—No, I do not think there is really much in it. If the patient is going to be seen very soon afterwards by medical men there is very little in it. There may in some cases be an advantage in having two medical certificates, an advantage to the medical men to have a consultation; they have to

17 December, 1924.]

Sir JAMES BARR, C.B.E., D.L., M.D., F.R.C.P.

[Continued.]

give their opinions separately, but it would encourage consultation between them.

7109. At present they must give their opinions separately?—Yes.

7110. The idea being, I suppose, to maintain independence of judgment?—Yes.

7111. I do not know the reason why, when you consult two people, you should ask them to give their ideas independently. The idea of consulting two people generally is to get their joint opinion?—Yes.

7112. I do not quite appreciate your point that the necessity for two certificates at the beginning is obviated by the early examination by other persons later on, because the detention for even a few days of a person against his will may be a very serious infringement of his rights and of his liberty?—I do not raise any point, I do not put any strong view of my own; I only think it is often unnecessary.

7113. Have you in your long experience had any cases where you have received complaints that a patient has been improperly detained?—Letters, you mean?

7114. Yes?—Oh, yes; I frequently get letters from patients, but generally they do not relate to questions of detention, it is general information, or something of that kind. They are often irrelevant rambling statements of all kinds.

7115. In your experience have you ever come across any case of a person who was, in your opinion, improperly detained in an institution which you visited?—Never have I come across a case of a patient who was improperly, or had been improperly, detained. As I said before, there is just a little difference of opinion as to when a person is fit for discharge; that is always apt to occur.

7116. One can understand that at that stage a patient is perhaps impatient to be out, and the relatives may either want him out or want him to stay in; and then there is the medical aspect of the case. At that stage there must be a margin of time, but apart from that element you are satisfied in your own experience that you have not had an instance of a person who you could say had been improperly detained?—Yes; and I know many patients who would not go out if they were allowed to go out.

7117. Unless you have any further observations to make for our assistance, I do not think we will detain you further, unless my colleagues have any questions to put to you. We have been through your notes. If you have any special point that you desire to bring before us, we should be very glad to hear you, with your great experience?—I really do not know that I have anything to add. Of course, I attach a good deal more importance often to conduct than I do to delusions as an indication of insanity. I have got in mind a case with any number of delusions, scores of them, but in the case of this lady, she is not in an asylum, and I would not certify her to be in an asylum.

7118. I am afraid in that respect we are getting into the region of mental pathology, in which I personally should not be able to follow you?—I mean there is no question of her being insane, but she is quite capable of looking after herself, and all that kind of thing, and therefore I think she has no right to be in an asylum; she is not in an asylum, and I do not suppose she will be. The only point about it is that I felt rather anxious about her at one time. She threatened to go and visit her husband in the Mediterranean, and I thought she was not fit to be at large to undertake such a journey herself, so I wrote to her husband and he seemed to think it would be all right.

7119. What is this case introduced for? Is this the case of a private patient?—It is with reference to conduct. This is a private patient, and judging by her delusions she is insane; there is no question about it; and no doubt if her conduct was injurious to herself or to others, then I think she ought to be locked up, but as it is not, I think the delusions

are no sufficient reason for confining her in an asylum.

7120. But one must remember that the law of the land does not say that every lunatic shall be confined in an asylum?—It is important to recognise that.

7121. And your case is the case of a private patient who, although a person who could be certified, is not certified, and in whose case you do not think it necessary to resort to certification because the delusions are of a harmless character, and she happens to be in circumstances in which she can be properly looked after?—Yes.

7122. That is the class of case in which the law does not attach any penalty to a patient being kept at home; there is no gain involved in that case?—No.

7123. And the law does not require every lunatic to be taken to an asylum?—No.

7124. *Earl Russell*: Do you see any new admissions in the course of the year?—Not a large number. In the two asylums, of course, I do.

7125. And do you inquire, or find out from the certificates, whether the judicial authority has generally seen the patient or not?—In a certain number of cases they have not, but I think in the vast majority they have seen him, if not before, almost immediately afterwards.

7126. The usual practice, you find, is for the judicial authority to see them?—Yes.

7127. Now I would like to ask you this, in view of the paragraph in your *précis* in which you say the patients are induced to enter asylums under false pretences. Do you think that the justice, in the case of a pauper patient, or the judicial authority, in the case of a private patient, ought to tell the patient that he is there representing the public, and that that is the moment for the patient to make any protest against being locked up, if he wants to make it?—You mean to say that the visiting justice—

7128. No, not the visiting justice, the certifying justice. Do you think when the certifying justice is seeing the patient, with the certificates before him, he ought to tell the patient that that is the moment for the patient to make any protest?—No. I think the justice has to satisfy himself whether the patient should be locked up or not. The patient may not be in a position to form an opinion on the subject, and it only disturbs the patient, because the patient will probably say, "I should not be locked up," but the justice has got to satisfy himself that the patient should be locked up.

7129. I feel that; but suppose the patient is, we will say, partially sane, at any rate sane enough to understand what is said to him: if the justice merely comes into the room and chats to the patient as a friend and goes out again, the patient may not know that that was his opportunity of appealing to a member of the public against the order for his detention?—The justice would not be satisfying himself according to my idea in that case. I think he ought to satisfy himself whether the patient is sane or insane.

7130. Only by the medical certificate?—He would be guided by the medical certificate. If he had any doubt on that point he could test the patient on the information which he had on the medical certificates.

7131. I agree he could. My point is this: Do you think at any stage the justice ought definitely to say to the patient something which would enable him to understand that that was the moment at which he could appeal to a public authority?—I have no objection to his doing that, provided he was not upsetting the patient.

Earl Russell: I quite know the difficulty.

7132. *Mr. Snell*: Just two questions, Sir James. In the earlier part of your evidence you said you had always found that the medical proprietor was anxious for the care and discharge of his patients. That is very interesting. Is it that the desire to get a favourable statistical record would be greater than any desire to keep a patient for financial or other reasons? That would operate, would it?—They are

17 December, 1924.]

Sir JAMES BARR, C.B.E., D.L., M.D., F.R.C.P.

[Continued.]

able to keep their asylums pretty full. There is no difficulty about getting new patients.

7133. So that there is no inducement to keep a patient?—There is no inducement beyond feeling confident about them themselves. The only thing that would make them keep them would be if they were afraid of the patients getting out and doing some depredation or other.

7134. Would the medical proprietor call your attention to a case that was approaching a convalescent state?—Yes, he would.

7135. You do not have to sort those out?—No; he would tell you at once that he thought this patient was improving.

7136. Would that merely be in a case of doubt, because in the ordinary way he would have power to discharge them himself, would not he?—Yes; the probability would be that when you are going round you discuss the case with the medical superintendent.

7137. Just one other question. You suggest that many patients would not go out of these institutions even if they were allowed to do so?—I do.

7138. But that might be a manifestation of their illness, might it not?—Yes.

7139. If they cared to prefer that sort of surrounding, I mean?—They know when they are well off and when they are comfortable.

7140. *Mrs. Mathew*: Sir James, do you ever find any difficulty in getting the friends to undertake the care of the patient?—Occasionally, yes. That is often a difficulty in turning patients out—the difficulty of getting friends to look after them properly.

7141. Those are patients who would be properly discharged if you had anywhere to send them?—If we had anywhere to send them they might be discharged; if you had responsible individuals to look after them, take the necessary care of them.

7142. They would still want some care, though?—Oh, yes. I mean to say, I do not think many of these cases would be fit to turn out at large to earn their own living.

7143. *Sir Humphry Rolleston*: Sir James, you touched very briefly upon a very important subject, at any rate for our profession, and that is the protection which should be afforded to medical men who give the certificates, and you say that you hope alterations will be made in the law. Can you give us any suggestions as to the lines upon which those alterations should be made?—I think if you want to get patients certified at an early stage you must give protection to the medical men, because at present there is such a dread with medical men to sign certificates that the patient requires to be pretty insane before he will get a medical certificate.

7144. How would you alter the law?—I think if the medical men took the responsibility afterwards of having the patient properly looked after, and of seeing that the certificates were in due order, you would have the certificates as they are at present. I think that you should not give an opinion as to whether a patient is insane or not, but give the facts upon which you base your opinion. If a man gives an honest opinion and gives such a certificate as passes the Board of Control and passes the ordinary magisterial visitors, that should be sufficient protection to the medical man to show that he has acted honestly and straightforwardly. Then he should not run the risk of being hauled up or liable to damages for a certificate which had been honestly given and which had been approved by legal authority.

7145. You entirely agree that it is very important that the early incipient cases should be treated without certificate?—Yes.

7146. What kind of mechanism would you suggest for that? Would you think there should be an out-patient room attached, say, to the Royal Infirmary, or attached to some mental hospital?—I think it would be better to have it attached to a mental hospital, because you want to get these patients out of town as much as possible; you do not want to have them in a busy street; the quieter they are kept the better.

7147. I meant an out-patient clinic.—You might have an out-patient department in connection with any big general hospital.

7148. Do you think it would be better to have the out-patients in a general hospital, which is in a town, or in a mental hospital which also happens to be in a town?—The more specialised it would be, the better, although you could not always have a special mental hospital in large centres of population, and you could not establish them, because there would not be a sufficient number of cases to make it worth while.

7149. In your *précis* you refer to a method of action by the magistrates in which the magistrates occasionally examine a cab full of patients.—That was a good many years ago; that does not happen now.

7150. *Earl Russell*: We had evidence from Birmingham that they were drawn up in a taxi.—I do not think it happens in Liverpool now, at any rate.

7151. *Sir Ernest Hiley*: Sir James, do you attach importance to the justice certifying a patient? We have had it put to us that the justice is a rather useless functionary, and that it would be preferable to have the certificates of two doctors. Do you agree with that?—No, I would not like to say that the justice is useless. It is wonderful what experience some of the justices get. For example, if you take Liverpool, I know one justice who signs more orders of admission than any other half-a-dozen put together, and he is a man with very considerable experience in that line. I attach a good deal of importance to his opinion.

7152. I was not quite sure that I heard your answer to Sir Humphry. You do attach importance, do you, to the patients being kept in touch with the general community?—Certainly.

7153. You would not segregate them out in the country and not let them have an opportunity of mixing with their fellows when they were convalescing?—That depends a good deal upon the condition of the patient—whether he is fit to mix with the community or not. Patients often stroll about, but, on the other hand, of course, in certain cases it would be rather unfair to the patients and to the public to let them out at large. There are also a considerable number of patients who have an antipathy to their relatives; the less they see of their relatives the better for them.

7154. *Chairman*: I was looking at Section 330 of the Lunacy Act of 1890, and it seemed to me that that practically states the law very much as you put it to us, and as you would desire it to be. I am paraphrasing it: Any person who signs a medical certificate that a person is of unsound mind shall not be liable to any civil or criminal proceedings, whether on the ground of want of jurisdiction or on any other ground, if such person has acted in good faith and with reasonable care. Does not the existing law, therefore, protect the medical practitioners or any other intervening parties, provided that they have acted in good faith and with reasonable care?—Yes, but the medical practitioner has to prove his good faith.

7155. Then you think the question of the onus is the difficulty?—Yes, there is often a great deal of difficulty, as some cases have shown, in proving his good faith.

7156. Is your point this, and it is an important point in procedure, that the onus is a difficult one to discharge, the onus of showing that what has been complained of has been done in good faith and with reasonable care?—Yes, and it is difficult to get the judge sometimes to stop the case.

7157. Does it also involve this, that the medical practitioner may be exposed to the expense of a full trial of the case, and at the end of the day, even if his case is established, have lost all his costs and not be able to recover his costs from the person who has sued him without ground?—Not merely the costs, but the worry and anxiety of the whole business, whereas, in my opinion, it might have been dealt with by a judge of first instance.

7158. There is provision made for staying the proceedings?—But does that often happen?

17 December, 1924.]

Sir JAMES BARR, C.B.E., D.L., M.D., F.R.C.P.

[Continued.]

7159. I am looking at the law as it stands: "Such proceedings may upon summary application to the High Court or a judge thereof be stayed upon such terms as to costs and otherwise as the Court or judge may think fit if the Court or judge is satisfied that there is no reasonable ground for alleging want of good faith or reasonable care." It does not seem to me that the suggestion you made in answer to Sir Humphry with regard to an amendment of the law would carry it much beyond that?—My own opinion is, that you require to do something more than that at present. I dare say that would be all right if it were carried out strictly according to the Act, but then the judge may not take upon himself the responsibility of saying that every reasonable care was taken.

7160. Of course, one sees from the public point of view the awkwardness of requiring a certain class, to wit, the professional class of doctors, to act as the media through which insane persons are protected against themselves, and the public are protected from them, and at the same time to say, "You shall certify at your peril." Naturally, the person who is at his peril prefers not to run the risk. Do you think that the reluctance to certify in consequence of the apprehension of judicial proceedings is an unfortunate thing?—I think it is unfortunate, and I think it is strongly felt at present by medical men.

7161. Of course, the medical man should deal with this question, which is a matter of professional skill, entirely on its merits, and unaffected by the question of whether there are legal proceedings on the horizon or not?—Yes.

7162. But, of course, human beings being what they are, if they are liable to be shot at in action, they must take that into account, naturally?—The law of self-preservation comes into force.

7163. And, of course, no medical practitioner can be compelled to give a certificate?—No, except in this way, that the law expects the ordinary medical attendant to be one of the two, and if he is not one of the two, it has got to be stated why he is not one of the two.

Mr. Cremllyn: May I ask a question, Sir, arising directly out of what you have said and what Sir Humphry has said?

Chairman: If you please.

Mr. Cremllyn: Supposing a doctor gives evidence in a Court of Law, is he not protected; is his evidence not protected?

Chairman: I think I can answer that question better than Sir James, cannot I? I should say that certainly the evidence given by any witness in court enjoys the highest form of privilege known to the law.

Mr. Cremllyn: Therefore, the evidence given by a doctor in an inquisition is protected?

Chairman: Yes, I think it would be.

Mr. Cremllyn: Therefore, may I put this question through you to Sir James: If the medical profession are so anxious for their protection, why not do away with certificates and give evidence before a tribunal?

Chairman: Now, Sir James, what do you think of that? Do you think we should go back to the method of inquisition in all cases?

Witness: It would be a very complicated business. It would delay matters very much. You can get a certificate at once, but if you are going to hold an inquisition, how long would it take? A fortnight at least.

Earl Russell: And how much would it cost?

Mr. Cremllyn: I am putting it, Sir, that the doctor should give evidence before the judicial authority instead of giving a certificate. In every case in court except this, the doctor's certificate would not be accepted.

Chairman: No; doctors' certificates are accepted constantly by the court in the absence of a witness, and a Judge would take it at once.

Mr. Cremllyn: The other day it was refused me by a High Court Judge.

Chairman: That may have been a case in which the judge was not satisfied. However, that opens a very large chapter of policy. The point really suggested to us for consideration is whether we should have a more forensic inquiry into a case before detention.

Witness: I think it would be a mistake, because you would delay matters, and what is happening to the patient during that time? Supposing he wanted an urgency order; supposing the patient wanted to cut his throat, and you wanted to get him locked up there and then, what would happen?

Chairman: I do not think the question is put on the hypothesis that there might not be meantime protective means.

Mr. Cremllyn: No.

Chairman: It is a question of certification, whether that should have more formal procedure than at present, and that the doctor should give evidence on oath, and I suppose, Mr. Cremllyn, be subject to cross-examination?

Mr. Cremllyn: Yes.

Chairman: However, that is a very large topic, as to whether the whole procedure should proceed on the basis of a more or less judicial inquiry, or whether some modification of the existing procedure should suffice.

Mr. Cremllyn: You recollect, Sir, that this morning Sir Cecil Chubb was of opinion that voluntary boarders were not to be encouraged, and Sir James Barr this afternoon is of opinion that they ought to be encouraged. What I want to ask Sir James, through you, Sir, is this. He says that the stigma can be removed by going as a voluntary patient. I suggest: Could not that stigma be avoided by going to nursing homes for voluntary boarders that are not associated with lunacy at all?

7164. *Chairman:* You have heard the question. Sir James. Will you give us your answer?—It would depend upon circumstances. The ordinary nursing home, I think, would be unsuitable. You would require to establish a kind of mental home for these cases, and I do not think that the ordinary nursing home, where all classes of patients are taken in, would be very suitable for these mental cases, because of the nature of the malady.

7165. Of course, one knows there are cases in nursing homes which give medical attendants considerable anxiety, because you cannot take a patient in for pay who is certifiable?—Yes, but, apparently, Mr. Cremllyn would propose that they should be taken in for pay.

Mr. Cremllyn: The witness said that they could thereby gain the advantages of institutional treatment. May I ask Sir James, through you, Sir, what that institutional treatment is, and what the difference is between that and treatment in an ordinary hospital or in an ordinary nursing home?

Witness: An ordinary nursing home takes in all manner of medical and surgical cases—pneumonia, pleurisy, broken ribs, and operation cases. Mental patients do not require treatment of that kind, and the numbers would be comparatively small, and to have them mixed up all together without any proper nursing would be very undesirable. Nurses in the ordinary nursing homes have no experience of mental cases, in the vast majority of instances, and they would not be able to deal with them satisfactorily.

Mr. Cremllyn: I think the point as to what exactly is the treatment that is given in these institutions ought to come before your Commission, Sir.

Witness: There is often a good deal of treatment required in getting a patient quiet, giving him a soporific, giving him something to get him to sleep, where a patient has been days and nights, before he is admitted, without an hour's sleep. Those cases you have got to get to sleep at once.

Chairman: We are very much obliged to you, Sir James.

(The Witness withdrew.)

(Adjourned to Tuesday, January 13th.)

5, OLD PALACE YARD,
WESTMINSTER, S.W.1.

THIRTEENTH DAY.

Tuesday, 13th January, 1925.

MEMBERS PRESENT :

THE RT. HON. H. P. MACMILLAN, K.C. (*in the Chair*).

THE EARL RUSSELL.

SIR HUMPHRY ROLLESTON, BART., K.C.B., M.D.

SIR ERNEST HILEY, K.B.E.

SIR DAVID DRUMMOND, M.D., C.B.E.

MR. W. A. JOWITT, K.C.

MR. N. MICKLEM, K.C.

MR. H. SNELL, M.P.

MRS. C. J. MATHEW.

MISS MADELEINE SYMONS.

MR. P. BARTER (*Secretary*).

MR. W. FAIRLEY (*Assistant Secretary*).

Chairman: Before the proceedings this morning are begun, the Commissioners desire to take this, the earliest opportunity, of correcting a misapprehension as to their procedure, which appears to have gained some currency. At the outset of their Inquiry the Commissioners decided that the most expedient course would be to hear evidence in the first place from those charged with the administration of the present code, in order to inform themselves as to its working and to put themselves in a position to appreciate the criticisms which might be made upon it. This course, it is thought, has been of advantage to those desirous of amending the present law; and indeed assurances have been received that the information thus elicited has been of material service to all parties interested. It is not proposed that the witnesses who are hereafter to give evidence criticising the existing system and putting forward suggestions for its amendment should be put on oath, any more than those who have expounded that system. But the Commission in addition to hearing general evidence by way of exposition and criticism,

have thought it right to undertake the judicial investigation of a few specific cases of alleged wrongful detention or ill-treatment selected by the National Society for Lunacy Reform, as illustrative of their general criticism. These cases relate not to matters of opinion but to specific issues of fact and serious allegations against particular individuals are involved. The Commissioners have decided that in the hearing of these cases both the persons making the allegations and the persons answering them should alike give their evidence on oath. While it is obvious that only a small number of test cases can be investigated in detail in this manner, the Commissioners have expressed their willingness to receive and consider statements in writing by any persons who desire to bring before them information that may assist their deliberations, whether relating to particular cases or of a general character. This announcement will be communicated to the Press, and those interested will have an opportunity of reading it

Dr. G. F. BARHAM, M.D., called and examined.

7166. *Chairman:* Dr. Barham, are you the Medical Superintendent of the London County Mental Hospital at Claybury?—I am.

7167. And have you held that post for over seven years?—Yes.

7168. I think you have had in all some 21 years' experience in the Mental Hospital service of the London County Council?—Yes.

7169. Now, first of all, will you give us a few particulars about your Institution? When was Claybury Mental Hospital opened?—In 1893.

7170. I see you adopt the nomenclature of "Mental Hospital" rather than "Asylum"—I have no doubt in deference to the views that are now so prevalent?—Yes.

7171. And was Claybury the first new asylum to be opened by the London County Council?—Yes.

7172. It is situated about nine miles from the City and stands in 219 acres of ground and includes a farm of 137 acres?—Yes.

7173. And I understand that a large proportion of your area is woodland, ornamental and playground?—Yes.

7174. The site forming, in fact, part of the old Hainault Forest?—That is so.

7175. Now you might describe to us the general lay-out of your hospital. What system is it built on?—It is built on the usual plan of all the large mental hospitals, an administrative centre and two divisions, a male and a female division, the female division at Claybury being much the larger, and we also have a private division, which is unusual in London, viz., Claybury Hall. The old Manor House has been devoted to gentlemen of moderate means who are enabled thereby to get the benefits of the County Asylum. There are 64 beds at Claybury Hall.

7176. That is a separate building altogether, I understand?—Yes.

7177. Called Claybury Hall?—Yes.

13 January, 1925.]

Dr. G. F. BARHAM, M.D.

[Continued.]

7178. Then you have in addition an isolation hospital villa for female patients?—Yes, that is for infectious cases.

7179. I think the present number of beds is for male, county and private list patients 1,035, and for female county and private list patients 1,361, making in all 2,396?—Yes.

7180. And then in addition, you have 64 beds for private male patients at Claybury Hall?—Yes.

7181. Since the opening of your Institution how many patients in all have been admitted?—Over 20,000 patients of the county class, and about 547 private patients.

7182. And at the moment how many have you under treatment?—There are 2,282 beds occupied.

7183. And 962 of those are, I think, in the occupation of males, and 1,320 in the occupation of females?—Yes.

7184. And another figure of interest is that 2,074 out of the total of 2,282 are wholly or partly rate-aided patients, while 51 are private list patients?—Yes.

7185. And 157 are service and ex-service patients?—Yes.

7186. With the addition of 42 private patients at Claybury Hall?—Yes.

7187. What has been the annual admission rate?—Taking it on an average it varies between 300 and 600. The average for the last five years I can estimate at 503.

7188. Between one and two a day, putting it shortly?—Yes.

7189. And what has been the discharge rate over the last five years?—The average number discharged was 195 patients.

7190. Of course those are not necessarily the same persons as came in that year; that is simply the total number of discharges made in the year from the institution?—Yes. A large proportion of the new admissions that year would be discharged, but, of course, it does not exclusively mean new cases during that year.

7191. We are interested in the early recovery cases, that is to say, the cases which make a complete recovery within a very short period after their admission. I forget whether you tell us later on in your *précis* what your experience has been about that—if not will you tell us now?—I cannot give you any figures, but I am very much struck with the number of cases which recover very quickly. It is a question which interests one very much.

7192. It has a great bearing, of course, upon one of the branches of our reference, and we have been searching for statistics as to what I call the early recovery cases; because we feel that cases which recover after, let us say, a period of two or three weeks under treatment might well have avoided certification altogether. You are of course aware of the point that arises there?—Yes.

7193. But you have no statistics of patients admitted, and the period they have been in your Institution before they have left recovered?—I could easily provide those figures. I think some cases have been discharged within a fortnight, probably not less. But I never remember having to discharge a patient absolutely as not insane.

7194. No. Of course one knows that the formula is either relieved, recovered, or unimproved?—Yes.

7195. But I was not thinking of it so much from the point of view of a person who never had been in your institution, but from the point of view of a person who in your institution has made a rapid recovery. I do not know whether it would put you to inconvenience to look at your records of admissions for five years. You have something like 500 people coming into your institution altogether in a year, and it would be very interesting to know how many of those admissions left recovered at the end, let us say, of a month, three months, or six months, so that at the end of the year they were out of your care

altogether. Are your statistics available on that basis?—They could be quite easily produced if the Commission would like them.

7196. I think to get a sample from an important institution like yours of the period that the patients are under your care might be very useful to us, because it would give us an indication of the proportion of cases which are really of quite short duration?—Yes. I will be very pleased to supply that *information.

7197. You might take perhaps five years back and just give us of the admissions in each of those five years the numbers who were discharged at the end of one month, three months, and six months?—Yes, I will.

7198. Now will you tell us something of the administration of your institution. What is the staff, and so on?—I have seven medical officers at the present time to assist me, and we are to have an eighth. The medical staff are not appointed particularly in London to any one hospital, but they are detailed to the general service, there being ten of these large hospitals in London, and the staff are liable to be moved about, or promoted from one place to another.

7199. And your senior officer has the rank of Deputy Medical Superintendent?—Yes.

7200. And no doubt can act in your absence?—Yes.

7201. Then with regard to the female division?—The female division is under the control for administrative purposes of a doubly-qualified matron, who has two assistant matrons to help her.

7202. When you say doubly qualified you mean she has both a general and a mental training?—Yes. One of the assistant matrons is now appointed as a sister tutor, her function being to train the nurses, both male and female. Then there are some 224 nurses at present of all ranks, which also include the head nurses; there are 10 head nurses.

7203. Does that figure of 224 include the nurses on both sides?—No, I am talking of the women only. On the male side there is an inspector, who is the chief male nurse, and there are 191 male nurses of all ranks.

7204. Ten of whom are head nurses?—Yes. All nurses are subject to a maximum of 96 hours' duty in London per fortnight. They work on the principle of two day turns of duty, that is to say, one shift in the morning and one in the afternoon, but the proportion of nurses on duty at any time would, of course, vary very much. If you took those on duty at any moment they would amount to about one to 15 patients.

7205. But the proportion will vary, of course, according to the class of patient whom the nurse is attending; some cases require, of course, much less supervision than others?—Yes.

7206. What is the highest proportion of nurses to patients?—About one to 4.5, I think, is the correct figure with me.

7207. That would be in the class that requires the closest supervision?—Yes.

7208. And have you also supernumerary nurses who are available for special cases when required?—There is always a proportion of nurses over the establishment number, for that purpose.

7209. I suppose you may have a case which requires individual attention?—One or two nurses sometimes, yes.

7210. Then as regards the superintendence of your institution from the public point of view, have you a visiting committee?—We have a sub-committee of the Mental Hospitals Committee of the London County Council. Really, the Mental Hospitals Committee acts as a visiting committee in London owing to the special powers they have.

7211. We are aware of those. Then you have a sub-committee in charge of your particular institution?—Yes.

* See Appendix XXI.

13 January, 1925.]

Dr. G. F. BARHAM, M.D.

[Continued.]

7212. And on that sub-committee there are, I think, six members, one of whom is a lady?—That is right.

7213. Is your hospital a recognised training school for nurses?—Yes.

7214. And does a nurse undertake to train for a period of five years?—There is no binding contract, but the Council rules that a nurse may be got rid of if she does not become trained in five years.

7215. She must qualify in five years, or else she may be dispensed with?—Yes.

7216. So that gives an indirect inducement to your nurses to go in for the course of training?—Yes.

7217. How many of your men nurses, and how many of your women nurses, hold the Medico-Psychological Nursing Certificate?—84 of the men and only 57 women.

7218. Does that reflect, what we have heard elsewhere, that the women nurses are a less permanent element in your staff?—Very much so, yes.

7219. And are your younger probationers now entering for the State examination?—Yes.

7220. I have no doubt you attach great importance to this question of the training of your nurses, in its relation to the efficient care and treatment of patients?—I think it is of supreme importance. We are very much encouraging now general trained nurses to enter the mental hospital service, and we send our nurses to be trained in general hospitals as well.

7221. Nurses, after all, are the persons who are in the most constant and immediate association with your patients?—Yes.

7222. And I suppose one may take it that their happiness and comfort, and, indeed, their prospects of recovery, largely depend upon the class of nurse you have, and their powers of dealing with the cases?—I think the personnel and quality of the nurses one has is one of the greatest factors in both the happiness and the successful treatment of patients.

7223. It is therefore desirable, I suppose, that you should have nurses who are technically qualified as far as possible, and who are also suited by disposition and sympathy for their vocation?—Yes; and, of course, one devotes a good deal of attention to obtaining that kind of nurse.

7224. Do you find difficulty in getting suitable applicants for your staff?—A very great difficulty for women; not so much for men.

7225. Is that a matter under your personal supervision? Do you engage the nurses yourself?—Yes, I engage them myself, and always see them.

7226. How do you get them; do you advertise for them?—We advertise, and we have agencies, through a labour bureau, and very often one gets them from other mental hospitals.

7227. Is the London County Council nursing staff interchangeable among the different asylums?—It is capable of interchange. There is promotion to another place to a higher rank—they will have that opportunity.

7228. Do you interview nurses when they are engaged?—Yes, always, and not only do I interview them in regard to certain instruction, but the sister tutor is now always placed in charge of a probationer, so that she does not enter raw into very difficult work.

7229. And does she give them both clinical and theoretical instruction?—Yes, and takes them round and informs them of certain important rules. I think it is a terrible thing to send an absolutely untrained person into an acute mental ward. I should always avoid that for some time.

7230. Until they have had some experience?—Yes.

7231. Now with regard to the men, you have not apparently had so much difficulty in getting male attendants?—Not since the war. There has been quite a number of a very good type of man obtainable.

7232. Are you satisfied with your male side?—Well, I am always anxious for something better. I am thankful for what I have.

7233. We notice you have on your male side altogether 191 male nurses, and that you have 84 who hold the Medico-Psychological Nursing Certificate?—Yes.

7234. Do you encourage them to go in for that examination?—Yes; first of all they have to go in for it; it is compulsory. Then they very likely will be got rid of if they do not; and finally they get very much better remuneration for it. The acquisition of a certificate means staff rank, which, of course, carries with it higher pay.

7235. What facilities have the male nurses for preparing for the examinations?—A regular class is held, courses of lectures and demonstrations.

7236. And who conducts those?—The head nurses and the sister tutor; and the doctors, of course, give the lectures.

7237. Your assistants give courses of lectures?—Yes.

7238. And have the men opportunities of private study?—Yes. We provide now a quiet room for the men to work in if they like, but, of course, it is only a personal and private matter to what extent they do that. They have a great deal of time off now, owing to our system—both men and women of course.

7239. Have they books that they can study?—They have a library, and they provide themselves with nursing books, and so on. They are provided with a proper lecture theatre as well, and facilities for training generally.

7240. Now in so large a staff as you have under your charge, there must of course necessarily be some variation in the quality of the nurses?—Yes.

7241. Have you had in your experience at Claybury any cases where male nurses have proved unsatisfactory in their treatment of patients?—Oh yes, certainly.

7242. And how do those cases come to your knowledge?—Observation of myself or one of my medical officers, or the inspector or head nurses, or a patient himself.

7243. From all those sources you have had complaints?—From all those sources one gets reports not infrequently.

7244. And when you get a complaint of that sort, what steps do you take?—If it is a trivial matter the medical officer who receives the complaint will look into it, and if he is satisfied, nothing further need happen except a report. If it is in the nature of a grave matter, I invariably see into it myself and, if necessary, held an inquiry into it.

7245. You of course possess disciplinary powers, with the ultimate power of dismissing a nurse on the spot?—I can suspend him, until the next meeting of the committee.

7246. It would be interesting to know what number of serious cases have come to your knowledge in which you have had to take the step of suspending the attendant for misconduct after investigation?—They arise now and again. I do not think in the last year I have had any, nor in 1923; I think the year before that I held a big inquiry over a case.

7247. Was that a case of alleged ill-treatment of a patient?—Yes.

7248. And what was the result of the inquiry in that case?—The result was that the evidence was not good enough. My sub-committee investigated the matter finally. We had no positive evidence that the patient had been ill-treated. Of course it is very difficult sometimes.

7249. One recognises that the subject matter is naturally difficult, and also the obtaining of evidence. Have you had cases on the other hand where you have been satisfied that there has been ill-treatment of a patient?—I can recall one in which a male nurse admitted it himself, and was dismissed.

7250. Was dismissed by the visiting committee?—Yes; it was not a very serious matter.

7251. What had he done?—One likes a concrete case, you know?—I am afraid I am rather quoting from memory; it is a long time ago, but I think he rather violently pushed a patient on to the bed, and did a thing which a nurse should not do. This matter came out afterwards, and he immediately confessed;

13 January, 1925.]

Dr. G. F. BARHAM, M.D.

[Continued.]

it was very nice that he did. The committee thought it a very hard case, because he had been so honest; but he had to go.

7252. What we are much concerned with is that when a case of ill-treatment, or alleged ill-treatment, occurs, there should be every facility for it reaching your ears, so that you can put in motion your powers of investigation which you have just described. Do you think that under the present system, as you administer it, a patient might be ill-treated, and yet not be able to bring his or her grievance to your notice?—I cannot think that it could be so, because the patients themselves have got the absolute power of reporting the matter.

7253. I am struck with what you have told me, that a number of trivial cases are reported to you, which shows that even trivial matters may come to your notice?—Yes. Of course it must be understood that with all the variety of patients one has to deal with, those who are disgruntled or unhappy in any way will make all kinds of trivial complaints. I do not think any of them are actually passed by entirely without some thought given to them. I have quantities of letters daily which I always open and look at.

7254. *Earl Russell*: From patients to you, do you mean?—From patients to me, yes. It may be nothing more than a desire to be moved from one ward to another because they are not getting on. I hand those requests on, and if possible they are carried out.

7255. *Chairman*: Of course one recognises that the duties of the nurses in a mental hospital are of a peculiarly onerous and difficult character?—Unquestionably.

7256. And I suppose you have many patients who unhappily are unable to appreciate that things are being done for their own good?—That is so, yes.

7257. And you will have also, of course, patients who for the time being have completely lost all control over themselves?—Yes.

7258. And you will also, I suppose, have patients the symptom of whose malady is that they are peculiarly irritating?—Undoubtedly, yes.

7259. What one is thinking of is this, that the staff of the mental hospital is more exposed to difficulties in the conduct of their duties than almost any other staff?—Yes, and the slightest want of tact goes a long way.

7260. Temperament is a very important matter?—Temperament is extremely important. I am quite sure of one thing, that the nurses are not unkind to the patients. It is a very rare thing to find a nurse who is deliberately unkind, but situations are bound to arise, and unless one is born with more than the ordinary amount of tact and self-control, it is not a question of ill-treatment, it is a question of whether you avoid trouble, and a small thing is very easily magnified.

7261. One can see that the atmosphere is abnormal altogether?—It is extremely difficult.

7262. But, on the other hand, the qualifications, I should imagine, for that work would be the possession of a very equable and placid temper, if possible, and a power of self-control in the attendants?—Yes, you are useless if you have not got it.

7263. The supply of persons so gifted is necessarily limited, is it not?—I am afraid it is rather; it is not always easy to find them.

7264. I should imagine that those are the qualities which you would look for in the selection of your attendants?—Certainly some of the qualities that are essential. If one finds anybody who is obviously unsuited one has the means of getting rid of them up to a certain point. I have the means of getting rid of every nurse I engage within six months. There is a probationary period of a week's notice. If they are obviously unsuitable, whether it is through an examination which is always conducted up to six months to test their intelligence, sometimes whether they write well enough even, or whether they are trainable in other respects, or whether by temperament they are unsuited, I have that power, which

the committee allows me, to get rid of them on a week's notice.

7265. I suppose you find that some nurses are not able to bear the atmosphere of the asylum?—Quite a few will resign of their own accord within a few days.

7266. They find they cannot accommodate themselves to their surroundings?—Yes.

7267. On the other hand, on the women's side you tell us it is more difficult to get suitable nurses. Have you ever thought of having women attendants on your male side?—I have had them during the war and, of course, I am well acquainted with the work of women nursing men at Long Grove, where I was for 10 years.

7268. What do you think of the idea?—I like it very much.

7269. Do you think that the influence of the woman nurse is good for the male patient, helping him to a certain measure of self-control?—Yes, with certain reservations; the touch of a woman in the ward is very easily seen at once, the ward is more presentable and prettier, and, of course, there is also a difference—women are naturally better nurses than men, though there are very many excellent male nurses.

7270. And I suppose one may say also that their powers of sympathy are perhaps greater?—Yes, and I think for certain kinds of male patients they are far better, whether it is a question of simple nursing, or elderly people; but, of course, there are limitations to their use.

7271. The problem seems to be rather difficult, because while you appreciate the value of the woman as a nurse, on the other hand your experience has been that it is more difficult to get suitable women nurses than male nurses?—That is so.

7272. I see that during the last five years, while you have engaged 97 new male nurses you have engaged no fewer than 492 new women nurses?—Yes.

7273. And that 124, that is, 55 per cent., of the female staff have less than three years' service?—Yes, that is the position now.

7274. What is the reason for that circumstance?—Well, I think that they have not got the same stake involved as the man has. A man very likely marries and has a home to support; possibly a woman is merely looking out to get a home, and does not take her work so seriously; some of them are like that, there is no doubt. I do not wish to be understood as saying that this applies universally at all; quite the contrary; but quite a number of young women when engaged are like that, and one finds they do not take up the work in the sense that a nurse does in a general hospital, where she is taken on to train, and if she does not train she goes. One finds a certain difficulty with the kind of nurse that I have to take on, in that respect.

7275. Do you mean you find some young girls say they will try a mental hospital and see how they like it?—Well, they want employment and they try it. Then they move on, and perhaps find they do not like it and have a change; or, of course, there is the question of their capacity for the work—very often that is the reason that they have to go.

7276. What measures have you been taking to obtain nurses of better education and greater suitability for their work?—During late years, the hours of duty are far more reasonable, less unjust than they were, and the pay, of course, has improved—those are two points. Then a thing I like to see very much is that one tries to attract the right kind of nurse by taking her on to train; that is part of the condition on which you take her on; you hope therefore to attract a woman who is taking the work up seriously.

7277. And you endeavour to make it a career?—Make it a career, yes.

7278. What steps can you take to impress that aspect of their vocation upon your nurses; is this still the women you are speaking of?—Women or men in this case. You consider their educational standard;

13 January, 1925.]

Dr. G. F. BARHAM, M.D.

[Continued.]

in engaging them, and then you interview them and have to form an opinion about them; the whole point of the training is placed in the very forefront. I invariably discuss this matter with them. A person who does not want to be trained you try to exclude.

7279. I have no doubt your subordinate officers in the institution have a good deal to do with the attendants, and much will depend upon their capacity in turn, as you yourself cannot undertake the training of all your own nurses?—Exactly, and for that reason now one is insisting not only on a mentally trained nurse, but on their having a wider training in a general hospital; we try to introduce the atmosphere of the training school of large hospitals.

7280. On that matter have you found any difficulty with regard to your nurses passing from a mental hospital to a general hospital, to supplement their training?—Yes, undoubtedly.

7281. We have heard something of the trouble that arises. I suppose the difficulty will arise in this way, that a nurse who has attained competence as a mental nurse cannot very well enter a general hospital at the bottom?—She has to.

7282. But she would naturally resent that, to begin as a probationer in a general hospital after having obtained a position of competence in a mental hospital?—I do not think they mind that very much if they are the right sort.

7283. What is the difficulty—is it the reluctance of the general hospitals to receive them?—Yes, in certain cases. The Poor Law infirmaries will take them, and are very glad to have them very often. I get testimonials back that I am very proud of, and some general hospitals will take them; but, generally speaking, I think the general hospitals can get all they require without it, as they have given a mental nurse a bad name, quite unjustly.

7284. Who has given the mental nurse a bad name?—The public and the general hospital—I mean they do not think they are the class of people they want.

7285. Do you mean they have not had experience in general nursing, but have only had a specialised experience which is unsuitable?—Yes, partly.

7286. On the other hand, mental disease is, of course, frequently associated with physical disease of one kind or another, and I should imagine that there is a certain common ground of nursing, common to the whole profession?—Undoubtedly, and I am perfectly sure it would do the general nurse a great deal of good to undergo a mental training, which we also very much desire, of course.

7287. Then you would advocate some scheme of co-operation between the mental hospitals and the general hospitals, whereby there could be an interchange of staff from time to time?—Yes. I have advocated that for a long time.

7288. At present any such interchanges must naturally be voluntary?—Yes.

7289. And while you have had assistance from some directions, in others you have found that no place could be found for your nurses?—It is sometimes difficult, yes.

7290. May one say that the difficulty arises from the two sources, first, that the general hospitals have already an adequate supply of nurses, and have no room for others?—I think that is often the case.

7291. And, in the second place, that they find it does not fit in with their system or with the framework of their institutions to take nurses who have already had a considerable mental training?—I think so, yes. I know of matrons who do not like them, and that ends the matter.

7292. But while there may be difficulties in the way, you attach importance, I gather, to the nurses having as part of their curriculum a period of general training?—I think it is a matter of extreme importance, and I think the London County Council voices that also in making it now a regulation for filling their posts of matrons that they shall be generally trained.

7293. Then would you advocate the mental nurses having general training before or after they have qualified as mental nurses?—I do not mind a bit about that; it will surely be the latter in the majority of cases.

7294. Now you have told us of the importance you attach to instilling into the staff a sense of responsibility and a knowledge of the work. You have told us also of your provision for lectures, and the clinical and theoretical training of your staff. Are you quite satisfied that you have a reasonably organised system of instruction now?—I think I am getting it; it is a very long and difficult problem.

7295. Then we have spoken of the question of the general training of mental nurses; and in attracting the best class of nurse something, no doubt, depends upon what social environment you are able to offer them, the amount of leisure and comfort of their lives?—Yes, that is very important.

7296. Have you a nurses' home?—Not what is generally known as a nurses' home.

7297. Where do they live?—I might say, first of all, that I have over 50 female nurses living outside. The male nurses generally live outside; they only have to live in in certain proportions as they are required.

7298. That leaves you about 170 resident?—Yes, and they have quarters; they are rather mixed up, and, of course, many are sleeping in rooms adjacent to the wards; they have various recreation rooms and mess rooms, and lecture rooms, and so on.

7299. Mr. Jowitt: Have they separate bedrooms?—Yes, in nearly every case, but not invariably; very often I have sisters, friends, sleeping together, but that point has been one that my committee has considered very carefully, and has very recently altered a good deal.

7300. Chairman: One would sympathise with the nurse's desire to have a certain measure of privacy at some period of the day; she is moving about all the day among the distressing cases which she has to handle, and then perhaps she finds herself leading a more or less communal life in the meal times, and so on. Personally, I attach great importance to everybody having a certain amount of privacy. What opportunity has the nurse of being by herself without feeling that there is always someone else there?—Of course, the public room she has to share, but she has her own room.

7301. Her bedroom?—Yes. If I may just sketch out the hours of duty, say from seven to two, after that she is free.

7302. Free after two o'clock?—Yes, up to seven o'clock the next morning. The next week she will come on at one, and will go off at eight—it varies, eight or nine.

7303. On the day she is on duty?—On the day she is on duty in the afternoon. Then she may go away for the night by permission, or if she is off the next day she may have a night and a day off.

7304. The day she is on duty in the morning, that is to say, the seven to two period?—Then she has to sleep in the hospital.

7305. And has she a day off in that week?—She has one complete day off in that week, and six days in which she works this seven to two, or one to nine.

7306. And does that represent her total duties?—No; it is the total actual duty, but if a nurse is resident and she is called upon, if there is an emergency, or anything of that sort, say a fire, or a serious incident of any kind, she is bound, of course, to render assistance, but nothing more than that.

7307. The normal life of a nurse seems to be that she has alternate weeks from seven to two, or from one to nine, on six days in each week, and beyond that her time is her own, short of any special call upon her services?—Yes. We run social clubs. The women can play hockey, and the men football.

7308. Tennis?—Yes, tennis, and, of course, they enjoy the social amenities in the hospital; there are cinemas, plays and that sort of thing.

13 January, 1925.]

Dr. G. F. BARHAM, M.D.

[Continued.]

7309. And a library?—Quite a good library, yes.

7310. Are the nurses moved about from one class of patients to another, and from one ward to another?—Yes; I encourage that as much as I can.

7311. Is that to enable them to have experience of all classes of mental illness?—Yes; if they want to get on they must have that experience.

7312. There is another aspect of asylum treatment that is important: you have, of course, inside your gates quite a number of industries carried on?—Yes.

7313. The principle upon which such an institution as yours is conducted is to make it as far as possible self-supporting in its internal economy?—We do all we can in that way. Of course, it is not really.

7314. You have a large staff of labourers, gardeners, and skilled tradesmen?—Yes, we have nearly 600.

7315. None of those are patients, I suppose, are they?—None of those are patients, no.

7316. Then having this large staff you must have a lot of work to do. Are you able to associate the patients with the carrying on of the work?—Yes; of course, that is a very important form of treatment in a mental hospital.

7317. 569 is the precise figure of labourers, gardeners and skilled tradesmen?—I include the nursing staff in that; that is the total staff at Claybury now.

7318. *Earl Russell*: Give us your numbers over and above the nurses?—36 farm labourers, gardeners, some 16 artisans, and then there is, of course, the domestic staff. Everyone has at the present time patients more or less in association; some are actually in charge, whether they are nurses or not.

Earl Russell: But 100 to 150 would it be?

7319. *Chairman*: That is almost exactly the figure I got, Lord Russell. (*To the Witness*): I suppose you include the medical superintendent and his medical staff in the total. It just looks round about 150, that we may call tradesmen?—Yes.

7320. Then you associate your patients with these people in carrying on various occupations?—Yes; about 60 per cent. of the patients would be employed themselves.

7321. And I suppose regular employment with supervision is itself a form of treatment?—Undoubtedly. It is a dreadful thing if they do not occupy themselves.

7322. Now there are all sorts of work?—Yes; one can always do any amount of this kind of thing. Of course I have a great many varieties of work, tailoring, bootmaking, laundry, needlework, gardening, woodchopping, actual work labouring on the farm—a great many varieties, mat making, and those sort of things.

7323. Would you give us the figure for the maintenance rate at Claybury at present?—At the present time it is 25s. 3½d.

7324. Is that merely maintenance, excluding standing charges?—Yes, that is just the maintenance, and it is common maintenance rate for the county.

7325. Just reverting to the question of the nurses for a moment, you told us of their hours. Has a nurse ever got to do a double turn on one day in a week?—Yes, under the system of hours I omitted to say that she has one long day in a week, and that is really a modification. I might say it is a temporary modification under the Council now, the one long day a week, and then five days either morning or afternoon work.

7326. What does the long day consist of?—The long day is seven to eight.

7327. That is 13 hours?—Yes, with, of course, intervals.

7328. *Miss Madeleine Symons*: How is the night duty arranged?—They have four nights off in a fortnight, and they work, of course just overlapping the day staff. They will come on—I have a little difficulty in saying, because we are just modifying our hours again, but on the male side they now come on at 9.15 and go off at 7.15.

7329. *Chairman*: Have you eight-hour shifts there too?—No, but it does not exceed a 96-hours fortnight.

7330. *Earl Russell*: They cannot come on at 9.15, because your other nurses have left at nine?—No, I was just saying the hours are under a process of modification again. The actual working hours now, and what will apply to the hospital now will be that the afternoon shift will run from 1 to 9.30, and the night staff will come on at 9.15; that is actually going on on one side and will be on the other shortly. Incidentally that was organised to enable patients to sit up till half-past nine.

7331. *Chairman*: That is rather an interesting point—the hours that patients get up and go to bed. What is the ordinary hour for getting up at Claybury?—Seven o'clock.

7332. And for going to bed?—If you are ill in any way and up in the day you will be in bed by about half-past seven.

7333. Is that compulsory?—Yes, that is to say if you are being treated in any way or are ill.

7334. Yes, but take the ordinary patient who is not for the moment requiring special treatment—do they all go to bed at 7.30?—No, they sit up till quite nine, and they will be in bed by 9.30; they have to be in bed before the night staff take over.

7335. When do they have their last meal before going to bed?—They have their last full meal at five.

7336. It seems a long time from five in the afternoon until breakfast next morning, which must be about eight, I should think?—It is, but one should explain that a certain part of that meal is always set aside, there is an issue of cake—I find, as a matter of fact, that that is taken as supper.

7337. There is no regular supper, is there?—There is no issued supper.

7338. *Mr. Snell*: But the patients reserve that for themselves?—Yes.

7339. They deprive themselves of it at tea?—The dietary I think is reasonably liberal. I should say the committee are interesting themselves very much in this point, and is probably arranging a supper meal, an actual issue of some beverage and, for instance, of cake.

7340. *Earl Russell*: At what hour, if they are put to bed at seven?—That would be given after, perhaps eight o'clock.

7341. After they are in bed?—No, to the people sitting up.

7342. I thought they went to bed at half-past seven?—Only the people who are ill.

7343. *Mr. Snell*: Do the people who go to bed ill get any food, if they need it?—If they need it, always, yes; there is always an issue of food for infirmary purposes.

7344. *Chairman*: But taking the ordinary residents, I confess it seems to me a very long period to go fasting, from five o'clock in the afternoon to eight in the morning next day?—It is a longish time. I think that is a matter which is under process of alteration. With the establishment of longer hours very likely the tea meal will be retarded.

7345. The distribution of the diet is rather an important thing, and I can imagine that, in the comparative monotony of an asylum, meals must bulk as a rather interesting feature in the day?—Yes, undoubtedly they do.

7346. Would you not be in favour of either rearranging your meals, or taking some other step to obviate that very long fast?—I am in favour of it, and I think that when these hours are changed it will possibly be so; I know the committee desire that it should be so.

7347. We have had a dietary put before us, the London County Council dietary which we know was adopted some years ago, and it has been modified. It may be quite an adequate diet; I have no doubt it is arranged on the best advice, but one has to consider not only the quantum of the diet but the way in which it is administered, that is to say, the distribution of the meals for the patients; and to have no meal after five o'clock is certainly different from what patients must have experienced in their own private lives. If one is wanting to assimilate

13 January, 1925.]

Dr. G. F. BARRHAM, M.D.

[Continued.]

the atmosphere of the asylum as much as possible to the feeling of home, there are very few homes in which nobody has anything to eat after five o'clock until the next morning at eight?—I agree that it would be desirable to have a later meal. I know there is much supplementing of diet.

7348. The fact that they do carry away some of their meal and reserve it for a later part of the evening is the best evidence that they feel the need of something later on?—I quite admit the desirability of what we were saying, but I do not think it does justice to the amount of food issued under the scale. I could quote a ward in which I was a few days ago where I asked a nurse what that large plate of cut-up cake was. It was not cake saved by the patients, it was cake that they would not eat, and was going to be used for their supper meal. What I mean is that the issue of tea, I think, is ample for that purpose.

7349. In short, they may pocket something?—They may pocket it, or what more often happens, the nurse reserves it.

7350. *Mr. Snell*: Is the tea meal a fairly substantial meal?—Yes; it consists of bread and butter and cake and sometimes jam or lettuce, and fruit sometimes, with a pint of tea.

7351. *Mrs. Mathew*: May I ask who settles those hours for meals?—They are settled really by the committee. There are points that present considerable difficulty—for instance, to retard this tea meal—in the sense that the kitchen staff have got to be considered. The kitchen have their hours too. I mean it is not an easy matter entirely to provide an enormous institution and pay all the staff and have an unlimited staff, as you might require if you go on extending your hours.

7352. *Chairman*: Of course one recognises that that has its effect upon the time of going to bed. With a staff of one to fifteen, or whatever the number may be, it takes time to get them all tucked up?—Undoubtedly.

7353. Similarly with regard to the meals, these are very large meals to get ready and to serve; but one is exploring now the social aspect of your institution, and how far it can be assimilated to what we may call the normal regimen of people's lives?—Working patients invariably sit up; they form a considerable proportion, although it is not the invariable rule, they will have what they call social evenings when tea and coffee and such like things are issued specially for that purpose.

7354. What hours do the patients work now?—They work after breakfast. A few patients will work more; they may get up and assist nurses from the very start at seven o'clock, but the majority of the patients will not go to work until after breakfast, about half-past eight or nine, or half-past nine; then they work till nearly dinner time, which is at one o'clock; I suppose half-past twelve would be a fair time at which work shuts down. They will resume in the afternoon. But I should say that all this work is entirely voluntary, there is no compulsion whatever.

7355. When will they knock off at night?—They will knock off at four to half-past.

7356. That looks to me something like five or six hours' work?—I should say at the outside it was less than the average, but patients are not very industrious as a rule; it is rather a difficulty to get them to work. What I call a worker in many cases will be the men or women who take a duster and polish a floor for an hour or so and assist in the bed making—he will be classified as a worker, but the rest of the day he may be doing nothing.

7357. The laundries are more or less like little factories?—They will not work regular hours.

7358. What are the hours in the laundry?—They will work there from half-past eight or nine, they dribble in; there is no going in at a regular time. They are not paid hands, they just go in as they like, they are not herded there; they will work there till twelve or half-past. Some of the women are

keen workers and will perhaps work better than a paid hand. I have men patients who are better than farm labourers, but it is done with an enthusiasm of their own.

7359. I do not quite understand how you run the machinery. Of course you have your skilled men who are there in charge, but if you are putting work systematically through a laundry, handling as you must do a very large number of garments and linen, I do not quite see how you work that with people dropping in and out?—The laundry is supposed to run with its fixed staff and all these patients, a lot of them, want just to iron or fold, or what not, and they do this. You go in there and you see them all sitting round the drying horses warming themselves; others would be ironing. Of course it involves a certain amount of management and tact on the part of the laundrymaids, who are specially engaged for that purpose.

7360. You have told us of the entertainments for the nurses, and so on: What have you by way of entertainments for the patients?—Every week they will have a dance, for one thing; practically every week they will have a theatrical or other entertainment, or cinematograph. There are other forms of entertainments in the way of games and amusements. A certain proportion of the male patients will watch football matches once a week, and the women will watch the nurses playing hockey; and then, of course, there are ordinary ward entertainments, and social evenings occasionally.

7361. Now let us pass to the private male patients at Claybury Hall. What are the terms there upon which the patients are received?—The present rate is 56s. for London settlement, and 59s. 6d. for outside London.

7362. That is a very moderate rate, of course, for paying patients?—It is, as rates go.

7363. Is it designed to bring within the reach of patients of moderate means the advantage of the treatment you can give them?—Yes.

7364. And do you find that it is taken advantage of and appreciated?—The rate has had to go up owing to the increased cost of living, and I think since then Claybury Hall has not been filled in the way it used to be.

7365. It is getting too expensive, is it?—I think so, yes.

7366. Then, apart from the patients at Claybury Hall, you have private patients in the general institution, have you not?—Yes, we have some 50 private patients on the private list cases.

7367. I am putting aside ex-service men for the moment, but are these persons who, having been admitted as rate-aided cases, have been found to have means of their own, and then are classified as private patients?—Yes.

7368. I think the only difference in their treatment is that they are entitled to wear their own clothing?—Yes.

7369. On that matter of wearing their own clothing or not, what is the rule in your institution for all patients, apart from private patients?—The hospital provides for all patients who are not on the private list, but I never refuse patients leave to wear their own clothing now, if they make a request or if they themselves object to institutional clothing, and they can produce their own clothing.

7370. Of course, clothing is a matter which has a psychological effect, one knows. May I take it that there is no uniform in your institution?—None whatever.

7371. There is no impropriety in saying that I recently visited one of the London County Council's asylums myself, and paid particular attention to that matter, and I noticed that the women had no uniforms at all; there was a very great variety of clothes. Are the clothes made in the institution?—Yes, practically always.

7372. When one hears of the clothes being supplied in the institution, as far, at any rate, as the London County Council is concerned, it does not mean that

13 January, 1925.]

Dr. G. F. BARHAM, M.D.

[Continued.]

the patients are all clothed in the same way?—Certainly not. A special ladies' committee has been sitting on this for a long time, and we have a very great variety of clothing, both male and female. There is no uniform whatever, and that is encouraged.

7373. The effect of a uniform may be depressing, as one knows?—Yes. I regard that as very important.

7374. There is the further question of the difference between clothes that are supplied to you and your own clothes?—Yes.

7375. Can a patient who is not a private patient get liberty to wear his or her own clothes, if they are supplied by their friends?—Yes, I always allow that at the friends' own risk. I do not undertake to care for their clothing, but if they like to provide it, it is always allowed.

7376. It must be consistent with it being sufficiently warm and adequate?—Yes; one has to consider that, of course.

7377. Where do you accommodate your service patients?—As far as possible in service wards.

7378. Are they by themselves?—They are by themselves.

7379. They are, of course, in the category of private patients?—Yes, they are.

7380. You have told us a great deal about your system generally. I would like now to ask you a little about your experience in the admission and detention of patients. Of course, you do not come in contact with the patient until the patient has been certified and sent to your institution?—That is so, yes.

7381. At that stage you meet the patient for the first time. Do you personally see each patient who arrives?—Not on arrival, no. I see them always within a few days.

7382. Where do they go when they come, first of all?—They are admitted in special admission wards.

7383. And what is the feature of those wards—what is the treatment and the routine of those wards?—They are wards set apart for new cases. They are more highly staffed, and the staff, of course, is selected specially, and they are hospital wards in the sense that they are set out as hospitals where patients are kept in bed.

7384. Have you adequate accommodation for keeping patients there for a time until you can investigate their cases and form some diagnosis and prognosis as to them?—Yes, I have.

7385. You do not find yourself cramped for space?—That depends on the admission rate.

7386. And I suppose that fluctuates?—That fluctuates enormously.

7387. When do the patients first come under your personal observation in these admission wards?—By statute within a week, but I generally see them at varying periods; I am often down there, and I often see new cases.

7388. Who actually receives the patient on admission?—The medical officer who is on duty. Then, of course, one of the senior officers will see that case also and is responsible for that case.

7389. Now there is an examination made on admission by a particular officer who receives the patient, and there is a further examination by you with a view to report?—There is a further examination before that by the medical officer who treats the case.

7390. And then there is the responsible examination by the medical superintendent, upon the result of which I suppose the future of the case largely depends?—That is so.

7391. What steps do you take to investigate the history of the case, which is so important in relation to mental illness?—We send out a form for the friends to fill in, and, if necessary, we write personally to the friends if we want to know anything specially. We also have the information from the hospital visitor, who will, on request, visit the home.

7392. That is a very important functionary, but do you always try to get in touch with the relations

of the patient?—Yes, and they are, of course, notified at once of an admission and are allowed to see the patient as soon as they like.

7393. There are some cases where there are no suitable relatives to communicate with, of course, but where there are any relatives you communicate with them?—Yes.

7394. This hospital visitor is an interesting person. Is that a voluntary worker?—She is a voluntary worker, and she has been there about a year. I regard her as of enormous value. She helps me extremely by being an outside friend to a patient. She wanders round the wards; she has no official standing, and they know she has not.

7395. She can go anywhere?—She can go anywhere she likes, or she is directed by medical officers. If a patient says to me, "My friends have not seen me for six months or a year," I say, "Well, get on to the hospital visitor," or I send the hospital visitor a note, and she immediately goes and sees that patient on her next visit, and will always go and see that home, hunts round in the most admirable way, and very often extraordinary things result from this. A patient's friends are sometimes hardly aware where the patient is; they come down and visit them and a great deal of good is done.

7396. *Earl Russell*: Do you mean that through carelessness they have lost sight of the patients?—Through carelessness or family indifference or what not.

7397. *Chairman*: Has she any uniform?—No. She writes reports which pass through my hands, and find their way ultimately into the case records, and therefore form very valuable information for that patient's case.

7398. She seems to fulfil a function of great importance as a sort of liaison between the patients and their relatives outside?—That is so, yes.

7399. She is unpaid, of course?—She gets nothing for it.

7400. *Mr. Snell*: Is she appointed by the Mental Hospitals Committee?—She is appointed in the sense that one is granted permission to get a hospital visitor.

7401. Anyone could not walk in and offer to do it?—No, but there is room for more help.

7402. *Chairman*: She is a volunteer who has volunteered her services and has been permitted to exercise her philanthropy in that way?—Yes, that is true, but I should say that this practice is older at another mental hospital. At Horton in Epsom they have held courses there for training hospital visitors, and they have had them longer there, and the lady that visits Claybury was under the training of a lady at Horton. It is all voluntary. It is very informal but it is recognised. We have no authority over these hospital visitors.

7403. *Sir David Drummond*: You suppose there is room for more?—Unquestionably if you get the right kind of people.

7404. *Chairman*: Yes, but one would want to keep out altogether the idea of her being an official?—Yes.

7405. One is so anxious to preserve the avenues of communication between the patient and the outside world, and she seems to fulfil in a remarkably useful way that function, but one would not like to see her officialised?—No. I asked her recently about that point, and she said at once if she was paid, or anybody was paid, the value of the post would go.

7406. They would simply become the same as the other officials; the important point is to have the other outlook for this purpose?—I think so, yes.

7407. She must give a great deal of time—does she attend every day?—No, she at present attends twice a week, but, of course, her work involves a good deal of visiting and outside investigation, and she always helps patients after discharge. She has found them homes.

7408. Does she to some extent fulfil the function of after care?—On her own, and by request, she sometimes will do that kind of work.

13 January, 1925.]

Dr. G. F. BARHAM, M.D.

[Continued.]

7409. Now in the admission wards are you able to make, even at the outset, anything in the nature of a rough classification of the cases?—It is possible to do so. Probably patients are admitted into one ward, but I have a variety—what I call an admission unit in the hospital where there is classification. I can put a patient in a quiet ward, and so on.

7410. What one has felt is this, that the early stages of the onset of this malady may be the most important stages—I think you will agree with me there?—Yes.

7411. And it is very desirable, is it not, to eliminate, if possible, all circumstances which might tend to aggravate the illness just at that critical stage?—That is most important, yes.

7412. One cannot but feel that a patient who we shall say is in a nervous state might suffer from association with cases of a more advanced or distressing type, and might in that way in the early stages, instead of benefitting, really suffer. You see what is passing through my mind. It is a difficult problem, I know, because you cannot have each patient treated individually; but cannot you by classification prevent cases which appear to you to be hopeful cases, temporary cases, or slight cases, from suffering by association with more extreme or distressing cases?—I think it is possible to do so. It is done up to a point. That is to say, I do not think I should ever subject a person, who we knew was a sensitive educated person who might have come down in the world and got into a mental hospital, to that sort of thing; if they were suffering from depression, or any incipient condition, I have a perfectly quiet and nicely conducted ward where I place women of that sort.

7413. That is what is in my mind. If one may put a practical case to you: suppose in one day there are presented to your institution a case of violent mania (what the public call a raving lunatic), a case of mild melancholia, and then possibly a case of depravity or a moral pervert—there you have three totally different classes of cases altogether. I could imagine that the second one, the case of mild melancholia, might have his or her condition greatly aggravated by finding herself or himself associated on the one hand with a raving lunatic, or, on the other hand, with a moral pervert?—I have always thought so too and have acted on that. I could go back many many years thinking of my admission hospital at Long Grove where such patients were specially classified, they were given the privacy of screened-off cubicles. You quote three cases. The mania cases will probably find their way into a special room, or into a continuous bath; the depraved case as likely as not will remain in the admission ward, or find its way into a room by itself; whereas the case you want to get at is the one which is given special consideration.

7414. So far as the case of acute mania is concerned which requires special treatment, such a case is put in a room apart, I have seen the sort of room myself; and the only thing that one would be anxious to secure would be that such a room where a patient has perforce to be secluded should not be in the immediate vicinity of this admission ward of yours, because a maniacal patient may scream, shout and so on, and disturb a quieter patient, and also excite a quieter patient. Are those separate rooms in which you would place an acute case contiguous to your admission ward?—No.

7415. Could you hear in the admission ward what is going on—suppose you have a case of acute mania, could those in the admission ward hear what was going on?—No, I do not think so, not in the quiet ward that I have at Claybury. They are both equally admission wards. If a patient is very noisy in the single room, although the single room is not exactly contiguous, sound penetrates very much, and there is a great difficulty over this, I am very very conscious of it.

7416. The only solution would be to have admission wards of more than one class into which you could

make a rough classification of cases so that they might not do mental injury to each other, and this would be preliminary to your more careful diagnosis and ultimate allocation?—Yes; that is really in effect what we are doing.

7417. I know that alterations are being carried out in a number of your institutions, but that is an ideal, I think, which you would agree with?—Well, some years ago I established what I call quiet admission wards; they do not satisfy me, in the sense that they are too much in the building; and, as I say, sound penetrates so acutely. If somebody is really shrieking you cannot get out of it; but the committee have now under consideration the establishment of an admission villa absolutely out of earshot, and out of sight of anything to do with acute insanity cases for this very purpose, so that a patient of the type we are considering would never come into contact necessarily with any case of a very acute nature, or obviously insane.

7418. I think one also ought to take this opportunity of bringing out from you that the number of cases of acute mania, and the class of person whom you describe as having lost all self-control, shrieking, and so on, is very small relatively to the total population of your asylum, is it not?—Yes, people are very often astonished how quiet it is. They expect to have noise.

7419. We have got the patient past the admission stage now. Will you tell me what facilities you have, if any, for the treatment of patients. You have told us, of course, that occupation is provided for the patients who can take advantage of it; that is, in itself, a useful thing; it helps to restore confidence and to steady the mind, but what treatment have you apart from providing work for those who can do work?—As regards the acute and early case of mental disorder, the first treatment that is provided is rest, whether that may be in the dormitory in a special room, or in the open air; then that is followed up, of course, with a complete investigation of the physical health of the patient.

7420. And apart from occupation, or rest in bed, or in the open air, is there anything provided in the way of treatment such as one has in an ordinary general hospital—I mean some particular method of treatment—medicinal, or physical?—I may mention several lines of treatment. First of all, apart from any mental treatment actually, there is the physical treatment of the patient, the investigation of any physical disease, and the correction of that. That can be assisted by any form of laboratory experiment or report that is required.

7421. You have a pathological laboratory, have you not, under your own roof?—Yes. Then that is assisted by such things as diet and massage, electrical treatment, hydrotherapy—all that is used constantly. I have a certificated masseuse at Claybury on duty. I think those, and occupation, form the general line of treatment, but as regards the more actual mental treatment of the patient, that is a far more prolonged and involved question. It would start off with a thorough investigation of the patient's state of mind, with a psychic analysis of his condition, and that is followed up sometimes by an actual psycho-analysis.

7422. Of course it is difficult to see what treatment you can give for the mind diseased apart from the case where it is associated with some definite or specific physical disease. Mental disease is so much on the psychological side that the treatment of it must be on lines of its own?—I think it is increasingly difficult, but by constantly watching a patient, by trying to rehabilitate his mind when you discover what is wrong with him, by methods of persuasion, diversion and correction, it is wonderful what you can do in that way. Of course, if you get an actually willing patient who wants to be treated (that being the great difficulty with mental cases—they do not want to be treated) it becomes much easier.

7423. Environment must have a great deal to do with it?—Yes, I think environment is extremely important.

13 January, 1925.]

Dr. G. F. BARHAM, M.D.

[Continued.]

7424. And in environment I would include recreation as well?—Anything which means help for patients. The appearance of the ward, the way dinner is served, literature—they are all adjuncts, of course.

7425. And possibly one may say the orderly character of the environment may help to have a steady effect?—Yes, I think the routine and discipline that some patients undergo is in the long run probably a benefit to a case that otherwise seems quite unamenable to treatment.

7426. On the physical side, have you a dentist?—Yes, a visiting dentist.

7427. And have you an oculist to look after their eyes?—We can always get the service of any specialist; we have no one specifically appointed.

7428. Suppose one of the patients wants a pair of spectacles?—I have the means of providing that, and I always send him up to an eye hospital if it is possible to send him; if it is not my committee will give me the services of an oculist.

7429. Then if a patient goes sick what happens? Have you special infirmary wards?—Yes, there are several infirmary wards.

7430. What steps do you take to satisfy yourself as to the condition of the patients under your charge in the matter of their recovery?—The doctors in charge of the various patients, especially admission units, gradually draft their patients into convalescent wards, and there they have a great deal of liberty and occupation, and as soon as he thinks they are fit he draws my attention to them.

7431. So that really the doctor who is actually in charge of the case is the medium of telling you whether the case is one approaching fitness for discharge?—The one infallible medium according to his own judgment, but of course it is not the only way.

7432. What other means are there?—My own personal observation, and perhaps I should say more than anything else by the friends, and the patient himself, of course.

7433. One of course is struck with this, that you must have very important administrative duties to perform; and with so large a population under your charge, do you find that you can get to know your individual patients?—I only know individually a few of them. When I say "know" I must be understood to mean that I know a great deal about them. It involves an enormous knowledge of a patient to say you know a great deal about him. I know a great many patients, of course.

7434. If one may put a common test, if you are going through a ward would you know the names of all the patients?—Oh dear, no.

7435. Then for your knowledge of the individual case are you dependent really upon the doctor who has charge of that section of your institution and on the records in your case book?—In general that is true. The doctor is a senior doctor who is my deputy on either division, and he is supposed to know all about the patients.

7436. Do you favour the view that the functions of the medical superintendent should be separated from those of the executive officials in an asylum?—I think it would be very helpful to the superintendent if it was possible, but I am rather convinced that it is impossible.

7437. There is an aspect of it that occurs to one: that in a mental hospital, unlike other institutions, the organisation of the institution, and of the system, is itself part of the curative treatment. You have told us that occupation, for instance, is a very important therapeutic agent. One would imagine that the person who was providing the occupation would have to make all the arrangements about that, the selection of patients, the work to be provided, and so on. All these things would really in a sense relate themselves to the treatment of the patients. I am thinking for the moment of the difficulty of dividing the functions. I can see the advantages of it, but I am also envisaging the difficulties. Is it not rather

a feature of a mental hospital that there must be someone who has control, not only of the medical side, but of the management of the institution which is itself connected with the treatment?—There must be a division certainly; but as regards an actual patient I think one official can control the treatment, the knowledge of the patient, and his recreation and occupation.

7438. Do you have much routine administrative work to do?—A great deal, yes.

7439. Can you delegate it at all?—Yes.

7440. You have a clerical staff, I suppose?—I have a large clerical staff, but, of course, the amount of writing and references that are made to the hospital are very large.

7441. Is the emphasis in your functions on the superintendent rather than upon the medical?—My inclination is upon the medical.

7442. But does your duty compel you to give more attention to the superintendent's side?—Well, Sir, it is inextricably mixed up, half of my clerical and administrative duties concern in one way or other the welfare of the patients.

7443. If you are taking up the question of discharge, for example, where you see letters from a patient, it may be said in one sense to be administration, but in another sense it is doing medical work?—Legal and compensation cases arise which take up a vast amount of time.

7444. Would it be possible for you to have an officer who, although under you, would be sufficiently responsible to relieve you of more of that administrative work, and enable you to follow, what appears to be your inclination, to do more on the medical side?—I think it is capable of development, yes.

7445. For instance, on the medical side you have, I think, seven or eight medical officers. I shall assume that those are gentlemen of competence in their profession to whom you can delegate a considerable amount of your work. Have you on the executive side officials comparable in status who could relieve you equally of superintendent's work?—Not quite in the same sense; but, of course, I have a good deal of help.

7446. I am trying to see if you could be released to some extent from the routine work. Recognising for the moment that you must be the ultimate court of appeal for the whole institution, if you had an official under you comparable in status to your senior medical assistant, such a person could relieve you to a large extent, could he not?

7447. *Earl Russell*: You have a steward?—I have a steward and a clerk of the hospital, who has perhaps six clerks under him; then, of course, there is the central organisation in London.

7448. *Chairman*: Is there any administrative means by which you could be relieved to a greater extent—any method you could suggest from your experience?—It is very difficult to know how it could be done. More clerical assistance, possibly.

7449. It seems to me that it is the responsibility rather than merely the clerical work that is involved?—It seems to me that the man in charge of such an institution has ultimately to keep the reins in his own hands largely, and the post must be more or less administrative. It ultimately comes back to that. Really what one requires is possibly more doctors, and that is recognised as the situation just now; they are increasing them.

7450. That may be so, but you are, of course, yourself the person ultimately responsible medically for the detention of the patients, that is to say, for deciding if their condition warrants their detention; the ultimate responsibility is, I think, with you?—Yes, that is so.

7451. Therefore, when so responsible a duty is laid upon you, you would naturally desire that you should have as ample an opportunity as possible of knowing cases under your charge, and being able to gauge their condition from time to time personally as well as through the medium of your officials?—Of course,

. 13 January, 1925.]

Dr. G. F. BARHAM, M.D.

[Continued.]

I have to devote that amount of time to every case that is of importance, where either the patient has brought himself to my attention, or my attention has been drawn to him by others as being a difficult case, a case that requires investigation.

7452. I can quite see that you attend to, and no doubt have time to attend to, the cases which are brought to your knowledge, but the initiative in dealing with those cases comes from others, not from yourself?—Not invariably.

7453. How do you deal with a case on your own initiative?—I am constantly perambulating the hospital, one way or another; I am going round as much as ever I have time. I know a great many of the patients; they do not leave me alone, I can assure you of that. They soon explain their condition to me, and if I have any doubt in my own mind I do not leave it there; I invariably carry an investigation through.

7454. Perhaps one should take along with this topic a fact which is worth bringing out, that, of course, while you have so large a population in your institution a very considerable number of the cases are cases as to which there is no difficulty at all?—That is so.

7455. I mean cases of senile dementia, and so on, for whom nothing can be done except to give a comfortable residence?—I think that is true, yes.

7456. Therefore, the field of enquiry, so to speak, is to that extent narrowed; the actual number of cases which require consideration from the point of view of their continued detention is not anything like the total number of your patients?—No, it does not represent the numbers at all.

7457. Is one difficulty about patients going out that they may not have homes to go to?—It does present a great problem, but, as you know, no doubt, we have the After Care Association, who help us loyally.

7458. After a patient has been for a considerable time in the institution, and has been relieved, are you sometimes apprehensive of sending the patient out in the world again, unless there is some place where shelter can be given for the time being and a new start made?—Yes, I am.

7459. You have, as you know, under Section 79, power to release patients to the care of relatives, even though they are still of unsound mind, more or less?—And that is acted upon a good deal, of course.

7460. There again do you have to satisfy yourself that the home is one in which the patient will not suffer?—My rule always is to make an enquiry through the After Care Association, or the hospital visitor, as to what the home is like. Then the application comes before the sub-committee with a report. Generally speaking, it takes effect.

7461. Do you have this difficulty, that patients may have recovered to the extent that in the institution they have steadied up and are more or less normal, but if exposed to the outer world, unsheltered by the routine of your institution and its protection, might break down?—It happens over and over again. I might perhaps quote one case.

7462. Yes, do please.—I have just re-admitted a very nice man, an educated man; he has a little means of his own. He was resident at Claybury for years and years, a very long time—I could not quote how many years. He had his parole, he was perfectly free; he had his liberty to go out whenever he liked. He did not want it. His contention was always that he had not confidence. He was extremely difficult to certify, but the Board of Control accepted my certificate, and he did not want to go. Had it been possible for him to have been a voluntary boarder he would have been one. Then came the point. Last spring I said to this patient: "You can go out when you like, you have only got to come and tell me, and I will discharge you under any conditions you like." He finally did come, and I was satisfied he was well enough to go. I made a good many enquiries to help him, and so on. He went out fully

discharged, and he came back a few days ago. He was out some months altogether.

7463. Was it a success?—An absolute failure. From the very start of his discharge he became absolutely miserable; he could not manage his own affairs; he simply dare not touch his money affairs at all and he has come back in a very profound state of depression, very much worse than when he went out. That is not a very rare instance of the kind of case you are referring to.

7464. *Sir David Drummond*: What were his home surroundings?—He had good relatives, but people who would not live with him. He could not of course get any work. Had he been able to get work he might have rubbed along better than he did.

7465. *Chairman*: Was he living with relatives when he went out?—No.

7466. Where was he staying?—I think he was staying in lodgings. I think the After Care Association helped him in the first place, but of course that does not last for ever.

7467. *Earl Russell*: He came back re-certified, I understand?—Yes.

7468. *Chairman*: And his last state was worse than his first?—Yes.

7469. *Mr. Snell*: He had no mental strain upon him. It was not inability to conduct his affairs, because he had none to conduct?—He had a certain amount of money. He had a Receiver when he was in the hospital. When he was discharged that money was handed back to him. He would not face the question of dealing with his own dividends; he has informed me that was so, since he came back.

7470. *Sir David Drummond*: Was he doing any work in the hospital?—Yes, he was always doing work.

7471. *Mr. Snell*: Was it the fact that he could not get work that depressed him?—I do not think so entirely; of course the absence of work encourages a morbid state of mind.

7472. *Chairman*: Yes, that is an interesting case. Now will you tell us the number of patients discharged in the present year up to the 30th October. It is 184 in all, I think?—Yes.

7473. What was the experience with regard to those? 126 were discharged as recovered?—Yes, that is the number.

7474. And 32 were discharged "relieved" to the care of friends; 13 are still on trial; one patient on trial has died and 12 cases sent on trial have relapsed, making up the 184 patients?—Yes.

7475. Do you find that there is rather a tendency on the part of friends prematurely to ask for the discharge of their relatives?—We have a lot of trouble in that way; it very often ends disastrously, but on the whole I think the freedom of discharge is now very marked and no good applications are refused.

7476. In the case of a patient who is recovering I suppose you find it difficult to say at what moment of time the patient has passed from mental unsoundness to mental soundness?—It is impossible. It is difficult to say the moment of course, but in connection with mental cases it is often a question of the tendency to relapse; and you hesitate to send a patient out prematurely, because you know that if a relapse occurs it is a most discouraging feature and will do the patient more harm than a month or two months longer detention.

7477. It seems that at that end rather than at the beginning your difficulties are most prominent?—They are very often. It is very responsible work discharging patients.

7478. Are the relatives inclined generally to ask for the earliest possible discharge?—I have an enormous number of applications.

7479. And do you find that if you, so to speak, accelerate the discharge in the case of convalescence, you may have a relapse which would not have occurred if you had gone a little slower about it?—I think that is undoubtedly so in a certain number of cases.

13 January, 1925.]

Dr. G. F. BARHAM, M.D.

[Continued.]

7480. Do you give financial assistance to the patients who are out on trial?—Yes, the committee allows an on-trial allowance.

7481. You told us in your *précis* that 63 patients on trial received allowances up to 15s. a week?—Yes, and of course on discharge they are allowed more, generally through the After Care Association. They get money granted to them from the Queen Adelaide Fund; 39 patients received grants up to £121 during those 10 months.

7482. You look after the patients; you give them cards which will allow them to go to Maudsley Hospital?—Yes, they are told to go there if they feel they are requiring help again.

7483. You have told us about your hospital visitor. You have got the usual chaplain, I suppose?—Yes.

7484. And clergymen of various denominations?—Yes.

7485. Finally there is one other matter we will discuss with you. You know that the second part of our Reference relates to the possibility of treating mental disease without certification?—Yes.

7486. We have already touched on it. Do you come across many cases which might be described as incipient cases of mental disease?—Yes, quite a good number.

7487. And of that number are there cases which by treatment or temporary rest might escape certification altogether, if there were some provisional method of treating them?—Unquestionably; a very considerable number I think.

7488. Do you think people are deterred sometimes from coming to a mental hospital until their malady is fairly well developed, just through a reluctance to incur the stigma of certification?—Yes, I am sure that operates as a very important deterrent to treatment.

7489. If some method of detention short of certification were devised whereby patients could for a time be under treatment and observation, and if some measure of restraint could be devised also, do you think a large number of cases would escape certification altogether?—I think so, yes.

7490. There seems to be a unanimity of view among the medical superintendents on that point. What is perhaps more difficult is to say how that should be done. Would you suggest that such a provisional period should be passed at the mental hospital itself or in the Poor Law infirmary, or, if not, where? The point is where is the patient to be taken. There is something to be said against taking the patient to a mental hospital, because at once the association of that place might be said to envelope the treatment. The Poor Law infirmary is undesirable for other reasons. Where is one to take this patient and where is this period of observation to be carried on? Have you any suggestion as to how that could best be achieved?—Well, Sir, as far as my own observation goes, I hope that if anything is to be done in this way it will tend in the direction of a great number of places where it is possible, with complete liberty on the part of the subject and the relatives, to go where they like. I do not see why it should not be a mental hospital or a Poor Law infirmary, if it is an infirmary and not an observation ward or workhouse, or a general hospital clinic or a place like the Maudsley Hospital, or a private clinic. I should like to see as much liberty as possible granted to relatives to have cases admitted where they like.

7491. Of course in dealing with rate-aided cases you appreciate there may be difficulty?—In rate-aided cases it is most likely to be a mental hospital or a clinic of a general hospital. I take it that the clinic of a general hospital under a scheme of this sort would be a reception house for early cases, and I feel that if there were only liberty in the matter and relatives were consulted more, they would send their friends to places like Claybury or a mental hospital quite freely.

7492. But one has got to bear in mind that sentiment has a great deal to say in these matters, and

it may be thought undesirable to associate such a system as this with the existing régime. If you could dissociate the two, we would need to find some means of dealing with the cases. The general hospital occurs to one, but is it not the case that there is a considerable reluctance on the part of general hospitals to receive mental cases?—They will not receive them in their ordinary equipment but they have received them; it is a fact; it is in existence.

7493. There are some general hospitals which have wards for such cases?—Yes, and I think others will follow when they know more about the matter.

7494. Of course one can see at once how very desirable it would be if the incipient cases, cases to be under observation, could be taken to a general hospital where they would incur no stigma at all, any more than a person who breaks his leg in the street and is taken to St. Thomas's Hospital?—Might I suggest that if the certification stigma were removed, it would not make a great deal of difference where the patient went, provided that the accommodation was suitable.

7495. I am not sure that the public discriminate between being in an asylum and being a certified person in an asylum. The public is inclined to say: "He has gone to an asylum." It is rather the aspersion which is supposed to attach to having had to go to an asylum?—After all the stigma will attach to the facts and not to the name you give them.

7496. You may put it either way you like. The unfortunate malady has attracted to itself the stigma?—I know it is so now, but still the clinic of a general hospital may get to be known as the mad ward, and the stigma would remain, if there is any stigma—that I would dispute; I do not think there is necessarily any stigma attaching to these conditions. It is a false public notion.

7497. That is a very good definition of a stigma, is it not? What one is concerned with is, is it possible to dissociate this form of provisional treatment from the circumstances which at present deter people from resorting to the institution. There are deterrents, as you know, against being certified; nobody likes to have his relatives certified. One wants, therefore, to dissociate as far as possible the atmosphere in any such institution for observation and treatment of incipient cases from the asylum atmosphere. I rather gather you think that the general hospitals should brace themselves to undertake that work?—I think they should; obviously they cannot possibly undertake the whole of it, so that I feel that it is perfectly evident if all general hospitals did their duty in the matter and there were clinics, it would still be necessary to admit early cases to mental hospitals. Therefore every hospital should have the proper equipment.

7498. Would you rather see the unfortunate patient, the incipient case, in the asylum than in the general hospital?—I do not mind where they go. As I said just now, I hoped it would be a matter for choice. If you like to go to the general hospital, do so, but I am not sure that the general hospital can do so much good as the mental hospital in many cases. If I get a case that I see is obviously suffering from certification and is unsuitably placed in a mental hospital, I move heaven and earth to get that patient out and treated elsewhere; but I do not find that so in the majority of my cases. They do not mind being in a mental hospital particularly. Nobody likes to be in a hospital, whether it is mental or general, but, generally speaking, I think the majority of the patients who come in are grateful for the treatment they have had; at any rate, they express their gratitude, and I do not think that the majority say they have suffered from being there; others undoubtedly do. It is to those cases I would like to say, "Well, if you do not like my treatment and my hospital, your friends may remove you," and I do, in effect, do so.

7499. That is not quite the problem I was putting to you. It is rather this: that certification is really

13 January, 1925.]

Dr. G. F. BARHAM, M.D.

[Continued.]

a barrier to treatment at the moment, because you have to have the process of certification with all that that means; and, after all, it does mean a good deal to an ordinary citizen to have to be taken before a justice of the peace and to have medical certificates, and so on. That could be avoided in incipient cases, and the case could be assimilated rather to an ordinary illness and dealt with on the same lines without these formalities?—But surely one way out of that is some form of provisional order under the voluntary boarder system.

7500. It is very much on those lines that our minds have been working. You would approve, I suppose, of voluntary boarders in the asylums?—Yes.

7501. You would wish it done?—Yes.

7502. You have no boarding-out system such as has obtained a good deal in Scotland?—No, not exactly in force. Occasionally we let patients out, but not in the sense that Scotland does. I know roughly what the system is. There are not people in England whom I have discovered who will take the patients.

7503. As you know, to-morrow we are going to have evidence from the British Medical Association. Have you participated with them in the evidence they are going to give?—I was a member of the committee, yes.

7504. Then we may take it that you will be in agreement with the views presented to us to-morrow?—Yes.

7505. *Mr. Micklem*: Doctor Barham, in making provision in the future for people suffering from mental disorder, do you think it a wise thing to have such large institutions as your Claybury Hospital?—I hope if they build any more they will not build them so large; they are too large.

7506. They are almost out of hand, are they not?—I will not quite say that, but it is that very difficulty which we were discussing just now; the question of administration and medical work; the larger the institution the more is that accentuated.

7507. You have told us frankly that it is quite impossible for you to be conversant with the numerous cases that there are in the hospital?—I cannot know everybody in the hospital, certainly.

7508. Do you think your hospital is staffed sufficiently with doctors?—For the time being, yes. I can remember the time when there were five.

7509. You have seven now, have you?—We have gradually increased; we have increased in the last month, I think. The Council have allowed an eighth doctor.

7510. The figures you gave us with reference to the staff and the attendants cover Claybury Hall, as I understand, as well as the hospital?—Yes, that is so.

7511. In cases where patients are admitted, as I understand, you do not in the first place see them at all; they will be all seen by some of your medical staff?—I do not necessarily see them, no.

7512. The reception order lasts for a particular time, and then comes to an end unless some further certificate is given?—Yes, that is the eight-day certificate.

7513. Do you give that certificate?—I will give it in the vast majority of cases, but naturally I have to be absent sometimes from the hospital, and then it is done by my deputy.

7514. But in most cases you will personally give it?—In most cases I will personally examine the patient and write a statement.

7515. At the end of the year, for instance, when there has to be a continuation of the reception order, would you personally examine the patient in every case?—In the majority of cases, yes.

7516. *Earl Russell*: And where you do not examine them you do not give the certificate?—No, the deputy who examines will sign the certificate.

7517. *Mr. Micklem*: In your *précis* you say that every patient in the hospital receives one statutory visit by the medical officer per day?—Yes.

7518. I do not quite know what that refers to?—I think it is a statutory matter that he should be seen every day by the medical officer.

7519. Do you mean there is some provision in the Lunacy Act to that effect?—Yes.

Earl Russell: I have been looking it up and cannot find it.

Witness: I think it will probably be in the Commissioners' Rules, anyway; but it is a recognised thing, and it is the rule of the committee that a medical officer shall visit his ward and see every one of his patients every day.

7520. *Mr. Micklem*: Does that mean an individual interview, so to speak?—No, that would be almost impossible.

7521. It simply means that he goes to the wards?—He goes there, and every patient has an opportunity of seeing him and of making a complaint.

7522. When an application is made for discharge, are those cases all ultimately brought to you, or would the doctors under you make the orders?—That will depend upon the nature of the application. If it is an obviously undesirable one or one that I know has been made before, as frequently happens, as a matter of fact I would not necessarily see that patient. I have friends who apply every committee day very nearly—cases which are impossible to let out.

7523. Are all those cases very carefully considered by you or by one of the doctors?—Yes, certainly, as a rule. If it is any question I do not know about, I first of all receive the doctor's special report upon it, and, secondly, I see the patient personally and see whether I agree with that report.

7524. In your opinion is there any reasonable possibility of a patient being detained in your hospital at a time when he has recovered from insanity?—No, I do not think so. I consider that discharge is exceptionally easy, except in cases that are positively dangerous to themselves or to the public.

7525. *Miss Madeleine Symons*: Dr. Barham, you told us that 60 per cent. of the patients were occupied in some way?—Yes.

7526. Of course, that is very largely outdoor work?—Yes.

7527. What about the women patients, those who do not actually work in the laundry or in the kitchen—are there any special occupations for them?—No. You mean art work, mat-making, and so on?

7528. Yes, I was just wondering whether anything was done?—No, I have nothing of that kind organised. I have seen such things in mental hospitals and have admired them very much. There is a certain amount of needlework of various kinds, either in the workroom or the laundry, for the women to work at; but, of course, the bulk of the patients will always be doing domestic work—assisting in the kitchens, mess-rooms, and so on.

7529. You told us a great deal about the way in which you chose your nurses and the difficulties in getting suitable women nurses. Have you any other views at all about the cause of that difficulty? Is it just the rather arduous nature of the work that does not attract many people, or do you think it has anything to do with either the salary or conditions or prospects?—I do not think it has got a great deal to do with the salary. I think the prospects have something to do with it, but I believe there are many educated women—in fact I know in many cases there are, I have had applications—who would like to take this work up provided that it offered a field of training. I feel the important point is to make it a vocation, to ally it to the general nursing profession as closely as possible and to offer an opening out of it.

7530. *Earl Russell*: Did you immediately succeed Sir Robert Armstrong-Jones at Claybury?—No, there was another acting medical superintendent who died.

7531. I want to ask you a little more about the question Mr. Micklem put to you with regard to the size of an asylum. Of course in a large asylum you have better opportunity, I suppose, for classification,

13 January, 1925.]

Dr. G. F. BARHAM, M.D.

[Continued.]

for arranging work and for arranging entertainments and for general administrative things of that sort?—That is so, yes.

7532. As against that, of course you have necessarily rather less individual attention and much less individual knowledge on the part of the head of the asylum?—That must be so.

7533. As between your institution with 2,500 and an asylum with something like 300, have you any idea what you consider would be the best size to combine those two qualities—the individual attention and the convenience of classification?—I have always thought—I have never worked in one—that an institution of about 1,000 beds would be the limit.

7534. Now you gave us a figure at the beginning of your evidence of the admission in the year of 503 patients?—Yes.*

7535. And a discharge in the year of 195 patients—or was it 195 out of the 503?—It is 195, but not out of the 503 necessarily.

7536. And a death rate of 8.22 per cent.?—Yes.

7537. That comes to something like 180 or 190?—Yes.

7538. That leaves a remnant of 100 to 120 patients unaccounted for. Does that mean that the asylum population grows at the rate of 100 a year?—No.

7539. What happens to them?—I do not know that those discharges did not necessarily deal with transfers to other institutions, and of course the population will increase one year and will diminish in another; it is never stationary.

7540. On the figures you gave us you said there were 500 admissions a year and you accounted for 400 of them. I want to know what happens to the other 100?—You mean my averages?

7541. Yes?—I have given the death rate in the form of a percentage.

7542. 8.22. On your population I make that out at about 190 or 200?—The discharges of 195 refer, I think, entirely to those who leave the hospital recovered.

7543. Supposing you did not get rid of some surplus by transfers, does that mean that the people remaining certified will be increasing at the rate of 100 a year—is that what it means?—It would be so if that were true, but it does not mean that there is an increase at that rate; it would be impossible.

7544. My only difficulty is to see how they are disposed of, but perhaps there is some other explanation. You are going to give us some tables, I think, about early discharges?—Yes.

7545. Could you tell me, without preparing tables, if you get many discharges after five years or more in the institution?—Yes, there are discharges after 20 or 30 years.

7546. Quite a number?—No, not a number.

7547. Would it be any trouble to add to your *table discharges after, say, 5, 10, and 20 years?—No, not at all.

7548. I think it would be interesting to see how many recover after that time?—If I give it to you for the last five years it will certainly include cases that have been there over 20 years.

7549. Do you find it necessary to do much artificial feeding in the asylum or not?—Oh yes, a good deal of it.

7550. Is that done without any trouble on the whole?—As a rule, yes. Sometimes it is very difficult; sometimes it is quite easy.

7551. What provision in your asylum, and in the county asylums generally, is there for female bathing. Is it comparatively private?—On the whole I think I have very good arrangements. Claybury is a very luxuriously built place compared with some of them. The bathrooms are very capacious, and nearly all the baths are slipper baths, and are each provided with a cubicle. I have recently added a curtain to each cubicle so that each female, who wishes it, can be private.

7552. You have had no complaints?—No, I have not had a complaint about bathing for a long time.

7553. With regard to the training of nurses in hospitals, we have had some medical witnesses who thought that the nurses had better be trained in a general hospital first and an asylum afterwards; others who thought they had better be trained in an asylum first and a general hospital afterwards. Have you any view about that?—I feel rather indifferent about it so long as I get the nurses. I think it is more an individual matter. I always think I shall get them mentally trained first in bigger numbers, because I think they will be attracted to the work if they are going in for it, and it will be the better ones who will go in for general training.

7554. Now a question about admissions. You get a history of these cases when they are admitted, and in that information you learn how long they have been detained in some other place before they reach you?—Very often, yes.

7555. What do you find in London as to that? Do you find that they are detained for a week or fortnight in a workhouse infirmary, or elsewhere, or do they generally come in straight?—They have always been detained a certain time in the observation ward of a workhouse.

7556. Generally only the three days, or generally longer?—It varies very much; they may have been detained there for 14 days or more.

7557. Apart from any question of stigma as to certification, and so on, purely from the point of view of the patient's treatment, would you attach importance to their being brought to an asylum at the earliest possible moment?—I think it would be probably very much to the advantage of the patient.

7558. Of course that is at present impossible unless they are certified?—Yes.

7559. Just one other question about discharging. Have you ever known of a case of three members of a visiting committee discharging a patient against your advice?—Not a case under my supervision.

7560. Have you ever known one at all at Claybury?—No. I have heard of one.

7561. *Mr. Jowitt*: I want you to tell me a little more about the life in the asylum, the recreations and that sort of thing. Take this time of the year: the patients would be indoors, all of them, by what time?—Between four o'clock and half-past; it depends on the light.

7562. Then tea, the last formal meal of the day, takes place about five o'clock?—Yes.

7563. And then, as I follow it, unless the patients are ill, they do not go to bed until nine to half-past nine?—Yes, that is so, nine o'clock.

7564. Tea is over, let us say, about half-past five?—Yes.

7565. We have got an interval from half-past five to nine o'clock at this time of the year, which has got to be filled up somehow or other?—Yes.

7566. Tell me, first of all, with regard to the women: what do they do?—They have private work. They have music, and they read; and occasionally there would be an entertainment.

7567. Sometimes you have an exceptional evening with an entertainment; but take the normal ordinary evening—reading, music, and games?—Yes.

7568. Have you any organiser?—No, not for that kind of evening.

7569. Do you provide facilities like Halma, draughts, or cards, or whatever it may be?—I think I can best answer that question by saying what a ward looks like under these conditions.

7570. Please do.—If you go into a ward in an evening after the ordinary bedding time of sick people, you will find patients sitting round crocheting and knitting, and some are dancing, some may be playing the piano, or there is a gramophone in the ward; it varies; others will be playing cards, and some may be doing nothing at all.

7571. Such facilities as are necessary to enable them to play these games are provided for them?—Yes.

* See Appendix XXI.

13 January, 1925.]

Dr. G. F. BARHAM, M.D.

[Continued.]

7572. And the same with regard to the men?—The men, of course, have their smoke in the evening, their cards, and billiards; most of them are able to play billiards of some sort.

7573. They have smokes provided for them, do they?—They earn it, you know.

7574. You told us that working was quite voluntary, but is there remuneration for work?—You cannot call it remuneration, but if a patient works he is entitled, if he is a male, to a certain amount of tobacco, and a woman gets some dry tea and sugar. They always get extra lunch and food for working.

7575. How often do you have entertainments?—Every week. On an average there is a weekly dance, and another entertainment of some sort.

7576. There of course the males and females are together; it is a joint affair?—Yes, it is a social evening. Now I have a cinema working.

7577. How often does that go?—If I get a film down I get it for three days, and people sitting up late will go in and see the film on a Thursday, and then there will be a long performance of it on Saturday.

7578. Amongst the various duties of the superintendent, do you have to select suitable films?—Yes, I have to have some control over them; they have to be cheerful.

7579. Do you remember what the last film you had was?—Yes.

7580. What was it?—I cannot recall its title, but it made me laugh very much; the patients enjoyed it immensely.

7581. Just one other question. You told us that your daily postbag was rather bulky, and that a good deal of that is internal—I mean to say it comes from the patients themselves?—I have a great many patients' letters addressed to me. I did not mean that when I was referring to my correspondence.

7582. But you do have a large number of patients' letters addressed to you?—An enormous number, yes.

7583. What topics do they deal with? Are a large percentage of them requests to be discharged?—I should say rather a small percentage are of that type, but quite a number, of course.

7584. A substantial number, anyhow?—Yes.

7585. And then I suppose a large number deal with complaints, either real or imaginary?—Yes, and the bulk of them I should say are absolute nonsense; I mean you cannot understand what they mean; they are illiterate, and they have delusional ideas.

7586. You gave us an instance of one man who was reluctant to go. That is quite exceptional, is it not?—Not so exceptional as one would think. I think, of course, it is part of a state of slight deterioration of mind in which initiative goes, and a patient hesitates to face the world again sometimes.

7587. But the other class is a good deal commoner, I suppose?—Yes, they would much rather go out.

7588. I suppose you are worried a good deal by patients who are importuning you to be allowed to go out?—A good deal, yes.

7589. That is the most responsible part, perhaps, of your task?—I always look upon it as such.

7590. And, if I may say so, it seems to be one of extreme difficulty?—I do find it very difficult.

7591. I ask you that because it seems to me that you assented rather too readily to a question put to you. You said there was no reasonable possibility of a patient being detained who ought to be allowed out. That all depends upon whether the doctor makes a mistake?—Yes; he is fallible like anybody else.

7592. You would not suggest for a moment that there is not a reasonable possibility of you or anybody else making mistakes?—No.

7593. And the trouble is to see if we can devise some means of reducing the number of necessary mistakes to the lowest possible minimum?—I had two or three cases on my books recently that presented me with a considerable amount of difficulty. I had a visit from a Medical Commissioner, and I had also had a visit from the Ministry of Pensions with regard to service patients. In this instance I mentioned these two or three cases. I asked the Medical Commissioner to give them private interviews; I did not tell him why. But in every case he stated that he thought the patient was of unsound mind and properly detained. I only did that because of this very point you raise. I sometimes feel the doubt in my own mind—not that I think the patient is sane, otherwise I should discharge him—but because the reasons for detention may have varied gradations.

7594. How would you formulate to yourself the question which you ask yourself? (Would you ask yourself: is this person suffering from some disease of the mind? Or would you ask yourself: can I discharge this person without any reasonable apprehension of danger?—I should ask myself both questions.

7595. Supposing you came to the conclusion that the person could be discharged without any apprehension of danger, either to himself or to the public, but at the same time was suffering from some disease of the mind, would you keep the patient in?—Not if the patient wanted to go out, or the relatives wanted to take the patient out, or I thought from my own observation that the patient would be better away from the institution. That situation arises frequently, and I act upon those principles. I discharge a number of patients under conditions like that.

7596. Generally speaking, that is the test you apply?—Yes; I certainly consider the mental state of the patient, what degree of abnormality there may be present, and also the question of danger obviously arises.

7597. But, generally, if you are satisfied with what I may call the danger point, you would allow a patient out if that were the patient's wish?—Yes, with a proviso, I think, that I do feel called upon to exercise a certain amount of judgment as to whether the patient's wish is a wise one in every case. I would put the case again of patients who are constantly coming back to the hospital, patients who go out and stay out a few months, a week or two, or a day or two, and come back. If those patients ask me to let them go out again, although they may be extraordinarily well, I do not necessarily accede to their request; but I take a lot of trouble to satisfy myself that the home outside is suitable.

After a short adjournment:

7598. Mr. Jowitt: I had nearly finished all I wanted to ask you, Dr. Barham, when you told me about the difficulty which you experienced in making up your mind as to discharge, and the extreme responsibility of your task. I should just like to ask you this: in your view is it a question upon which a layman—I mean an intelligent layman—can form an opinion which is of any value, or is it purely a medical question?—I am sure an intelligent layman can form a very valuable opinion, though I do not think in every case it would entirely serve the purpose.

7599. But at any rate an intelligent layman has an opinion to which you would attach weight in making up your mind?—Yes, I should.

7600. As a matter of practice, when you have got to adjudicate upon a case, and to make up your mind as to whether or not a patient shall or shall not be discharged, what have you got to aid you? Of course, you have the opinion of your Deputy Medical Superintendent, or the medical officer in charge of the ward. Do you get opinions from anybody else?—Yes; I should take into consideration the opinion of everybody who is in contact with the patient, if I want it.

13 January, 1925.]

Dr. G. F. BARHAM, M.D.

[Continued.]

7601. But those in contact with the patient are almost always, are they not, part of the establishment—I mean either doctors or nurses?—Yes, but not entirely. I should not be unprejudiced by the opinion of the hospital visitor, or of the chaplain.

7602. Do you find, as a matter of fact, that the opinion of the hospital visitor is sometimes useful to you?—Undoubtedly. My hospital visitor is a peculiarly tactful lady who never imposes her opinion upon me, but I appreciate everything she says; I consider it of value.

7603. It is quite obvious that you do attach very considerable weight and importance to what she says and what she does?—Undoubtedly.

7604. That is the homely touch, the extra-departmental touch, apart from the visiting committee?—Yes, and of course you would include the friends and relatives of the patients. I mean, there again their opinions are considered, and sometimes they are valuable; they are often perfectly worthless, of course. But if the friends happen to be intelligent and educated people and advance a certain point of view, it is always considered, of necessity.

7605. Do you find that the visiting committee (of course they have many duties to perform) as a matter of practice give you much assistance in the question of the discharge of individual cases?—The visiting committee as a rule only see cases that are recommended by me; but, of course, if a patient writes to the committee, and they see the patient in consequence, they sometimes come to a perfectly independent opinion as to what should be done with the case.

7606. With the exception of the hospital visitor, have you anybody outside your staff going round the wards, seeing people, and making suggestions or reports to you as to what they see or hear?—Reports to me about what?

7607. About the condition of patients, and possibly the discharge of patients?—We have the visits of the boards of guardians periodically, who come to see their own patients, or patients chargeable to their parish, that is to say. Then I have the official visitors, who come from time to time, and who often make suggestions.

7608. Does it not occur to you that without in any way wanting to belittle the official element, perhaps one might from this point of view usefully increase the unofficial element?—Yes, it does; in fact, it has been rather a policy of late to throw the hospitals open as much as possible. One tries to avoid, not only the appearance of the locked door, or the shut-up window, but, on the contrary, we are leaving doors open wherever we can, and removing blocks from windows, and at the same time encouraging outsiders to come in and visit as much as possible. My complaint is that the outside public do not want to see.

7609. You think the aim of the policy should be to encourage the outside public to come and see for themselves?—Very much so. It would be very helpful indeed if they knew what the inside of a hospital was like. The general observation that is made is one of intense surprise.

7610. And the mere fact of somebody being unofficial perhaps in itself commends itself to some of the patients?—I think undoubtedly it does.

7611. This system of the hospital visitor is the beginning of it, and it is a system which exists in some other mental hospitals?—Yes.

7612. But in a large number of mental hospitals they have no such visitor?—As far as I know, no.

7613. Now there is only just one other matter which I should like to ask you about, and that is with regard to the discharge section, Section 83 of the Act. When a patient has recovered, you send a notice. In the case of a non-pauper patient you send a notice to the person on whose petition the patient was certified. In the case of a rate-aided patient, a pauper patient, you send a notice to the board of guardians?—Yes.

7614. I am told that the pauper patients would value such a notice either being given to them, or being sent to their own relatives. Have you come across that at all—a request for a notice of recovery?—I think every relative gets such a notice.

7615. Is that so, as a matter of practice? The law is Section 83 of the Act. It does not seem to be so under the law?—Our practice in the case of a patient going on trial or discharge is to enter into correspondence with the friends, and to arrange for that trial. I could not do it without. Perhaps you are thinking of a case in which one is not very sure of the friends.

7616. I am thinking of Section 83 of the Act. The substance of it is this: That the superintendent of every hospital shall upon the recovery of a patient send notice thereof, in the case of a patient not a pauper, to the person on whose petition the reception order was made, and in the case of a pauper patient to the guardians of his union. I am told—you can tell me whether there is anything in it or not—that the pauper patients who are discharged would very much like the notice of recovery to be given either to them or to their relatives, or a duplicate of it?—I have no experience of such a request. It seems hardly to arise with the material that I deal with.

Chairman: It does not affect the merits of your question, Mr. Jowitt, but Section 83 does not apply to asylums such as Dr. Barham administers.

7617. *Mr. Jowitt:* If you please. (*To the Witness:*) What is put to me is that a person who has been in an asylum and has been discharged wants something, so to speak, to show the world at large that he or she is quite well again, and all that happens in the case of a pauper patient is that certificate which is sent to some board of guardians or local authority; but you have not had experience of this question?—No, not in that way, and I should not have thought a discharged patient would desire it. What they want is no publicity in the matter.

7618. In practice they do sometimes ask for a certificate?—Almost invariably I have to sign several certificates to say that a patient is discharged on such and such a date.

7619. And was discharged as recovered?—Yes, or as the case may be, whatever it was. That certificate is frequently asked for and given.

7620. But it is not given as matter of course. It is given by special request?—No.

7621. *Mr. Snell:* Dr. Barham, in considering Section 83 where it speaks of the recovery of a patient, does recovery in the official sense mean recovery from the condition which would justify certifiability, or does it mean complete recovery?—I think I understand your question. It is a personal point of view. What one man calls recovery another would not. I think I may say that; but as far as I can throw any light upon that, what I should regard as recovery, in the case of any patient I have under care, would be recovery from what they were admitted for.

7622. If a man improved beyond the margin of health at which he was certified you would consider him eligible for discharge? There are some patients who, whilst not being well in mind, are yet not ill enough to be certified. When they are improved, suppose they improved up to the state at which they were certified, would you then consider them eligible for discharge, or would you wish to keep them until they were completely restored?—I think the answer to that would depend upon whether the conditions held out any prospect of complete recovery or not. I should regard it from the point of view as to whether I could do the patient any more good or not.

7623. You appear to be quite satisfied with the experiment during the war of having one or two, or a few, female nurses upon the male side?—Yes.

7624. If you tried this experiment and were satisfied it was helpful to the patients, why was it not continued and developed after the war?—At Claybury it was discontinued for several reasons. First of all, the women went over to replace the men; when the men came back they had to resume their posts. Secondly, the structure at Claybury is not

13 January, 1925.]

Dr. G. F. BARHAM, M.D.

[Continued.]

designed for the purpose, therefore there were arrangements which were not satisfactory, always causing a certain amount of anxiety; but it was not because I am not in favour of it; and, as my committee have under consideration the structure of two villas, one for male patients, I have advocated the nursing of that villa by women nurses.

7625. That is to say, if those particular difficulties had not been in the way, you would probably have continued what you were doing?—Yes.

7626. There was a point about ex-service men being all put in one ward: does that mean that they are not classified in any way, that the noisy and refractory cases, for instance, would be in the same rooms as the quiet cases?—No, that is not so. There are 157 service patients roughly, and I have two almost entirely service wards, but those wards do not accommodate more than perhaps two-thirds of the patients. They are classified in those two wards in two categories, but any service patient who is sufficiently acute, and who would require an acute ward, would go to the wards provided; so the classification of ex-service patients is very much the same as the others, in fact.

7627. To me one of the most interesting suggestions in your evidence was that as to the value of the honorary hospital visitor. I would like to get your opinion, if I might, as to whether, based on experience, it is your opinion that one or more suitable voluntary visitors should be attached to mental hospitals?—Yes, I can find work for several.

7628. Helpful to the patients in every way?—Yes.

7629. You stated that you held an enquiry into cases of alleged ill-treatment on the part of attendants to patients. Is any minute or record of such enquiries kept?—Yes.

7630. With the evidence attached?—With the evidence attached, yes.

7631. *Mrs. Mathew*: I suppose, Dr. Barham, you attach great importance to dietary in the treatment of patients?—Yes, I do.

7632. Is the dietary good at Claybury?—It is the dietary that has been recently worked out at very great elaboration and applied to the London County Mental Hospitals generally. I have no control over it, excepting that it is a dietary scale which allows of a very great variation. It was designed for that purpose, and I think does meet most of the requirements. I think more important than the dietary is the question of the cook—I mean the food that is provided is on the whole sound, but the question of getting a good cook is not always the same thing.

7633. But surely it is a little unusual for the doctor not to have the full control of the dietary while he is treating patients?—But I have in that sense. When I say I have no control over the dietary I mean that so much bread, so much meat, so much other things are placed on a scale; I may not go below a certain minimum, and I have to keep my dietary within a certain calorie value; that has all been fixed after very deliberate consideration. What I order for a patient within that dietary is within my discretion, and, of course, every patient who is being treated for anything, whether mental or physical illness, may be ordered an entirely sick dietary. That is at the discretion of the medical officer who is treating the patient.

7634. Does the average patient ever have butter?—No.

7635. Has that got your approval?—Not entirely. I am not for a moment going to defend margarine, although I think the Council issues a very wholesome margarine so far as it goes; but again this matter has been given really an enormous amount of consideration. I can remember the time when part margarine and part butter was issued, and at times it seemed a better substitute for a complete issue of butter; it is more variable, and I came to this conclusion rather reluctantly, that a wholesome margarine, although I detest it personally, is a better thing than bad butter, and it is very difficult to get a constant and sound butter. But I could order

butter (it is within my right to do so) for any patient I thought ought to have it.

7636. Then there was the question of supervision. When the patients are out in the fields, for instance, working, who supervises them?—It may be a farm labourer, and it may be what we call a garden nurse or attendant, or one of the gardeners, or artisans.

7637. Not a male nurse?—Those we call garden attendants are trained as male nurses; there are a certain number of those. They are under the supervision of an officer whose business it is to go round and inspect.

7638. Are those gardener nurses paid extra?—No.

7639. They are in fact labourers?—Not entirely, because they have certain duties in the hospital, and they have gone through ward experience, and very often they hold nursing certificates. They are paid at a different rate from the labourers, and they are interchangeable. Sometimes it is a question of ill-health. I have got ex-soldier nurses who, for various reasons, are better working out of doors all day long, and they are put on the garden staff.

7640. What are the gardener nurses paid?—The same rate as the indoor nurse. They start now at a total wage of £2 11s. 6d. a week, and they may rise to that of a chief charge nurse, which may raise them to £3 7s. 6d. That includes a bonus.

7641. *Sir Humphry Rolleston*: When you were speaking about the period between supper and the time at which they ordinarily went to bed, which I think you suggested was half-past nine, is it not within the power of the patients to go to bed earlier if they wish to? I mean they have not got to stay up and spend the time between six and nine—if they feel bored they can go to bed and sleep?—Absolutely, they can always go to bed and, as a matter of fact, since the later sitting up has been in vogue it is rather difficult even to suggest to some patients that they should sit up, they are rather inclined to go. There is no obstacle to their going to bed as a rule, I think.

7642. With regard to the difficult question of getting suitable women to take to nursing, I suppose that you have to take them at a comparatively early age, otherwise they are all specifically earmarked for something else?—Yes.

7643. What age do you take them at?—Eighteen.

7644. That of course is rather an early age for a girl to take up responsible duties?—I prefer them to be older, but it has been a necessity to lower the age to get the nurses.

7645. Do you think the proportion of those that stay comes to 25 per cent. of the entrants?—Do you mean the proportion that ultimately go through the training?

7646. Yes.—I think more than that, I am not prepared with the exact figures.

7647. There is the question of the position of yourself as Medical Superintendent, which has been discussed. You yourself feel that what you would prefer, if it were possible, would be to occupy the position of a man whose energies are almost entirely devoted to looking after the patients; at the same time you feel that it is impossible to delegate the greater part of the administrative work. Is your reason for that that you would lose control of the machine, so to speak?—I think it is an essential in an institution such as I have charge of that I should have very wide insight into what is going on everywhere. I would gladly delegate a great deal; I do delegate a lot.

7648. Is half your working time occupied, do you suppose, on administrative work?—I am sure you will appreciate how hard it would be to estimate the work exactly. Medical matters come up in the midst of everything else; although administrative work takes fully half my time, it would be intermixed with certain medical questions, including seeing patients.

7649. *Sir David Drummond*: Dr. Barham, I judge that you would not countenance separation of the

13 January, 1925.]

Dr. G. F. BARHAM, M.D.

[Continued.]

executive from the medical aspect of your appointment?—Again it is rather difficult for me to answer. All my interest is medical, or a great deal of it—I would not say all.

7650. Does the fact that the two are combined militate against the possibility, or the probability, of getting, if I may be allowed the expression, our best men in positions such as you occupy? We know you cannot imagine a physician to a general hospital having to do the executive work of the hospital as well; his interests would be all medical, and you, I take it, are appointed because of your executive knowledge and skill as well as your medical. The two are difficult to combine in general medicine, I take it?—They are, and one must militate against the other, I am sure. I mean this is such an old question that one has thought of it backwards and forwards, and I do not know how it can be done.

7651. If it could be done would you favour it—is that your idea?—Yes, I should. It seems to me to be very much like the high positions in the Army Medical Service, the higher you get the more administrative you become.

7652. Yes, but you know what was found during the war—a great deal of the work of the medical service was performed by non-military men?—Yes.

7653. You have had 21 years' experience, have you not, in this kind of work, I think?—Yes.

7654. During those 21 years have you seen great or fairly considerable advance in the management and treatment of the insane?—Yes, I have, undoubtedly.

7655. In what direction particularly have you seen improvements?—I do not know in what direction I have not seen improvements.

7656. Particularly. You need not go over the whole subject?—As regards the actual medical treatment do you mean, or as regards the general care of the patient?

7657. You have told us you cannot differentiate your duties as an executive officer from the treatment; that is to say, the management of the patient largely consists in arranging his work, and so forth?—I think as regards the position of the patient it has changed for the better very, very considerably.

7658. May I ask you if, in your experience, the results have been commensurate?—To judge by the recovery rate, I do not think you will notice very much difference, but I do not think that that is any criterion at all. First of all, one is dealing, so far as medical knowledge goes, with a very high percentage of irrecoverable people, and I do not think unless some new treatment comes in, or new ways of understanding cases arise, that one will see such a great difference. But that to my mind is of less importance than the fact that patients are treated and understood in a very much more intelligent and more humane way than they were.

7659. But you do not judge by the number of recoveries?—No, because the recovery rate sometimes seems to go down the more you know about your cases; your discharge rate does not alter, or probably goes up. That is really a technical question, as to what you call a recovery. It does not alter the fact that I send patients out if they are not recovered, but if you are going to take a recovery rate and say what you really think to be recoveries, some have different standards. Some are very stringent and narrow.

7660. It is a little discouraging to think that though things have improved so much there are not a greater number of recoveries?—It is discouraging in a certain sense if you like, but there are many aspects of it which are quite encouraging as well.

7661. Now in what direction would you look for further improvements specially. If matters were to go on advancing, in which particular directions would you look for further improvements?—In a general way, as regards my hospital, I should like to see it linked up with a general hospital and attached to a school of medicine, and I should like to have the co-operation of an outside staff.

7662. An increased staff, perhaps?—And an increased internal staff. The further you go in this treatment, and the closer the investigation, the more medical men you will want.

7663. *Sir Ernest Hiley*: Dr. Barham, supposing you were able to divorce yourself entirely from the administrative side of your work, would it be possible to take complete control over all the patients in your institution?—No, I do not think even that. I mean I think the Board of Control consider, and I think quite rightly, but depending upon the nature of the case, that a section of more than 200 or 300 patients is undesirable.

7664. You have about 2,000?—2,400 nearly; we have nearly that number of beds now.

7665. So that even an examination of your subordinate's report on each patient every day would take up a good many hours?—Yes, it would, it does take up a lot of time; but again if one has acute and recent cases, 50 patients is a lot to look after.

7666. How many medical officers have you under you?—I have seven now. In considering that, it must be remembered that hundreds of patients want very little attention at all, many are practically looking after themselves within the supervision of the place.

7667. Do you think that medical staff adequate?—I consider it sufficient for the moment, but if work develops on certain lines I shall want more assistants. For instance, I have one medical officer whose time is taken up with pathology. He has a couple of laboratories, and an assistant, it is very important work; that may develop enormously. I could increase the medical staff considerably if that work were to develop.

7668. Do you think the patients get better attention in these big institutions such as yours, or do they do better in the smaller ones?—I think that must entirely depend upon the large one and the small one. I am sure that some small institutions are excellently managed. I do not think the size really is very important in that respect.

7669. The question of medical supervision then does not come in?—I think one could easily quote institutions of, say, 300 or 400 patients with a medical superintendent and one medical officer, where in some of those places outside work is allowed. I do not know, I cannot say exactly, what supervision goes on; but it seems to me that with eight medical men in the place and with over 2,000 patients, the comparison is not unfavourable.

7670. You are satisfied that there is sufficient personal touch between the medical officers and the patients who require attention?—Yes.

7671. Just one other small point. Is there any real difficulty in altering the time of your evening meal—moving it on a little?—Yes, there is a real difficulty.

7672. What is it?—It is a question of kitchens.

7673. Do you mean the kitchen staff is to decide the time of the meal?—No, it is not the kitchen staff who decide it; but the kitchen staff, like all workers nowadays, have a certain limited week of work, and to meet that you have to close your kitchen down at a certain hour; it can be extended, but it may be very costly.

7674. Are the hours of the kitchen staff limited?—Yes, exactly; they have a 48-hour week.

7675. They come on and clock off?—Yes.

7676. And whatever is wanted in the institution has got to come within those hours?—Yes, unless you make special arrangements. Occasionally they are kept on, and the overtime question comes in.

7677. That is really the only objection?—That is the main objection, I think, yes. I think it will be overcome; it is a question which, I feel sure, will be solved shortly.

7678. I must say it seems rather a peculiar position if the patients cannot have a meal later because the cook wants to go out?—Well, you have got to remember this—it is a question in evolution. Until quite recently patients were all bedded by eight

13 January, 1925.]

Dr. G. F. BARHAM, M.D.

[Continued.]

o'clock. That was the hour. The evening meal was some two hours before they went to bed, which was not unreasonable. These things come gradually. The process of altering the tea hour is coming after the sitting up. The sitting up at Claybury is not universal to-day. It exists on the male side; it is coming on the female side, and the modification of the tea or supper meal is under consideration, and is likely to follow. It is not an easy matter to organise.

7679. Are these kitchen rules the rules of the visiting committee, or are they trade union rules?—Primarily they are the rules of the visiting committee. They are responsible for the number of hours a cook works. The limit is 48 hours a week, and the time is arranged accordingly. It works perfectly well for bedding at eight o'clock, as I say, and it is a matter which only the committee can deal with really.

7680. *Sir David Drummond*: With reference to the attendance of the dentist—how often does your dentist attend?—He visits twice a week—two afternoons a week all the year round.

7681. Is he able to deal with 2,400 patients?—He is doing very excellent work, and it is often against a good deal of resistance.

Mr. Walter Stewart (representing the National Society for Lunacy Reform): Would you ask the witness, Sir, out of the 25s. maintenance a week rate at Claybury, how much is in respect of the simple diet that the patients have?

7682. *Chairman*: What would you say, Dr. Barham? I think the 25s. included establishment charges. How much of the 25s. is allocated to food?—I have not got the figure by me. For patients' food and provisions you mean?

7683. *Chairman*: Yes.—I believe the round figure (I speak subject to correction) for patients' provisions will be 5s. a week.

7684. *Chairman*: And how much for the attendants?—The attendant pays for his own food, and he is charged so much a week for it.

Mr. Stewart: I can give you the Board of Control figure for 1923: 4s. 3½d. for patients, so it is better; it is now 5s.

Chairman: If it was 4s. 3d. in 1923, prices are rather down since 1923, are they not?

Witness: The dietary has increased since 1923. I know it is veering round about that figure, but I have not got it in my mind.

7685. Can you get that figure?—Yes, I can send it to you.*

7686. Can you give the comparable figure for the attendants?—Quite easily, yes.

Mr. Stewart: Would you ask the witness if he is acquainted with the report of the Inter-departmental Committee appointed to inquire into this question of diet, and that they reported in 1924 that out of the 95 mental hospitals whose diet they investigated only six showed returns of any sort of food after tea time. That is at page 65.

Chairman: Does it matter whether he knows, if it is reported as a fact? I have read it already I may say.

Mr. Stewart: Your institution was one of the six, I take it, in 1924?

7687. *Chairman*: He has no meal after six, you know. His last meal is five o'clock, except for something that they may save. (*To the Witness*): I think

*Note.—The cost of provisions for patients for the year 1923 was 4s. 7½d.; and for 1924, 5s. 0½d. per week. The charge made to a nurse if she takes all her meals in the hospital is 14s. per week.

(*The Witness withdrew.*)

Miss VICKERS, called and examined.

7695. *Chairman*: Miss Vickers, you are Secretary of the Mental After Care Association?—Yes.

7696. Is that an Association which has its offices close by—at the Church House in Dean's Yard?—Yes.

your last stated meal is at five o'clock at Claybury?—Yes.

Mr. Stewart: I thought he supplemented it. Could the witness tell us, if you think it right he should, how many of the newly-admitted patients are accommodated in the admission ward, and how many in the quiet ward that he spoke of.

Witness: Well, the female admission ward, I think, has 55 beds in it, and the quiet ward contains 23 approximately.

7688. *Chairman*: I suppose the numbers in those would fluctuate with the character of the cases that come in?—Precisely.

7689. *Mr. Stewart*: Then with regard to the treatment, could the witness be asked how many of the 2,282 patients are the subject of psycho-analytical treatment?—In my experience in the last few years, perhaps four or five.

Mr. Stewart: That was one of the methods of special curative treatment which was stressed by the witness.

Witness: Might I correct that statement?

7690. *Chairman*: Yes.—I do not think I did stress that point. I pointed out, on the contrary, how rare it was that it was applicable.

7691. *Mr. Stewart*: Would the witness welcome any method whereby observation by the medical staff of the underlings amongst the attendants could be facilitated, so that cruelty, if there were any danger of it, could be prevented by observation?—I take it that the question suggests that the underlings, who I take it are the nurses and attendants, should be more directly supervised by the medical officers.

7692. *Mr. Stewart*: May I put the question, Sir, that occurs to those who instruct me? As in the case of a billiard room it is possible for a person outside to see what is going on inside without being himself observed, would it be desirable, in the opinion of the witness, that there should be some simple method of observation of the wards from without?—As a matter of fact it does exist.

7693. Do you regard that as desirable?—No, I should be loth to treat my staff like a spy, but I do not hesitate to walk around my hospital at all sorts of hours night and day, and it certainly is not always known where I am, nor is it known where other doctors are who are walking about. Obviously, for most of the time he is not there; and this question of supervision is, of course, a difficult one.

7694. Would the witness welcome the formation of a small class of convalescent patients which he would thereby be enabled to keep under his sustained personal observation, as he has to decide about discharge—a small percentage of convalescent patients under his individual sustained attention?—I should not in the least object. I think the work, as it is done in that respect by a very experienced doctor, can be equally well done, if not better, in the sense that he is less occupied with other matters than I am, and it does not in the least prevent me from having a considerable and close touch with the convalescent patients, patients that I know and see individually, and they are very often personal friends. They are people who are, of course, much more companionable. I may say I never refuse the request for, and I often invite, a personal interview. I had a patient for five hours in my office one afternoon—who has now gone out; I do give them personal interviews and let them talk themselves out, and I get a great deal out from the patient under those conditions.

Chairman: We are much obliged to you, Dr. Barham, for your kindness in coming, and for the great assistance you have given us in your evidence.

13 January, 1925.]

Miss VICKERS.

[Continued.]

after illness. It is a charitable society, and nearly all the funds are raised voluntarily; but now that boards of guardians have seen the value of the work they are subscribing to the work. The Board of Control also gives us a private fund, but there is no official fund. When we receive cases on trial in our homes they have the usual maintenance grant while they are with us.

7698. Have you any rules of your Association? Have you any Report we could see?—Yes, I have.

7699. One would like to know the constitution of the Association.—May I hand this in? (*Handing document to the Chairman.*)

7700. I see you describe it as the only charity of the kind in the United Kingdom, and that you assist cases from all parts of the country?—Yes.

7701. What funds have you at your disposal? You say you get charitable contributions from the public; are those collected in the usual way?—Yes.

7702. And that you have some money from the guardians?—Yes.

7703. And then you receive some money from the Board of Control, not directly public funds, but from some special fund?—It is a private fund of theirs.

7704. Does that exhaust the sources of your income?—We have grants from the visiting committees and from the various mental hospitals almost throughout the country.

7705. Are your activities confined to London or do they extend throughout the country?—Last year we had cases from 117 different mental institutions, not only in London but throughout England, and from clinics, from observation wards, and from mental departments of general hospitals.

7706. You speak in your *précis* of cases being received from all over the country. What do you mean exactly by "received"? Where are they received?—We have 21 cottage homes. In the case of a patient for whom a change is desirable, or whose home conditions are unsuitable, the medical superintendent writes and asks us to receive that patient, either for a period on trial, or to give patients a rest and change before they take up work. These homes are distributed throughout the South of England, where we have to keep them, so that we can constantly visit them from Westminster.

7707. Do you have a staff at these cottage homes?—Each cottage home is run by a retired mental nurse, so that they can understand the illness and not be afraid or nervous of anything that may happen; but in every case they are registered as boarding houses and we try to do away with the idea of an institution, so as to give them, as far as possible, a fresh start.

7708. What does your actual organisation at headquarters consist of? Have you any council?—Yes, we have a council of 32 members. A good many of them are doctors and others are people who are interested in this matter, chairmen of various visiting committees and members of boards of guardians.

7709. What executive staff have you, and people who visit, and so on?—We have six ladies who visit.

7710. Are they voluntary or are they paid?—They are paid, but they are supposed to give part of their services.

7711. The pay does not represent full remuneration?—No.

7712. Now let us see what your activities are. First of all, I suppose you make inquiries with regard to the home conditions of patients in advance of their being discharged?—That we consider one of the most valuable things we do, to find out really what the home conditions are and to what surroundings the people are going to be discharged, because if they are sent back to exactly the same conditions they are not likely to be any better when they go back; it is waste of time to send them back really.

7713. Who invokes your services?—The medical superintendents in almost every case.

7714. Are you informed in advance that a particular patient is convalescent, may shortly be discharged, and are you asked to ascertain the home conditions to which the patient is about to return?

—Yes. Then we go round and visit the homes and find out what we can, and establish friendly relations with the people to whom the patients are returning.

7715. We had a most interesting account from Doctor Barham this morning of a hospital visitor. What is the relationship of your inquiries to the inquiries which the hospital visitor would make?—The hospital visitor deals entirely with the patients still in the hospital, and we take them on from the time they leave, making a few inquiries before they leave. Doctor Barham is one of the doctors who sends us a list of his patients who are about to be discharged every fortnight, and we send him an account of the home and also whether the patient shall be allowed to be sent out on trial or not, and I think on this report the discharge will generally be decided by the committee. We also find out what chance there is of patients obtaining work, whether their clothing has got to be augmented, whether their tools are intact, and all that sort of thing.

7716. But the organisation is entirely voluntary?—Yes.

7717. As we know there is no provision made in the Statute for the services of such an organisation as yours. You supplement the public service with this voluntary aid?—Yes. It has been felt that this is almost a national work, and yet it obtains no official support in that way. I believe there was in the Bill which was dropped a provision for funds to be allocated to the after-care of patients discharged from mental institutions, and it was thought that it would be used to help our institution in increasing its work and its activities.

7718. In addition to investigating the home conditions to which a patient may return, I think that after patients have been released on trial or permanently, you also keep an eye upon them in their homes or wherever they may be?—Yes, we visit them and try to make them understand that we are someone who understands their illness, and is willing to help or advise them.

7719. Do you find the ex-patients appreciate your visits?—Oh, yes, and we find that for years afterwards, if they are in any trouble or difficulty, they write to us.

7720. Then you also, I suppose, consider whether they require further medical or surgical assistance?—Yes.

7721. And are you able to afford them such help?—Yes. Nearly all the doctors on the council will give them appointments free of charge, and we also take them to the various hospitals and supply them with teeth or glasses.

7722. Are you able out of your fund to help them to start in a trade or business?—Yes; we make grants for that when we are satisfied that there is quite a satisfactory start for them. Of course, many women go into residential posts which we find for them. We have also lately had homes which we have opened for paying patients, those who can afford to pay something; we take them in homes where they pay for themselves 35s. to four guineas a week—very carefully graded.

7723. Have I exhausted the various forms of your Society's activities, or are there any others?—Of course, we still like to keep in touch with them afterwards and let them feel that if they are in trouble they can come to us, because in so doing we feel that we prevent relapses to a great extent. We know all about their illness and we do our best to prevent anything causing a relapse.

7724. How much accommodation have you in those cottage homes?—We have 136 beds.

7725. Are they fully occupied always?—Yes, but I do not think we have ever refused a patient for want of accommodation; we have always one or more homes waiting that we can open.

7726. What is the condition of eligibility for admission to one of these homes?—They must be recommended by the medical superintendent as convalescent or recovered. We do not take cases that are unimproved.

13 January, 1925.]

Miss VICKERS.

[Continued.]

7727. But in the large number of cases, of whom obviously only a small proportion can have the advantage of the cottage home, what is the principle on which you select those cases?—The medical superintendent does that. He writes to us and says, "I should like this patient to go into one of your homes," and we can generally fit them in between the time he lets us know and the date of his discharge committee.

7728. Are all the ex-patients you receive in that way rate-aided cases?—No. We have these homes for private patients who come from small hospitals or who have paid for themselves in the paying departments of large hospitals.

7729. Do some of those in your cottage homes pay and others not?—Yes.

7730. Is there no differentiation between them?—No, not in the homes to which they go.

7731. How many cases altogether has your Association assisted up to date?—Last year, 1,167 altogether. We had more before the end of the year; I think that was the figure on the 22nd December.

7732. And altogether up to date your Society was assisted, I gather, between 10,000 and 11,000 patients?—Yes.

7733. Do you think there is scope for an extension of your activities?—Yes. I think every mental hospital ought to have some branch of the work so that they can keep in touch with the people and get them a fresh start.

7734. Dr. Barham expressed to us this morning his great appreciation of the lady visitor and the use that she was to him as being in liaison between the patient and outer world. Do you to any extent fulfil that function also?—Yes, only he, of course, uses his lady visitor where the patient is still under certificate, and I understand from him and from other medical superintendents that the connection with the visitor ceases when the patient is discharged, and ours begins, so that we only overlap in the way that we make the inquiries before the patient leaves.

7735. On the other hand there is the point that people may be exposed to too many visitors in their homes. If the visitor is inquiring as to the family conditions for one purpose and you are inquiring for another purpose there would be a danger of overlapping?—I thought the lady visitor did it when the patient went in. We do it when the patient is coming out; so that the lady visitor can report to the medical superintendent when the patient is certified, but it is for us to find out how the conditions have changed when the patient is coming out. The London County Council make a great deal of use of our work.

7736. You have not any provincial branches, have you?—Yes, we are forming them now. We are in touch with 43 medical superintendents who are desirous of forming branches of the work, and the whole scheme is being considered by them now.

7737. That would involve a very large extension and considerably greater financial responsibility?—Yes, and hitherto we have been handicapped in forming branches because of the lack of public support and interest of people in mental disease, until recently. It has not been an easy thing to get the outside public to appreciate either the difficulties of the work or the need of it. We are very anxious that every mental hospital should have a branch and anything we could do to help them we would. For instance, Cardiff has a very good branch which affiliates with us.

7738. Are you in favour of the method of dealing with this by voluntary agency, employing in turn a certain number of paid officials?—Yes, I think the people prefer it altogether, someone from quite outside, quite a private person as far as they are concerned. Also with regard to the cottage homes, I always find they are very glad to go to quite a small one. There are five as a rule in most of the smaller ones, so that they get individual care, and we are able to find out just what they are fitted for and find them the right sort of post.

7739. Could you give us any idea what the cost per head of your guests is in one of these houses?—We pay 27s. 6d. in most of them.

7740. Is that all?—That covers board and maintenance and laundry. Some of them are a little more expensive; some are less.

7741. Will that cover your establishment charges, rent and everything?—That covers everything.

7742. For that are you able to give them good dietary?—Yes, we have never had any complaints about food; they are always very surprised at and pleased with what they have.

7743. You have no really official link between your Association and the asylums, but it is a voluntary relationship; they utilise your services?—Yes. The London County Council have always very much recommended that their medical superintendents should use our Association as far as possible, and so have the Board of Control.

7744. Do you approve of that type of relationship?—Yes.

7745. You think it is satisfactory?—Quite.

7746. And partly because it represents a transition from the institution on the official side to normal life?—Yes. I think it is a great stepping stone from the institution back to their home lives.

7747. We have heard a good deal about the desirability of publicity in connection with institutions of this sort. Do you find that the people who are in your organisation, the members of your Board, and so on, take an interest in the work?—Yes, very much.

7748. Do you find that they ever visit patients in the asylums?—I think those who are also members of the boards of guardians do, but I do not think many of the private ones do. I go down to see many of the hospitals in turn throughout England and Wales.

7749. That is the institutions of the London County Council and others?—Yes. I have been to a great many.

7750. Have you always found that you could have every information placed at your disposal?—Yes, I have never found any reluctance to tell me anything I want to know, or to show me anything I want to see. Of course, I see so many patients that I hear a great deal about the institutions. Altogether, I have interviewed over 7,000 patients.

7751. Has any obstacle been put in your way when visiting these institutions?—None.

7752. Have you been allowed to interview anybody you wished alone?—Yes, always alone.

7753. Have you discussed with them the circumstances under which they were proposing to return to ordinary life?—Yes; and of course when they come to see me at my office they talk very freely about their time in the hospitals.

7754. I am going to commit the indiscretion of asking you a question as to the impression you have yourself formed of the administration of the institutions you have seen?—My impression is entirely favourable. Of course there are minor complaints from time to time, but I think the majority of the people are very much surprised, after they have been in an institution, to find how much better everything is than they thought it would be, and how different the treatment is. I mean, they often say, if people who talk about it a lot outside could only come in, they would see how unfounded a great many of the complaints are.

7755. Do you think that some of the suspicion which attaches to such institutions is the relic of unhappier times when there was much more amiss than there is now?—Yes, I do. I think the people have very much more freedom altogether, and are treated quite differently now. I do not think any of them have grounds of complaint.

7756. It is not a question which was in your *précis* at all, and I ventured to ask you as a person who had visited a large number of institutions what your own candid opinion was?—I am very pleased to answer it.

7757. Mr. Micklem: Miss Vickers, have you been

13 January, 1925.]

Miss VICKERS.

[Continued.]

able to purchase these cottage homes?—No, we only rent them; we have not had the funds, unfortunately.

7758. *Miss Madeleine Symons*: Can you tell us, Miss Vickers, how many districts outside London have branches of the After-care Association?—Very few have at present, but Durham and Oxford are forming branches. Cardiff has formed one; York is talking of doing so, and four or five of the others up in the North.

7759. There is some kind of association, however loose, with those organisations?—Yes, by affiliation.

7760. You are suggesting a development of that?—Yes, all to be in touch and help one another with advice and experience.

7761. As to these cases that you have helped, are they all cases that have been certified, or are some of them early cases sent to you by clinics?—A few have been sent out from observation wards, not certifiable at the end of the period of detention, and a few of them have been treated at the out-patient departments of general hospitals, the Mental Department at St. Thomas's and Guy's, and so on.

7762. So they are not all certified?—No.

7763. Could you tell us anything about the steps you take to find work for them?—We generally advertise and quite frankly state that the person has had a mental illness, because we think it is only fair to the employer and to the patients; but we tell the employer that we regard it as a secret between the patient, ourselves and the employer; otherwise I think we should be doing an injustice to the patient, and the employer.

7764. Do you mean that you obtain work for the patients mostly by advertisement?—Certainly, by advertisement, and certain people help us to find posts; we have a number of employers who will always take some of our people.

7765. It is not done by the regular machinery of the Labour Exchanges, or anything of that kind?—No, we do not find them very much good, because most of the people cannot produce references, of course.

7766. *Earl Russell*: I think I am right in saying that Mr. Macdougall, who was Chairman of the London Council Council Asylums Committee, always took a very keen interest in your association, did he not?—Yes.

7767. Have you any objection to telling us what your expenses were last year?—£5,674 10s. 4d.

7768. *Mr. Jowitt*: Miss Vickers, I want, if I may, to join the Chairman in his indiscretion. You told us that you saw a very large number of patients after discharge from hospital?—Yes.

7769. I have no doubt that they unburden themselves quite freely to you?—Yes, they do.

7770. Would you mind telling me this: is it quite an exceptional thing to find any complaint made at all?—Yes, quite exceptional.

7771. The vast majority of patients who come out and see you express themselves as satisfied and contented with the treatment they have received?—Yes, a very large majority.

7772. I suppose you see hundreds in a year?—Yes.

7773. And it is quite a few who make any complaint at all?—I should think it is about 4 per cent., roughly speaking.

7774. Would quite a small number of those complaints have any reference to ill-treatment?—Quite; that would be still smaller.

7775. That would be very exceptional?—Yes.

7776. You might go through a whole year and perhaps have only two or three complaints of ill-treatment at all, although in the course of the year you would see hundreds of these patients?—Yes.

7777. The bulk of the complaints would be, what?—Perhaps one person complained that he or she was kicked or punched in the chest, or something like that, by a nurse.

7778. That is rather a case of cruelty?—That would be about one in the year.

7779. Would the bulk of them be about lack of privacy, and so on?—Yes, and not being discharged soon enough.

7780. That is the commonest type of complaint of all, is it?—Yes, it is really.

7781. Tell me, if I may continue my indiscretion, have you had any material upon which you could form an opinion as to whether that complaint—that is to say, not being discharged soon enough—is not well-founded in a considerable number of cases?—No, I do not think it is well-founded. Only in a very, very few cases have I ever been really convinced that it has been so.

7782. In certain cases you have?—Just a few, but very few in the course of six years.

7783. *Mr. Snell*: I understood you to say, Miss Vickers, that you board these ex-patients for 27s. 6d. per week?—Yes.

7784. Does that include all the establishment charges?—Well, we have to allow them pocket money and things of that sort.

7785. I was wondering whether under such a price you found you could give them a dietary sufficient to build them up after an illness such as they have had?—I wish I had some of the letters from the patients here to show you.

7786. It seems an extraordinarily low price?—Most of these people have gardens and poultry and things like that.

7787. *Sir Humphry Rolleston*: As far as I remember from the meeting we had in the City, Miss Vickers, you depend entirely for money on voluntary subscriptions?—Yes, except for the grants that are made to us with the cases on trial.

7788. But you do not get any substantial grant from any Government Department?—No. That is what we should like to have.

7789. *Sir David Drummond*: Is your approach ever resented?—No. I have only had two people who have refused to be visited in the last 14 months.

7790. You visit a large number of asylums, I gather?—Yes.

7791. Do you visit any in the North of England?—No, I have not seen any in the North.

Mr. Walter Stewart: Would you ask the witness if she usually gets into touch with the patients through the medical superintendents?

7792. *Chairman*: How do you come into touch with your cases for after-care?—As a rule through the medical superintendent, who sends us, in most instances, a list of patients who are about to be discharged and asks us to visit, or to visit as soon as the patient is discharged; in some cases to act as almoner for the grant, and in others to find any employment we can for them. Others apply through their friends; they get to hear of the work because there is a notice in most of the hospitals of the work, and the friends who visit hear of it and they come to see us and ask if we will visit as soon as the patients come out. In many instances we have letters from patients who are still under treatment hoping to come to us in a short time. The guardians occasionally notify us. Kensington notifies every patient chargeable to them.

7793. And in some cases the relatives?—Yes.

7794. How far do you think you are brought into contact with all the cases? To what extent do your activities cover all the rate-aided cases that are discharged?—I think last year there were between 6,000 and 7,000 discharges—something like that number. There are among those all the people who have comfortable homes to go to, senile cases, and so on.

7795. I was just wondering how far your labours are co-extensive with the demand?—One of the members of the Board of Control was saying that he hoped before long every case would be notified to us; they are anxious for it to be so, but of course we cannot go further afield without further funds.

Chairman: We are very much obliged to you for your evidence to-day, Miss Vickers.

(The Witness withdrew.)

(Adjourned to to-morrow at 10.30 o'clock.)

5, OLD PALACE YARD,
WESTMINSTER, S.W.1.

FOURTEENTH DAY.

Wednesday, 14th January, 1925.

PRESENT :

THE RT. HON. H. P. MACMILLAN, K.C. (*in the Chair*).

THE EARL RUSSELL

SIR THOMAS HUTCHISON, BART.

SIR HUMPHRY ROLLESTON, BART., K.C.B., M.D.

SIR DAVID DRUMMOND, C.B.E., M.D.

MR. N. MICKLEM, K.C.

MR. H. SNELL, M.P.

MRS. C. J. MATHEW.

MISS MADELEINE SYMONS.

MR. P. BARTER (*Secretary*).

MR. W. FAIRLEY (*Assistant Secretary*).

Evidence (on behalf of the British Medical Association) of: Dr. R. LANGDON-DOWN, M.B., M.R.C.P. (London), Member Medico-Psychological Association, Chairman of Lunacy Law Committee, B.M.A.; Dr. J. W. BONE, M.B., C.M. (Luton); Dr. F. H. EDWARDS, M.D., M.R.C.P. (London), Member Medico-Psychological Association, Medical Superintendent, Camberwell House; Dr. C. O. HAWTHORNE, F.R.C.P., M.D. (London), Consulting Physician, Hampstead and N.W. London Hospital; Dr. E. W. G. MASTERMAN, M.D., F.R.C.S. (London), Medical Superintendent, St. Giles Hospital; Dr. CHRISTINE MURRELL, M.D. in Mental Diseases and Psychology (London), late Clinical Assistant, Northumberland County Asylum; Sir JENNER VERRALL, LL.D., L.R.C.P., M.R.C.S. (Leatherhead), Consulting Surgeon, Sussex County Hospital; Dr. C. COURTENAY LORD, M.R.C.S., L.R.C.P., Assistant Medical Secretary of the Association.

7796. *Chairman*: We have before us this morning representatives of the British Medical Association who have come to assist our deliberations by giving evidence. The Commission have received from the Association a valuable memorandum summarising the views entertained by the Association on the subject matter of our reference. We recognise that it is a considered and deliberate statement of the views of the Association, and I think it is desirable that we should preserve the statement in the form in which it has been drawn up, obviously with great care; and we therefore intend to incorporate in the record of our proceedings the memorandum* as it stands in its entirety. At the same time it would be very desirable to investigate a little more in detail some of the topics which are dealt with in that memorandum; and we propose to utilise this sitting by going into those various matters, elucidating any points of difficulty and expanding other matters which are dealt with in more summary fashion in the memorandum. I understand that Dr. Langdon-Down is good enough to act as spokesman this morning for his colleagues. It is superfluous that we should place anything on our notes as to the standing of the British Medical Association. Of course, it is recognised that the Association speaks for the profession throughout the country, and that it uses in this matter the most authoritative voice.

I understand that when the announcement was made that this Royal Commission had been set up, the Council of your Association appointed a special Committee to consider possible modifications of the Lunacy Laws?—(*Dr. Langdon-Down*): Yes, that is so.

7797. And to prepare evidence for submission to our Commission?—That is so.

7798. In your memorandum you set out the names of the distinguished medical men who were appointed to act in that capacity, and, may I take it, that the memorandum which is before us represents the considered views of that special Committee, and so, indeed, of the British Medical Association in general?—Yes. You may take it that the Committee's views are fully expressed and satisfied in this memorandum, but further the memorandum has been submitted to the Council of the Association, circulated to all its members, debated, passed and accepted in its present form.

7799. And I observe that in the course of compiling the memorandum you made investigations to ascertain the opinion of persons whose opinion was of value on such a matter, and that the memorandum contains the result of those investigations?—Yes. We took various steps to try and secure a fully representative opinion, first of all, as you can see by the selection that was made for the Committee, which was partly appointed by the Council and partly co-opted by the Committee itself, so that every special aspect of the matter might receive consideration. We further used the columns of our Journal to invite communications; we had debates at the general annual meeting of the Association where medical topics are discussed, and the question of certification was one of the topics last year for discussion. We have personally and individually consulted with our friends, of course. We have invited communications through the columns of the Journal, and we have received memoranda. We have also invited selected representative general practitioners to come and see us and talk to us, and I think in that way we have been able as far as possible to present a broad general view which will represent the view of the profession.

* See Appendix XXII.

14 January, 1925.]

Dr. R. LANGDON-DOWN, M.B., M.R.C.P.

[Continued.]

7800. In approaching the consideration of the problems, it appears to me that in your eighth paragraph you have stated the general position in a very useful way. I shall venture to read it. "The Association recognises that mental disorders differ from other ailments in that the proper treatment of the patient may necessitate, either for his own good or for the protection of his family or the public, interference with his liberty of action; and, further, that the patient may be prevented by the nature of his illness from forming a proper judgment on the measures necessary for his welfare. Consequently in the scheme of treatment there must be introduced safeguards which are not necessary in dealing with ordinary bodily ailments where the mind is not affected." It appears to me that there you have placed your finger really on the important differentiation between this class of ailment with which we are concerned and ordinary ailments; and I suppose your Association has recognised throughout that the real problem is the accommodation of the medical aspect of treatment with the legal aspect incidental to the restraint which must be imposed upon the liberty of the subject. These two considerations have to be accommodated in such a way as, on the one hand, not to injure the patient, and, on the other hand, not to injure the public?—Quite so, yes.

7801. I have been struck in reading your memorandum with one aspect of the case—that while mental ailments differ in this important respect to which you allude in paragraph 8, on the other hand there are varieties and degrees of mental ailments which do not necessarily involve compulsory restraint—I mean compulsory restraint is not necessarily incidental to every case of mental ailment?—Yes. On that point I would specially call attention to the fact that that is one of the difficulties inherent in the present position; the Lunacy Acts only regard mental disorder from the point of view, as far as I can judge, of detention and restraint.

7802. I think it takes the case of the person who is of unsound mind, and who requires to be subjected to exceptional measures of restraint which are unnecessary in any other case?—Yes.

7803. But you point out in the course of your memorandum that there are, as I put it, varieties and degrees of mental ailments which do not require the putting in force of those compulsory powers of detention?—Yes.

7804. It is not every case of mental unsoundness that requires compulsory detention?—No.

7805. I gather that the policy of the Association is to differentiate the various categories of mental ailments, drawing a broad distinction between the cases which require this compulsory detention on the one hand, and a large number of cases, on the other hand, which may be treated, and treated successfully, without putting into force this compulsory element. Have I got the principle?—Yes, I think so. We feel that there are some persons who might be described as of unsound mind to whom it is very desirable that something short of the full compulsory treatment should be actually applied.

7806. The special element of compulsion in the treatment of mental disease is only necessary, is it not, in cases where the patient is unwilling to be detained, is unable to co-operate in his own treatment, and therefore must for his own good be subjected to the unusual measure of compulsory detention?—Yes, either for his own good, and of those about him, or for the protection of the public.

7807. And again I think that running through the whole of this memorandum there is emphasis upon the criterion whether the case is one in which it is necessary to invoke the exceptional measures of the Lunacy Act, or whether the case is one which, consistently with its own good and the safety of the public, can be treated without resort to such measures?—Yes. At present the voluntary treatment to which you refer, the consent of the patient to treatment, has been very little used, because, as

you are aware, at present the voluntary boarder system only applies to a limited number of institutions under the Act; therefore for the most part the compulsory element is predominant to-day.

7808. I would infer from your memorandum that in the view of the profession the extreme measure of the reception order, the compulsory order, should be the last resort rather than the first resort?—Exactly. It should be recognised that there are stages before that.

7809. And, further, in considering the stages before the last resort is reached, there may be more than one expedient which can be resorted to in the interest of the patient and of the public?—Yes, certainly.

7810. You suggest a grading, if I may so put it, of the cases, a classification of the cases?—Partly that, and partly that the processes should be step by step, instead of precipitate.

7811. Again we are talking of general policy just now, and one wants to get the principles in one's mind. It is useful if one takes the larger view first before coming to the details. The view being that certification is really the last resort instead of the first resort, you take this further view, that if various methods adapted to different cases were introduced or developed, there would be a tendency to avoid to a large extent the unfortunate consequences of certification, which seem to be firstly to prevent people coming for early treatment, and, secondly, to involve an unnecessary stigma upon persons who have suffered from this particular form of ailment?—Yes. What we feel is that the machinery for its purpose, which is rather an eighteenth and nineteenth century purpose, is very effective and on the whole works very well, and, as a matter of fact, we think the machinery is almost too efficient; at all events, it tends to obstruct the twentieth century attitude towards disease; and what we want to do is to get a new attitude, I think, both on the part of the profession, and more especially on the part of the public, towards the handling of these diseases. The public attitude will not be changed until the provision made for the treatment of the disease and the medical knowledge available are different and better and more varied. I think you will see my point of view.

7812. Yes, I follow exactly. In short, you are treading the path of evolution here; from the early, crude, primitive methods considerable advances were made when you had all the safeguards introduced into the code; there has been a progressive development in the conception of mental disease, and its proper treatment; but you think we have now reached a further stage of development?—Yes; I think it must be admitted that medical knowledge in regard to these matters has tended to lag behind medical advances in other fields. We think that is partly not due to neglect on the part of the profession, but to the circumstances with which the thing is hedged around.

7813. Of course, one must recognise this also, must not one, that this particular form of ailment in its various manifestations is peculiarly obscure in its causation?—Extraordinarily difficult, yes.

7814. You are dealing, whatever be one's views on the matter, with an element in life that is different from the ordinary pathology of the broken leg, or the dyspeptic patient?—Yes. I think in any case it would have been the last field for medicine to develop apart from the circumstances, but the circumstances have made development difficult, I think.

7815. Of course, there are two aspects of the question. There is one, the legal aspect, which is this: to what extent is it legitimate or necessary to interfere with the liberty of the subject? And there is the medical aspect: what is the appropriate treatment for such cases? And the two seem to be associated, because in order to give appropriate treatment in certain cases it is necessary to invoke a legal element of restraint?—Yes.

14 January, 1925.]

Dr. R. LANGDON-DOWN, M.B., M.R.C.P.

[Continued.]

7816. And we come back again to what I started with, the accommodation of those two interests?—We recognise the difficulty. We are not prepared to lay down any complete solution, I think.

7817. I think in this matter the lawyers and the doctors are not involved in their familiar conflict upon the subject of criminal responsibility—fortunately that does not arise here. We are both engaged in the same pursuit, namely, the pursuit of the best system which will enable cases to be dealt with, with the minimum of interference and the maximum of medical benefit?—Yes.

7818. Now as a result of the consideration of the present position, I think the Association has selected a number of points in the existing law and administration upon which they have suggestions of amendment to make. You have already said that in your study of the existing law you have been impressed with the number of safeguards from the legal point of view contained in the present code?—Yes.

7819. Therefore, your criticism is not so much directed to the provisions of the existing code, whose efficiency you seem to appreciate, but rather to its incompleteness, in the sense that it provides only for one aspect of the subject, rather than for the various other aspects to which you give prominence?—Yes. On that point, I might say that we specifically sought information from those whom we consulted as to any failure in the efficiency of the protection of the patient by the present law, and we failed to get any evidence that there was substantial failure to protect.

7820. That evidence, of course, would no doubt be obtained from medical superintendents?—Doctors, yes. Of course, we could not cover an extraordinarily wide field, but we invited information in the *Journal*, and put specific questions to the gentlemen whom we asked to attend.

7821. The criticism from the point of view of illegality of detention has not really emanated from the profession—that has emanated from outside?—No doubt.

7822. But I gather that so far as the safeguards under the existing system are concerned, you think, and the result of your investigation has been to assure you, that there is adequate protection?—It is so, yes.

7823. Then in paragraph 9 you say that “where the law appears to be defective is in the unsatisfactory character of its terminology, in the differences made in the treatment of patients because of differences in social or financial standing, in a failure to regard the person of unsound mind primarily as a patient—a sick person, and in the failure to provide adequate facilities for treatment without a reception order.” The first point, the question of terminology, is to a certain extent one of sentiment, is it not?—Yes.

7824. And you think that the associations which have gathered round the terminology of the Lunacy law have had an unfortunate effect?—It is rather difficult to speak positively on this matter, but I think I may say for the Committee that we were not unduly swayed by the sentimental aspect of the matter. I think we should have been prepared even to accept crude terms which corresponded to the old established facts ourselves, but we recognise that already a change has been made in that direction by many people, and undoubtedly the public is swayed by sentiment. This word “lunatic” has come to be associated with a flavour which repels, and we think concessions must be made—though perhaps we should not feel the need of them; we think it is desirable that concessions should be made in order to start the new idea, to encourage the new idea; therefore we endorse the public demand that the word “lunatic” should be dropped. “Lunatic” is a word which does not express any modern view of the matter at all, and it has objectionable associations undoubtedly in the public mind, and we think we must concede something to that sentiment.

7825. Of course, one knows that it is becoming rather the custom to avoid blunt terms in legislation nowadays by periphrasis, but in this matter perhaps it is of more importance than in other branches of the law, because you are dealing with a subject where susceptibilities are themselves related to the merits?—Yes.

7826. If you are desirous of encouraging persons to come, say, for early treatment, you do not want them to be discouraged by depressing associations clustering around the nomenclature of their state. I do not know what my colleagues feel about it, but I have been much impressed with the view that “person of unsound mind,” which is the phrase selected by the Association, seems to be the happiest phrase for the description of the persons we are concerned with. Do I understand your view to be that the “person of unsound mind” should be restricted to the class of case where legal measures have to be taken—that is to say, where compulsory detention is necessary?—Should be restricted to the class of case where the person is such a person as might properly be submitted, if necessary, to legal measures; yes.

7827. It is a phrase that would, of course, have to be defined, because there are all degrees of unsoundness of mind, and even your suggested voluntary patient would be abnormal, at least, in his mental condition?—We have suggested a definition, as you will notice, and we think that that is important, otherwise it will be used in a loose way which will only bring in confusion. The definition is on page 5 at the top. “‘Persons of unsound mind’ means persons who by reason of mental disorder may properly be taken charge of and detained for care and treatment.” The term “lunatic” was never defined in the Act, is not at present defined in the Act so far as a real definition goes; it is only certain synonyms that are stated. “Lunatic” means an idiot or person of unsound mind—that is the statement in the Act. Of course that does not define either of those words; it only says that they are in some ways synonymous.

7828. This also is not a definition in the medical sense at all, it is not a pathological definition?—No; that would be quite hopeless, I think, and quite useless.

7829. It proposes to define it by the question of whether the person is appropriate for a particular method of treatment or not?—Yes, exactly, that is what we want to fix upon, what are the particular measures to be applied to particular cases, that is much more important than other matters.

7830. Then under this definition no person would be classified as a person of unsound mind unless he was such a person that the measures available for compulsory detention were appropriate and applicable to his case?—Exactly.

7831. Short of the person of unsound mind so defined there would be a whole series of gradations of mental ailments?—Yes, quite so; they would all come under the heading “mental disorder,” and we suggest for the other cases the term “mental ailment,” just for clearness of understanding when we talk.

7832. Of course, with regard to those other cases, cases falling short of mental unsoundness in the terms of your definition, you do not suggest that all those cases should be dealt with exactly as an ordinary case in a general hospital is dealt with, because I see you do propose certain modified measures of restraint for persons who have not reached the category of persons of unsound mind?—Could you show me where we suggest that?

7833. I was thinking, for instance, of a voluntary patient who may be a person not of unsound mind, but who is to subject himself in an institution to certain terms, about not leaving within a certain time, and so on, which you do not impose upon a person who comes in with a broken leg to a hospital?—We do not impose that; we say the person shall be at liberty to submit to treatment under those terms in the various institutions which receive such patients; but we do not propose to put any legal obligation upon persons of that category being de-

14 January, 1925.]

Dr. R. LANGDON-DOWN, M.B., M.R.C.P.

[Continued.]

tained, nor should we regard it as a wrong thing for any person to treat such persons without a formal order.

7834. Of course we do not escape under your definition, or, indeed, under any definition, the difficulty of the classification of the individual patient. Whether the case is one where it is proper that the person should be taken charge of and detained for care and treatment or not, will always be a matter to be determined on the individual case and in reliance upon skilled judgment?—That is true, but we do suggest that with a greater variety of accommodation the difficulty will be eased.

7835. I think your suggestions do render it easier to work, but in the ultimate resort the discrimination between the person who must be detained, and the person who need not be detained, will always be a matter of discretionary judgment in the particular case?—Yes.

7836. And I suppose ultimately the discretionary judgment of the doctor who is attending the case?—Yes; it would be the discretionary judgment of the justice who signs the order.

7837. Proceeding on medical evidence?—Yes.

7838. And proceeding also, to some extent, upon his own judicial view of the case?—Certainly, yes.

7839. That will always be the crux, will it not; because, of course, one knows that a great number of cases present no difficulty, as in all other branches of science; there are cases on the one side and cases on the other side which are quite easy to deal with; it is always the cases about the borderland which become so controversial?—Yes, but I would again say that if there were in existence more institutions short of asylums for detention where early cases could be received and observed, the transition would be more gradual, and the judgment would be better formed by observation.

7840. It would be a more deliberate judgment founded upon more data and more observation?—Yes, and, of course, therefore fewer mistakes.

7841. I should imagine that no system which human ingenuity can devise dealing with a matter of this nature could be absolutely perfect?—No, it is impossible.

7842. You always have the human equation in these matters, and there must be a margin of error in the application of any system?—We quite recognise that.

7843. But one's goal would be the elimination of error as far as possible?—Yes.

7844. And, of course, the effort of myself and my colleagues is to see whether we can assist in the elimination of possible error in the cases where error is possible, which always must be the cases about the borderland. I think that has been the effort, if I may say so, of your Association also?—Yes.

7845. As regards terminology, just to pursue that topic, you think that the expression "asylum" with its unfortunate associations should be abolished?—I think we are not very pronounced on that particular point.

7846. It is paragraph 10.—We say that the change may be justified. I think there are some members of our committee, at all events, who are quite content with the word "asylum." It is in its beginning a very harmless and proper and expressive word.

7847. I am afraid its etymology is not what the public think of; they think rather of its associations.—Yes, but the difficulty is that whatever word you apply will also be coloured by associations in the course of a very short time.

7848. I am afraid it will attract to itself the unhappy ideas which relate to such an institution?—Yes.

7849. But for the time being at least the use of the expression "mental hospital" seems to be more in the line of development?—Yes; that has already been adopted in many cases, and that is a very good reason for adopting it throughout.

7850. It is not a statutory term?—No.

7851. It has been adopted more or less at their own hand by certain officials?—Yes.

7852. But there is just the danger that it may in turn attract to itself unhappy associations?—Yes.

7853. That is one of the terms to which you draw attention. Then the word "lunatic" you have already discussed; etymologically of course it is merely a vestige of superstition?—Yes.

7854. And its associations also seem to be unnecessarily harsh. Your refer to Section 315 of the Lunacy Act of 1890 in this connection, and Section 315 has caused a good deal of anxiety to members of your profession, has it not?—Undoubtedly.

7855. It creates a statutory misdemeanour in the case of any person "who, except under the provisions of this Act, receives or detains a lunatic, or alleged lunatic, in an institution for lunatics, or for payment takes charge of, receives to board or lodge, or detains a lunatic or alleged lunatic in an unlicensed house." The result is that taking the simplest instance, a person who for payment takes charge of, or receives as a boarder a person who would be certifiable under the Act, but who has not been certified under the Act, is exposed to the criminal law?—Yes.

7856. And I understand that in the case of many patients whose condition is not very easy to diagnose, and who are sent to nursing homes for treatment, very difficult questions have arisen in the mind of the doctor who conducts the nursing home, as to whether he is within or without the law?—It is inevitably difficult. Patients do not remain in the same condition continuously to correspond to any Act of Parliament.

7857. Quite. I am afraid the human body does not regard the sections of Acts of Parliaments, therefore it is the same trouble that one has in the grading off at the other end, the recovery end?—Exactly.

7858. I remember it was put by somebody that you can speak about a matter that has occurred in the day time and a matter that has occurred in the night time, but the twilight is always a difficult thing to define. Now in connection with Section 315 which creates this statutory misdemeanour, how precisely do you propose to alleviate the position? Your definition will help, I think, will it not?—I think it is important to realise that the section will become a very uncertain and doubtful one if the change is made which we suggest in the nomenclature, unless the term "of unsound mind" is carefully restricted by definition as I have suggested. Otherwise if you substitute in Section 315 the term "person of unsound mind" for "lunatic" or "alleged lunatic," and do not define it, then it will become a penal offence or misdemeanour to receive any person of unsound mind in the broad sense of the word.

7859. Then again do you appreciate this—I am anxious to get over a difficulty that arises under Section 315, which I understand is a very real difficulty: if you merely substitute in Section 315 for the existing "lunatic," or "alleged lunatic," "person of unsound mind" as defined by you in your paragraph 16, will not the doctor still have just the same difficulty of saying to himself "Now I wonder if this patient of mine is a person who may be properly taken charge of and detained or not?" That is to say, if the criterion of the commission or non-commission of the misdemeanour is to be whether or not the patient's state is one where he may be properly taken charge of and detained, I should think the doctor would have the same difficulty once again?—Yes. I do not think we have got over that difficulty. I only hope we shall not fall into another, that is the point of our laying stress here, but you will of course recognise that Section 315 is governed by the other provisions of the Act, and if you modify the Act in various ways you then incidentally and *ipso facto* modify the effect and result of Section 315.

7860. I follow, and probably the solution to which you are attending is to eliminate the cases in which this problem will arise?—Exactly, that is the point.

7861. Sir Humphry Rolleston: Will you indicate how the broad impression of a person of unsound

14 January, 1925.]

Dr. R. LANGDON-DOWN, M.B., M.R.C.P.

[Continued.]

mind differs from your definition, excepting in the provision that a person of unsound mind is a fit and proper person to be detained?—In our Committee who were discussing matters, I gathered that people were willing to apply the term of unsound mind to the very mildest forms of ailment for which no measures of control or detention were desirable, that is to say, it is used by some people, and perhaps pretty generally, to cover all mental disorders, all departures from the normal other than mental deficiency. That would be impossible and undesirable if you are going to apply the term “persons of unsound mind” to persons who need certain measures of restraint and control.

7862. *Chairman*: It looks as if this specialised connotation which you are going to give to a person of unsound mind has perhaps one disadvantage, and that is, that it dissociates it from reality, because a person of unsound mind may be of all degrees of unsound mind, but in the technical sense is a person whose unsoundness has reached such a stage as to justify detention?—Yes. You must reserve certain words for certain purposes, and we suggest for the general purpose we should reserve the term “mental disorder,” then we should be clear. “Mental disorder” does not necessarily connote the need for detention or control. Where that arises then let us reserve for those who are properly to be submitted to measures of restraint and control “persons of unsound mind”—then we are clear.

7863. Then the whole class of those who are disordered mentally would be divided into two. On the one hand there would be the person who is not of sound mind in the technical sense, and, on the other hand, there would be a large class of persons whose minds, though disordered, are not unsound in the technical sense?—Exactly.

7864. Are we to give them a name, or are we just to leave them at large?—We suggest the term “mental ailment,” or the “mentally ailing” for the intermediate class, for convenience.

7865. It would not be necessary, of course, to give that class a statutory name, I think, because if you have defined the one class that has to be subjected to special restraint then all the other persons fall outside that category; all the other degrees of manifestations of disorder will fall outside that class; there will be persons who are affected, but who would not be persons of unsound mind in the statutory sense?—Quite so, but when it becomes a question of prosecution, and so on, in courts of law it would be very convenient to say we regard this person as coming in the category of the “mentally ailing,” not in the category of the “mentally unsound.” It might come to be a well-recognised arrangement.

7866. The criterion, however, is still, if I may say so, a criterion of opinion, because the criterion is: is this person one whose state of mental disorder is such that he ought to be taken care of and detained, whether he wishes or not? Now that will always be a criterion of opinion. A criterion involves a judge, and every criterion must be applied by someone, and, in the end, when you get down to a difficult case, someone will have to apply that criterion and someone's judgment will have to be relied upon in the application of that criterion?—Yes that cannot be controverted.

7867. I do not say it is wrong for a moment, but I want to analyse the matter down?—But we do suggest it is not simply a jump from the normal to the lunatic; it is a step from the normal to the “mentally ailing,” and a step from the “mentally ailing” to the “mentally unsound.”

7868. I think that that conception is one of very great value; the conception that before the person is classified as a lunatic in the old sense, a certified person with all that that entails, there should be a series of stages for observation, diagnosis, prognosis and preliminaries of all sorts, which will protect the subject against resort to what, after all, ought to be the last resort, the certification. That seems to be the general scheme on which the whole of your principles are based?—Yes.

7869. Then do you and your colleagues think that the very real difficulty which arises just now under Section 315, although it would not be eliminated by your definition, would be alleviated by the definition in conjunction with the other proposals which you have to make for what I may call preliminary treatment?—That is our view, yes.

7870. It is always a very undesirable position when any section of the community has to do things which they think are beneficial and at the same time are afraid that they are contravening the law; that of course has been the dilemma, I understand, of many members of the medical profession who have patients in nursing homes, under Section 315?—Yes; we feel that the position is very unsatisfactory.

7871. But I suppose it will depend very much upon the temperament of the particular medical attendant as to whether he is afraid of the law, or not afraid of the law—whether he is prepared to take risks, or not?—Yes.

7872. That one recognises is a rather undesirable state of matters?—Yes.

Sir David Drummond: Does it not entirely turn upon the question of whether the patient is certifiable or not? It is conceivable that many patients may be of unsound mind in a sense, and yet not certifiable.

Chairman: I think the difficulty of the particular case is that the medical attendant has a patient—he is not sure whether he is a certifiable case or not—he sends him to a nursing home where he is taken charge of for payment by a brother practitioner, the brother practitioner is also not quite sure whether the patient is certifiable or not; if in fact he is certifiable, then an offence has been committed.

Sir David Drummond: Is not that the whole crux of the question?

Witness: We try to avoid the word “certifiable,” as I daresay you have observed in the document. We say, “a proper person to be placed under a formal reception order.”

7873. *Earl Russell*: It involves consideration of exactly the same facts?—It does, but still it has a different implication and suggestion; but the point I was going to make is this: We have laid down here in our definition certain criteria which shall enable you to judge, and those criteria were never laid down before, that is to say, does the patient in fact need and have for his treatment measures of restraint?

7874. *Chairman*: Yes, I think it will assist, and it is perhaps a more easily applied test, because it is not so much a question of the pathology of the case, of the state of the person's mind, as a question whether restraint is necessary in his case for his own interest or in the public interest. But whether the definition carries us clear of the trouble or not, I am not sure that there is not more protection to be found in the proposals you make for legal treatment short of certification?—Quite so. If there were recognised homes for the reception of the doubtful cases the trouble would be largely got over.

7875. *Sir David Drummond*: That is just the question of licence again, is it not?—I am not quite sure what Sir David means by licence, but it would not mean the formal full certification certainly; there would be no doubt some possibility of knowing about these patients, but it would be a very different thing, I take it, from the full reception order at all events in the view of the public, which is what we are aiming at partly.

7876. *Chairman*: But you would still be left, I think, with at least a residuum of cases, as to which it might be difficult to say whether the particular patient was one who did or did not fall within even your improved definition of “person of unsound mind”?—I quite agree; we have not completely solved all the difficulties.

Sir David Drummond: May I ask whether the witness proposes to eliminate all kinds of restraint in connection with the early cases, e.g., the 72-hours notice?

Chairman: I do not think that is the view, is it?

14 January, 1925.]

Dr. R. LANGDON-DOWN, M.B., M.R.C.P.

[Continued.]

Witness: Oh no. Taking that 72 hours, I imagine the patient is under full control.

7877. We shall examine in a moment your proposals as to the preliminary, or provisional methods, but I am anxious with regard to Section 315, of which we have heard a great deal, and we know it is a source of much anxiety to the profession. We do not want to leave it still in the position that many medical men, anxious to do their best for their patients, are embarrassed by the existing state of the law. One would like, if possible, to eliminate cases of that sort, cases where they do not know whether they are contravening the law or not, and cannot know until a jury tells them?—We contemplate the treatment of mental disorders partly in nursing homes, entirely free from any supervision, and partly in recognised homes where it is known that doubtful cases are received, and where there is some assurance that at all events the treatment will be wise and proper. After all, that is the main thing, that the patients shall not be wrongfully used. That is the object that the public aims at, that there shall be no abuse.

7878. Yes, and Section 315 is designed of course to prevent an abuse; it is to prevent the abuse of persons making money out of the boarding of persons who are of unsound mind in their houses or their homes which are not under statutory supervision. It is detaining persons, on the one hand, but not detaining them with the proper safeguards, on the other; and that is really the trouble which Section 315 is designed to meet, I think?—Yes, quite so.

7879. I am still not quite clear how far the mere change of definition will obviate the difficulty, the difficulty in the individual case as to whether or not a person is contravening Section 315. I am inclined to think that the position will be rather alleviated by your other suggestions which we will come to shortly?—Yes.

7880. Turning from Section 315 of the Act to the Form 16 to which you make reference, it uses the expression "mental disability." I see you find that a useful and convenient phrase?—Yes, we think it is useful and convenient, and being useful and convenient we say why not use it throughout for similar cases?

7881. Then really the main class would be persons suffering from mental disability, and then within that class you would have all the grades up to the case of the person of definitely unsound mind?—I think there is a verbal slip in your statement. There is the main class of mental disorder—mental disability is the smallest sub-class.

7882. Mental disorder is the genus, so to speak?—Yes. Of course, those who are mentally unsound are obviously mentally disabled from managing their affairs. But among the mentally ailing there are some who are able to manage their affairs, or, at all events, do not need to be treated as mentally disabled from that point of view; but there are others who are mentally disabled from managing their affairs, and for them arrangements for the management of their property should properly be made.

7883. This, of course, relates only to a property matter?—Yes.

7884. That reminds me very much of a formula we use in Scotland. We have applications to the Court to appoint a *curator bonis*, who is a person to look after the property of a person who may not be insane, and there there are two certificates by doctors, who merely state that they have examined a particular person, and have found that he is unable to manage his affairs, or to give directions for their management; and upon that the Court appoints a judicial factor, which is equivalent here to a receiver, but that leaves his liberty unaffected. That is very constantly resorted to in the case of aged persons, of whom it would be ridiculous to say they are lunatics but who are simply, through failing powers, unable to look after their affairs. It is an exceedingly convenient provision. You refer to Form 16 really for the purpose of borrowing the phrase "mental disability" from it?—Yes. All we wished to do was

to show where these people come in this scheme, and to suggest a uniform term for them. The provisions for managing their property, as you are aware, already exist.

7885. Yes, Section 116. I think probably there is a certain lack of uniformity of expression throughout the statutes. In Section 116, sub-section (1) and paragraph (d), to which you also refer, we have a class of person who is described as a person "not so detained and not found a lunatic by inquisition, with regard to whom it is proved to the satisfaction of the Judge in Lunacy that such person is through mental infirmity arising from disease or age incapable of managing his affairs"?—Yes.

7886. There are two criteria there—one arising from his physical state, that he is diseased or is senile, and the other that he is incapable of managing his affairs. Now that is a different phrase from "mental disability"; this is "mental infirmity"?—We feel that "mental disability" would cover it quite well.

7887. The scheme which you set out in paragraph 23 of your memorandum as a scientific classification of cases starts with "mental abnormality" as the genus?—That is so as not to lose sight of the other group of "mental deficiency." I may say that we hardly claim to lay down a scientific classification in this little table, but only a convenient logical arrangement. "Mental abnormality" includes both "mental deficiency" and "mental disorder." I understand that you are here not dealing with "mental deficiency" at all.

7888. No.—It is the other sub-division, "mental disorder," that we are concerned with.

7889. It may be treated as a subgenus for our purpose?—We wanted to show where we place "mental deficiency" in relation to this.

7890. I confess I was a good deal puzzled when I read the definition of "mental deficiency" in the Act of 1913; it seems to me to cover a very large number of things which the ordinary layman would call "mental disorder," not only the congenital case, but a number of other cases which would fall into the category of lunacy. I do not know whether the medical profession find it easier to relegate cases to the one category or to the other. You remember the definition under the Mental Deficiency Act?—I do very well, yes.

7891. It is certainly very remarkable. It includes idiots and imbeciles, both of which categories are more or less intended to cover the congenital case. Then it goes on to feeble-minded persons—that is probably intended to cover congenital cases also, and then moral imbeciles. Some of these cases struck me as cases which might be possibly found in the other category of "lunatic," and certainly I imagine there are cases of that sort to be found in asylum records, are there not?—Yes, undoubtedly there tends to be in nature an overlapping here, but the unfortunate thing about the Mental Deficiency Act was that it endeavoured to set up a psychological classification to some extent of these patients; and it is partly with that in our minds that we suggest you should not attempt any scientific definition of mental disorder or mental unsoundness. The real thing is that you should get the practical measures adopted and provided which are needed for dealing with these young persons for the most part; their malady begins either from birth or at an early age. That is the essential factor, and they need, even where they are really at the beginning of insanity, different treatment in different institutions from the fully-grown insane.

7892. Of course, we have not to consider, as you know, the Act of 1913, or the case of "mental defectives." You select therefore as your genus "mental abnormality" for the purpose of including both classes, i.e., the case of the "mental defectives" who probably fall under the Act of 1913, and the case of "mental disorder," which is taken by you as the class of case governed by the Lunacy Acts?—Quite so. I must safeguard myself again in saying that

14 January, 1925.]

Dr. R. LANGDON-DOWN, M.B., M.R.C.P.

[Continued.]

the Lunacy Act only regards the persons who need detention and control.

7893. You would now suggest that the lunacy legislation (if I may still retain for convenience the old title) should be extended so as to deal with cases which at present it does not deal with, the cases of persons who, although either certifiable or not certifiable, need not be subjected to the ultimate process of certification?—Yes. Perhaps this is my own personal view rather than the view of my committee, but I am more familiar with the working of the Mental Deficiency Act, perhaps, and there is provided in the Mental Deficiency Act an arrangement called "approved homes" where patients are received without any certificate under the Act at all.

7894. Is it Section 50, "Provisions as to approved homes"?—Yes.

7895. "The managers of any premises wherein defectives are received and supported wholly or partly by voluntary contributions or by applying the excess of payments of some patients for or towards the support of other patients, and any person desirous of receiving defectives in his house for private profit, may apply to the Board to approve the premises or house, and the Board, if satisfied of the fitness of the same and of the applicant, may if they think fit grant their approval"?—Yes, and you will see "It shall not be lawful to receive or detain in an approved house any person ordered to be sent to an institution for defectives."

7896. It excludes from such a place the persons who are subject to an order?—Yes, it recognises there are people who are "mental defectives" but who need not be made subject to an order. That is the point of my comparison.

7897. Again looking at your classification, and taking for the purposes of our investigation the genus to be "mental disorder" because we will leave the "mental deficiency" side, your broad differentiation is between the "mentally unsound" in the sense of the definition you propose, on the one hand, and, on the other hand, all other persons who are disordered in mind, but whose mental disorder has not reached the stage of statutory unsoundness?—Quite.

7898. *Sir David Drummond*: Would you include under "mental ailments" all these cases that have a physical basis such as a condition of anæmia and other toxic conditions?—No doubt any mental symptoms would be mental ailments, but of course in that case the predominant fact is usually the physical one.

7899. Does it not complicate the whole question as to the law to deal with these cases?—I think I have already made it clear that large numbers of the mentally ailing will and must remain entirely outside the provisions of the statutes and the law.

7900. *Chairman*: I think that is so. We shall examine a little more closely the class on the left-hand side of your table here. You have given us your definition of the mentally unsound, but when we deal with the class of cases on the other side, what you call the "mentally ailing," I suppose that would include all sorts of people who are, for the time being, mentally disordered. Even the person who is in delirium would be mentally disordered for the time being, but of course he is not "mentally unsound." How we are to deal with him you will disclose in the sequel?—Yes. At all events I would safeguard myself against the suggestion that they should all be put under statutory arrangements.

7901. We have heard it suggested that in some of the Poor Law infirmaries where mental upset follows upon pneumonia or may be a symptom of Bright's disease, the patient is hurried off and certified because it is difficult to impose the necessary restraint in the infirmary; the patient is certified and taken to the asylum or removed to the mental ward. I think that is what *Sir David* is probably recalling.

Sir David Drummond: That and quite a number of other chronic conditions that depend upon a

physical basis, which are dealt with in general hospitals.

7902. *Chairman*: I think you do not contemplate that that class of case would ever find its way into the category of the "mentally unsound" in the statutory sense?—No. All we want to do is that they shall not be lost sight of. We recognise their existence, as we must, and place them somewhere.

Sir Humphry Rolleston: Before we leave this point, it is really perhaps rather a quibble, but I am not quite sure whether the term "mental abnormality" is preferable as a main heading to "mental disability," because one might say the term "mental abnormality" would apply to a good many who might be anything. Would not the term "mental disability" be a quite good one instead of "mental abnormality"?

Witness: You see we have selected a word already used in the Act, "mental disability" and applied it as far as possible to that particular purpose, to all cases that are allied to that particular case; therefore we are precluded to some extent from using that term for the biggest class of all without creating confusion. I know the difficulty of choosing right and proper words. Any word you may choose will have its difficulties.

7903. *Chairman*: There is a point, if I may suggest it to you, in *Sir Humphry's* criticism. Abnormality does not necessarily suggest a pathological condition, or a defective condition, because you may say of a person that he is abnormally clever. Disability does suggest defect of some sort or other, does suggest something that is less than the normal?—Well, what do you say to "mental disease"?

Mrs. Mathew: "Mentally deranged"?

7904. *Chairman*: I do not know whether you call a congenital idiot "mentally deranged"?—That is the difficulty.

Sir Humphry Rolleston: "Subnormality" would hardly do?

Witness: After all, there is no suggestion that these terms should be incorporated in any statutory document.

Chairman: No, but it is very useful; a discussion on terminology is never wasted, because it always brings one up against the real questions of principle which one has to consider.

Mr. Snell: I was wondering if there is such a person as the perfectly normal person. What is the normal?

Chairman: It is like what is known in law as the reasonable person who, I understand, does not exist.

Witness: In the same way if you use the word "disease" some people say that nobody is perfectly healthy.

Chairman: I do not suppose any of us is in the precise poise of health at the moment of which any doctor would say: "You are absolutely well."

Witness: No; so long as we understand the meaning we apply for the purpose of this document to that word, I think we shall be clear.

7905. *Chairman*: I do not think for the purposes of our investigation it is of so much importance what is the genus with which we start, because we do not become interested until we meet the class of "mental disorder." Your first classification is really outside our purview; we start with "mental disorder," and I think upon that, *Sir Humphry*, you have no difficulty with the phrase. We are concerned with the sub-classification under "Mental Disorder." (*To the Witness*.) May I just ask your view for the moment on the word "pauper." There again we have a word with unhappy associations, and the classification of patients into private and pauper patients runs, of course, through the statute at present?—Yes. You see the whole attitude of the law has altered since those words were introduced and it really is used factitiously now.

7906. It is a very artificial definition that is attached to the word "pauper" in the Lunacy Acts?—Yes, very.

7907. I shall want a little later on to consider with you how the element of Poor Law administration

14 January, 1925.]

Dr. R. LANGDON-DOWN, M.B., M.R.C.P.

[Continued.]

comes into this topic at all. For the moment I will only say this, that it seems peculiar that a person stricken with this kind of ailment, and who obtains assistance and treatment, should by that very circumstance be classed as a pauper, although he may up to that time have been a well doing working man, or professional man; while the person who breaks his leg or who is damaged in an accident in the street, and is taken to St. Thomas's or St. George's, is accommodated there, treated, and in due course leaves, and nobody ever suggests he has been a pauper. But because a man gets the treatment which is given to patients mentally afflicted in a particular way, he thereby *en route*, so to speak, attracts the legal character of "pauper." We have been much impressed with this, particularly in the early part of our deliberations, that it seems an unfortunate thing that there should be added to the misfortune of the illness a social stigma of pauperisation. I am sure my colleagues share that view with me, but we will have to consider how that comes about. It is partly due to the fact that there are no places other than Poor Law premises to which a patient can be taken, and no places where he can be treated other than public institutions, that is to say, places which are rate-aided, with the exception, of course, of a certain number of the registered hospitals and licensed houses. Then do I take it that the view of the British Medical Association is that while we are about it we should try to eliminate, not merely the word "asylum" with its associations, but also, if possible, the word "pauper" from the Lunacy Acts?—Yes, and particularly with its associations.

7908. Of course if we can cut out the associations then we get rid of the word which is the result of those associations?—Yes.

7909. Now we come to your criticism of the procedure, apart from the matter of nomenclature. In the first place you emphasise the fact that at present persons are often deterred from resorting to institutions for treatment by those very associations to which we have been alluding?—Yes.

7910. The association on the one hand of the asylum and the association on the other hand of the notion of pauperisation, both of which elements enter into certification in so large a number of cases?—Yes. If I may enlarge a little, we hear from the people that have to deal with these cases that the public is partly deterred very much by the mere formality of the reception order. It really is a terror to many people. Then they say that the people complain, not of the treatment they receive in the institutions that they are placed in, but of the association, in the early days at all events, in the insane wards of the workhouses—the association with very objectionable cases from their point of view; and they object to the wearing of the workhouse clothes.

7911. On this question of clothing which I see you refer to in paragraph 25, I suppose that Carlyle was right when he regarded clothes as having a very important effect; he figured a certain House of the Legislature without clothes, and thought it would have lost most of its dignity; but it has, I suppose, a very important psychological effect upon the patient?—I think so, and a physical effect.

7912. But one has to remember, I suppose, that one is dealing with persons who may be in a peculiarly sensitive state, whose sensitiveness may be abnormal, and therefore things which to the robust mind might seem unimportant may have much more importance in the mental state of the patient?—Yes.

7913. The only thing I should like to put to you on the subject of wearing apparel is this: if the clothing were a uniform in the sense that uniform is worn, let us say, in prisons by convicts, I should have appreciated your criticism, because it would tend to destroy individuality; but you must know, I think, that in the asylums, at any rate in many of them, the patients are not all dressed alike. I do not mind saying that I visited an asylum recently, and was very much impressed with the fact that the women there were wearing all kinds of clothes;

so were the men, and I asked "Are these provided by the rates?" and the answer was "Yes." "But," I said, "there is no uniformity among them." The answer was, "Oh, no, we do not put the patients here into uniforms because that is the very thing we want to avoid. It is destructive of individuality, and the sense of independence." It seemed to me that that made a great difference. If the clothes are varied, the drawback to their being provided by the rates has to a certain extent disappeared?—I was aware of that. When the patient reaches the institution, in many of the institutions the uniform is gone. I am simply recounting to you what we hear through our sources of information of the objections of the patients; and the objections of the patients are to the wearing of the workhouse clothes in workhouses, or on immediate reception during the first few days.

7914. What I wanted to get at was this, is the objection of the patient due to the fact that it is uniform, or is it due to the fact that it is provided by somebody else's money, and not their own?—I am afraid I cannot give you any useful answer to that. One of my colleagues says that no doubt the friends feel the indignity of clothing being supplied in that way.

7915. Of course one has to recognise this, that there are many cases unhappily which reach asylums, where neither the patient nor the patient's friends are in a position to supply clothes and renew clothes which would be suitable for the patient. I am afraid sometimes poor people are rather anxious to cling to garments which it is very undesirable they should retain in an institution; there is always great difficulty there?—I quite recognise that.

7916. In some cases it will always be essential, I take it, to supply clothes for a patient?—Yes.

7917. Would the case be met if patients were to be entitled to wear their own clothes, that is to say, clothes provided for them by themselves or their friends, in all cases in which they desire to do so, and where the clothes were approved—they would have to be approved by somebody?—I think it would, but I may say that we do not feel ourselves as a body particularly qualified to deal with the internal arrangements in the institutions; our experience does not extend there very much.

7918. This is, after all, a matter put in brackets by you; it is merely an observation of the type of thing that we should attend to?—Yes, that is so.

7919. But these ideas were passing through one's mind as to how you could help us upon a principle of that sort; its bearing seems to be this, that you must do everything you can to preserve the independence of the patient, to give every opportunity to restore individuality?—I think we should thoroughly agree with the principles that you have just enunciated, in dealing with the matter.

7920. Then you speak of the deterrent effect of the formalities which at present obtain. Are you aware that there is another view on this matter, which I have no doubt we shall hear—there is a view that the formalities are insufficient, and that there should be more formal procedure rather than less formal procedure in dealing with these cases, because a suggestion is made that the safeguards at present against wrongful detention and improper certification are inadequate. Again, one must bear in mind that part of that criticism may be obviated (we shall hear with interest later on) by the new methods proposed by you, by treatment of voluntary patients, and so on, and that the present fear in the public mind of improper certification may be alleviated by that; but for the moment there is undoubtedly the suggestion to be made that the formalities are insufficient?—In regard to that we made careful enquiries and specifically asked that question, and we got no evidence that in fact the thing does not work well on the whole. The machinery works well on the whole; we have explored, as we say, the safeguards given in the Act, and if you are going to rely upon machinery we think you have got very good machinery, and I think you must rely upon it. You have very good machinery for the carrying out of

14 January, 1925.]

Dr. R. LANGDON-DOWN, M.B., M.R.C.P.

[Continued.]

safeguards. We have suggested a few modifications and improvements, but in the main we think the machinery is very good.

7921. But with those modifications, and the modification you are going to tell us about in a little while, the machine as a machine is probably as good as we can get?—I think so.

7922. Of course we always have to come back to this, that the machine is worked by fallible human beings?—Yes.

7923. On this question of greater formality rather than less formality in the procedure, one is a good deal puzzled; on the one hand, you are most anxious to have every form of safeguard to reassure the public?—Yes.

7924. On the other hand, one has to recognise that one is dealing with patients, with persons, that is to say, who for the time being are suffering and in whose case the multiplication of formalities seems undesirable. Certainly the person who is suffering from an ordinary physical ailment would like to have as little as possible to do with lawyers and justices, or anybody else. He wants to get off to bed and into the hands of a kind doctor as quickly as possible, whereas suggestions are made that in certification the formalities should be of quite an elaborate kind, and there should be cross-examination of witnesses and a more or less forensic tribunal set up before any person is deprived of liberty. That is one view that has been suggested?—We are aware that there are two streams of thought in the matter, one tending to the eighteenth and nineteenth century view, and the other tending to the twentieth century view; but we think that the risks of wrongful detention are infinitesimal, and that the stringency of the law vastly outweighs in the interests of the patient the ills that may arise from wrongful detention.

7925. Of course the real interest of the whole machinery is the welfare of the patient—that is what one must think of the whole time?—Yes.

7926. And if one were to have elaborate machinery which would be very detrimental to a large number of patients but might possibly prevent one or two doubtful cases being improperly detained, which is the better course to adopt?—Oh, I think the welfare of the great majority of the patients. (*Sir Jenner Verrall*): But we so far increase the formality by suggesting that there should be two certificates, and that the magistrate should see the patient.

7927. Yes, but I rather put it in this way, that taking Dr. Langdon-Down's additional safeguards, taking it as so strengthened up, your view is that there is enough of the law about it?—(*Dr. Langdon-Down*): Yes, honestly. We have strong views upon the importance of safeguarding the liberty of the subject too—we are not at all apt to lose sight of that—our Committee I mean, and the Association; but honestly we feel that the safeguards will be adequate.

7928. Of course it is a very difficult topic. Personally I should have thought that a judicial investigation into the case of each person before certification, in the sense not merely of a justice having before him the evidence of one or two doctors, as at present, but actually conducting an inquisition into the case, that is to say, medical evidence possibly on both sides, and the usual apparatus of a forensic controversy would be very inappropriate to the great bulk of the cases?—It is quite contrary to the medical view of what is best for the patient.

7929. It has been suggested that the patient shall be apprised that his liberty is at stake in this investigation, that the result of what may happen before the justice is that he may find himself detained against his will, that he should be afforded the assistance, shall we say, of a solicitor, or even possibly of counsel, at any rate legal assistance, to have the doctor or the relatives (in the case of an application by a relation) cross-examined, and a considered judgment arrived at by the judicial authority or justice of the peace after an investigation conducted on these lines. Now let us see where that would lead us. Take the case of a person who is really furious—I know that these cases are relatively few; the public are apt to think they are very much commoner than

they are, but they do occur, of course. Let us take the case of real fury—such a person of course would not really be in a position to give instructions to any legal person, would he?—No.

7930. Can you conceive of any useful purpose in a judicial investigation in such a case?—No, I cannot.

7931. Then, on the other hand, there are cases, not of fury, but take the case of a patient with deep-seated melancholy, a lethargic case, who will not respond to any outside stimuli of any kind. Again such persons would not be able to avail themselves of any forensic machinery, would they?—No.

7932. Do you think it would be good for such a person to be brought into a forensic atmosphere, a controversial atmosphere?—Quite the reverse.

7933. I am putting for the moment the points against it rather than the points for it. If you had a person in a very unstable state of mind, possibly not over the score, but in a very upset state of mind, to hear his condition in his own presence discussed and debated, with possibly a prognosis of his future, in the presence of a justice of the peace, or of a judicial authority—would not that be rather distressing?—Most.

7934. I am very familiar with judicial disputes, because I have spent a good many years in that atmosphere, and I can imagine that if an unhappy patient, whose only desire was to get rest and peace for the time being, heard a solicitor cross-examining the doctor, and saying: "You examined this man, do you think there is any chance for him?" and the doctor may have to say: "No, I am afraid it is a hopeless case," it would be unhappy for the patient sitting by to hear that?—It would be terrible.

7935. And yet the doctor would have to say that if he were cross-examined on the subject?—Yes. May I say the sort of view we take is this, that a justice is there to use his discretion as a friend of the patient and represents public opinion, the right public opinion. He has a great many resources at his command if he is in doubt. Further, after the patient has been received, the authorities, both the superintendent of the asylum and the authorities in London, the Board of Control, may be regarded as the friends of the patient; we firmly believe that.

7936. Yes, but let me put this suggestion to you: It has been said that the intervention of the judicial authority, or the justice of the peace, is a mere formality?—It is what he likes to make it.

7937. Yes, but then the question is this: What ought he to be compelled to make it? For instance, we had one gentleman before us who said that the cases were brought to his house commonly in a taxicab, he was handed the medical certificates and he looked into the 'cab and said "All right" and signed them. That is hardly an exaggeration of that gentleman's evidence. He said the patients did not come out of the taxicab. I ask him if he took them into his house and discussed matters, and he said: "No," he was satisfied; he would look into the 'cab and sign the certificates?—Our view is that it is one of the most difficult questions that we have discussed among ourselves, this question of the justice, and we do not feel that it is our duty to lay down, or to advise you what should be laid down, with regard to the duties of the justice. We found it very difficult to define in our own minds how far the duties of the doctor went, and how far the duties of the judicial authority went in regard to this matter of the order. But we do feel that he should regard himself more or less as a court to satisfy himself that the evidence put before him is *prima facie* sound. I can conceive a case in which the certificates would be so convincing in their information, the evidence laid before him, that it would be really quite superfluous for him to do more than to look into the 'cab. What he has to do is to weigh the evidence before him; he has not got to descend into the arena and write a certificate, or go fully into the case and produce evidence as to the patient's insanity; he has not to be the expert, or to regard himself as the expert necessarily. All he has to satisfy himself about, in our view, is that the evidence put before him appears to be genuine,

14 January, 1925.]

Dr. R. LANGDON-DOWN, M.B., M.R.C.P.

[Continued.]

logical and convincing, that is to say, to justify the conclusions which are founded upon it.

7938. *Earl Russell*: I rather wanted to put this question to you upon that point: If the judicial authority is to act really as a court on very strong uncontradicted evidence, as he would in the majority of plain cases, he really need not do much more, need he, than be satisfied that the evidence is honestly given and that the patient appears to be on the face of it a proper patient for detention?—Yes, and that the patient has an opportunity of saying something if he wishes.

7939. Do you think that the justice ought to intimate to the patient that that is the time for him to say anything or not?—I think of course that the justice must be guided by the evidence given in the medical certificates as to the mental condition of the patient, the strength of the form before him.

7940. But assuming that the patient was sane or, at any rate, perhaps not certifiable, that he was one of the people whom the justice was interposed to protect, if the justice does not at some stage give the patient an opportunity of making his protest, then he has rather failed in what he is put there to do, has he not?—Yes, but you are postulating a sane man behaving in an insane manner.

7941. Either the justice must at some time or other give the patient an opportunity of making his protest by letting him know what is going on, or else he must assume he is insane, and then he may just as well not be there, so far as the patient's interests are concerned?—Does not this formality of the 'cab strike a sane man as being something out of the ordinary which should put him on his guard?

7942. *Chairman*: We have had one or two cases where a patient has been put off his guard. It has arisen in this way: it is said of the patient, "Do not tell him about this question of the asylum or certification; it will upset him." He is taken to see a doctor, and possibly a justice of the peace, without being told that there is any formality about it. They may tell the patient, "It is a question of getting an opinion about you," or something of that kind; and one has read of cases where a patient has found himself a certified inmate of an asylum without ever knowing that he has been subjected to any judicial process of investigation at all. That is the suggestion?—As you see, we favour the justice visiting the patient, or seeing the patient in every case, but we also expect that the justice shall read the certificates with intelligence, and judge whether the evidence is conclusive or not, and whether he wants to make further enquiries, or whether he thinks it is right to tell the patient.

7943. I think you are quite right to say that the question of legal machinery is really not in your province; but what I think is very much in your province is the welfare of the patient, and you can assist us upon the question of how far a more elaborate system of investigation might be prejudicial to the patient. That is a thing that is troubling my mind, I confess, a good deal. I cannot figure without dismay the holding of an investigation which would involve cross-examination and so on in the case of a patient suffering from mental upset?—Quite so. We have gone a very large way to meet those cases by the suggestion of a provisional order, where the patient is under supervision and observation for a time, and where it will be quite clear to him that his mental condition is under consideration, and where a right judgment will almost inevitably be formed, as far as human nature can form a correct judgment.

7944. The ordinary citizen accustomed to courts of justice figures the case where the evidence is not all on one side; that is to say, where testimony is directed to a particular end, and counter testimony is given, and evidence is explored critically. It is true, of course, though perhaps it may be due to the necessity of the case, that the evidence upon which a justice of the peace is called upon to proceed in certification is evidence from one side only. It is not subjected to what, after all, is the most searching

and useful instrument of investigation, namely, cross-examination. It is one-sided evidence, and it must be so probably. Therefore it is not a judicial investigation in the ordinary sense; it is an administrative jurisdiction that he is exercising, but a discretionary jurisdiction founded upon evidence. The only point is this, that it is evidence from one side?—Yes. I think the answer to that question is to get some concrete cases of the certificates, and see them before you, and say: "Now, should a justice seeing these certificates have been satisfied to sign the order, or should he have gone further?"

7945. Now that raises, of course, a question at once. We shall assume the competence of the medical man. After all, we have to rely at some stage upon some person. We shall assume he has examined and has given his certificates, and we shall assume there are two certificates. These are examined by a justice of the peace, and the justice of the peace and his clerk are, no doubt, competent enough to see that the formalities, because they are fairly simple, are observed?—Yes.

7946. They are not competent, I should imagine, to say whether the data which are set out in the certificate lead necessarily to the inference that the person is of unsound mind. A justice cannot do that; that is the doctor's affair, is it not?—Yes.

7947. The doctor says, "Here are certain symptoms observed and reported to me; upon those I say he is a person who requires detention"?—Yes; he writes down certain facts. We have carefully analysed in our minds what the certificates consist of. I think it is a very important thing, first of all, that concrete facts of conduct observed will be detailed in the body of the certificate. The doctor forms certain conclusions from those certificates, which are in the nature of an expert opinion; the justice will have those facts put before him. If he feels that there is some difficulty in his mind in believing that the facts are abnormal, or is doubtful about the truth of the facts, whether the doctor has been careful enough to obtain all the facts, or to test and check them, then he can make further enquiries; but all these things depend upon the actual certificate before the justice.

7948. Quite, but they seem to me to depend even more upon the justice himself. You might have a justice who was a most conscientious person who scrutinised every case he had before him, who referred back cases and made further investigation, and so on, and performed his functions exceedingly well. On the other hand, the body of the justices of the peace is a very large one; you might have a justice of the peace who treated his functions very lightly indeed, who said, "Well, there are a couple of medical certificates. Are they all right? I suppose I may sign the order." That is not unknown in public life you know?—I quite agree. Then if the worst comes to the worst, and your justice fails at the critical moment—and, after all, the number of difficult certificates he will have to sign are very few—then you come back to this, that the patient would be admitted under another independent skilled observer, and various other safeguards come into play.

7949. *Earl Russell*: I rather want to go back to the justices' difficulty because I do feel the difficulty. Assuming I were the judicial authority in this case, and that I were conscientiously anxious to do everything I ought to do, I do feel a difficulty if I am not in some way or other letting the patient understand that I am making some sort of enquiry, that is to say, if the case is in the least doubtful, so that he at any rate may have the opportunity of putting his version before me. Supposing afterwards he has been detained and when he recovered he turned round and said "Oh yes, it is perfectly true I saw you, but you never told me you were a justice, or had anything to do with it." Should I not feel that I had failed in my duty, and is it not difficult to know what a justice must do in these cases?—I think he must use his discretion. It is open to him, if he thinks it is right, to intimate to the patient before

14 January, 1925.]

Dr. R. LANGDON-DOWN, M.B., M.R.C.P.

[Continued.]

him that there was a special reason in this enquiry, and he should do so.

7950. I agree there may be only one per cent. of the cases in which real difficulty will arise, but it is in those cases that it is a little difficult for a conscientious justice to know whether he should give the patient some sort of opportunity?—I quite agree, but that is the solution we suggest.

7951. *Chairman*: We must bear in mind that the cases which attract public attention, and upon which unfortunately a good deal of the impression of the administration of this branch of the law depends, are not normal cases of treatment. It is the exceptional case, and people are liable to judge of the generality of the cases from these special cases; but we do not judge railway travelling in this country by an accident now and again. Therefore one must not judge of a system merely because it occasionally breaks down; but one is concerned to see that the possibilities of a breakdown at any stage are reduced to a minimum. Now on this question of apprising the person whose fate is in issue that judgment is being passed upon him by the justice of the peace, again you must envisage what actually happens. It would be rather a futile proceeding, would it not, to say to a person who was brought to you by a couple of men, and who was in a state of violent excitement, "My dear Sir, I am a justice of the peace; I hope you fully realise that I am about to perform my official functions." In that way again one must deal with these cases sensibly. As Lord Russell points out in one per cent., or possibly more cases, a patient is able to appreciate that something is happening to him, and does want to say something. No one can go through the wards of an asylum without knowing that there are a great many patients who are quite able to speak about their own condition, and to talk to you. It would be almost impossible to compel the justice of the peace to satisfy himself that in every case the patient realised he was being dealt with by a justice. On the other hand, there are a number of cases where the person is able to take quite an intelligent interest in what is happening to him, and where he would like to say things to the justice if he knew he was a justice. How are we to accommodate those two things, do you think?—I think it is by flexibility, and the spirit in which the justice deals with his certificates—the evidence before him.

7952. That comes back again to the discretion of the justice?—Yes.

7953. Let us follow that a moment further if we may. Discretion is one thing, but a directed discretion is another thing; and, as one knows, the discretion that is confided in judges is frequently a directed discretion, that is to say, they have a discretion within certain limits, but they must fulfil certain requirements, in the first instance. Do you think that at present under the existing code there are sufficient directions to the justice as to what he ought to do in such cases, so to speak, defining his discretion so as to prevent the concurrence of a justice being a mere formality; because under the existing code it may be said that he had done his duty, and no further duties were explicitly imposed upon him?—When you speak of the code you mean the law?

7954. Yes?—There are other codes besides the law, and I would rather rely upon other codes, traditions, and the attitude of the public mind towards the law, than that the law should lay down precisely what he is to do.

7955. Reflect for a moment. If you were dealing with a professional body, if you were dealing with the Judges of England, or the County Court Judges, who have a tradition and a code such as you refer to, it would be one thing; but you must remember that this jurisdiction is confided to a body, against whom I am going to say nothing at all, but who are certainly very miscellaneous, and whose capacity is very varied, and many of whom, through no fault of their own, but for want of training or aptitude, must have very little ability for discharging judicial func-

tions?—Well, I think it is partly because the attitude has grown to be wrong. I think this constantly talking of certifying the patients tends to accentuate the matter—the power of the doctor to put a patient away; whereas if you stick to what really is the fact, the making of an order, the justice would realise more that something hangs upon him—a great deal hangs upon him.

7956. *Miss Madeleine Symons*: There was another difficulty on this point, which I think was brought before us in evidence on the right of the private patient to have a friend present when the justice is seeing him. That is rather difficult, is it not, unless the patient is given to understand something of what is at stake? I think we had that difficulty brought up by a justice who told us that he always visited the patients quite informally, and told them it was merely a friendly visit, because he felt so strongly it would be bad for them to suggest any formality or the purpose for which he had come. Presumably in a case of that kind the patient would not avail himself of the right under the Act to have a friend present, if he did not know in the least what was going to happen. That was a difficulty that I think arose?—But I suppose the justice would enter into conversation with the patient. He would either be satisfied that the evidence was valid and led to the conclusion that the patient should be dealt with as insane, or he would still be in doubt. He would then act accordingly. He could either go and see some of the friends, or he could tell the patient. He must use his discretion, it seems to me.

7957. *Earl Russell*: There is a statutory difficulty here. The section that Miss Symons has drawn attention to is Section 6, subsection (3), and that says that "The petition shall be considered in private, and no one except the petitioner, the alleged lunatic (unless the judicial authority shall in his discretion otherwise order), any one person appointed by the alleged lunatic for that purpose" and the persons signing the medical certificates shall be present; that is an actual statutory direction. Obviously the alleged lunatic cannot do that if he does not know what the purpose is and what is going on?—We are anxious to assist, but we really feel it is rather beyond our powers.

7958. *Chairman*: Yes. I do not think it is quite fair to put to you these legal difficulties, but the point to which you always come back is the question of how far proceedings are desirable in the interests of the patient. I am always thinking of the patient. I can imagine a person who is in a disturbed state of mind, and to whom every form of procedure is repugnant; the last thing he wants is to be exposed to a justice of the peace or anybody else?—I feel that to make it a general rule would be very unfortunate.

7959. *Earl Russell*: We might ask whether this statutory provision is difficult of fulfilment in many cases?—It is; in many cases it is a dead letter.

Chairman: One reads the Act, and all of us may feel that you may have what appears to be 'an admirable code; then you come to deal with the crude material of human beings, and you find one case—as I put it, the case of a furious maniac—is it possible to go through all the machinery of this Act of Parliament for the purpose of literal fulfilment of what is required here? On the other hand you may have cases of all varieties. I may say that in Scotland the certifying authority is the Sheriff substitute, who is the equivalent of the County Court Judge. Indeed he has a much larger jurisdiction in Scotland than the County Court Judge has here, and I know that the Sheriff substitutes in Scotland frequently decline to accept the medical certificate that is put before them; they read it through, and say, "That is not enough; I must have better evidence than that before I sign my certificate." He at once brings to bear upon it a trained mind; he is a trained lawyer with a responsible position.

Sir David Drummond: May I ask if the witness thinks the difficulty would be got over if special justices were appointed?

14 January, 1925.]

Dr. R. LANGDON-DOWN, M.B., M.R.C.P.

[Continued.]

Witness: We have considered that, and we feel that anything which would add to the difficulties of getting easy access to a justice would be very much to the bad. If I may make a suggestion entirely my own, it is this, that there should be some method of training justices in their duty.

7960. *Chairman:* A school for justices?—It is a curious thing, but it is being done, I know, by the Central Association for Mental Welfare which is working under the Mental Deficiency Act; and they do hold courses for justices to make them familiar with the very difficult provisions of the Mental Deficiency Act, and quite a number of justices attend at these courses; so that something can be done. But if public opinion is focussed upon the point of view that the working of this Act does depend upon something more than a mere formality on the part of the justice, I think the justice will rise to the occasion.

7961. Again one must not lay out of sight that the amendments that you propose in the law, and particularly the provisional methods of treatment, will reduce the number of cases that come before the justices very materially?—Yes; all the voluntary cases will not come before a justice.

7962. It may, at any rate, have that effect?—Yes.

7963. This is a matter out of the order of your *précis*, but I think we had better exhaust this topic while we are at it. You think that so far as the legal code is concerned, with certain improvements which you propose, it would be adequate. Now, looking at those improvements, I think the view of the Association is that there should be two medical certificates in every case?—We think so, yes.

7964. There are two certificates, as you know, required in the case of the private patient, and there are two certificates required in a certain class of pauper patients?—Yes.

7965. It is one of the anomalies which exist in the law?—Yes.

7966. Is it the considered view of the Association that no person should be certified and detained except upon two medical certificates?—It is, except, of course, in the case of the provisional order. I would also limit it to, say, where it is proposed to apply control, not in voluntary cases.

7967. But the cases where a subject is to be deprived of his liberty ought to proceed, I understand, in your view, on the evidence of two medical practitioners?—Yes.

7968. Now may I put to you this: a recommendation to that effect, if it were carried out, would of course cause a very considerable additional expense, because two medical certificates cost more than one?—Yes, but really does it amount to anything vital? I happen to have read in the paper of that question being discussed here. Supposing at the present time there are 20,000 persons placed under these certificates (I think that is an exaggerated number) in a year—supposing we reduce those by 5,000 for voluntary admissions—15,000 certificates a year—is that a vital expense to the country?

7969. No, I do not think it is. I should say not, but I am not the Chancellor of the Exchequer?—Naturally I do not wish to increase the public expenditure at the present time unnecessarily, but I think it is quite certain that in some cases it is very necessary that there should be two medical certificates.

7970. I think that is undoubted?—And if you are going to make exceptions how are you going to do it? You cannot leave it till the justice is there; it complicates procedure so much.

7971. *Earl Russell:* I should just have thought you could do that, if you could detain him provisionally on the one?—Yes; that is adopting our provisional method; but I am supposing now the full order.

7972. *Chairman:* We must look at your scheme as a whole because it is very carefully adjusted, and one thing bears upon the other all the way through?—Yes, but if it is to be the doctor I think it is an unreasonable responsibility to put upon him to say:

"In this case one certificate will suffice." I do not think he ought to be asked to make such a decision, because it is the very people who may be quite clearly insane at the time who subsequently have the grievance that they have been wrongfully detained.

7973. Of course there is this point, that I do not understand why the mental state of a private patient should require two medical certificates, while the mental state of a pauper patient, on the other hand, requires only one?—I suppose we have to go back into the last century again to appreciate that point of view.

7974. Therefore if two certificates are appropriate for one class of society and that is regarded as an appropriate and necessary safeguard, one has difficulty in seeing that the same safeguard should not be applied to all cases?—That is the view we take.

7975. It is not as if the task is easier in one case than in the other?—Or more important.

7976. *Earl Russell:* It would add a good deal to the difficulties of relieving officers and to delay probably, if you have to get two certificates?—The provisional order, and other things, come in to simplify that.

7977. *Chairman:* We know the large extent to which patients are at present detained under an urgency order. You contemplate the modification or the continuance of that system?—Yes, certainly.

7978. One has always to think of the difficulties that are to be encountered in the provinces. In London, as one knows, everything is very carefully organised. One has, however, to think of the instruments of local government in the country. The difficulty of getting two doctors in some cases may be quite a serious one.

Earl Russell: On the Welsh hills, for instance.

Sir David Drummond: May we have the opinion of Dr. Langdon-Down upon the desirability of altering the statutory provision, that the doctors must see the patient separately and apart?

7979. *Chairman:* You, first of all, think there should be two doctors where detention is to be imposed upon the subject?—Yes.

7980. Then, further, you take the view, I observe, that the present requirement that the doctors should see the patient independently and give independent certificates should not be continued?—Should not be necessarily continued, not be required by law. We think the doctors can be trusted to form their opinions genuinely and not make collusive statements; that it is really this, that in the interests of the patient in many cases it is a misfortune to submit him twice to the examination by a doctor which is necessary to elicit the evidence. In some cases it is very difficult to procure adequate evidence to put down in writing to form the ground of a certificate, and if the two doctors can hear the evidence at the same time it saves the patient unnecessary strain; moreover, the two doctors can consult about the matter—those are the principal points. Moreover at the present time the two doctors do see the patient very often together, and then one goes out of the room and the other makes a few further inquiries.

7981. And so does lip service to the statute?—Yes.

7982. It obviously is a vestige of distrust?—Yes, we rather resent that.

7983. *Earl Russell:* It has no other object, has it?—No, I see no point in it.

7984. *Chairman:* It is rather odd, of course. If I am attended by my medical attendant and say I should like another opinion, I do not say to the first doctor who is attending me: "Of course, you will not see the consultant at all." Of course they go and see me, and then consult together outside the room, and come back and tell me my fate; but the suggestion here is obviously that they must not consult together lest, I suppose, they should collusively arrive at a decision?—Yes. I would further point out that after all we have the opinion of the House of Lords that it would be quite wise to have joint consultations, because in the Mental Treatment Bill which passed through the House of

14 January, 1925.]

Dr. R. LANGDON-DOWN, M.B., M.R.C.P.

[Continued.]

Lords last year they do not require it—in fact they require that they shall see the patient together. We feel that it would interpose no difficulties and obstacles, but in that Bill, I think I am right in saying, the requirement is that the doctors who sign the two recommendations shall examine the patient together.

7985. I should have thought the value of conference among professional men was extraordinarily great. If one may refer to one's own profession, if two counsel are consulted they confer together, and the effect is that they are able to produce as a result of their deliberations something which is much better than one could have produced separately. I have heard in the legal profession of an opinion being taken from one counsel, and then of the client, being dissatisfied with that opinion, going away to another counsel without telling him that he has consulted the first one. I do not know that distrustful clients of that sort are the best class of clients?—They do not get the best out of the lawyers either.

7986. No, they do not. Distrust is not confined, shall we say, to the medical profession. But looking at it apart altogether from questions of distrust or collusion, what one is again concerned with is this: do you think that the best opinion on the case can be obtained by the doctors conferring rather than by their being secluded from each other in their consideration?—Yes, we feel it should partake rather of the nature of a consultation.

7987. *Sir David Drummond*: Before you pass away entirely from the question of magistrates, do you think it is at all desirable that the patient should be taken to a police court to see a magistrate?—No. I think we have a specific clause dealing with that; we definitely express the opinion that that is very undesirable, that patients who are not charged with any offence should be examined as to the state of their minds in a public court?

7988. *Earl Russell*: What is the number of that paragraph?—That is among the miscellaneous provisions at the end, page 14.

7989. *Chairman*: I just wish to say one thing further on this topic of the double certificate, and the idea of collusion. If you cut deep enough into the question, what is it we are anxious to guard against? You say collusion, two doctors in conference deciding to give an opinion which is not their genuine opinion, for some ulterior object. There is nothing like trying to unmask these things and see what is behind it. What is the suggestion? That these two doctors desire, contrary to their professional duty and their professional opinion, to incarcerate the patient or the person they are examining? What could be the object of such conduct on their part?—It is very difficult to see, because they have no common interests. Their relationship with the patient is already precluded by law, and relationship with the person who is going to see the patient is also precluded by law.

7990. Then the only thing that could possibly operate as a sinister element would be that the doctors had been seen beforehand by some relative who had an interest in this person, and were willing to become parties in a conspiracy to have this person unlawfully detained. That would be the implication in the matter?—Yes, that would seem to be so, and that is governed by the other statutes.

Sir Humphry Rolleston: On this point might we take paragraph 65: "The Association does not support the suggestion that second certificates should be signed by specially approved practitioners"?

7991. *Chairman*: Yes; we have got two certificates, according to your proposal, and two certificates by two medical practitioners who had been in consultation on the case.—Who may have been in consultation.

7992. Are not forbidden to consult together—that is the point?—Yes.

7993. The next point is the question of the qualification of the practitioner; at the present moment any medical man will do. A young fellow who has

just graduated, or two of them, may the next day be qualified to sign medical certificates in law?—Yes.

7994. Do you think there is any necessity for exacting from the medical practitioner, on whose evidence the justice proceeds, that he should have any special qualification?—We have very carefully debated that question, and we think not, excepting that we do think it is desirable whenever possible that the usual medical attendant of the patient should be one of the certifying doctors, for the obvious reason that disorder of mind implies a change, and the habitual medical adviser of the patient is best in a position to judge of change. That is clear, I think. For the rest, we think that the medical curriculum does provide sufficient education to qualify a medical man in signing a certificate, having regard to what the certificate contains. We have carefully set out our analysis of the certificate, and we do not feel that it is asking too much to allow a qualified medical practitioner, who has been through his curriculum and passed his examinations and obtained admission to the register, to act in the filling and signing of such a certificate. Naturally in most cases the youngest medical practitioners would not be those usually sought to sign the papers. The friends in difficult cases very often go to other practitioners. But if you are going to lay down distinctive qualifications for the doctors who are to be allowed to sign certificates, how are you going to do it? What is your test to be? As far as we can see any very rigorous test, such as a specific qualification in psychological medicine, would at the present day reduce the number of available men so much in the country as to add to the difficulties of obtaining the necessary certificates to a grave degree. If you are going to adopt the plan of allowing the local authorities and the Board of Control to set up a list of men whom they may approve, we do not know by what criterion they would form the list; but presumably doctors who happened to be on the register would apply, and provided their general professional reputation was good they probably would not be refused admission to the list; but in some cases I have no doubt it would happen that all the medical men would apply, and I do not see why all the medical men who applied should not appear on the list. It appears to me it is very probable in some cases that the local authority would have a list which would include all the qualified men in the district. Those are practical difficulties. But the other thing is, what are your objects in having an official list of doctors of special qualifications? If you are going to have men who have passed some special test, and who have had some very special experience, is that going to be a greater safeguard to the patient? Is the specialist more likely to detect insanity or to fail to detect insanity? I do not wish to say anything which would be derogatory to specialised professions, but I have heard it stated that the specialist is very apt to see the disease in which he specialises. I have heard that stated. But there is no doubt that in some cases the friends will feel: here is a very doubtful case. It is always open to them to say: "We want a real consultation with a highly qualified man to advise us in this matter," and that very often happens at the present time. But we think that it is a great pity that this work should be narrowed down into very secluded channels. We believe that the profession should work as a whole in the main. We do not believe in these compartments in the profession. We believe that our qualified men are capable and are to be trusted to sign this certificate, which, in the majority of cases, is not a difficult thing, and that it is a pity to narrow it down further than it is. For one thing, the first certificate would more and more fall to be signed by people who have had less and less experience of doing so. As it is, the tendency is for a very large number of certificates of patients that are received as so-called pauper patients to be signed by one man, and the experience of signing certificates tends to be very much localised, so that the number of certificates that any doctor signs tends to get perhaps

14 January, 1925.]

Dr. R. LANGDON-DOWN, M.B., M.R.C.P.

[Continued.]

less. It would tend to get still less if the signing of the second certificate were shut off to an approved section of the profession.

7995. Only two points arise to my mind on what you have been saying. One is this, that after all it is in a sense an act of diagnosis?—Yes.

7996. And you say in the generality of cases not a difficult act of diagnosis?—That is so.

7997. And when large issues are involved one would have thought that the specialist's diagnosis would be the most valuable. After all, when issues of life and death are at stake, and the question is whether a murderer can stand his trial, it is not the general practitioner who is brought in, it is the specialist?—Yes; there are two sides to the question. I have put one side of the question.

7998. I can quite understand the suggestion that the specialist, as you say, is perhaps prone to find the existence of his speciality, and not, if one may say so, through any defect; but he has known so many manifestations of his speciality, and seen it associated with so many other things that the general practitioner may not have seen, that he expects to find it turning up more frequently than the other practitioner will?—Yes, and he may be right also.

7999. That is one point of view—the other is this, and I think it is rather fundamental. You referred in passing to the existing curriculum. Now the young medical practitioner newly fledged would have come from various schools of training, and what one would like to know from you is this: Does his curriculum at the moment contain a sufficient course of training in this branch of medicine to enable him to give a judgment of any value—straight from school, so to speak?—I think in most cases, yes.

8000. *Earl Russell*: Does he ever see any insane persons?—Yes.

8001. *Chairman*: Of course it must vary a good deal in different centres?—I believe it is a necessary requirement now in all cases as a part of the education; but of course with the proposals we make we hope that he will see more of the earlier aspects of the disease than he does at present. He is rather apt to see the later stages, but of course he has lectures on the disease, and, after all, he sets down the abnormal conduct that he observes. Well, his conclusion from that is, first of all, that it is abnormal, further that the abnormality is due to disorder of mind, and then he forms the opinion from his teaching and knowledge that the disorder is of such a degree and nature as to require measures of control in the patient's interest.

8002. But what one would like assurance upon is this: your recommendation is that the general medical practitioner should remain as heretofore qualified to give the medical certificate. One would like to be assured from the public point of view that the existing training of the general medical practitioner is sufficient to equip him to discharge this duty without specialist training; and one would rather like to know what is the existing curriculum through which the ordinary medical student has to pass, and what element of knowledge of this subject goes to his make up at the present moment—what does he know about it?—May I refer that question to Dr. Edwards? (*Dr. Edwards*): 30 or 40 years ago the attendance at lectures dealing with psychological medicine, or the attendance at hospitals where clinical instruction was given was a purely voluntary act for the student. At the present time it is compulsory, both as to the clinical and theoretical instruction; students have to attend a course of at least 12 lectures, the lectures are given in the hospital, and a course of at least 12 theoretical lectures. As far as I know, it is universal to instruct the students in the filling in of certificates. I mean I very frequently myself at the conclusion of a course of lectures have given the students the opportunity to examine an individual patient, then get them to fill in the certificate, which I subsequently criticise. I

think that that is the general practice now throughout the country. It is perfectly certain that all the examining boards insist on a schedule being signed showing that the candidate being presented for examination has received instruction, theoretical and practical.

8003. Is there a separate examination on insanity?—No, but there are in the examinations general questions inserted which bear on mental disorders, as on other disorders. I think any candidate sitting for an examination can be sure that he may get an individual question on any branch of medicine. He may be asked to reply to certain questions on certain forms of physical disease; there may be a question on mental disease; but he has to prepare himself to reply to questions bearing on every form of disease, whether physical or mental.

8004. Can you tell us whether that course of instruction obtains in the other medical schools other than the University of London?—It is the same everywhere.

8005. And therefore may one take it that when you meet a medical practitioner who holds a qualification from any university or any of the licensing bodies, he has had both clinical and theoretical instruction in insanity?—Yes, he must have, both clinical and theoretical.

8006. Now the extent of it does not seem to be very great. He gets 12 clinical lectures and 12 theoretical lectures. That, adding the two together, is only 24 lectures, and that is not what we call in Scotland even a half course?—I would put it to you, Sir, that a student trained in, shall we say, infectious diseases, would have to attend only half-a-dozen seances, as it were, at a fever hospital. He has to go out in the practice of his profession prepared to diagnose the various forms of infectious diseases, but the act of registration recognises that he is at least a medical man, and must perhaps amplify his experience subsequently, but he is at least equipped to face it.

8007. Of course one knows that in practice the young medical graduate does not enter at once into a position of great responsibility, and he amplifies his experience. You do not find him generally in a position of responsibility within a short time of his graduation. Still theoretically he is entitled to certify the moment he has qualified.

8008. *Mr. Snell*: Could we know from Dr. Edwards how long this newer instruction has been given?—It depends, I think I may say, on the regulations, not made by the General Medical Council, but on the regulations which are from time to time instituted by the various examining bodies. The tendency is for one examining body to level up its standards to the standards of other examining bodies.

8009. Would it be right to assume from what Dr. Edwards has said that more than middle-aged practitioners may not have had this clinical instruction?—Quite possible, in fact very probable. Speaking from my own experience as a student at Guy's Hospital it was regarded rather as an unnecessary thing for us to attend the clinical lectures which were given at Bethlem Royal Hospital, for instance. I personally attended some of them, and I believe I did in fact learn a very considerable amount by those comparatively few attendances.

8010. *Chairman*: We would rather like to have made available to us the information upon this point. Of course it must be contained in calendars, in regulations, and so on. Possibly Sir Humphry, or Sir David, might be able to assist us upon this, that is to say, the dates when the more exacting requirements have been prescribed, because it is a little remarkable if most of the middle-aged practitioners in this country have never had clinical or theoretical instruction in insanity?—(*Dr. Langdon-Down*): I think it would be a pity to under-estimate the value of experience in real practice.

8011. *Sir Humphry Rolleston*: This seems to be a most important point, and we have now got the collected opinion of the profession with regard to the

14 January, 1925.]

Dr. R. LANGDON-DOWN, M.B., M.R.C.P.

[Continued.]

question of having a whole-time practitioner who should go round and give an opinion to supplement the general practitioner's knowledge of the patient and it had occurred to me they might take a different view, because is there not a great deal of difficulty at the present time in getting medical practitioners generally to certify at all?—I do not

think that is on the ground that they distrust their own capacity.

8012. No, but the penalties which may accrue to them are so considerable?—I do not think they feel that they have done anything wrong, and will therefore suffer any damage, but they are afraid of prosecution.

After a short adjournment.

8013. *Chairman*: Dr. Langdon-Down, we had, I think, almost exhausted the question of the suggested amendments upon the certification procedure. We must not forget that it is a recommendation also on the part of the British Medical Association that the justice or judicial authority should see the patients. I understand that you attach importance to that?—Yes.

8014. Then we had come to the question which Sir Humphry raised, namely, that in view of proceedings in the Law Courts, recent and past, there might be a tendency on the part of the medical profession to hesitate to certify because of the legal sanctions which attach to improper certification. I notice that in the course of your memorandum you develop that topic and suggest that the medical man who gives the certificate is in each case properly a witness, not a certifier in the sense of certifying the case for detention, but as affording the testimony upon which it is proper that such an order should be pronounced; and you therefore suggest that in discharging that duty of testimony he should enjoy the immunities which attach to a witness in a court of law?—Yes.

8015. At the present moment the legal protection which a certifying doctor possesses is to be found, I think, in Section 330 of the Act, and, if one may read the part of it which relates to you, it is: "a person who after the passing of this Act signs any report or certificate purporting to be a report or certificate under this Act or does anything in pursuance of this Act, shall not be liable to any civil or criminal proceedings, whether on the ground of want of jurisdiction or on any other ground, if such person has acted in good faith and with reasonable care." So that the criterion of immunity is that the doctor—I am applying it to his case, although this also affects the justice—shall have acted in good faith and with reasonable care. I appreciate the point which you refer to in the memorandum as to the question of the onus. Is it upon the person who has brought the proceedings to establish want of good faith and want of reasonable care, or is it upon the doctor to establish positively that he has shown good faith and exercised reasonable care? Of course in law the distinction is a very important one on the question of onus. I gather that the view of the profession is that that protection is inadequate?—Yes, that is so, based upon our experience.

8016. In the case of an ordinary diagnosis where a doctor is examining a patient, not with a view to detecting mental disorder but to discover what ailment the patient is suffering from, of course he has no responsibility for the correctness of his diagnosis other than that it must be made with proper professional skill?—Yes.

8017. Every professional man has to answer for his professional skill and care, but no further, with the single privileged exception of the profession to which Mr. Micklem and I belong?—Yes.

8018. But the Latin maxim is *respondeat peritiam*; he must answer for his skill. You would not wish a medical man to be absolved from answerability for exercising his professional skill in good faith in the matter of these certificates, in conformity with his ordinary responsibility when he diagnoses a case?—I think there is a distinction in this case.

8019. What is it?—When a doctor is questioned in the witness box, does the question of his professional skill ever arise?

8020. No, you are quite right. A doctor, like any other witness of course, enjoys absolute privilege in the witness box. Then you would assimilate the case of the doctor who gives his testimony, which may result in certification, to that of a witness in a court of law?—Yes.

8021. *Earl Russell*: But he may have to answer for the acts, as when he failed to diagnose appendicitis the other day; he may have to answer for the acts where he has failed in his skill?—Yes.

8022. *Chairman*: He may not have treated the case properly; there was that diphtheria case the other day; but what one wants to get at is this: if he is simply exercising his skill in diagnosing, then, like any other professional man, he is responsible for the exercise of his art with due care, but if he is acting as a witness—that is your point—you say that he ought to enjoy the special immunity which attaches to a witness?—Another distinction between this particular act and most of his professional acts is that he is submitting his evidence to an outside person and the outside person is authorised, deliberately authorised, to call in somebody to check his opinion, or he can ignore it, if he chooses.

8023. You have collected in Appendix A a series of quotations from the Act of Parliament which go to show that the function which the doctor discharges is that of testifying, rather than that of exercising his ordinary professional skill in diagnosis?—At all events going to show that he is regarded as a witness. I do not think there is any desire to underestimate the duties and responsibilities of the doctor.

8024. No. Of course it is never proper that the terrors of the law should be such as to prevent a person from doing his duty when he is acting in good faith. I understand that some difficulty has actually arisen in this way: doctors say, "Well, if we are going to be made targets for litigation whenever we are called in, we shall decline to certify at all"?—We all felt that, personally and collectively.

8025. In short, it is not worth your while, to put it bluntly, to get a couple of guineas for certifying in a case and finding yourself exposed to an action for damages for £1,000 or possibly £10,000 or £20,000?—That is so.

8026. And as there is no obligation upon you to exercise your profession, the profession might go on strike. Is not that so technically?—Yes.

8027. You do not want to deter the medical profession from giving the public service?—No. The profession is ready to run risks, because it knows the great distress that is caused in family life by the occurrence of these disorders of the mind.

8028. The question really comes down to this then: does the state of the law at the present moment really deter doctors from performing their part in the administration of the Lunacy law of the land?—It would, if the interpretation of the law according to our recent experience were to become general, undoubtedly.

8029. Of course at the moment a doctor is not responsible for a wrong diagnosis in mental ailments, any more than in the case of any other ailment. As long as to the best of his ability he considers his case, he is under no responsibility for an incorrect diagnosis—that is just the common law?—Yes.

8030. The only question is whether in arriving at his diagnosis and in prescribing the treatment he has given a proper measure of care to the case?—In this

14 January, 1925.]

Dr. R. LANGDON-DOWN, M.B., M.R.C.P.

[Continued.]

particular case the evidence of the care that he has taken is to some extent apparent in the particular act.

8031. There does seem to be prevalent, to some extent, an impression that a doctor is liable at law for a wrong diagnosis. If he thinks that a person is insane, that is a diagnosis just as if he thinks a person has got measles, and he may be wrong in either case?—He may be wrong.

8032. But the legal question is not whether he is wrong, but whether in arriving at his decision he applied due care and arrived at his decision honestly? Yes.

8033. No one would wish to protect the medical profession against dishonest opinions, or opinions arrived at without proper care?—No.

8034. The only point then that seems to arise here is whether, if you were to give to the doctors, on whose testimony a reception order followed, the immunity which is enjoyed by witnesses in a court of law, you might not be putting the protection too high and, although it was not your object, be incidentally protecting a person who had acted carelessly and without due consideration?—Again I would call your attention to the safeguard, namely, that the action of the doctor is set down on paper; the grounds of his testimony are set down on paper in writing and submitted to an impartial authority. It seems to me that that is where the justice comes in. He can prevent action going forward, if he is not satisfied that due care is being exercised. That is where it should be stopped.

Earl Russell: Are you right in saying that, because if he has written a very strong certificate it is quite impossible for the justice to know whether he has written that certificate with or without due care?

8035. *Chairman*: Just figure the case, no doubt an unlikely case, of a doctor who is quite casual and reckless about it and has chosen to write down about a patient things which really would not hold water. These, presented to the justice, may be most convincing and conclusive and he would have no alternative but to make an order?—But you are presupposing something worse than carelessness, surely.

Sir David Drummond: Dishonesty.

8036. *Chairman*: I am perhaps; but take a case where it is nothing more than carelessness but which in the case of ordinary practice would have exposed a doctor to an action; that question could occur. Is he to be protected against the consequences of that carelessness in his diagnosis of insanity which he would not be protected against in his diagnosis, let us say, of diphtheria?—There is the official safeguard of the second certificate, by which one set of inquiries can be tested against the other.

8037. That carries you a certain length, but not the whole length?—Not the whole length. Still, if a doctor has to write down the grounds for believing a patient to be insane, he either writes them truly or not. If they are not true, then, of course, he has done something which is very grave.

8038. May we say honestly?—Yes, honestly. If, on the other hand, he has written honestly, the nature of the statements he has made shows a certain amount of care or the absence of care.

8039. Of course, one feels, with regard to this whole system of administration, that it ultimately depends to a large extent upon the reliability of the medical profession. At various points you come to this in the ultimate resort: unless you can trust the professional men engaged, your system will break down?—Clearly.

8040. *Earl Russell*: Do you happen to have examined any number of certificates in ordinary pauper cases?—No, it does not happen to come within my experience.

8041. I was just wondering, if you were to look at that point, whether you would not find that some of them are what I might call extremely thin—the facts stated are very insignificant?—Have they been accepted by the justice?

8042. And they have been accepted by the justice, yes. I should be rather glad if you were at some time to take an opportunity of examining them and give us your opinion upon this question, because some of the certificates would not show the care that you have been suggesting?—I can only say it would not happen more than once or twice, if the justices exercised their proper discretion.

8043. I think I agree with you?—In addition to that, the Board of Control exercises a great supervision over the quality of the certificates sent in, and if a certificate is not adequate from the point of view of the Board of Control, it is sent back for amendment.

8044. That is perfectly true, but meanwhile the patient has been deprived of his liberty?—I quite agree with that point; that is a very unsatisfactory method. In a recent important case you will remember only one medical certificate is required. There is no doubt the second certificate would be a stiffener of both.

Earl Russell: Yes, very likely, particularly with consultation.

8045. *Chairman*: I think, as I say, one comes inevitably to a point at which you must ultimately rely upon the medical profession?—Yes.

8046. And, if one may again invoke the analogy of the sister profession of the law, take counsel's opinion, which is a diagnosis on a matter of business or a matter of law, for which at the moment he has no responsibility at all; one has not heard of persons giving opinions which are dishonest. There is that other code to which you refer which comes into operation?—Yes.

8047. Still, when you ask us, as you do here, to recommend that the full reach and scope of the immunity of a witness should be extended to the doctor in respect of what he states in his certificate which is to go before the justice, you are asking us to make a considerable alteration of the law?—Yes, on grounds of urgency we submit that.

8048. Then the question comes to be whether there is sufficient justification for it, and whether one might not be overstepping the limit in the other direction. What it has come to is this: that the medical profession shrink from the performance of their duty because of the risk of vexatious litigation?—It is honestly afraid of that.

8049. Then some redress must be accorded or we shall lose the benefit of the assistance we can receive in the carrying out of the Act, because no one else can perform the function that the medical profession perform in the administration of the Lunacy Act. But do you say that this feeling of apprehension has become far-reaching?—I can assure you that the underground excitement in the profession on the first verdict in the Harnett case was very marked. The offices of the British Medical Association were inundated with letters of protest and anxiety.

8050. *Mr. Micklem*: Do you think it would satisfy the medical profession if the onus were shifted the other way, so that, instead of the doctor having to prove good faith and reasonable care, he should be protected unless he was shown to have acted without reasonable care and not in good faith?—It appears to me that the protection wanted is from a Government official as well.—(*Sir Jenner Verrall*): He has to prove good faith now, according to the words of the section.—(*Dr. Langdon-Down*): It would help.

8051. Supposing the onus were shifted?—It would be an advantage. It is a legal question, but we feel that the status of the doctor is all the way through so definitely regarded by the Act as a witness, as we have shown by quotations, that it is anomalous that it should not be carried to its logical conclusion.

8052. *Chairman*: What *Mr. Micklem* suggests would be an alleviation, would it not?—Yes, it would.

8053. If you take an ordinary action against a professional man for negligence, there is no doubt whatever that the onus is on the plaintiff to establish want of care. He would have to set out in his pleadings

14 January, 1925.]

Dr. R. LANGDON-DOWN, M.B., M.R.C.P.

[Continued.]

that he employed Doctor So-and-so and he neglected him, and would have to state specifically in what respect he neglected him; he would have to set out that the diagnosis was not a *bona fide* diagnosis and was made without proper care and consideration; and before a judge and jury he would have to establish positively all these allegations before a judgment against the doctor could be reached?—Yes.

8054. It does seem quite wrong that a doctor, because he has played his part in the execution of the law relating to lunacy, should, on that account, be put in the dock, so to speak, to justify himself, rather than that the person who is attacking him in the performance of his duty should have to prove he has done something that is wrong?—We feel that very strongly.

8055. But it is going rather far to go on and ask us to say that he shall have in this particular case an immunity which shall absolve him from all possibility of action?—Unless he perjures himself.

Earl Russell: That is criminal.

8056. Chairman: That does not involve any financial responsibility, you see?—No.

8057. It would go a long way?—We certainly think that the least we could ask is that the onus should be transferred and that prosecutions should have to be sanctioned by officers of the Crown.

8058. In short, that the proceedings should be with the consent of the Attorney-General?—Yes.

8059. Of course there is at present legislation relating to vexatious actions, but it is not much fun to have to go through half-a-dozen actions before a person qualifies as a vexatious litigant?—That is so.

8060. Mr. Micklem draws my attention to Section 330, Sub-section (2), under which you may apply to the Court to stay the proceedings and the Court may stop the proceedings if the Judge is satisfied that there is no reasonable ground for alleging want of good faith or reasonable care, but there again the onus is put upon you, so to speak?—Yes, and all the trouble and inconvenience have occurred, and, remember, there is an *a priori* possibility that the person who brings this action is likely to take erroneous views of things.

8061. Yes, you are dealing with an abnormal class of person?—Yes.

8062. And one of the complications of this subject is that you may also be dealing with grievances which, although unfounded in fact, are sincerely and honestly believed by the person who conceives himself to have suffered?—Yes, we recognise that.

8063. Mr. Micklem: Is not a doctor in rather a different position from an ordinary witness? Is he not in most cases the adviser who is suggesting the proceedings? An ordinary witness would be summoned by subpoena or come voluntarily, and give his evidence and be protected, but here the doctor is something more than a witness?—One of them at all events is a mere witness. It may be that the family doctor has recommended a course of treatment. The second certificate is given by somebody who is not in that position, but in any case all through the Act he is treated as a witness in its specific terms.

8064. Earl Russell: And of course when he is called in by the relieving officer he does not in any sense initiate proceedings?—No.

8065. Chairman: Now may we go on to what is a very important contribution from the British Medical Association, that is to say, dealing with the cases short of certification. You deal with these cases in various ways. Your general proposition is that there should be greater flexibility in proceedings, that there should be more time for considering cases, that there should be different kinds of places in which patients should be kept, all of which are designed to preclude the necessity of certification?—Yes.

8066. There are now to be a series of pauses on the road to certification, pauses which may be taken advantage of for the purpose of better observation and better diagnosis and treatment incidentally?—Yes.

8067. And again in appropriate places and in circumstances that will tend to alleviate rather than to aggravate the condition of the patient?—Yes, that summarises our conception very well.

8068. Your first suggestion is this: that the case might be treated in the first instance by means of a provisional order or urgency order, that is to say, you may have a case for which something must be done at once, but there has been no time really to gauge what class of case it is, so that for that case you suggest that the present urgency order might be made generally applicable, with certain modifications. I see you do not like the term "urgency order"?—We do not like to call a thing by a name which implies its uses for only one particular purpose when in fact it is used very frequently for a different purpose. Therefore it seems better to adopt a new term, also for clearness of discussion. Probably when the urgency order was first introduced it was intended to be used for cases of extreme danger.

8069. We might call it an emergency order?—Yes. It was so worded in the Act that it could, within the letter of the Act, be used very generally for cases on the ground that it was good for the patient's welfare. We understand that a very large proportion of the patients who are detained are originally certified under an urgency order.

8070. So that an expedient devised for one purpose has been used for other purposes?—Yes.

8071. I am not sure I like the term "provisional order" because it rather suggests a form of legislation with which we are very familiar, that is to say, Board of Trade Provisional Orders, which really mean that they are orders made by the Department and sanctioned by Parliament. What would you say to "temporary order"?—Yes, I would agree to that; and as a matter of fact I have used the term "temporary" in regard to the patients under some proceedings similar to those of the Mental Treatment Bill, where the period contemplated is 6 or 12 months.

8072. I think "temporary" is probably the best word; it happens to correspond with the fact; it is something which it is intended to be temporary?—Yes. Then it would be necessary to use a different word in the other place, a word which could easily be found.

8073. Yes, quite. Now your view is, I understand, that this kind of order should be made in the first place and that it should be a three days' duration order?—Yes.

8074. At present in the case of pauper patients, by utilising various provisions of the Act, you can actually get a 17 days' moratorium, can you not?—We were very much impressed by that when we heard from doctors, who are concerned in Poor Law administration, that quite a large number of cases which come under their treatment actually recover during the period of 17 days. There is the three days first and then the 14 days' continuation.

8075. I understand your view is that the three days' order might be obtained on the application of a relative or a relieving officer, coupled with one medical certificate?—That is so.

8076. But that its duration should be limited to three days, which three days would be taken advantage of for sizing up a case, if I may so put it; and then that there should be liberty to prolong the period by an order of the justice, the civil arm being brought in at that stage; so that there can be no detention without the intervention of a justice beyond three days?—That is our view, yes.

8077. Before the three days are over, if the case is one that it is desirable to observe longer, you would suggest that the justice be brought in and that the patient be detained on an order from him, not as it can be done at present for 14 days further without an order, but with an order up to 28 days?—Yes.

8078. That being adjudged by you to be an adequate period for a consideration of the case?—Yes. It gives an extension to certain private patients and a

14 January, 1925.]

Dr. R. LANGDON-DOWN, M.B., M.R.C.P.

[Continued.]

certain diminution of liberty of action in dealing with pauper cases.

8079. *Earl Russell*: You have three days without any medical certificate now?—Yes, you have, but we suggest that there should be uniformity, if practicable. We should welcome uniformity of procedure in the whole matter so that there should not be this distinction.

8080. But you still must have for urgent cases the possibility of taking a man somewhere at once while a doctor is being found?—Well, if the Commission thought that that was necessary for the first three days I do not think that we should object to it.

8081. Assume a violent maniac?—Yes. Of course, in the case of a private patient who is so bad as that, he must be dealt with as a pauper.

8082. But with the petitioner equally I think you have an urgency order?—There must be a medical certificate under the urgency order at present.

8083. *Chairman*: I think what *Earl Russell* has in mind, and it did occur to me, is this: supposing you have some person out in the street suddenly seized with a fit of mania, what is to be done with him?—Of course action must be taken.

8084. *Earl Russell*: We are told that what happens now is that the policeman may take him to the workhouse and may say, "Here is this man; detain him under my order," and then you have three days in which you can find a doctor?—Yes. He would probably ride off on some other charge against him if there was any difficulty.

8085. But the difficulty of that is that it means confinement in a police cell?—Yes, we quite see the point and we quite agree that there must be powers of that kind.

8086. *Chairman*: I should have thought that the proper place to take such a person would not be either the poor house or a police cell, but the nearest place where there are proper facilities for treatment. If you take a violent case of that sort to a police office or to a poor house, there may be nobody there sufficiently skilled and really able to take charge of the case?—I think that would be far more reasonable action.

8087. Then the asylum cannot receive him at the present moment at all without a certificate; that is the ticket of admission to the asylum.

Sir David Drummond: That pre-supposes the proximity of such an institution.

Chairman: It does, of course.

8088. *Sir David Drummond*: The police cells are there, the workhouse is there, but there is no other accommodation in many districts?—No, but we hope that if some of our further proposals are carried out, there will exist other places for dealing with and diagnosing cases of this sort in large centres of population.

8089. *Earl Russell*: You mean that a hospital would have one bed reserved for such violent cases?—Yes, and clinics and receiving houses, whatever it may be. We do not lay down exactly what the provision is that should be made, but we suggest that the law should be so widened that the possibility of these things may be recognised.

8090. *Chairman*: The fact remains that there must be a certain number of cases where something has got to be done at once; and where you cannot get a doctor at once, somebody has to take charge of the situation?—Yes, leaving the question open for the time being of the cause of his behaviour.

8091. Yes. All that you know is that a person is conducting himself in such a way that some step must be taken by somebody or else something is going to happen?—Yes.

8092. In the interest of the patient of course the desirable thing is to get him into skilled hands at the earliest possible moment?—Yes.

8093. However, your programme is, first of all, in the case, which is the ordinary normal case, that the three days' provisional order should be the first official order pronounced; whenever the thing becomes formal it must be a three days' order, and no longer,

and that should have one medical certificate?—Yes. We think that the time a medical certificate should be valid should be the least possible period, for convenience, that is to say, without a further validation, and we think that three days is, roughly speaking, a convenient period to name as the shortest period.

8094. Then you have told us that you think it should expire on the termination of the three days, unless meantime the judicial authority or justice has ordered its prolongation to 28 days?—Yes.

8095. That will give us a programme which in your view, I think, should be applicable to all classes of cases?—Yes.

8096. Rate-aided and private alike?—Yes.

8097. *Sir Thomas Hutchison*: Is that 28 days including the three, or a further period of 28 days?—We think it should be 28 days from the time the justice comes in. The justice may come in at the very beginning and the justice would deal with the 28 days.

8098. *Earl Russell*: Anything from 28 to 31 days?—Yes.

8099. *Chairman*: When the 28 days have expired, that is to say, when the order which has been made by a justice, and which (I take it) is proceeding still upon one medical certificate, is about to expire and the patient has not recovered—we have not considered where he is yet—but he has not recovered, would you then contemplate his being certified by two doctors and sent to an asylum?—Yes. I should have said that we do not insist that the provisional order should necessarily be the beginning in all cases. We are quite prepared to have the full order signed straight away where it is quite clear; but there are some cases in which it would be much better (and you cannot get the two doctors perhaps) to have a provisional order, and particularly where there is a hope that a case may clear up. By the end of the 28 days it is quite possible that the patient might be in such a frame of mind as to desire a prolongation of his treatment under some voluntary arrangement, that would then be a possibility, either as a full voluntary boarder or as a voluntary patient under the provisions of the Mental Treatment Bill for a period of six months. Failing that, and if his mental condition is still such as to make him in need of care and control and detention, then the full order.

8100. And that full order would proceed upon two medical certificates?—Yes, on two medical certificates.

Chairman: We can, I think, see the programme that you contemplate there.

Mr. Micklem: May I ask you this, Dr. Langdon-Down: You would not abolish, would you, in all cases the procedure by petition? You see at the present time the common form is to present the petition, and then, if necessary, an urgency order is applied for pending the hearing of the petition, in the case of private patients?—Yes. I regard the petition as part of the full order, and we contemplate in some cases the petition and full order being used straight away.

8101. But how would your temporary order apply in the case where a petition is presented?—It would not apply.

8102. But you would still want the urgency order, or you might want the urgency order?—Then you would have the two overlapping, as at present in the case of private patients. Pending the presentation of a petition, the urgency order is signed.

8103. You would not supersede the urgency order entirely by your temporary order?—I should substitute the one for the other, substitute the temporary order for the urgency order. It would meet all the requirements of the urgency order and do something further.

8104. It would not apply, would it, in a case where a petition is presented, because where a petition is presented then the proceeding goes on, and within seven days you have to get the certificates, and your three days would not apply there at all?—That is what happens at present where an urgency order is presented. A petition is concurrently made and

14 January, 1925.]

Dr. R. LANGDON-DOWN, M.B., M.R.C.P.

[Continued.]

certificates are signed and an order is made. That supersedes the urgency order at the end of a week.

8105. Yes, but still the urgency order may come in while the petition is pending. If your order takes the place of the urgency order, the proceedings would not apply, would they, because you are only giving three days under your provisional order?—We think that that should be enough. We think it should be enough to enable a full petition and order to be presented and signed in cases where it was clear what the course should be, and if it was not clear what the course should be, there would be a further period of 28 days available during which the petition might be presented.

8106. *Chairman*: Would it not be better to be more radical and to cut out all the existing procedure applicable both to private patients and pauper patients and reform it all on a line such as you suggest, assimilating the procedure for all cases?—That is our view.

8107. So that the person making the application, in the first instance could apply for either a provisional order on the threshold, or for a final order, and then that there could be a discretion to make either a temporary order or a final order, as the case might be. If a temporary order is made it would have a certain duration, which could be extended, and then it might issue in a final order?—Yes.

8108. What one is thinking of is this: reading the various methods which culminate in certification applicable both to paupers and to private patients, and applicable to them separately, one cannot but be impressed with the complications, different periods of time, and so on, which appear to have no particular justification except that they are there. If one could assimilate the procedure for all cases with sufficient elasticity to provide for the different contingencies, I for one would like to see it?—We hope it may be possible. We have had a great deal to do in preparing our suggestions, and we were unable to follow it out in detail as to whether it was possible, but we hope it may be.

8109. *Earl Russell*: Dr. Langdon-Down, what you want to do is to get a first period of three days, then a provisional period, and then, if necessary, the full order?—Not necessarily in every case.

8110. I agree, but you want to be able to do it in doubtful cases. Of course you hope that during the provisional period some cases may clear up?—Yes.

8111. And you want to do the same for pauper and private cases?—Yes.

8112. Cannot you do that best by using something like the procedure in Section 6 now? According to your suggestion, the petition is to be deemed to be presented by the relieving officer, if it is not a petition by a relation?—Yes.

8113. You get the pauper case in in that way?—Yes.

8114. Under Section 6 you could get in a justice fairly early, and then you notice that under Subsection (4) he may adjourn the case for 14 days. Now if you increase his power of adjournment so as to enable him to adjourn it for 14 or 28 days, or even, if necessary, for a further period, during that time you get the advantage of not even having a provisional order; you merely have the adjourned consideration of a proposed order?—Yes.

8115. Will not that meet what you are trying to do?—It would.

8116. Before I leave that I want to ask you whether you consider that 28 days is sufficient. You have introduced the representative of the public to protect the patient. Might it not be in the interests of the patient if you gave the justice power to adjourn the case for a second 28 days if so advised?—I think so. We hardly dared to suggest such a thing.

8117. We are all concerned in avoiding certification, if possible?—We felt we were making a great demand in suggesting these 28 days.

8118. If you adopt this method you will give flexibility surely, will you not?—Yes.

8119. By calling in your justice you have someone there representing the public at large, who will make the necessary order and give the medical man a chance to do his job and cure the case before the person is certified?—Yes.

8120. Does that strike you as being a system that would meet what you want?—It does.

8121. Subject, of course, to what I think you will agree, that somebody must be able to lock a man up at once if he is violent in the street—that is still necessary?—Yes.

8122. So where he is to be kept meanwhile is what we need to discuss?—Yes.

8123. *Chairman*: Of course you have this odd circumstance, that although a petition for a reception order is a speciality of the private patient at the present moment, you are also aware that under Section 13 a pauper is to be dealt with as if a reception order has been made. It is a most unfortunate complication, if I may say so?—Yes.

8124. *Earl Russell*: It does seem to me that what we have been discussing would give you as flexible a procedure as you could get?—Yes.

8125. *Mr. Micklem*: Dr. Langdon-Down, the temporary order, of course, would be a reception order?—Yes.

8126. Now would not there be exactly the same stigma applied to a reception order of that kind as to a reception order of to-day?—I hope not.

8127. *Chairman*: Something would depend upon where he was sent to?—Yes, it depends so much upon the provisions that are made and upon the general attitude. Here is a chance for a new attitude towards these things, and introducing patients at an earlier stage of their illness. The objection to the full order is because it applies to patients of fully developed insanity and generally in a fairly advanced stage. In so far as you can accelerate the process by making the procedure less formal you alter the character of the patients received under the order, and so you will reduce the feeling about it in the public mind.

8128. Might I put the point in another way? I understand you rather suggest that there should be two classes under any new legislation, the class of persons who are of unsound mind, and persons who are mentally ailing but not of unsound mind?—Yes.

8129. Now are you not really providing this provisional order, or temporary order, for persons mentally ailing, not of unsound mind?—No. (*Sir Jenner Verrall*): No; the fact that you are going to recognise a mentally ailing class will result in these people being dealt with in a different way, so there will not be any of these cases dealt with by a provisional order at all. That is our line anyhow.

8130. This class of case will only get into the circle if the other methods are inappropriate?—Yes, quite.

8131. This is a system which is designed really to deal with the certifiable case; the other class of case is a case which you would hope will never be certified at all. This is a process of certification which you are proposing to reform?—(*Dr. Langdon-Down*): Yes, it definitely applies to persons of unsound mind.

8132. *Earl Russell*: Many of those who cleared up quickest would be obviously certifiable at the beginning?—Yes, that is so.

8133. *Chairman*: There is no reason why all cases should not take their inception in some kind of application. Personally, I rather favour the idea of some form of application. If it is a case of what is now called a private patient, the proper person to apply is a relative; on the other hand, in a pauper case, or, if it be one of those unhappy cases of a lunatic found wandering at large, why should not the relieving officer be the petitioner in that case as it is contemplated he shall be under Section 13, so you would always have a responsible person making the application, and tendering the evidence of the medical man in support of that application? Then the detention following on the application might be either three days or

14 January, 1925.]

Dr. R. LANGDON-DOWN, M.B., M.R.C.P.

[Continued.]

28 days, as the case may be, or even, as Lord Russell suggests, there might be a longer period for particular cases, on cause shown, so to speak?—Yes.

8134. And in that way you would get a process which would be applicable to persons of unsound mind, but yet not stamped indelibly with that characteristic?—Yes.

8135. And you would so afford an opportunity for observation and so on, with the possibility that during the currency of this programme they might escape the ultimate certification. Is that the scheme?—Yes.

8136. And one would like to see that applied, naturally, to the pauper case and to the private case. There is a little difficulty still to clear up. The cases that are to be dealt with under this programme that you are contemplating are cases as to which there is a presumption that they are of unsound mind; if however in the course of the moratorium it is found that the person is not in point of fact going to become a certifiable case, but is rather progressing towards recovery, is there anything to prevent that person from being side-tracked into the category of a voluntary patient at that stage?—Nothing at all; we contemplate that.

8137. He may go off into one of these other categories *en route*, so to speak, and therefore may never issue in a certified case?—Quite.

8138. Then you contemplate that there may be cases which, *ab initio*, will be voluntary cases as well?—Yes, a large number.

8139. But the ranks of the voluntary patients may be recruited both from persons who have initially started as voluntary patients or from persons who, having started as cases likely to become certifiable, have fortunately proved not to be certifiable cases, but cases suitable for voluntary treatment?—Yes, that is what we mean by "flexibility."

8140. Let us take the case now of the voluntary boarder. I think you are all of opinion that the voluntary system, the simple form of voluntary system, should be available to anybody in want of it in any institution on paying the usual tariff of that institution, in a charitable institution if they are able to take you, and in a rate-aided institution, I suppose, if they are able to take you and if it is justifiable that you should be taken. You must have some protection for the rates, or else some people may want to take advantage of residing in the institutions.—We quite appreciate that point. We think the superintendent should be a guardian against the hotel user.

8141. How would you do it? You say it requires the approval of the medical superintendent; but you have not suggested any safeguards against a large influx of the population to the asylums, in preference to workhouses and other institutions, who might simply say they would like the protection of the institutions.—We think the medical superintendent should be able to exercise a sufficient safeguard against that.

8142. *Earl Russell*: Yes, but in addition to that I suppose you will still give the guardians the right to collect from their relatives, or themselves, their maintenance just as if they were in the workhouse?—Yes.

8143. If they have no means, then you must be able to reject them if they are frauds?—Yes.

8144. *Chairman*: I can imagine that a person would very much prefer to go in as a voluntary boarder to one of the London County Council asylums than to go into a workhouse?—Yes. Clearly some safeguard must be arranged.

8145. This is the person who is not to be certifiable at all?—No, he may not be certifiable at all.

8146. He is merely a person to whom it occurs that it would be suitable for himself to reside in one of those institutions for a time. Who is to be the judge of his suitability, because, after all, if he is going to have that privilege at the public expense you will need to safeguard the position?—Yes, it needs safeguard.

8147. Then you also think there is too much procedure at present about the reception of the voluntary boarder, and that it would suffice if his presence in the institution was reported to the Board of Control?—Yes, I think it is as well that I should mention that originally, when this voluntary boarder principle was introduced, the idea was that it should not be applied to persons who were certifiable. The practice in regard to that matter has altered of late years in view of the decisions of the Board of Control, and it is freely applied now to persons who might be placed under a full order. Therefore that class of patient is contemplated now as among the possible voluntary boarders, and the easier you make it the better. You do not want to interpose obstacles in the way of the voluntary boarder obtaining admission or to alarm him.

8148. Now the voluntary boarder, by the very force of his definition, is a person who does not require compulsory detention, because he is voluntarily submitting himself to the process?—I do not understand that; I understand that he voluntarily consents to be detained.

8149. Yes, I agree, you correct me quite properly; but, strictly speaking, his detention is the outcome of his own volition rather than imposed upon him by somebody else?—Yes.

8150. It is true that he must submit as a condition of his treatment to a certain restraint upon his liberty, but he has assumed that himself?—Yes.

8151. Then the contemplation is that that restraint, self-imposed as it has been, will be safeguarded, and that he may, so to speak, withdraw his consent and regain his freedom of action again on giving notice in a short period of time?—Yes.

8152. It is essential that there should be that time, because the person by the very nature of the ailment might have become much worse, and might suddenly become violent and lose that very element of self-control which had dictated his submission to the process. He might say: "I want to go out at once" and you might have the immediate sequel of that person throwing himself in front of a train. Therefore you must have a time which will enable you to consider the case, and if it was seen plainly that it was a case that could not be liberated, you would then use the stronger measures of the law to obtain further powers of detention; and 72 hours is the period you suggest?—Yes. At present the period is shorter, and in practice is found to be too short.

8153. 72 hours is contemplated in the Mental Treatment Bill—Lord Onslow's Bill, clause 5?—Yes.

8154. You want the law reformed in that respect; 24 hours is too short a time to put the law in motion, and 72 hours you think would be sufficient?—Yes.

8155. *Miss Madeleine Symons*: May I just ask what the view of the Association is on this point—if you do find it necessary at the end of the 72 hours' notice to take further steps for the detention of a voluntary boarder—I mean in a case which got worse—do you see any objection to that being done while he is in the institution, or do you take the view that has been expressed to us that it should be done outside?—We have not specially considered that in our Committee. (*Dr. Edwards*): If I might answer that question, I have had some personal practice in the method of dealing with such a matter. Generally speaking, if a voluntary boarder submits to treatment it is because that voluntary boarder has previously probably been a patient and has recovered. Alternatively he may be a patient who has been there as a voluntary patient before. If such a patient in the early stages of his or her illness realises that they are getting ill again they come to you voluntarily, and it may be perfectly certain that within a few weeks, or within a few days possibly, the mild symptoms would develop into acute symptoms, and we know we have no means of preventing it; and it would therefore be a matter of hardship if that person who desired to come to you personally for treatment had to be sent away in order to be certified. It would merely be a physical inconvenience to the

14 January, 1925.]

Dr. R. LANGDON-DOWN, M.B., M.R.C.P.

[Continued.]

person, and consequently the practice, which I think is the only proper one, is that the patients should be certified where they are.

8156. *Earl Russell*: On the other hand the Maudsley people told us that they never did that?—The Maudsley people are barred by their regulations from doing it; they have a special regulation which bears on it. The old practice was this—I am speaking of some years ago: if a voluntary boarder became insane, a notification was sent to the relieving officer to say that at such and such an hour a person of unsound mind would be found on the high road immediately outside my front door. Under Section 13 the relieving officer would have to act, and the patient would be taken to the insane ward of the workhouse, where he would be dealt with as a pauper, subsequently certified, perhaps on petition, and returned. The only advantage the patients would then have would be that they acquired a little experience of the interior of the parish workhouse.

8157. *Miss Madeleine Symons*: But you do not think that in general the other procedure may deter some people from going in as voluntary boarders?—I think it may, but, on the other hand, I have in my personal experience several cases that have been on more than one occasion received as voluntary patients, and subsequently certified; and I may say that a person who makes a complete recovery who has a true insight into the illness, perfectly well recognises afterwards that the steps which were taken were right and proper. It is not the case that every person who is certified and subsequently becomes decertified, has a grievance; on the contrary, it is a very very small proportion.

8158. I think I am right in saying that that is not the whole of your suggestions, you have other suggestions?—Yes, I was trying to answer that question that was put to me by Lord Russell.

8159. *Chairman*: Again, laying bare the question which is implicit in Miss Symons' observation, I suppose the feeling may be this, that if a voluntary patient may subsequently be certified in the institution which he has voluntarily entered, it may be said that he has entered the lions' den, and that would be a deterrent. On the other hand, it does seem rather preposterous, as you put it, Dr. Edwards, that if a person has gone in voluntarily in recognition of his own abnormal state of mind, but unfortunately his illness becomes worse and technically it is necessary to have some measure of restraint placed upon him, he should then be excluded from the very place in which he had sought shelter, in order that he may go through a judicial process and be reinstated in the same place again. The only reason for that would be to avoid the sinister implication, which might suggest that it is unfortunate that a place where you have voluntarily taken shelter should become your involuntary prison?—Might I say that a person who comes to you voluntarily, and then passes into a condition in which he is fairly obviously certifiably of unsound mind, speaking quite generally, would be permitted to remain as a voluntary boarder until the period of the acute stage had passed, and that the process of obtaining a reception order would not necessarily be invoked. I think the only circumstances that would ever induce me personally to take that step would be if the voluntary boarder, having become insane, decided to leave, and at that moment was definitely dangerous to himself or to others. That would be the only inducement that would cause certification to take place.

8160. *Mr. Snell*: Then what would you do at that stage?—At that stage I should notify the nearest relative, and I should say: "We have now reached a stage when another step by law must take place." You would then know that it would rest on the nearest relative to decide what should be done; and the nearest relative having knowledge that the patient has placed himself under you, would come forward and say: "We must obtain a reception order."

8161. That would take 24 hours at least, and in that 24 hours you would detain the person and persuade him to stay?—I would point out that where a case was exceedingly urgent, you would not obtain a reception order; you would apply for an urgency order.

8162. Detaining him meanwhile?—You have power to detain him for 24 hours.

8163. *Chairman*: Assimilating the procedure you are outlining to the general procedure: in that case a person who is a voluntary boarder with you is just like a member of the public, a guest in your institution. It is observed that symptoms of acute insanity are supervening, and action would then be taken in the case of that patient, exactly the same as in the case of a patient outside the institution altogether; but meantime the patient would have this advantage, that there would be compulsory protection and shelter for the period now proposed of 72 hours, which would enable you and the relatives to look round, and an opportunity would be afforded to a justice of the peace to make an order justifying further measures in the case. If such an order were not obtained, then you would have to release the patient, if the patient no longer wanted to stay with you. That part of it seems to be consistent. Now the next class of person which you propose to create is the person known as the temporary boarder, and in this part of your recommendations you are largely following the lines of the Mental Treatment Bill?—(*Dr. Langdon-Down*): We are, yes.

8164. Do you approve generally of the proposals of that Bill?—We do, in the main. The defect, from our point of view, was that it only contemplated utilising the existing institutions under the Act. There is one other point on which we rather differ: the Bill requires two medical signatures to a recommendation. I think our view is that one medical certificate would be sufficient in that case, seeing that the patient can determine his stay under the recommendation by giving notice.

8165. Are you not under a misapprehension in paragraph 43 in criticising the Bill? You indicate that the voluntary boarder principle does not apply under the Bill to county and county borough asylums. I think it does, doctor?—It is simply a misunderstanding between us there. The voluntary boarder principle I am speaking of is the voluntary boarder principle as at present in force under the Lunacy Acts.

8166. But under the proposed legislation in the Mental Treatment Bill it is provided that voluntary boarders should be admissible to any institution?—Yes, I recognise that, but what we say is that it does not effect the same result as would come about from extending to those institutions the voluntary boarder principle. You see the voluntary boarder principle is indeterminate in its duration, and can be renewed.

8167. *Earl Russell*: And informal in its inception?—Yes; whereas this proposal differs in both those respects.

8168. *Chairman*: There are two classes of people contemplated in the Mental Treatment Bill; there is the voluntary boarder and there is the patient?—Yes; the voluntary boarder and the person so-called a minor, or incapable of volition.

8169. Under Clause 2, sub-clause (3), provision may be made for receiving and lodging as a boarder a person who is voluntarily desirous of submitting himself to treatment, and who may be received as a boarder. Then in Clause 4 the reception of a person as a patient is spoken of; then a "patient," I think, is defined?—We have not contemplated any such distinction.

8170. I think that when one examines the Bill it is a little obscure, but, after all, it is not the law; it is merely a *projet de loi*; and therefore you need only consider it as an outline of a suggestion. But your view is that legislation should be enacted which would deal with the case of temporary patients?—In this way you see you entirely get rid of even the stigma of a judicial order.

14 January, 1925.]

Dr. R. LANGDON-DOWN, M.B., M.R.C.P.

[Continued.]

8171. May I ask this? We have the voluntary boarder, a person whom you propose to make eligible for any form of institutional treatment or single care treatment; then this voluntary boarder may become a certified person?—Yes.

8172. Might he also become a person who might be subjected to this process of temporary treatment?—I see no reason why not.

8173. His period of voluntary residence may issue in one of several things; it may issue in his leaving on recovery; it may issue unhappily in his becoming a fully certified case; it may issue in his deciding to remain on indefinitely as a voluntary boarder; or it may issue in his becoming a person who desires to take advantage of this temporary treatment, or whose relatives desire he should take advantage of it?—Yes. Of course it is a little unlikely that the voluntary boarder should ask to take advantage of this which would only give him an extension of six months, when he could take advantage of a continuation of the other voluntary boarder principle which would give him a longer period.

8174. It looks therefore as if this chapter of your recommendations was rather designed to meet the class of person who has not got volition, but who may be recoverable, and who for the time being is really disabled from making a choice and becoming a voluntary boarder, but who nevertheless is not a case which ought to be fully certified right away?—Yes, and I think it is possible that we might extend this principle to a different and larger class of homes and institutions than is contemplated by the voluntary boarder system.

8175. The two things are, of course, very closely associated; there are persons who are in different legal categories. You are contemplating the creation of certain new legal categories. Equally one has to contemplate different physical residences for those people, and I gather that your view is that the legal category and the physical residence should be related—that is to say, you should, if possible, have those persons who fall short of certification in institutions of a specialised character?—Yes, as far as possible; but I think there is a distinct feeling on the part of physicians that it would be desirable that they should have some such arrangement as this for the treatment of patients under control in houses not of the ordinary recognised asylum type.

8176. In paragraphs 77 and 78, with which your memorandum concludes, you give us the different types of institutions you contemplate, and the different categories of patients who might find their way to them?—Yes.

8177. Before we come to that final round-up of the situation, I wish you would give us your views upon what I mentioned earlier, the question of what you are to do immediately with the case. Of course, the most abrupt case of all is the one I figured of someone suddenly in the street having an attack of mania; or you may have a person in a small house where it is quite impossible to deal with the case and instant removal is necessary. What is to be done with that case—because I am bound to say that is a case which gives one a good deal of concern. At the present time the police, if it is in the streets, or, if in a house, the relieving officer takes the case right away off to a workhouse, as being really the only place where there is any accommodation—you would not want them to be taken to the police cells. Apparently the workhouse is a sort of universal repository?—You say the asylum is not available?

8178. It may not be available; it may be too far away. There are police cells always with us, but asylums are not so available.—We have hesitated to recommend anything involving costly measures; but, of course, if money were unlimited, receiving houses and clearing houses could be established everywhere for these cases. That is an ideal outside our present purview, except in very dense populations.

8179. London, of course?—Yes; but we do think that there should be greater facility for direct transfer to asylums.

8180. Let us examine that for a moment. In our anxiety to avoid technical pauperisation may we not just be jumping into the other risk of incurring the stigma of asylum residence? Take the case that is at present moved to the workhouse, it may be that it is a very passing phase, and in the 17 days available a person may emerge from the workhouse perfectly fit and well. If, on the other hand, he desires to avoid temporary residence in the workhouse, and he is taken to an asylum, every one of that man's friends knows that he is off to the asylum?—Yes. We have said in one paragraph that if the accommodation and arrangements at the workhouse were better and the classification better, the objection to it as a receiving place would not be so great.

8181. I cannot but feel that some intermediate institution is the real solution if it were feasible—neither a poorhouse nor a workhouse nor an asylum, because they are in a transitional stage?—We contemplate various possibilities, possibly annexes to the asylums under the same supervision. We also have wards in ordinary hospitals, cottage hospitals even.

8182. In point of fact at the moment are not some of the general hospitals making provision for mental cases?—They are.

8183. Is not that a more hopeful line to follow up? Why should not a man who has gone off his head be taken to St. Thomas's or St. George's, just as if he has broken his leg in the street?—If the authorities in control of the hospital would make the necessary arrangements and provisions, I should welcome that. In the interest of the patient I think it is a thing much to be desired.

8184. Would it not be the ideal solution if you could get the patient taken to a hospital and then detain him for a time? Then just as, for example, if it were found that the case was an epileptic one, the unhappy subject may ultimately be sent to an epileptic colony from the infirmary, so also if he were found to be insane, and could not recover without a long interval, send him to one of the specialised institutions, namely, an asylum properly so called?

8185. *Sir David Drummond*: Would the Association not go a step further and advocate the ideal, though it may cost money?—We suggest that the law should be so drawn as to render these things possible; that is the first thing to do. The actual development of accommodation must be gradual and would be the result of experience under the law.

8186. *Earl Russell*: Could you tell me this: it is a purely medical point, but I think the Commission want help on it? Take the case of distance. You have an acute case at Red Hill in Surrey, where the asylum is somewhere near Woking, a matter of 30 or 40 miles. Would it be better from the medical point of view in the majority of cases for a patient like that to be taken to a very moderately equipped workhouse ward in the first place, or to be taken in a motor ambulance so long a distance as 40 miles to the asylum?—(*Dr. Edwards*): If I may answer that question, I should say, does it not inevitably depend upon the equipment of the workhouse? It is perfectly certain that you cannot get either the nursing or the medical care there. In such a case I should have no hesitation in saying that the ambulance should move the patient to the place where all such skill as is available would be obtained.

8187. The disadvantages of the journey would be more than outweighed by the advantages of the treatment?—The disadvantages of the journey would hardly count.

Chairman: I must say that if one had a free hand and were able to dispose of the destinies of the general hospitals, it would be an attractive method of utilising the general hospitals for these cases of mental breakdown, just as you would for cases of ordinary physical breakdown.

8188. *Earl Russell*: Of course, it would be very easy if you had one ambulance attached to an asylum. One in the County of Surrey would be probably sufficient.—I have constantly to employ an ambulance.

14 January, 1925.]

Dr. R. LANGDON-DOWN, M.B., M.R.C.P.

[Continued.]

8189. *Sir David Drummond*: That would have all the disadvantages of sending a patient to an asylum. What you want to do is to avoid that?—As far as London is concerned you would find that they have what is virtually a clearing house. Take an asylum like the asylum at Horton; there is a definite clearing house to which such cases are taken. The acute cases would be treated there just as they would be treated in an annexe to a hospital or an infirmary. The cases that are obviously passing into a chronic condition would have to be drafted to the wards in the other parts of the building, but they have in that annexe all the appliances that are possibly desirable or obtainable for the treatment of acute insanity. That of course cannot be obtained in any local work-house or any annexe to a local infirmary.

8190. *Chairman*: May we take up again the question of the general hospital being used as the first place of resort? I want to consider the drawbacks to that. The attractions of it are manifest. The first drawback that occurs to one is that the managers of the hospital may not wish to have this rather troublesome and possibly rather noisy and difficult class of patient introduced. That would mean that they would have to have a separate annexe, a separate section altogether, would it not? I mean you could not have your ordinary patients disturbed by possibly fractious mental cases. Another thing is this: from the legal point of view you would need, of course, because of the specialty this ailment requires, to arm your hospital authorities with powers of compulsory detention?—(*Dr. Langdon-Down*): Yes.

8191. You would then be extending the area of institutions in which persons may be compulsorily detained?—Yes. Still it would be a different period of detention; it would be a different type of case; it would be a temporary thing.

8192. It would be pending disposal?—Yes.

8193. But you would certainly require legislation for that, because otherwise the hospital might come under the lash of Section 315 and be infringing the law by detaining persons?—Yes, and of course the provision would be something similar to what is proposed in the Mental Treatment Bill.

8194. So that if a person were taken straight from the street to the hospital and were there found to be a mental case and not an ordinary street casualty, the case would be taken away to the mental ward. After a rest of 24 hours the man might say, "I want to get out"—but he might have shown symptoms of acute insanity. Then you would require to have power in some way or other to detain him. You would have to be able to keep him for a certain short period, until you got the requisite sanction entitling you to detain him longer. His case would then probably follow the same programme as you have described?—Yes.

8195. All that in a general hospital would introduce rather a different element. You would have to bring a justice of the peace to the hospital and have a certificate, and so on?—Yes.

Sir David Drummond: But would he not go as one of the minor ailment cases to the annexe?

Chairman: We are assuming that he does. How is he to be kept against his will? All the other patients in the hospital are co-operating in the treatment and wish to stay there, but this man wants to go out.

Sir David Drummond: But do all these cases which are kept for 72 hours require the attention of the magistrate?

8196. *Chairman*: We would require the hospitals to detain a patient. At present they cannot detain a patient for a moment. Technically he is entitled to say, "I want to go out"?—If in the long run the patient is bad enough and refuses to stay, he must be treated as insane—there is no getting away from it—and dealt with as such, and sent to an asylum.

8197. I can conceive that a patient who is being operated upon may be in a state of delirium after the operation and may wish to get up, which may

mean death. I suppose in that case the doctor would have no hesitation in using, through the nurses, proper restraint.

Sir David Drummond: That is done constantly. Porters and men are put in charge where otherwise the nurses are women.

8198. *Chairman*: It is only consonant with good sense that that should be so. But if you are going to detain in a general hospital, pending disposal, cases for more than a very short time, one would require to give some form of licence to these places, would one not?—I quite agree.

Earl Russell: You might very much affect the flow of public subscriptions.

8199. *Chairman*: That again is a difficulty, of course. You cannot convert our general hospitals into rate-aided institutions. That is a question which, as you know, is being investigated at the present moment; indeed there is a Committee sitting on it in Scotland just now. Is it not the case that some of the hospitals are doing this work already? I understand that there are mental wards in some hospitals?—(*Dr. Edwards*): There is one, Sir; St. Luke's have one ward for very very carefully selected cases with a good physical basis. Of course the old method of attempting to nurse the insane in association with the general hospitals was tried at Guy's for very many years, but they had a separate wing; it was called the lunatic ward. It is now 45 years since that was given up. Such patients as there were were transferred to Bethlem.

8200. Did it fail as a method?—There was no generally adopted distinction between mental disorder and physical ailments at that time. They were merely regarded as among those chronic patients that Thomas Guy founded his hospital for, and consequently it was felt that there should be some provision for the insane sufferer as well as for the physically sick, so that some 40 patients were detained.

8201. Of course there is something attractive in the idea. It helps to break down the idea of the difference between mental and other ailments, if you have the cases treated in a general hospital, at any rate in their initial stages?—(*Dr. Langdon-Down*): I think I ought to say that we have not included that in our proposals. What we propose is reduced to what is said in section 71 of our memorandum.

8202. That really amounts to this, that you ought to have better provision in Poor Law institutions?—Yes, that is to say, although we recognise the value of the hospitals, should they be willing to help us, for cases under the Mental Treatment Bill or similar provisions, we have not contemplated making them receiving houses for the really acute and difficult patients.

8203. It is that stage that is giving us a good deal of trouble. We recognise the desirability of there being a moratorium interposed between the case first coming under medical cognisance and the ultimate destination. That period has to be bridged by some form of provision. You have made most helpful suggestions as to the categories under which patients might be treated, but we still have difficulty in knowing where they are to be treated?—One organisation has not yet been discussed, and that is the Poor Law infirmaries. Dr. Masterman can speak on that point with great authority.

Earl Russell: On the other hand, the superintendents of the mental hospitals say they would like the patients at the hospitals at the earliest possible moment.

Sir David Drummond: Some of them suggest the desirability of having them treated at a general hospital, if it were feasible.

8204. *Chairman*: The trouble with all the points we have to consider here is that the considerations on both sides are so balanced. Take the Poor Law infirmary; first of all, that is a pauper institution and any patient who goes there is classified as a rate-aided patient, if he is receiving treatment there. If

14 January, 1925.]

Dr. R. LANGDON-DOWN, M.B., M.R.C.P.

[Continued.]

he goes again to St. Thomas's Hospital he is not a rate-aided patient. It is a very odd accident?—(Dr. Masterman): Of course, that is an absurd position which we hope will be done away with.

8205. What is your suggestion with regard to that?—It cannot be done away with except by legislation.

8206. We are at your disposal. Tell us what we are to do?—The abolishment entirely of the term "pauper." We have patients with us who are paying fees, but who in the eyes of the law are paupers.

8207. That seems rather ludicrous?—Of course it is ludicrous.

8208. But the person who is genuinely rate-aided will have to remain.

8209. *Earl Russell*: Nine-tenths of the present asylums will continue to be rate-aided, whatever you call them?—One does not see why there should be any disgrace in it. If it is no disgrace to go to a hospital which is supported by voluntary subscriptions; why should there be any disgrace in a man going into his own hospital, to which he to some extent contributes?

8210. *Chairman*: It seems rather ridiculous that a person who is not a pauper at all should, by the very fact of his becoming ill and being taken to a particular institution designed to cure that illness, become a pauper in order to have the advantage of the treatment. The real stigma of the pauper is this: a person who is prepared to be a parasite upon his fellows rather than work for his own living; and that is a stigma which is a proper stigma to attach to a person, who, although able, is not willing to support himself. But there should be no stigma attaching to a person who is a good citizen and anxious to work, but who has been overtaken by a particular form of mental illness. If he had taken an infectious disease nobody would call him a pauper, but because he is afflicted with a mental illness and requires treatment he gets into the asylum and becomes a pauper?—It is a much bigger question. If you tumbled down in the street and were taken into an infirmary you would become a pauper. It is not only peculiar to mental cases.

8211. It seems to me to require very careful consideration by us, but, as I have said already, the stigma of a pauper is quite a different kind of thing; it is nothing to do with illness at all. The stigma of a pauper is a stigma which attaches to the person who, being able to work, will not work?—I only want to say that in London, in particular, as you have already heard from other evidence, the accommodation offered for lunatics is just the kind of thing that is wanted in the case of the larger and separate infirmaries. We keep talking about the workhouse,

but, after all, in the larger London institutions these people are accommodated in the infirmary itself. We use the term "infirmary" very much as applying to the Poor Law hospital or Poor Law infirmary, and I think you have there the accommodation needed. Our recommendation is that none of them should go to the workhouse; that they should all go to separate Poor Law infirmaries.

8212. *Chairman*: You have the institution of the Poor Law infirmary. That is an institution which, of course, is maintained out of the rates in contradistinction to the hospital, which is maintained by voluntary subscriptions and the produce of endowments. What determines, in the case of a person who falls ill—not mentally ill—whether he shall find his way into a Poor Law infirmary or into a general hospital? I am assuming that he is a case that cannot be treated at home?—In the case of many institutions, it is urgency, because they can be taken in at once there, and they do not have to wait. When it is an operation, in my own district it almost always comes straight to the infirmary, because they know they will be taken in night or day and dealt with at once, whereas the neighbouring hospital is so small that they could not touch it. I mean I have 800 beds and King's College has about 200 available.

8213. But it has no relation to the means of the party at all. In the one case a person becomes a pauper and in the other case he does not?—Yes. We never use the term, of course.

8214. I know its name is never heard, but still the substance remains.

Earl Russell: Of course it is a rate-aided institution to which everyone contributes.

8215. *Chairman*: I do not regard myself as rate-aided because I enjoy the parks of the City in which I walk about, although I have provided the parks out of my rates like anybody else. I am afraid it will not be possible to conclude the evidence to-day, and we should like to consider the evidence that has been given. Do you think, Dr. Langdon-Down, it will be possible to give us another morning later on?—(Dr. Langdon-Down): It will be rather inconvenient for me to come again this month.

Chairman: Our Inquiry will take longer than that. I think the most useful course is that we should adjourn now and ask you to come back at some time which is convenient to you. We have really got the great bulk of your evidence, but there are some other points in your memorandum which I do not want to take too quickly. Therefore I think we had better adjourn now and the date of your return visit can be arranged later.

(The Witnesses withdrew.)

(Adjourned to Saturday next at 10.30 o'clock.)

5, OLD PALACE YARD,
WESTMINSTER, S.W.1.

FIFTEENTH DAY.

Saturday, 17th January, 1925.

MEMBERS PRESENT :

THE RT. HON. H. P. MACMILLAN, K.C. (*Chairman*).

THE EARL RUSSELL.

SIR HUMPHRY ROLLESTON, BART., K.C.B., M.D.

SIR ERNEST HILEY, K.B.E.

SIR DAVID DRUMMOND, C.B.E., M.D.

MR. W. A. JOWITT, K.C.

MR. N. MICKLEM, K.C.

MR. H. SNELL, M.P.

MRS. C. J. MATHEW.

MISS MADELEINE SYMONS.

MR. P. BARTER (*Secretary*).

MR. W. FAIRLEY (*Assistant Secretary*).

MR. WALTER STEWART (instructed by the National Society for Lunacy Reform) appeared on behalf of Mr. H.

MR. H. C. DICKENS (instructed by Messrs. Hempson) appeared on behalf of Dr. Robert Percy Smith and Dr. J. G. Porter Phillips.

MR. R. P. CROOM-JOHNSON appeared on behalf of Dr. Reginald John Stilwell and Dr. Bulkeley Footner.

MR. D. B. SOMERVELL appeared on behalf of the Doctors Newington.

Chairman: The Commission are to-day to take the evidence of a witness, Mr. W. H., whom they have been invited by the National Society for Lunacy Reform to hear. Mr. H. some seven or eight years ago was an inmate in succession of Moorcroft and Ticehurst Licensed Houses, and as the *précis* of his evidence with which the Commission have been furnished contains complaints regarding his detention and treatment in these Houses, the Commissioners have thought it right to notify the persons concerned, in order that, if so advised, they might attend and take part in the proceedings. As controversial matters of fact are involved the Commissioners have decided to utilise the powers which by Resolution of both Houses of Parliament have been conferred upon them under the Tribunals of Inquiry (Evidence) Act, 1921, and to take the evidence of parties on oath. The procedure will be that Counsel for the National Society for Lunacy Reform who tender Mr. H. will, in the first place, examine him in chief. Then any parties present, who satisfy the Commissioners that they have an interest in the subject-matter of his evidence, will cross-examine by themselves, their counsel, or solicitor. Any relevant evidence which these parties desire to lead will then be taken in turn. It must be clearly understood that the Commission desire to hear Mr. H. on the subject of his own personal experiences only, and cannot allow the cases of other patients to be mentioned or discussed by him. It would obviously be improper to permit the cases of other patients to be publicly discussed without their express sanction.

The Commissioners have further to point out that, while they have certain judicial powers, they are not a Court of Law and cannot pronounce any judgment upon particular cases. The reference to them as regards this part of the investigation is to inquire into the law and administrative machinery in connection with the certification, detention and care of persons who are or are alleged to be of unsound mind, and to make recommendations. It is not within their province to announce decisions upon particular cases, and they do not propose to do so. The evidence to be given to-day will form part of the material upon which the Commissioners will ultimately base such recommendations as they may have to make.

Mr. Dickens: Before the case, if it can be called a case, is opened, may I say that I am instructed here on behalf of two gentlemen, Dr. Percy Smith and Dr. Porter Phillips, who have been asked by the Commission to attend, and who attend here purely out of courtesy to the Commission. It has been intimated to them, in the very courteous letter which they have received from your Secretary, that some sort of charges will be made against them in connection with certificates they gave with regard to the gentleman of whom you have spoken, some eight years ago. The Courts have been open to that gentleman to regulate any grievances which he may have had in that connection, for the last eight years; and he has not thought fit to take any advantage of the procedure that has been open to him by the law of the land. Is he to make use of the existence of this Commission to make these charges; and, if so, do I

17 January, 1925.]

[Continued.]

understand from the Commission that these charges are to be gone into, but that they cannot be determined because, as you say, you are not a Court of Law and are unable to determine this matter? If so, we are in a very strange position. In the first place, very serious charges, I gather (I do not know what they are) are made against two very eminent medical men. There has been no formulation of these charges at all. Some other gentlemen for whom my friends appear seem to have received some sort of *précis* of the charges against their clients. I have received none. Am I to have this matter tried without knowing what I am to be charged with? If that is so, and the matter is to be gone into, I presume I am to be allowed to go into the whole of the facts and to call evidence. I may tell the Commission at once that that will take several days, as far as I know, and, of course, I have been instructed at the last moment. I do not know that I have got sufficient satisfactory material to cross-examine Mr. H., and I shall have to ask you to give me leave to recall him on another day. I shall have at least eight or nine witnesses to call to justify the action my clients took eight years ago. As an instance of the difficulties in which my clients are placed, I may tell the Commission that two of the witnesses whom I would have called are dead. Then another point arises. You may not decide this matter; but if these charges are to be gone into it will mean very great expense: who is going to pay the costs of my clients for this? It is going to be a very expensive thing; it will be necessary for counsel to appear, witnesses to attend, and transcripts of the shorthand notes to be made. Has the Commission any power to reimburse my clients for this? All these difficulties I put before the Commission. My clients are in your hands, and are willing to abide by any decision you may come to. I put their difficulties before you, but I must in their interests say this, that if the matter is to be gone into, it will have to be gone into thoroughly, because it is a matter of very great importance to them that their reputation should not be challenged in this public manner without its being adequately answered.

Mr. Somervell: I am instructed on behalf of the Doctors Newington, and if I might make an application to this Commission at this stage, the facts are rather different. I support on the main grounds the contention put forward by my learned friend, Mr. Dickens, but I am in a slightly different position. The part of the case with which I am concerned is with regard to the institution at Ticehurst. Now, so far as the allegations made against Ticehurst are concerned, there is no allegation of any improper treatment; Mr. H. has no complaint as to the treatment he received there; his complaint is as to negligence, that he ought to have been released sooner. The Courts were open to Mr. H. on that matter as on the other matter, and he took advantage of them; and when he was sued for the expenses which were due from him in respect of his stay at Ticehurst, he defended, and in his defence and counter-claim he raised every single point which is raised in the proof, of which a copy has been sent to us by you, of the evidence which he proposes to give before this Commission. Every single point was raised, and a judgment which I think has been sent to you (I do not know whether you have perused it) was given by Mr. Justice Sankey. Now every witness who could be called was called; a very material witness, Dr. Newington, who actually was in charge of the institution when Mr. H. arrived, was dead and could not be called; and that is perhaps another reason why this particular case is not a very profitable one to investigate, because a very material witness is not available, owing to his having died. There is a long judgment by Mr. Justice Sankey, and he submitted the case to what he called a microscopic examination. He relied on various things, a statement by the defendant, as he then was

himself, and the evidence of his own doctor, Sir Thomas Horder, a very distinguished authority, that the defendant was at the time he arrived a very suspicious and suggestive case; and Mr. Justice Sankey, on page 16 of his judgment (if I may just read one sentence) said he had come to the conclusion not only that the authorities at Ticehurst "were not negligent in acting as they did, but I want to say something just the other way; I think they would have been negligent if they had released the defendant under these circumstances." That was the judgment of Mr. Justice Sankey. If I turn to this document which you have sent, there is one other matter which I ought to tell the Commission. There are allegations, paragraphs 80 to 83, as to the treatment of Mr. H. when in Ticehurst with regard to his liver. Now those allegations were made in the action. They were set up in the defence, and they were on the pleadings; but before the action was heard they were withdrawn, so that if I may say so that disposes of that. I do not think the Commission will probably spend their time in going into an allegation with regard to the liver treatment which has already been put on the record before the Court, and abandoned when the case actually came on for hearing. So that in those circumstances this matter having been fully investigated, *res judicata*, though, of course, I am in the Commissioners' hands, I would ask the Commission, with respect, two questions: Is it fair to these gentlemen, who have already had the matter thoroughly and publicly investigated at considerable expense of time to themselves—they have had it investigated once, and they have been, if I may say so, acquitted with honour, because not only were they not negligent, but it was found that they would have been negligent if they had acted in the way suggested—is it fair to them that they should again have to appear here and go into this matter, and it must be gone into in detail if a satisfactory investigation is to be made; and also, if I may say so with respect, is it possibly a profitable case for the Commission to spend its own time in investigating, when it has already received such a microscopic treatment, the results of which are available to everybody in Mr. Justice Sankey's judgment?

Mr. Croom-Johnson: I appear here for two doctors. Their cases are quite distinct, and, indeed, I am instructed by several independent and separate firms of solicitors with regard to them, but I desire to supplement what has been said by my learned colleagues, on behalf of each of them; and I think I may possibly be of some assistance in endeavouring to dispose of one of them, in a certain view, which my friend, Mr. Walter Stewart, who appears on what I may be allowed to call the other side, may take with regard to it. I appear, first of all, on behalf of Dr. Footner, who was the gentleman who operated when the patient was at Ticehurst, and who is the gentleman connected with what my learned friend, Mr. Somervell, has called the liver incident; the operation with regard to the gentleman's liver complaint was, as a matter of fact, in respect of his gall bladder. As I understand it, any kind of allegation that was made against Ticehurst with regard to any negligent treatment at that time was withdrawn in the action which was heard by Mr. Justice Sankey; and I do not quite gather that even now (I have read the *précis* very carefully) any accusation at all is made against Dr. Footner himself with regard to the treatment and, so far as I can see, the perfectly admirable treatment which he gave to this patient. I am here and Dr. Footner is here to give any assistance which the Commission may desire, but if no accusation is made against him personally with regard to what he personally did, then I was going to suggest to the Commission respectfully that Dr. Footner might be allowed to withdraw. I shall be here representing other people, and if at any time it should emerge that Dr. Footner can be of any assistance to the Commission, then he will be perfectly ready and willing to come forward and do anything that is right

17 January, 1925.]

[Continued.]

and proper that the Commission would desire him to do. I rather gather from a shake of the head which I perceived from my learned friend, Mr. Stewart, that no charge at all is made against Dr. Footner; and perhaps in those circumstances the Commission would be good enough to indicate to me that the course I propose to adopt on his behalf would be satisfactory to them.

Mr. Jowitt: I observed the same shake of the head, and I gather that Mr. Stewart makes no charge against Dr. Footner.

Mr. Walter Stewart: The moment I have an opportunity to be heard, I will explain the position with regard to this matter.

Mr. Croom-Johnson: If you please. Now with regard to my other client, I appear also for Dr. John Stilwell, who is the licensee of Moorcroft, the place at which the patient was first of all housed, and the position that I desire to take up with regard to Dr. Stilwell is this: he has no desire whatsoever, and I am sure my learned friend has not either, to burke any kind of investigation or discussion of any sort or kind; he is here to give every assistance, and I am here on his behalf to give every assistance which the Commission may desire; but what he does feel about it is this, that grave charges are being made with regard to his particular premises, with regard to their adequacy, and with regard to other matters, some of which, I gather, as the result of the ruling of yours which I have listened to, will not fail to be dealt with in the evidence of the particular witness who is now to appear in the witness chair; but, of course, this is a very grave matter for Dr. Stilwell. These matters could have been investigated in the Courts. There were some proceedings taken some years ago by the witness which were in fact dismissed. The witness took a particular line, and presumably he made complaints at that time against my clients which were intended to be exhaustive. They were discussed in a County Court not very far away from London; leading counsel was engaged; the matter was investigated in full, and according to my instructions at the conclusion of it the learned Judge, after a very patient hearing, said publicly that the action ought never to have been brought. Now in those circumstances after this lapse of time my client of course may be in some difficulty with regard to calling evidence. A great deal of it is, I am thankful to say, still available, but I should certainly like to have the Commission's ruling as to the particular course they propose to adopt with regard to these charges, whether they propose to go into them exhaustively; and I should ask you that they should do so, and whether some arrangement can be made under which the distinguished witnesses who would fall to be called on behalf of my client might be called of course upon some future occasion, and upon some date or dates which are satisfactory and convenient to them. The matter of expense is, of course, important, but I am not here on behalf of my clients to say that that will deter them in any way from giving the Commission all the assistance which the Commission desire; but in arriving at the decision at which the Commission have arrived, I imagine that they have considered the extraordinary difficulty that the persons against whom these charges are made would be placed in, and the grave expense to which those people will be put in what is after all now a public inquiry. I desire therefore respectfully, if I may do so on behalf of Dr. Stilwell, to associate myself with the observations which my two learned friends have made.

Chairman: Do counsel appear for any other parties concerned?

(No answer.)

Then, Mr. Stewart, I should like to hear what you have to say in answer to your learned brethren.

Mr. Walter Stewart: This is, of course, as the Commission will bear in mind, the first opportunity that I, representing as I do the National Society for Lunacy Reform, have had of addressing you at all.

Hitherto any speeches which have been made have proceeded from other quarters; and I assume from what has been said, that I am not at this stage to do anything in the nature of opening a case, though I should very much like to have such an opportunity. But my friends quite properly and very adroitly availed themselves of an opportunity of a preliminary defence of such persons as they represent. All I wish to say with regard to that is this that as far as my friend Mr. Croom-Johnson's client, Dr. Footner, is concerned, my friend is perfectly right in what he apprehends with regard to Mr. H.'s attitude towards that gentleman. Here and now so that it may be publicly known, and so that Dr. Footner may suffer no detriment in this matter, I will say this, that Mr. H.'s complaint is not a complaint against that gentleman at all of a personal character with regard to the way in which he performed the operation which he performed. His complaint is of a different character, and it is one which reflects not upon Dr. Footner but upon the gentleman who was the medical superintendent of the establishment in which that operation was performed. Mr. H.'s complaint is that, though it must have been or should have been apparent to anyone who was observant that his case was an extremely serious one, steps were not taken in time to deal with the extremely serious physical symptoms which were manifest; and that therefore when at last at the eleventh hour and the fifty-ninth minute the surgeon was procured to perform the operation, that gentleman, through no fault of his own, was placed in a position of very serious disadvantage and detriment both to himself and to his patient.

Mr. Somervell: Is it not enough at this stage for my friend to say that he makes no charge against Dr. Footner?

Chairman: I think that will be sufficient.

Mr. Stewart: As my friend Mr. Croom-Johnson is representing other interests I thought it desirable that I should indicate—

Chairman: However it is quite apparent to the Commission that no allegations are to be made against Dr. Footner; therefore he may withdraw from the proceedings unless he takes an interest in them for other reasons.

Mr. Stewart: I take it I have said enough.

Chairman: We, of course, have read the *précis*, and are fully apprised of the evidence you wish to bring before us, but I would like very much if you would address yourself to the question raised by the various Counsel here as to the scope of the inquiry, and as to the manner of conducting it. We have our own views and shall announce them shortly, but not until we have heard your views as to what will be the most expedient course.

Mr. Stewart: So far as any views have been already announced by you, of course you are masters of your own house, and we bow to the view that you take, that Mr. H. must by your ruling be strictly restricted to personal matters relating to his own case, though he has, in fact, made a study of this question for years, being a person who has the very best reasons for desiring to investigate the abuses which exist, as he believes, in the administration of the lunacy law. He is prepared with evidence such as would be admissible in a Court of Law to show that other people have suffered; but if you rule here and now without hearing any part of the evidence that we would be prepared to tender through Mr. H. with regard to certain matters—if you here and now rule that any such matter is excluded, to that decision we must bow, with this sole observation that it is not our fault if those matters, which are susceptible of demonstration before this Commission in the way that we hope to demonstrate them, fail to be demonstrated. Our case, of course, is that not only Mr. H., but many members of the public have been wrongfully certified, not owing to any wickedness on the part of the gentlemen concerned, but owing

17 January, 1925.]

[Continued.]

to the method which at present obtains, which is a method of secrecy and which prevents, as the Society will submit, the proper determination of the question of whether a person is of sound or unsound mind.

Chairman: One moment, Mr. Stewart. On that subject we have had the advantage through your courtesy of a *précis* of this gentleman's evidence, and it originally contained observations with regard to the treatment of other patients, both in the matter of alleged cruelty and alleged wrongful detention. We then received from you an amended form of the *précis*, which excludes all those matters, before we had made any ruling at all on the subject. The mention of the names of other patients contained in the latter portion of the original *précis* has accordingly of your own choice been withdrawn from our consideration. I should also add this that we have received protests from one gentleman saying that he really does not wish his relative's affairs examined publicly at your instance, because he says you do not represent him; and therefore you can understand the impropriety of discussing the cases of gentlemen who are not here, and who also may resent their personal history being investigated at the instance of a volunteer, without meaning any offence to you. I thought, therefore, the value of your contribution to our investigation would be that Mr. H. should tell us himself what his own experiences were; that is really the first hand and important evidence which I understand he has to contribute to us to-day. I do not think we need pursue the topic of other cases, in view of our ruling.

Mr. Stewart: I have bowed to your ruling, as I always do, therefore all I say with regard to that is this, that it must not be thought because we only put forward Mr. H., supposing he is one witness who deals with the question of certification and the evil restrictions surrounding it, that we are not in possession of a great deal of evidence with regard to other sufferers. That is all I desire to say.

Chairman: I think, Mr. Stewart, I have repeatedly assured you, and have also said in public, that we proposed to take evidence with regard to a few cases which you have selected, without in any way failing to recognise that you would like to place before us a much larger number of cases. I have also indicated that we shall personally be prepared to read the statements of such witnesses and consider them, but it would be manifestly against the public interest that we should resolve ourselves into a Court of Law and spend days and days in investigating cases, with the appearance of counsel and so on—we should never come to an end. The mere fact that we have asked you to give us one or two typical cases, illustrative of your general criticisms, is not intended to open the door to a whole series of cases being brought here and fought as if we were in a Court of Law, nor, of course, to shut out any general evidence which we are anticipating to receive later on, such as the general critical evidence which you are going to bring. This case is taken out of its order to suit the convenience of Mr. H. These cases were merely intended to be brought forward by you as illustrative. We are aware that you have a great many cases to bring, but within the limits of time it would be quite impossible to deal with them with the formality in which we have met this morning.

Mr. Stewart: We have all along recognised the practical difficulty of getting before you all the evidence we should like, and we must accept such measure of bread as you are in a position to offer us. I think with regard to the position of those who have been described as the critics, I am sure it is only right I should say this. You, and I have no doubt, every member of the Commission have read the *précis* of our case on wrongful certification, environment and cruelty; you will see that under those heads alone it might be desirable that we should call separate witnesses as to each, because it is not likely that the same witness will be in a position to speak to, or to complain, under all three heads; and there-

fore the limitation of our evidence to six witnesses in all, speaking to personal experiences, is a limitation so severe that we cannot hope with that number of witnesses to cover even the fringe of our case more than in the most perfunctory way; and I do trust that it will not be thought by any member of the public, who reads the evidence which is given here, that that is all the sort of attack that can properly be made by means of sworn witnesses against the administration of the present system and the law as it at present stands. That is all I wish to make clear. We must submit to the limitations that are placed upon us, we recognise it. But as this is a public enquiry intended for the purpose of informing the public eye or ear is the administration of the lunacy law at the present time conducive to abuse and evil and danger to the liberty of the subject, as that is the question upon which the public mind is sought to be set at rest, I hope that opportunity will be given to other people, quite outside those whom we put forward, and to a considerable number of them, who are prepared to come forward as they have personally informed me, to deal with these matters, and to deal with them fully and not with restriction to the mere personal experience; because these people have spent their lives subsequently to their escape or release in investigating these matters. It may be said that they are interested witnesses—I grant it; but you will also observe that the great majority of those witnesses who are called to depose to facts intended to support the administration of the lunacy laws as at present administered, are equally interested witnesses—that must of course be apparent to anyone who has heard the evidence; they are people who have important positions with large salaries, who are administering a system upon which their very bread and butter depends.

Chairman: I think you are trespassing a little on my intention when I asked you to assist me. What we want to have your assistance on at this stage is the question of procedure. If you have anything to tell us about that we shall be glad to have it; if not, I propose to deal with the points taken by counsel a few moments ago.

Mr. Stewart: If you stop me I stop at once.

Chairman: I wanted to know what views you have to submit on the question of procedure which has been raised by learned counsel.

Mr. Stewart: I have answered you already, I think, with regard to the ambit of the evidence which I shall seek to elicit from Mr. H. With regard to the procedure I take it it will be this: Mr. H. is to be subjected to cross-examination, and the documents which will be necessary either to support or to attack this case are documents of which we are not in a position to obtain discovery; though this is a judicial enquiry, this is not a litigation; but the Commission is in a position to obtain discovery of them, under the powers that they enjoy, and we should ask that you would secure the production here before this Commission of such documents as we desire, and which we can only obtain in that way; and I take it, it will be open to my friends, or any of them, to call for such documents as they themselves think will assist their attack upon Mr. H.'s evidence. When his cross-examination is completed, I suppose I shall be allowed the ordinary opportunity of re-examination.

Chairman: Certainly, and the opportunity of the cross-examination of any witnesses they call.

Mr. Stewart: Then with regard to that of course this observation must be made: our case must necessarily be an attack in a broad sense upon a number of people; for instance, it is an attack in effect upon every member of the Board of Control, and that being so, I should ask, if any allegation of ours relating to what we regard as grievances of witnesses against the Board of Control in the way that they have treated the witnesses in question is gone into, that some witness representing the Board of Control should be called, in order that we may

17 January, 1925.]

[Continued.]

have an opportunity, which of course up to now we have had to forego, of cross-examining those who seek to support the system, to show that the evidence they give in chief can be discounted by facts, which they would, we believe, have to admit if they were subjected to cross-examination. Certainly, as you know, though I wrote a letter to you quite early in the proceedings to point out the difficulty we were in, you ruled that no cross-examination or anything in the nature of cross-examination would be permissible. In these circumstances we had to remain here and listen to witnesses one after another who were making statements of fact relating to specific facts, to use the words which you used on Tuesday, as to which we were in a position to discount or to contradict from matters which were known to us, but we were not able to put those questions because of course we knew they were ruled out by your former ruling. At some time we hope that there will be presented to us an opportunity to cross-examine those witnesses who have been called to support the administration of the system, and with regard to whom we are in a position to show that they are not altogether disinterested.

Chairman: One other matter I should like your view upon, Mr. Stewart, is that it appears from the *précis* that Mr. H. has been involved in a number of litigations, and counsel has referred to that circumstance as having a bearing upon our investigation this morning. We of course cannot possibly sit as a court of review upon questions which have been determined in a Court of Law. On the other hand the mere fact that a case has been before the Courts does not preclude us from hearing your witness, in my opinion; but it does of course make the matter a little more difficult when the case of the particular witness tendered has been subject to the very class of examination which you have always told me you desired, namely, the independent examination of a Court of Law.

Mr. Stewart: I desire it on both sides.

Chairman: One does feel a little difficulty about that. I do not know whether you feel yourself that Mr. H. may not suffer to some extent from the fact of its not being fresh evidence—I mean evidence which has not been already subjected to examination, and disposed of in a Court of Law. That is a matter for your discretion, of course.

Mr. Stewart: All that is fully present to our mind. We do not suggest that it is possible for us to call any single witness who has been certified against whose evidence some attack may not successfully be made, that we face boldly; that is bound to be so owing to the very nature of the witnesses whom we are bound to rely on.

Mr. Jowitt: Attack is one thing, but a judgment of a Court of Law is a quite different thing.

Mr. Stewart: Yes. With regard to any matter which could be called in a litigation *res judicata*, as far as I am concerned I should not desire to ask the Commission to devote much time to the consideration of anything which might appear again to be covering the old ground; but even there, there may be a few observations that are properly to be made to show that that litigation did not necessarily cover the whole field. For instance, supposing I could show this with regard to a complaint made against the doctor that the defendant in those proceedings—because Mr. H. was the defendant inasmuch as he did not want to pay the charges for the Ticehurst detention because he said they were excessive—supposing I could show that the defendant, desirous of obtaining medical evidence to show that he had not been skilfully treated, had gone round London and had been told by doctors that no medical man would dare to go into the witness box to make an attack on the management of such an institution—that he would be a marked man—that would be some explanation of the reason why that part of the case was dropped.

Chairman: May I put this to you, because it is really a practical difficulty. I am afraid this question is hedged about with a good many difficulties,

but on this point of the previous investigation in the case, one of Mr. H.'s grounds of complaint is that he was improperly detained. Now that question was undoubtedly tried out before Mr. Justice Sankey in the case in which Mr. H.'s own counsel stated that the issue before the Court was that the plaintiffs, that is the managers of Ticehurst, kept Mr. H. in their asylum longer than they ought to have done. Following upon that, there was led on both sides distinguished medical evidence, and in particular I see Sir Thomas Horder, and Dr. Munro—who has been a protagonist in the same interest as yourself—were called. Upon all that evidence Mr. Justice Sankey reached the following conclusion: "I have come to the conclusion," he says, "not only that the plaintiffs in this case were not negligent in acting as they did, but I want to say something just the other way. I think they would have been negligent if they had released the defendant under these circumstances; I am sure that none of these gentlemen would have taken the responsibility, in the face of these certificates, and in the face of what they know, to allow Mr. H. to get out sooner than indeed he did in fact. It is not for me to pronounce here anything definitely with regard to his insanity during that period, but I am satisfied of this, that the plaintiffs had every reason for acting as they did, and in my view, had they done what the defendants now say they ought to have done" (the defendants being Mr. H. and his wife) "the plaintiffs would have been acting very wrongly, both in the interests of Mr. H. himself and the public generally. I quite accept what Mr. Hawke says with regard to the duty of persons who keep these private lunatic asylums. The patient's actions must not only be watched with care; they must be watched microscopically, in the interests, not only of the public, but of the patient. Looking at these actions, even through a magnifying glass microscopically, I cannot say that there was any negligence by the plaintiffs. They did what I am sure a proper, skilful, kind and considerate doctor would have done under the circumstances."

Now while I do not say that you are precluded from if you please, re-airing Mr. H.'s views upon this matter, you will appreciate that when a matter has been fought out in a Court of Law with testimony on both sides and a judgment, and the very neutral person whom you so frequently tell me you wish to invoke in these matters has come to that deliberate and considered opinion upon this particular, do you think it is very useful for us to hear Mr. H. upon the matter? The disappointed litigant is always anxious to tell the story over again.

Mr. Stewart: All that may be truly said, but you will observe that in the very words you have read occur these words: "in face of these certificates"; and that was what Mr. Justice Sankey had in mind, as I suggest, when he said that it would in those circumstances have been perhaps negligent on the part of the managers of Ticehurst to let him go because of the certificates, that was the mischief which had already been done, and it is that we want to lay before you, the circumstances under which those certificates were obtained; and even supposing he were seeking to obtain redress for wrong certification, it might well be that the law would be a cloak to the persons who had certified, and yet *non constat* that the enquiry ought properly to extend to this question: Is that law, as it at present exists, and as it is at present administered a danger to the liberty of the subject, although he was rightly certified under the law? Is it because the law as constituted and administered was a danger to the liberty of the subject? That is one of the things we want you to find affirmatively. (Hear, hear.)

Chairman: There must be no interruption in the way of expression of opinion on the part of the public; if anyone offends in that way it will result in their being excluded from the proceedings. I

17 January, 1925.]

[Continued.]

quite see your point, Mr. Stewart, on the certification, but would it not be superfluous to consider the propriety of Mr. H.'s detention in Ticehurst? It looks to me as if the gravamen of your case was that the certificates were no doubt, if they were correct certificates, ample warrant, as Mr. Justice Sankey found, for the continued detention of this gentleman, and thus relieved the managers of Ticehurst from any responsibility whatever if they acted improperly. Would not your real complaint be that in this case there was a wrong diagnosis of the case by two doctors. Is not that the whole point?

Mr. Stewart: If I may say so, that is the strict logical conclusion, which I am afraid I must admit might be drawn from that judgment, if we are precluded of course by that judgment from seeking to go into the matter afresh.

Chairman: We are anxious to get evidence that is of importance and that may have some impression on our minds. You have selected this case, and you told us in your communication with regard to this witness that you regarded him as a witness of particular importance to your case. The only comment I would venture to make is that in selecting that witness you appear to have selected a witness whose case is different from others you have, in the respect that it has been, in part at least, the subject of judicial investigation. I am putting this to you in your own interests. You are accepting in the case of his allegations this very serious onus, the onus, namely, of satisfying us that in the matter of his improper detention the learned Judge of the High Court went wrong. I think we all know that a litigant who has failed in his litigation is not always persuaded that the Judge is right and that he is wrong.

Mr. Stewart: Especially one who thinks he has been wrongfully certified.

Chairman: But that is a different question. Are we to understand then that in view of Mr. Justice Sankey's ruling on the matter of his detention in Ticehurst, you have no complaints of the action of the managers or proprietors of Ticehurst in what they did; but that your case is, as regards this gentleman, that the diagnosis upon which the certificates proceeded was a wrong diagnosis, and that therefore those certificates were incorrect and ought not to have been granted?

Mr. Stewart: The way I should like to put it, if you ask me, with regard to Ticehurst is this, that that is an exposition of the evil of the administration as at present practised; that the proprietors of Ticehurst found their judgment fettered and tied, and that in law that might exonerate them from an action for negligence, yet as an exposition of the working of the law, what happened to Mr. H. at Ticehurst is relevant. I do not propose, if Mr. H. is guided by me in the matter—I should not seek here and now, that he should try to suggest that there was negligence except in that sense, that they were misled by the documents that they had to take into consideration.

Mr. Croom-Johnson: I should rather like to know whether that would apply to Moorcroft as well?

Mr. Stewart: No.

Chairman: But the certificates were exactly the same.

Mr. Stewart: Yes, but there was something more that could have been known to the proprietor of Moorcroft.

Chairman: Let us clear the ground and see how far we have got. As I understand from you, first of all, there is no allegation against Dr. Footner. Then, secondly, do you accept the position that as regards the detention by those in charge at Ticehurst, as Mr. Justice Sankey found, the Act, quite correctly upon the documents which were presented to them, is the warrant for what they did, and therefore they are not to be here and now challenged for their conduct in the management of their institution, and that so far as his detention there is con-

cerned, you are critical rather of the warrant for his detention than for the conduct in detaining him?

Mr. Stewart: If it is left to my judgment and discretion, and I take it it must be, as to the line I desire to take with regard to Ticehurst, Mr. H. has already said in that very action that the one white spot that he found as far as the administration of the law was concerned was the management of Ticehurst as a general thing, and that they tried to be honest. That he has given public testimony to. Therefore, it is with all the greater pleasure, if I am allowed to act on my discretion, that I say with regard to Ticehurst I do not want to complain, except that they were misled.

Chairman: Now can we clear the ground any further so as to limit the ambit of our inquiry?

Mr. Jowitt: Does that involve the representatives of Ticehurst being able to go?

Chairman: May I take it then that the doctor from Ticehurst, that is to say, Dr. Newington, represented by Mr. Somervell here to-day, may regard himself free from the necessity of further attendance?

Mr. Stewart: I am glad to say that my client instructs me, because I am briefed on behalf of Mr. H. at this moment, to say that he is quite of the view you have expressed, that it would not be useful to occupy the time of this Commission in what would be a losing battle.

Chairman: It is not really from that point of view; I am looking at it from the point of view of propriety and fairness rather, and, if I may say so, I commend the course which you and your client in this matter propose to take. Therefore, the managers of Ticehurst may have the satisfaction of knowing that nothing will be said against them here as regards their detention of Mr. H., or as regards the treatment which Mr. H. received in their institution. Mr. H. really adheres to what he said himself in the proceedings, that there was nothing to complain of as regards the asylum so far as he himself was concerned. Then beyond that we must just proceed. I want to say a word in view of what has fallen from learned counsel on this matter. The Commissioners have been fully sensible of the difficulty which surrounds the present Inquiry. The National Society for Lunacy Reform indicated to us at an early stage of our proceedings that they desired to bring forward some general testimony critical of the existing administration which they thought might assist us in our deliberations. We have been hearing an exposition of the existing system, and we proposed in turn then to hear persons who were in a position to afford us useful criticisms of the system. We are to hear shortly a representative of that Society, who is to inform us of the general criticisms which his Society has to make upon the existing regime. That will be general evidence of a critical character no doubt—I have seen the *précis* of it—and will make constructive suggestions for the amendment of the law. Incidentally to that general critical statement, the Society informed the Commission that they desired to put before us some concrete instances which would satisfy the Commission that their criticisms were not based merely on theory, but had a foundation in fact. They informed us that they had quite a large number of cases, I think all cases of ex-patients—

Mr. Stewart: No, four attendants.

Chairman: I beg your pardon—four attendants and a number of ex-patients, who would recount, if we desired, their experiences of the existing system, and that those cases would be brought to our knowledge by way of concrete illustrations, so that we might have some assurance that the criticisms of the Society in theory were not without foundation in fact in particular instances. We felt that it was proper that we should accede, so far as the limits of time of our Commission permitted, to the suggestion made that we should hear some concrete cases. It is true that we cannot possibly hear anything like the number which Mr. Stewart has at his disposal, nor

17 January, 1925.]

[Continued.]

indeed can we hope to satisfy all the persons who would like to come before this Commission. Such would be entirely beyond our capacity, but the Society, being a representative and responsible body, have selected a certain number of cases which they thought it would be useful for us to hear about in more detail. There is inevitably some embarrassment from the point of view of a public Commission such as ours in dealing with concrete cases at all, because they inevitably involve the mention of individual persons, and a certain degree of hardship is necessarily involved in comments and criticisms being made upon the professional conduct of those persons. On the other hand, we felt that it would not be proper to deprive the critics of the existing system of an opportunity of putting before us at least some of the cases which they had investigated. We had accordingly to adopt the form of procedure which seemed to us fairest, and that was, just as other Commissions have done, to accept evidence tendered to us by responsible persons, although it related to individual cases and was not merely critical of the general system. But upon observing what was about to be said by some of those witnesses, we felt it was proper to apprise the persons, whose names were mentioned in the proofs of evidence which were submitted to us, that their names would be mentioned in the course of the evidence of the witness, and that they should have an opportunity of being present. I regard, and I am sure my fellow Commissioners regard, that as being an inevitable consequence of an investigation such as we find ourselves charged with, involving highly controversial matters—that some inconvenience, and I am afraid some expense, is thus imposed upon individuals. I am afraid that that is an inevitable concomitant of an enquiry such as we have embarked upon. We propose to keep that part of the enquiry relating to particular instances within comparatively narrow limits; but in the cases which we are investigating, I am afraid I cannot listen to the suggestion that because persons are mentioned by name in the course of the evidence that is to be given, such evidence should not be taken; I am afraid we should have to receive that evidence and give it its proper value and proper place. But the public will, of course, hear, not only Mr. H.'s evidence; they will also hear any evidence which may be brought by way of answer to it, and they will also have the advantage of hearing what may be put in cross-examination. We felt that we should discharge our duty of fairness to the parties concerned if we took that course. But we are not going to pronounce judgments upon those cases; we are merely receiving that evidence for the purpose of enabling us to evaluate the testimony we are receiving critical of the existing system. Accordingly, I think we should now proceed to hear Mr. H.'s evidence upon the lines which I proposed in my opening remarks. I certainly may say that I do appreciate that, incidentally to this enquiry, trouble and expense has been imposed upon persons who perhaps thought they had heard the last of those incidents which may be referred to here, but I shall do my best and I hope we shall have the co-operation on both sides in keeping this enquiry within limits; and one must always bear in mind that you are not conducting a case which is either prosecution or defence in this matter; we are merely eliciting information and we do not want therefore the atmosphere of a Law Court, or an atmosphere of prosecution or defence to be imported into the matter; and no doubt I can rely upon counsel to assist the Commissioners in maintaining that attitude throughout the proceedings. I should deprecate exceedingly any other course being taken.

I would invite now Mr. Stewart to put to Mr. H. the questions by which he desires to elicit from him his personal experience, so that we may have the advantage of hearing it.

Mr. Dickens: Before that is done, I would ask, in justice to my clients, that the charges against them

should be formulated. I have just had handed to me a *précis* of Mr. H.'s evidence; I have only been handed it by the courtesy of some other party to this matter, and the only thing I can find in a hurried perusal with regard to my client's action is contained in paragraphs 48 and 49. I have gathered from what Mr. Stewart has said that the gravamen, the seriousness of the question of the certificates was the secrecy with which they were enabled to be given by the present state of the law. Of course, if that is the only charge, that is no personal charge against my clients at all, but if you look at these two paragraphs it is something very much more serious than that. "I discovered for the first time the untrue grounds of my certification, and that Dr. Stilwell had sent in a report to the Commissioners which was absolutely false and misleading. I produce a copy of case book, and deal seriatim with these allegations. I told Dr. Stilwell what I had discovered, that the whole thing was dishonest, and I should take the law into my own hands at the first opportunity." I gather in a roundabout way that the charge against these two eminent medical gentlemen is that they knowingly gave dishonest certificates. I want a charge of that kind, if you please, formulated in detail and in writing. I want to be able to call evidence about that. I have not got the evidence here. I have not got the proofs of my witnesses. It may be that I can cross-examine Mr. H. to a certain extent. It is quite impossible that I can cross-examine him exhaustively to-day, and I shall have to ask you to recall him on another day; but before I do anything else I ask that Mr. Stewart should put in writing and clearly what the charges against my clients are.

Chairman: There is a little difficulty, Mr. Dickens, with regard to Mr. H.'s position. He is being heard to-day really rather out of order, because we are informed that he is leaving the country, and we were asked, as a matter of convenience to Mr. H., to take his evidence to-day. We acceded to that request, and I do see a little difficulty from the point of view of what you are putting to me now. Of course, we would certainly adjourn in order to give the eminent doctors you have mentioned an opportunity of coming and telling us their versions of the matter, but I do not think we can ask Mr. H. to remain in this country indefinitely for that purpose. The version of those doctors will be received by us and examined with exactly the same eye as we shall bring to bear upon Mr. H.'s evidence.

Mr. Dickens: All I can say is that I cannot put the necessary questions to Mr. H.

Chairman: Would it not be better to wait and see whether Mr. H. is going to say that these doctors are dishonest? I have no doubt he has said so in the *précis*.

Mr. Dickens: May I have the charge made now? It is a very distressing position for my clients to be in.

Chairman: Mr. Stewart, that, of course, is a serious matter, if Mr. H. is going to say that two members of any profession are dishonest persons.

Mr. Walter Stewart: Mr. H. will do nothing but state facts. He will make no comments on them unless invited to by my learned friends.

Chairman: In that case, if he will not characterise conduct, he will not say a good many things that are in this *précis*.

Mr. Walter Stewart: I shall trust Mr. H. only to answer such questions as I put to him, and to answer them in the literal sense.

Chairman: I think the best plan is to wait and see, if I may use a well known formula.

Mr. Dickens: Are the words in this *précis*, the allegations, withdrawn against me, or is Mr. H. going to ask you to draw some inferences from the facts he is going to prove? Am I to wait and see?

17 January, 1925.]

Mr. H.

[Continued.]

how these nebulous charges formulate themselves in the course of the proceedings? I have to prepare my answers.

Chairman: This is in no sense a public document; it is merely a document made in advance of what the witness may say. I do not know what he is going to say now. I think at the moment you may take it that no charges are made against anybody, until they are made through the mouth of the witness who is going to speak, and we will really take every opportunity to protect your clients.

Mr. Dickens: If you please.

Chairman: There was one thing Mr. Stewart said with regard to documents. When we heard that Mr. H. was coming, we directed that all relevant documents should be made available, that is to say, that the case books of the two institutions should be brought here; that the file of the Board of Control should also be available; and further, in view of the fact that a number of litigations were referred to,

I took steps to see that the papers should be made available to myself and to my fellow Commissioners. Quite a series of actions have been raised, and I have here the file relating to a number of them. Therefore, so far as documents are concerned, they will be upon the table of this Commission and available to all the parties who desire to refer to them. More than that, in the interests of justice, I am afraid we cannot do. I think we might now proceed with Mr. H.'s evidence.

Mr. Walter Stewart: Do you desire that the witness should be sworn?

Chairman: Yes. All the witnesses at this stage we propose to take on oath.

Mr. Somervell: I should like to be quite clear that none of the Ticehurst doctors are any longer required by the Commission.

Chairman: That is my understanding of Mr. Stewart's statement.

Mr. Somervell: If you please, Sir.

Mr. H., sworn.

Examined by Mr. Walter Stewart.

Mr. Walter Stewart: Before I put the first question to the witness, I am told now for the first time that the file of the proceedings relating to Mr. H.'s case before the Master in Lunacy is not forthcoming. That file contains, amongst other things, the opinions of three eminent medical men, Dr. Crichton Browne, Dr. Hugh Munro, and Dr. Spitta, who examined Mr. H. immediately after his escape from Ticehurst, and who certified him sane. Those are the three documents with regard to Mr. H. to which I attach particular importance. I am told they are not available.

Chairman: They are not available, for this reason, that I directed enquiries to be made in the appropriate quarter, because I thought the documents should be before us, but on enquiry unfortunately it appears that the file is missing. It is not the responsibility of this Commission. You must settle that matter, I am afraid, with the responsible authorities.

Mr. Walter Stewart: Then I take it that I shall be permitted to tender secondary evidence of the lost documents, though I have given notice to produce them?

Chairman: We are not applying the ordinary canons of evidence in this Inquiry at all. If you have any copies of those certificates which could be spoken to, we should accept that, but I am not going to apply rigid rules of evidence in the matter.

Mr. Walter Stewart: I have the solicitor here who put the documents in.

Chairman: He may have copies of them. Shall we reserve the point until it arises?

8216. *Mr. Walter Stewart:* If you please, Sir. (*To the Witness*): Is your name H.?—Yes.

8217. Are you 57 years of age at the present time?—58.

8218. You are a consulting engineer and naval architect, and I think you were for many years engaged in the practice of your profession?—Yes.

8219. In the autumn of the year 1913 did you sustain an accident?—In the autumn of 1914, at Dover.

8220. And as a consequence of that accident were you laid up for some time?—Yes, for three or four months—the first time in my life.

8221. After that—in order to show what was your then mental condition—I think you became an honorary secretary to a Red Cross hospital, and you continued to work in that capacity for no less than two years, I think?—Yes, for two years.

8222. Do you remember the autumn of 1916?—Yes.

8223. Had you an attack of any illness at that time, when you were working in Lord Roberts' workshops at Brighton?—In October, 1916, I fell ill with pneumonia—what was alleged to be pneumonia.

8224. Were you attended at that time by any medical man?—I was attended by a medical man at Brighton. I have forgotten his name. My wife, with whom I was living, sent for a Dr. Dempster, who was her medical attendant.

8225. And I think he had a house, had he not, in Croydon?—Yes, in Brighton Road, Croydon.

8226. And convalescing as you were from your attack of pneumonia, were you taken to his house at Croydon?—Yes. The local doctor could not make out the case, and while I was pneumonic I was moved in an ambulance to Dr. Dempster's house at Croydon.

8227. Do you know of your own knowledge whether your temperature at that time was normal or abnormal?—My temperature was high.

8228. You had at the time you went to Dr. Dempster's house a high temperature?—Yes.

8229. Were you very ill while you were there?—Yes, I was very bad.

8230. I think it was necessary for you to have day and night nurses?—Yes.

8231. And you remained until the 8th December an inmate of his house?—Yes.

8232. I do not want to go at any length into what you did there, but were you in the enjoyment of a good deal of leisured time?—Yes.

8233. Whilst you were an occupant of Dr. Dempster's house?—Yes.

8234. And did you occupy at any rate a part of that time in correspondence?—Yes.

8235. I think you do write a good many letters in the ordinary course of affairs, do you not?—Yes, I should think so.

8236. There is one other matter only I want to ask you about. You are a gentleman of easy circumstances in life, and I think you have at different times been very much interested in different kinds of pets that you have had?—Yes.

8237. Can you recall at this time whether there were any pets at all at Dr. Dempster's house?—Yes, I had two small Capuchin monkeys.

8238. How long had you had them?—I have always kept apes of some sort.

8239. That was nothing new or referable to your state of mind since your attack of pneumonia?—No.

8240. Have you still got them?—Yes.

8241. It is not suggested by anybody that you are not now sane. You have still got those same pets?—One of them.

8242. That being so, while you were at Dr. Dempster's house did some people call upon you who were strangers to you?—Yes.

8243. Can you recall their names?—Firstly a man called Elrich Adler.

8244. What did he purport to be?—Elrich Adler purported to be a friend of a gentleman called Maurice Craig.

17 January, 1925.]

Mr. H.

[Continued.]

8245. And who was Maurice Craig?—He was a mental doctor whom I consulted two years before.

8246. Now this gentleman with a German name came to see you—(Mr. Dickens): I hope this sort of thing is not going to be allowed. Mr. Alder is dead.

Chairman: Does it advance the case at all to interject the suggestion that he was a German?

Mr. Dickens: He was a very eminent gentleman in his profession.

8247. Mr. Walter Stewart: Be it so. (To the Witness): Did this "eminent gentleman" tell you for what purpose he came to see you?—Craig had told me that he would send a friend of his down, and that some minor operation was required to see whether my blood was still pneumonic; that is what I was told.

8248. What did the "eminent gentleman" who came to see you do to you?—He put a needle in my arm and took several ounces of blood. He then asked me to curl up on the bed, and he put a needle into my spine; it was a very unpleasant operation. I did not know what he did it for.

8249. Did he at any time tell you with what object he was treating you in that manner?—No.

8250. Now I must go out of order of date, because I want to follow this up to make it intelligible. Did you subsequently, long after you were certified, discover that that "eminent" professional man on that occasion had taken a specimen of your blood?—Yes; I knew it after I consulted Dr. Munro—after my escape.

8251. How long was it before you became aware of that? Was it after your escape from Ticehurst that you found it out?—Yes.

8252. That was in June of the following year?—I escaped in August, and I was free in September, 1917.

8253. Putting it in rough figures, for over nine months afterwards you never knew what had been done to you, or the purpose for which it was done on that occasion by the "eminent" medical man?—I never knew the purpose.

8254. Directly you found out what had been done, did you yourself voluntarily submit to a blood test being taken?—I had five blood tests taken, so as to be quite sure.

8255. And those blood tests which you had taken immediately after your escape from the private hospital at Ticehurst—were those blood tests submitted for the purpose of seeing whether there was any re-action under what is known as the Wasserman test?—Yes.

8256. Was any re-action disclosed by those tests?—The medical people called it negative—all of them.

8257. Mr. Walter Stewart: I desire to take your instruction here, Sir. I do not want, unless I am obliged to, to name here, in fact, what was the nature of the disease for which that test is considered proper. At any rate, those tests were made, and disclosed what is called a negative result. (To the Witness): I am afraid I must put it to you. Were you ever told when you were taken to Moorcroft that you were alleged to be suffering from general paralysis of the insane?—No.

8258. When first did that very serious statement concerning yourself come to your knowledge?—Well, I think I saw some documents in Dr. Stilwell's office.

8259. Now let us go back to the point at which I diverted—

Earl Russell: What date is that?

8260. Mr. Walter Stewart: I will get that elucidated. We are now dealing with things that happened in December, 1916. You have told us of the visit of the "eminent" medical man, as we have agreed to call him. Now come, please, to any other visits that were paid to you while you were at Dr. Dempster's house?—By friends or doctors? Do you want names?

8261. Visits by doctors?—I wrote to my friend, Hugh Munro, who was an official at Claybury at that time, and Dempster appears to have stopped that letter. Munro never received it.

8262. Did a doctor whose name you have already mentioned, Robert Percy Smith, come to see you?—Yes.

8263. Had you invited him?—No.

8264. Did he tell you what the purpose of his visit was?—No. He told me he had been sent by Craig. He was a heart specialist, and he had been sent by Craig to examine my heart.

8265. Did Dr. Percy Smith say he was a heart specialist himself?—Yes.

8266. That is what he told you?—Yes.

8267. And that being so, did you permit him to examine you in any way, believing him having come to examine your heart?—Yes.

8268. Did he talk to you at all, and, if so, for how long?—He talked to me for, I think, 10 minutes, but I was very sleepy.

8269. On what subjects did he talk?—I disliked the man; he was very insolent, I thought, and I did not want to have any conversation with him.

8270. Can you tell us what he talked to you about—this stranger who said he wanted to see about your heart?—From the certificates I know what was alleged.

8271. Tell us what you remember, and then we will see what is alleged?—I think it was more on general topics. Of course, he was the second doctor who had been sent. A man called Butter Stoddart was the first.

8272. When did Dr. Stoddart come to see you?—He came to see me when I was barely out of the pneumonia, he being the second doctor. Adler was sent down first of all, and found a positive reaction, and a perfectly dreadful reaction, which I think was quite untrue, in fact it must have been untrue.

8273. Now that being so, Dr. Stoddart comes down?—Yes. I had that day dismissed a nurse for insolence, and he asked me a lot of questions why I had dismissed her and so on. I told him that she had been saucy and that I could not put up with it. He then took from her a statement, which is perfectly absurd, and I do not think Craig could use it—

8274. We need not trouble with anything that was done behind your back, even though you may have heard of it. At the time that Dr. Stoddart did whatever it was he did, were you informed as to the object of his visit?—No, I was absolutely in the dark.

8275. Chairman: I wonder if you would just bring out who was sending these doctors to see this gentleman? Doctors do not appear out of the blue, so to speak?—As a matter of fact, I had considerable confidence in the eminent alienist.

8276. Sir Maurice Craig?—Yes. I could not get Dr. Hugh Munro, whom I trusted, so I invited Maurice Craig down, because Dr. Dempster was not—he is dead now, so I do not want to say anything about him.

8277. You asked Sir Maurice Craig to come and see you. He was unable to come himself, was he?—No; he came himself, and he then sent these satellites of his down.

8278. Earl Russell: Did you not know them at the time?—I knew they were friends of his; I trusted him.

8279. Chairman: Did they introduce themselves to you and say: "Craig has asked us to come and see you"?—Yes.

8280. Mr. Walter Stewart: Let us get this quite clear. Did any one of them at any time introduce himself to you by saying: "I have come to inquire into the state of your mind"?—No.

8281. Or give you any hint or suggestion that anything of that kind was on the tapis?—No.

8282. If that had been the case, and they had told you that, tell us, just aye or nay, would you have desired to be specially represented?—Certainly.

17 January, 1925.]

Mr. H.

[Continued.]

8283. Do you think that would have been necessary for the safeguarding of your interests at such a serious crisis in your life?—I think so now.

8284. And you would have thought so then, had you known?—Of course; a solicitor was in the house making my will.

8285. I pause there to ask a question which is relevant and in respect of which we have called you as a witness. In your view, with the experience you have had with regard to certification, do you think it is either safe or fair that a person sought to be certified should be left without any sort of representation?—It is most unjust and improper.

8286. As a matter of fact, at this very time had you a solicitor, if not on the premises, at any rate in the vicinity?—Yes; I had Alec Muther, of Drummonds, Croydon, who was drafting a new will, and I had my friend the Chancery barrister, Paley Baildon, and a Home Office official called Angel Bradford.

8287. So in your own case, if you had not been kept in the dark, you could have obtained separate representation and protection?—Certainly.

8288. You did not enjoy that benefit?—No.

8289. Why not. Was it because you were kept in the dark?—Exactly.

8290. You were also examined, as we know, by another gentleman, whose name, I believe, was Phillips?—Yes, Dr. Porter Phillips.

8291. Just tell us how he introduced himself.—He came with the usual story, that he was a friend of Maurice Craig's, and he was to take me to his country house. He examined my eyes with a little flash lamp, and he tried the knee jerks—the clipping on the back of the knee-cap.

8292. Did he tell you why he did that?—No. He simply said he wanted to examine me. He said he was a friend of Craig's, and so on.

8293. Was he an agreeable man?—A delightful fellow.

8294. I think you took a great fancy to him, did you not?—Yes.

8295. I think you actually went so far as to say that you hoped, if he were ever in that part of the country again, he would allow you the pleasure of seeing him again?—Yes, I think so.

8296. That is one of the grounds he alleges in his certificate which we now know he made, that you were unduly effusive and communicative; that you told him about your private affairs and invited him to your country house?—Yes.

8297. Then he said that you exhibited signs of general paralysis. That is what is known as general paralysis of the insane?—Yes.

8298. You tell us that he flashed a light in your eyes?—Yes.

8299. Tell us with regard to your eyes: at any period of your life antecedent to the autumn of 1916, had you ever had any mishap to either of your eyes?—Yes.

8300. What was that?—My eyes had been under the care of Sir Arnold Lawson.

8301. When first?—Long before these incidents.

8302. What for?—Principally for new glasses. He has the records.

8303. Have you ever had any physical injury to your eyes?—I have three times had this eye injured with boxing, and once with hockey, so badly injured that the eye was all blood, and it was a question whether I should get the sight back.

8304. Did any of them, and especially Dr. Phillips, who examined your eyes, ask you whether you had had any injury to your eye at any antecedent date?—No.

8305. Now he also in his certificate, as you now know and as you did not know at the time, included certain facts which he said were communicated by others?—Yes.

8306. He said in that certificate that Dr. William Thomas Dempster, of 94, Brighton Road, Croydon, had informed him that latterly you had shown lack

of judgment and had written foolish and abusive letters to comparative strangers. With regard to that, at that time, had your attention ever been called to any foolish or abusive letters that you had written to any comparative strangers?—Certainly I wrote very strong letters.

8307. To whom?—To kinsmen who were misappropriating my property.

8308. If you are cross-examined about it, you are prepared to go into that?—Yes.

8309. You did, in a subsequent litigation with those very people, obtain a finding which was favourable to your contention, did you not?—Yes.

8310. If my learned friends want it, you are prepared to go into it?—Certainly.

8311. I do not propose to do so. Let us pass on from that; that is Dr. Porter Phillips' certification, and those are the grounds upon which, as you now know, he then found you to be a person of unsound mind?—Yes.

8312. Let us now turn to Dr. Robert Percy Smith's certificate. You say that you did not feel quite as attracted by Dr. Smith as you had been by Dr. Phillips?—That is so.

8313. He says that he is a person registered under the Medical Act, and he says that on the 9th December, 1916, at this house of Dr. Dempster's as we know it to be, he separately from any other practitioner examined you personally?—Yes.

8314. And came to the conclusion that you were a person of unsound mind and a proper person to be taken charge of and detained under care and treatment. Now let us see upon what grounds he formed that conclusion.

Mr. Jowitt: What is the date of this?

Mr. Walter Stewart: This is the 9th December, 1916. It must be the day before he was taken.

Earl Russell: He said he was taken on the 8th December.

Mr. Walter Stewart: The 10th is the real date.

Chairman: Was there not an urgency order, first of all, and then the final order?

Mr. Walter Stewart: Yes. This was on the 9th, and I think it was acted on the next day.

Chairman: I have the certificates in front of me. There is one certificate on the 12th December, 1916, by Dr. Percy Smith. There is one on the 10th December by Dr. Porter Phillips.

Mr. Walter Stewart: This one is dated the 9th.

Mr. Dickens: There is one on the 9th.

Mr. Jowitt: By whom, Mr. Stewart?

Mr. Walter Stewart: By Dr. Percy Smith.

Chairman: That is the urgency order.

Mr. Walter Stewart: This is the one I am on.

Chairman: Yes, I have got that. There is one on the 9th.

8315. *Mr. Walter Stewart:* I call the attention of the Commission to what the facts were upon which Dr. Percy Smith issued that certificate: "I formed this conclusion on the following grounds, namely (1) Facts indicating insanity observed by myself at the time of examination. He tells me that while in a nursing home for a nervous breakdown two years ago he was vilely and improperly treated and that one of the attendants tried to give him a venereal disease from which he (the attendant) suffered." (*To the Witness:*) Tell me, was there in fact any attendant at the nursing home which you had been at two years previously who was in fact suffering from any venereal disease, to your knowledge?—Of course I deny that I told Dr. Percy Smith this. I had discussed it with Dr. Dempster—a man on a more friendly footing.

8316. What did you discuss with Dr. Dempster?—I told Dr. Dempster that I thought it was a vile thing that a man with a complaint such as is suggested should be in the position of an attendant.

8317. An attendant where?—At a place at Teignmouth—a nursing home.

8318. Had there been any such attendant at the place at Teignmouth when you were there?—Yes.

17 January, 1925.]

Mr. H.

[Continued.]

8319. And that you had communicated to Dr. Dempster?—Yes.

8320. Did you ever say that the attendant had tried to communicate the disease to you?—I thought there was danger of it—not tried; but it was an unpleasant condition.

8321. You did not like being attended by an attendant suffering from that particular form of ailment?—No.

8322. *Chairman*: Let us be clear about this. This was not an attendant in an asylum, but an attendant in a nursing home?—Yes.

8323. *Mr. Walter Stewart*: You thought there might be a danger of his communicating the disease to you?—Yes.

8324. And that is what you said to Dr. Dempster?—Yes.

8325. Did you ever say that, as far as you recollect, to Dr. Percy Smith separately from Dr. Dempster?—No, I think not.

8326. It may be a long while ago?—Yes.

8327. He says next that on four occasions you told him you had removed pieces of surgical dressings from meat pies?—There was a good deal of practical joking. I might have said it.

8328. I suppose sometimes in such places surgical dressing is left about?—I daresay.

8329. Can you remember as an actual incident whether at any time any piece of surgical dressing ever did get into contact with a meat pie?—Yes, I think so.

8330. But you did not intend that to be a serious aspersion upon the nursing home, I suppose?—No.

8331. You do not now suggest it?—No.

8332. Now that being so, he says further that "The property which became his and his wife's on his aunt's death had been stolen from him by his first cousin." Tell us what, if anything, you had to justify that about the property?—That is a fact.

8333. What property was it?—It was some land and houses in the parish of Topsham in Devonshire.

8334. Who was the cousin?—A fellow called P. H.

8335. He was a defendant in a litigation you instituted long after, was he not?—Yes; I had to go for him in Chancery.

8336. With what result?—They gave in at once.

8337. And this is put down as one of the delusions upon which you are found to be a person of unsound mind?—Yes.

8338. Those were all the facts that he says he observed himself?—Yes.

8339. Now facts communicated by others. One, "His brother Mr. E. S. H. tells me that it is a delusion that the patient had any property left him by an aunt"?—That is a different statement; that is a mixture.

8340. What was the question with regard to the aunt and the property? Do you recollect it at all?—Yes. This old lady had a gift of certain property which should come to me by agreement on her death. Not only was that property taken, but part of my own property under leases and under agreements, my own house there, had been alienated.

8341. Where?—At Topsham in Devon.

8342. Where you now live. What happened?—They annexed this property. They jumped it really.

8343. While you were otherwise occupied?—Yes, while I was sick.

8344. Tell me this: Did you ultimately recover that property?—Yes, it is all back again.

8345. *Mr. Jowitt*: By this Chancery suit?—Yes.

Mr. Jowitt: May we have the pleadings in that suit?

Mr. Walter Stewart: The case is H. against H. and H.

8346. *Chairman*: I have got that. The suit, as far as I can judge, arose over a dispute as to what were the subjects covered by a particular agreement, and whether the defendants were prepared to convey

to Mr. H. the precise subjects to which he was entitled under the agreement. The dispute was simply a dispute as to the subject-matter of purchase and sale. (*To the Witness*): I understand that you succeeded in that suit?—It was more than that. There were letters definitely giving my wife and myself these properties, the whole of the property which I now own.

8347. But it is only fair to say, looking at their defence, that they say you were entitled to something, but they disputed that you were entitled to all that you claimed?—That is so.

8348. *Mr. Walter Stewart*: Upon that Dr. Percy Smith says that it was communicated to him. (*To the Witness*): Tell me, were you ever told by anybody that that communication had been made to Dr. Percy Smith behind your back by Mr. E. H., namely, that it was a delusion on your part that you had any property left to you by your aunt?—Of course not.

8349. He never told you at the time?—No.

8350. So that this is something that is going on behind your back, like all the rest of it?—Yes.

8351. A step further. He puts that in among facts communicated by others as a fact on which he found you to be a person of unsound mind?—Yes.

8352. Then he goes on to say: "Dr. William Thomas Dempster, of 94, Brighton Road, Croydon, tells me that his statements about his treatment are quite imaginary." Was Dr. Dempster present at that nursing home where you had been two years before?—He had been down there twice, I think.

8353. Was he in a position to say whether what you said about the home was true or imaginary?—No.

8354. However, that is enough for Dr. Percy Smith. Now he says that you were restless and garrulous, and that you wrote many letters. It is true, is it not, that at that time, having much leisure on your hands, you did write a good many letters?—My secretary was ill, and I certainly took on his functions: I wrote my own letters. I was in bed, of course. Either Craig or Dempster said: "Well, let me post these letters." Many of them having cheques in them, and I left them open so that they might look at them.

8355. All this time, right up to the 9th December, 1916, were you conducting your own personal affairs?—Yes.

8356. Had you actually been giving instructions to your solicitor to make your will at a date quite shortly antecedent?—Yes.

8357. And was that very will on those instructions subsequently witnessed and signed by you after you had been deprived of your liberty?—Yes.

8358. Now you tell us it is true that you wrote many letters. I will not ask you what your opinion is. The Commission will have to decide whether that is a proper ground. I think you were restless in bed?—I think anyone with jaundice and post pneumatic would be restless. Neither of my nurses complained about it.

8359. But whether it is a fact or not, there it is. And you were talkative. That may be said, I suppose, of sane people of both sexes, may it not?—I believe so.

8360. Now to pass on from that. "The said H. W. H. appeared to me to be in a fit condition of bodily health to be removed to an asylum, hospital, or licensed house. I give this certificate having first read the section of the Act of Parliament printed below," which provides that "any person who makes a wilful misstatement of any material fact in any medical or other certificate, or in any statement or report of bodily or mental condition under this Act, shall be guilty of a misdemeanour"?—Yes.

8361. He signed that and on those grounds?—Yes.

Mr. Dickens: My learned friend left out the reasons which are specially given on the second certificate. I am looking at the one of the 9th December: "He has symptoms pointing to the early stage of general paralysis."

Mr. Walter Stewart: That is not in this copy.

17 January, 1925.]

Mr. H.

[Continued.]

Chairman: There are two certificates, Mr. Stewart. First of all, there is the one of the 9th December, which I think you have before you, and there is also one of the 10th December.

Mr. Walter Stewart: Might I have that, Sir?

Chairman: Certainly. The urgency certificate, which is the first one, contains the statement to which you have just alluded. It is right that it should be read. In the urgency order it is "I certify that it is expedient for the welfare of the said H. W. H. (or for the public safety, as the case may be) that the said H. W. H. should be forthwith placed under care and treatment. My reasons for this conclusion are as follows. He has symptoms pointing to the early stage of general paralysis, is changeable, talkative and excitable and cannot be properly controlled in a private house. The said H. W. H. appeared to me to be in a fit condition of bodily health to be removed to an asylum, hospital or licensed house. I give this certificate having first read the section of the Act of Parliament printed below." That is dated the 8th December, and is the single medical certificate which is necessary for the urgency order. Then follows the one which Mr. Stewart has been reading, the one of the 12th December.

Mr. Walter Stewart: There is some confusion about the dates, I think.

Chairman: The one I have been reading from is dated the 9th; then follows one of the 12th. That clears it up, does it not?

Mr. Dickens: Yes, thank you.

Mr. Walter Stewart: These are copies supplied to us. The first one is the 9th, and then there is one on the 10th.

Chairman: Yes, and one of Dr. Percy Smith's on the 12th December.

Mr. Croom-Johnson: In my copy the words "for the public safety" are struck out.

Chairman: The document I have is the Board of Control file; the words have not been struck out on it.

Mr. Walter Stewart: I am sure my learned friend will help me. In which documents does my learned friend say the word "for the public safety" have been struck out?

Mr. Croom-Johnson: In my copy of the urgency order.

Mr. Walter Stewart: That of the 9th?

Mr. Croom-Johnson: Yes.

Mr. Walter Stewart: They have not been struck out in the original.

Chairman: Nor in my copy either.

Mr. Walter Stewart: "I certify that it is expedient for the welfare of the said H. W. H. (or for the public safety as the case may be) that the said H. W. H. should be forthwith placed under care and treatment." Of course, Sir, I must deal with the document as it is, and I take it that that is a certificate that for the public safety it was necessary, as the document stands.

Chairman: It puts it alternatively.

Mr. Walter Stewart: But it is still left in. However, as it may be either it may be both.

Chairman: No doubt.

8362. *Mr. Walter Stewart (to the witness):* I have dealt with Dr. Porter Phillips and with Dr. Percy Smith. Is there any other certificate which you subsequently found had been made?—Yes. Of course, I always said that the issue of the urgency order was a wrong thing.

8363. You say they ought not to have taken that step?—An urgency order. Here was I quite peaceable in bed. I was not a menace to myself and others. I was enjoying the use of my cheque book and correspondence, and these doctors came into this house, which was only a working man's house, and they in an autocratic way issued these documents without my knowledge; and I should always have expected to have had a judicial authority, a magistrate, to see me being carried away. Trapped.

8364. As the judgment of Mr. Justice Sankey has been craved in aid here, I desire to call attention to a passage in that judgment. The Commissioners will see that in that judgment Mr. Justice Sankey specially says: "It was never alleged that this gentleman was dangerous to the public, that he was always a quiet, well-behaved patient."

8365. *Chairman:* I do not quite understand your allusion to a working-class house. What is the working-class house you were in?—I was in the house of this small medical practitioner, William Thomas Dempster, being a friend of his wife, who was a nurse. It was a small double-fronted villa in the Brighton Road, a house of about £30 or £40 rental.

8366. *Mr. Walter Stewart:* You call that a workman's house?—Yes.

8367. I daresay nowadays people wish they could get it?—Yes.

8368. You were not apprised of the object of these unsolicited visits. What happened to you next? Give a quiet explanation of your personal experience under the existing law relating to certification?—I have described Dr. Porter Phillips' visit; and going with him for a motor drive, and somewhat later, after dark, I was landed at Moorcroft with only a small bag of clothes; no winter warm clothes, no case book, none of the temperature charts or anything which is usually transferred with a patient. I was dropped into this place, Moorcroft.

8369. As you mention that, I am bound to turn to the Moorcroft case book, because we say that the proprietor of that establishment ought to have communicated himself with the Board of Control.

8370. *Chairman:* Perhaps you will tell us whether you were in bed at this time. Did you get up to go to Moorcroft?—Yes, I got up to get some of my things packed.

8371. Were you in bed right up to the time of your removal to Moorcroft?—Yes.

8372. You must have got up and dressed?—Yes.

8373. Were you taken in an ambulance?—No, I was taken in an ordinary motor.

8374. If you were merely going for a drive why did you take a bag of clothes with you?—Porter Phillips, of course, told me that he was taking me to his house to recuperate after this attack.

8375. And he asked you to take some things with you. Were you thinking you were going to pay him a personal visit at his own house?—I thought I was going to be a paying guest there.

8376. And you took your own clothes with you?—I took some things with me.

8377. You would naturally take the clothing suitable to the season if you were paying a country house visit?—I took a thin suit only.

8378. You had chosen yourself the clothes you had taken?—Yes. You have got to remember that the temperature dropped.

8379. We get surprises in this climate very often?—It was intensely cold.

8380. *Earl Russell:* The temperature dropped in the course of your journey, did it?—No, it became very snowy and cold, and I had no warm things.

8381. *Mr. Walter Stewart:* How long did you apprehend that you would be at the house, which you believed you were going to, Dr. Phillips' house?—I did not know. I thought perhaps a week or two.

8382. Did you anticipate that you were going to spend the time in bed, or what?—I thought I should be up more; I hoped so.

8383. And had you any idea that you were going to be deprived of your personal liberty?—No, not in the least.

8384. If you had had that idea, would you have taken steps or not to procure a more ample wardrobe to take with you to Moorcroft?—I should.

8385. As it was, I suppose you thought you would be able to get anything you wanted at once?—Yes.

8386. You were taken in a motor to this Moorcroft establishment, which I believe is in the neighbourhood of Uxbridge, is it not?—Yes.

17 January, 1925.]

Mr. H.

[Continued.]

8387. A longish drive?—Yes.

8388. Still, there it was. There was the urgency order?—Yes.

8389. Did you suffer at all any ill effect from the journey?—No, not at that time.

8390. You arrived in due course at Moorcroft?—Yes.

8391. How soon did it dawn upon you that you were detained against your will at Moorcroft?—As soon as I was put into my sitting room, an old attendant came in with a wig on.

8392. You are, I gather, of a philosophical temperament. You did not make any violent disturbance, did you?—No; I took it as a tremendous joke.

8393. What did you do when you found you had been tricked?—I first realised the sort of place I was in because this old man, a fellow called Alfred Hall, came in and sat down in an aggressive sort of way. I looked at him. I asked him what his name was and what he was doing there, and he said: "Well, I have been sent in here to look after you." "Oh," I said, "I am in an asylum then, am I?" and he said "Yes, you are in an asylum all right, and you will have a devil of a difficulty to get out." He said "You can easily get in, but it is very difficult to get out."

8394. Did you in your experience find that it was so, or did you contrive to get out?—I took that as rather a challenge.

8395. While you were there, I want you to tell us quite calmly what sort of treatment you were subjected to—ameliorative treatment. What was your routine?—On my first admission into the place they treated me with great courtesy, with considerable courtesy. I objected to having these old keepers, very common chaps, in my rooms, and Stilwell did take them away, and I was not always in their presence. He allowed me to wander about the place; but you see I was still a very sick man, and of course I collapsed a few days afterwards.

8396. Now I want to ask you this: Did you receive a notice intimating to you that you were entitled to see a justice?—No.

8397. But you did see a justice, did you not, after some time?—One evening.

8398. How came that to pass?—I think that is the formula of an urgency order.

8399. He, in the ordinary routine, visited you?—I think so.

8400. Tell us about that experience, how far that availed you to obtain any redress. Describe the interview with the gentleman?—He is called William Ashton.

8401. What was he?—He was by trade a grocer, so my keepers told me, and he had been co-opted on to the Uxbridge Bench, and he was a special Commissioner, I think, appointed by the Board of Control. This old man came into my room and said: "I am a justice of the peace." I said: "I have been wanting to see you." Young Stilwell was there. I sent this justice a note demanding my release or an inquiry.

8402. Is that document available on the file?—I think I have a copy of it.

8403. Let me have the copy you have?—I have not got it here; it is in one of my letter books.

Mr. Walter Stewart: Of course, Sir, we have to see whether this is an insane man, and that might be a relevant document.

Witness: Yes, I think I can find it, but my secretary has died lately and I am a little astray with my papers.

8404. Chairman: The justice who saw Mr. H. had nothing to do with the Board of Control, had he?—Excuse me, Sir; Dickinson, who is the most important person in the Board of Control, wrote me and said that this was a special Commissioner appointed by the Board of Control.

8405. That Mr. Ashton was a special Commissioner? I think you must be wrong about that?—I have got the letter in my book.

8406. Perhaps you will let us have the letter?—I think Dickinson is a man who is occasionally very inaccurate; that is my experience.

8407. Mr. Walter Stewart: You say that the letter is in your possession?—Yes.

8408. Could you give us any idea of how long it would take to procure it?—I could telegraph for it now.

8409. Will you do so during the adjournment?—If I go down to-night you shall have it on Monday. He is a special justice appointed by the Uxbridge Bench.

Chairman: Now you have got it right.

8410. Mr. Walter Stewart: Go on, please, and describe the interview. What benefit was it to you?—Ashton obviously knew nothing about lunacy, and he turned to young Stilwell and said: "Well, what am I to do about it?" and Reggie Stilwell said: "Oh, leave it to the Commissioners."

8411. This is the judicial authority?—Yes. I protested. I said: "Don't you do that, Ashton. You take notice of my complaint. I protest against being imprisoned."

8412. I want you to think carefully before you answer this question. Would you yourself, as a man who has gone through this experience, if you had been given an opportunity, have preferred a really judicial procedure, or the procedure which was observed on this occasion?—There must be a judicial procedure if you are dealing with liberty.

8413. That is the opinion which you deliberately express to this Commission?—Certainly.

8414. Would you like to give the reasons for that opinion which you are now expressing?—In the great Dependencies, in the United States, it is always a judicial function, the taking away of a person's liberty.

8415. And even in England?—And even in England.

8416 Mr. Dickens: As a rule?—But the judicial authority of it disappears entirely, as with Ashton.

8417. Mr. Walter Stewart: Had you been given an opportunity to meet the facts as alleged in these three certificates, and on your oath to have explained them, would you have welcomed the opportunity?—Yes.

8418. Do you think it would have caused any mental detriment to have had the opportunity to do that?—None whatever.

8419. If you had been able to, would you have welcomed the intervention of an authorised representative to do that for you?—Certainly.

8420. As in any other relationship where skilled assistance is required?—Yes.

8421. Do you think that that in common fairness is a thing that should be available to a man who is deprived, or who is sought to be deprived of his liberty, or not?—Certainly.

8422. I pass from it, and leave my learned friends to cross-examine about it. Now how long after that interview did they keep you in detention at Moorcroft?—I protested, immediately I fell ill again; I was ill with jaundice on the 18th January.

8423. What caused you to fall ill with jaundice, do you think?—Well, I think I got a bad chill.

8424. Did you ever ask for any different raiment to that which you had taken?—Yes; I was expecting it to come.

8425. Did it ever come?—It came about four months later. Stilwell bought some fresh stuff for me.

8426. We are talking of December and January, 1916-17 now?—Yes.

8427. How much was charged for your maintenance at this private establishment?—The total bills, which I strongly objected to, in six months while I was there amounted to £700.

8428. We will do the arithmetic. Now pass from that and tell us quite quietly what sort of menage for maintenance was it, in which your bills amounted to £700 for a period of about six months?—I think the schedule of the Master in Lunacy allows about five guineas a week for it; that is the sort of regulation allowance, I think.

17 January, 1925.]

Mr. H.

[Continued.]

8429. In the Moorcroft case book to which I have access, I have this, that he complained—

Mr. Croom-Johnson: Date please, Mr. Stewart.

8430. *Mr. Walter Stewart:* This is the entry in the Moorcroft book, January 10th: "Full of complaints, which are quite unfounded, about his food. He tells me he is employing detectives to watch the doctors who certified him"?—What are the initials against that—was that that Irishman, De Courcy Potterton?

8431. The initials are R.W.C.?—That is Bob Cole.

8432. What is he?—The less said of him the better. We must not go into these other people's business.

8433. At any rate that is what he said, that you complained of your food. In this establishment was there ever cause, as there may be even in all establishments, to complain of the food?—I would rather you did not take anything that Bob Cole put down as correct. I have no recollection of complaining of the food. I wrote to the Commissioners; they have got the letters. I said I thought, considering it was war time, the food was extremely good.

8434. You do not accept the accuracy of the entry?—No; nothing that man has put down.

Mr. Jowitt: May I have what he did put down? He complained of his food and said he was employing detectives to watch the doctors.

8435. *Mr. Walter Stewart:* Was it the document over which you had no control, Mr. H.?—No, nothing to do with me.

Earl Russell: Just before you read that, ask the witness if he complains to-day of the food at Moorcroft.

8436. *Mr. Walter Stewart:* I am obliged. (*To the Witness:*) Do you to-day at all complain of the actual food, meat and drink, you got at Moorcroft?—At the time I was first in Moorcroft I have said everything was very good. When I was put in among the inferior patients I objected very strongly.

8437. Was it different?—Yes.

8438. This is a document constructed without our knowledge or responsibility, which is in these terms: "January 10th. Month's report. He is mentally excitable and talkative. He wanders in his conversation; he is careless about his dress and his habits. His room is most untidy and accurately exhibits his mental disorder. To-day he is full of complaints which are quite unfounded about his food. He tells me he is employing detectives to watch the doctors who certified him, and that he is claiming £5,000 from them. He has signs of general paralysis of the insane. He has inequality of pupils and some tremor of the tongue and occasional impediment in his speech. He has recently had an attack of jaundice. R.H.C." That is the 10th January, 1917. We are now speaking on the 17th January, 1925. How do you feel to-day?—With regard to these statements?

8439. With regard to your health?—At that time I was a sick man physically, but I was perfectly right mentally.

8440. And how are you now with regard to your physical health?—I am not in the most robust physical health, but I am, I believe, mentally sound, and always was.

8441. It is fair to put it to you, so that there may be no misapprehension. Are you to-day suffering or have you ever to your knowledge and belief, suffered from general paralysis of the insane?—I am perfectly certain it is untrue.

8442. I am not going to ask you with regard to the pathology of that, but there are doctors, for instance, who know the usual course of the disorder. Have you studied it?—I have read a good deal of it.

8443. What is the average duration of that distressing and generally fatal malady?—Of course it is a death certificate. For Dr. Porter Phillips to have put a thing like that on a certificate—first of all it is a criminal libel, and secondly no wise

physician would ever say a man had got cancer after he had been examining him for ten minutes. There should have been at least three Wasserman blood tests; at least, Sir Thomas Horder tells me so; and Stilwell was engaged, his statutory duty was to find out if this was true. He should have taken a few drops of blood and sent them to a pathologist, and he would have found that these filthy certificates were untrue.

8444. If you had known of these filthy statements in those filthy certificates?—I would have had my blood tested again.

8445. There is one other matter which I think it is right to put to you: Do you know that G.P.I., as it is generally called, is supposed to be one of the sequelæ of syphilis?—I know it now.

8446. Have you ever in your life suffered from that distressing malady?—I have never had any sexual disorder of any type, at any time. On that case book there is the question why that statutory duty was not carried out. There is a statutory duty on the doctors of these asylums that on reception of a patient they should enter up a proper report, such as a physician would give. These people never bothered about it, and Stilwell explained it in the Newington action. He said: "Oh, it was forgotten." There were three doctors.

8447. You had no idea then as to what they should do and what they should not do?—No.

8448. The status of an alleged lunatic under detention under an urgency order does not enable him personally to investigate it very much?—I cannot help thinking the most desirable—

Chairman: I think there is some mistake. I have got the medical statement. On the file there is the usual medical statement which is given within a day or two of the admission. This is the report made at Moorcroft; it is in two parts, as you know. It is first of all on the mental state and then the bodily state. Certain observations are made with regard to your mental state and with respect to your bodily condition certain other observations are made, and that is signed by "R. H. Cole, Acting Medical Officer at Moorcroft." That such a report was made in conformity with the statute is obvious from the file. Whether its contents are accurate or not is another matter. The date of that is the 10th December, 1916.

Witness: I have no note in my diary of an examination, and he made no examination.

8449. *Mr. Walter Stewart:* Your evidence is borne out, I see, by the entry with regard to the jaundice, because on 23rd December I see it appears that "Mr. H. has been in his room suffering from abdominal pains this morning. He has developed jaundice and has been given H.G.G.G. and put on milk diet." Then it goes on to say what your condition was: "31st December. Has been very feverish, 104." That is the temperature?—Yes.

8450. "Pulse 120, marked jaundice, vomited once. Sleepless." That is signed "J.B. 31."

Chairman: The point we were on for the moment was whether there had been some negligent breach of a statutory duty which is imposed upon an institution.

Witness: It does not matter what is entered in the case book. What is the truth according to my knowledge is that there was no physical examination.

8451. *Mr. Walter Stewart:* And that you will swear?—That I will swear.

8452. We shall hope to have the benefit of hearing Mr. Cole's version presently. I do not want to labour this, but look at this entry: "23rd January, 1917. The patient spends most of the day in his own room playing with his monkeys and writing letters to various people. He has expressed a great dislike to me personally, and is best left to others for the time being." That is signed "C.P."—That is Potterton; he was an Irishman.

8453. What sort of an Irishman?—He told me his father was the Dean of Raphoe, but wherever that is I do not know. Still, he was quite a courteous, nice fellow.

17 January, 1925.]

Mr. H.

[Continued.]

8454. But he accurately expressed your feelings with regard to him in that entry?—I think so. I always read a great deal. There was very little to do. I had four newspapers every day, I think. I used to cut from the newspapers statistics and things of that sort, and glue them on to a German oleograph.

8455. Why did you do that?—Because I did not want to damage the walls of the place. I glued them on glass and stuck them on with gum, and these people seemed to think that that was proof positive of G.P. I wanted to have these statistics relating to ships. I am a naval architect, I am a naval man, and I wanted to have these things in a visible position.

8456. *Chairman*: Where did you put them?—I stuck them on a German oleograph that was in the room. I stuck them on the glass. Reggie Stilwell told my friend, the Rector of a place down there, he said, "That is proof positive that that man has G.P. He is so untidy."

8457. *Mr. Walter Stewart*: Did you know that they were making these entries against you?—Yes.

8458. You got a peep at the case books, I think?—Yes. I saw something about paralysis.

8459. What did you do when you saw them?—I asked Stilwell about it, and he said it must be untrue; he passed it off. It beat me altogether that I should be paralysed, I knew it was quite untrue that I was in any way paralysed. What "general paralytic" meant I did not know then.

8460. You know it now?—I know it now all right.

8461. Did you seek at any time to obtain access to any statutory body outside, in order to obtain redress for the treatment that you were subjected to?—Yes; I wrote to all my friends who were in a judicial position. I believe those letters were sent.

8462. I am talking about the statutory people, the Board of Control?—I used to write to the Board of Control every week.

8463. With what result?—Nothing doing. They sent down the Commissioner.

8464. Who was he?—Rather a nice fellow, called Branthwaite. He had lived in India a good deal. I got a lot of visitors

8465. Tell us about him and his visit, and how far it availed you to recover your liberty, or to obtain any form of redress?—He came into my room. I had just come in from the dentist with a keeper. He was rather interested in these little tiny monkeys I had. We talked about India.

8466. *Earl Russell*: Had you the monkeys at Moorcroft?—I had them in a parrot cage. Branthwaite was dogged by Reggie Stilwell, and we talked for a little time. I mentioned that I was anxious to get my release, and that I had written a good many letters to the Board of Control to which I had not received replies, and Branthwaite seemed rather bored with the correspondence. He turned on his heel and said to Reggie Stilwell: "I suppose the diagnosis is not complete?" and Stilwell gaily said, "Of course not."

8467. Were you able to obtain any redress at all from that Commissioner?—I wrote him a personal letter, which went, and said I hoped I had not treated him in any way discourteously, and he replied quite nicely. No notice was taken of it. I was expecting him to take some action with the authorities.

8468. Did he ever take any, as far as you know?—As far as I know, none.

8469. Or did the Board of Control?—No

8470. *Chairman*: But why were you asking that he should not take the interview in a discourteous sense? Had there been any passage or discussion between you?—The impression left upon my mind was that he was annoyed at something I had said. Of course, I complained about imprisonment. I was a prisoner.

8471. *Mr. Walter Stewart*: You were only then an inmate?—I was a prisoner.

8472. *Chairman*: I merely want to know why you thought it was necessary to write him a letter saying that you hoped he had not taken anything you said discourteously?—The idea was very much to remind him of my case, to look into my case and to do something.

8473. Was the interview a private one?—No; Reggie Stilwell was there. He would never allow anyone to see me without his guidance.

8474. *Mr. Walter Stewart*: Now you have been asked about your complaint as to medical treatment. In that illness that you suffered at Moorcroft with regard to the first period of your detention, had you any medical treatment from anybody other than the treatment of this attendant whom you have told us about—the head attendant, I think he was?—The first treatment I received there was by Potterton and Gray. I think the head keeper came into my room rather late at night, after I had been to sleep, and said that Dr. Porter Phillips had ordered me a draught. I asked him what the draught was for, and he said, "Oh, it is a sedative." "Well," I said, "I will not take it," and he rather pressed me to. I said, "I have been asleep already and you have wakened me up."

8475. Did he wake you up to take a sedative?—Yes.

8476. This was not a lunatic asylum, was it?—I do not know. He pressed me to take it, and he went on arguing, and I said, "You had better get out of it," and I threw it in the fire. I was afraid of being in an asylum. It is the sort of thing you have read about in "Hard Cash" and other books.

8477. You were afraid to take it. Never mind whether you had reasons, you were afraid?—Yes.

8478. Supposing you were again subjected, in your present state of mind, as to which the Commission must judge, to such a treatment, would you now be willing to take a drug, the nature of which you were unacquainted with, if it were forced upon you?—No.

8479. Same or insane?—No.

8480. So much for the treatment. Did you have the benefit at that time of any other treatment than that of the head attendant, as far as you know?—I do not look on a doctor walking about in a place as treatment. There were plenty of doctors there.

8481. Treatment, I am talking of?—There was no treatment except what is mentioned in the case book, and of course as soon as I was *in extremis* they did then bring several eminent people.

8482. I think Fagg was brought down?—Yes.

8483. Can you give us the date of his visit?—Yes.

8484. You were very ill then; I see your temperature was 104?—Yes. Fagg was brought down because I insisted upon an operation.

8485. That is someone from outside the establishment?—Yes. You see, I knew pretty well what my symptoms were, because my father died of the same thing, and I nursed him.

8486. What did he die of?—He died of gall stones. I am not sure it was not carcinoma of the gall bladder.

8487. And you were suffering from an affection of the gall bladder?—Yes. We never really knew what it was, because they do not take much notice of these things. They are not scientific places, you know.

8488. You have told us about the visit of the member of the Board of Control, or the Commissioner. I think during your stay at Moorcroft you also did see one other Commissioner, did you not?—I saw two Commissioners.

8489. Was that a lady—a Miss Dendy?—Yes, Miss Dendy.

8490. Just describe your interview with her.—She was a dear old thing. She came into my sitting room. My coat was off; I immediately got up and put on my coat as a matter of courtesy, and she started away, thinking I was going to attack her. She said, "Is your name Mr. H.?" I said "Yes," and she bolted out then. She ticked me off.

17 January, 1925.]

Mr. H.

[Continued.]

8491. You did not obtain any satisfaction in that way from Miss Dendy?—No, it was no good with regard to Miss Dendy.

8492. Now finding this state of affairs, did it occur to you that it was for you to take the initiative? You are a gentleman who has a good deal of manual dexterity. You are able to improvise tools and use them?—I think so.

8493. I think you used the knowledge you have got as a craftsman, in order to remove the fastenings of the windows at Moorcroft and descend from your bedroom window to the ground?—Yes; it was rather difficult getting out of that place. It was very much of a gaol, so I induced Reggie to buy me a large-scale 25 in. Ordnance map. I made him a drainage plan, and at the same time I was able to see the minutiae of the walling. Then I invited Reggie to buy me a new box for my clothes, and he gaily sent up a box with two very good, strong straps on it. I was able to fit these together, and take down a fitting from the roof of the place, screw it on to the floor, hang the straps out of the window, and so perhaps get 18 ft. or 20 ft. down into the garden at night.

8494. Although recently recovered from an illness, you took that risk?—Yes.

8495. Why did you take such a risk as that?—I told Stilwell, "I am satisfied that the whole place is dishonest, and I am going to take the law into my own hands." He had never given me parole, but he had given me a good deal of liberty. I think he tightened up observation after that, but the police attendants in the place were very favourable to me, and would do much that I wanted them to.

8496. *Chairman*: If you had had a good deal of liberty, could you not have escaped less elaborately—less like the "cat burglar"?—No.

8497. Why should you go through this elaborate machinery?—It is very much a lock-up place, with walls all round; it is quite different from Ticehurst. Ticehurst is a country estate where one could really walk away.

8498. *Mr. Snell*: Was the liberty that you had restricted to the institution?—My liberty was restricted to the institution, except under guard.

8499. *Chairman*: I think, Mr. H., you went to Uxbridge. Were you not alone in Uxbridge?—No, I always had somebody at my elbow.

8500. *Earl Russell*: Wait a moment. Take paragraph 41: "I was allowed to go into Uxbridge occasionally with an attendant, who often left me by myself."—Left me at the dentist's.

8501. *Chairman*: Could you not have given him the slip then, if you wanted to?—I thought it would be perilous to get away in the daytime.

8502. *Mr. Jowitt*: Just read on: "It was owing to this I attended the Court there, with a view of making a protest to the justices."—I slipped the attendant at the corner, but he was within sight, because he followed me into the place.

Chairman: Why was it necessary to go through so elaborate a procedure to escape when you had been able to move about in Uxbridge?

Mr. Walter Stewart: No, Sir; he said that even then the attendant was at his elbow, and followed him into the Court.

8503. *Chairman*: "An attendant, who often left me by myself"?—I was left alone in the dentist's, but in the street there was always somebody with me.

8504. *Earl Russell*: May I just follow the rest of this paragraph 41? You now tell us, I understand, that you could not get into the Court because the attendant caught you up and stopped you?—I got into the Court, and Jack Stilwell, the father of this man here, was sitting on the Bench, and I intended to make a protest then, but he had spotted me.

8505. *Mr. Walter Stewart*: And having spotted you, who was it that accompanied you back to the institution?—I think it was a man called Jacobs.

8506. So he was there?—Yes, he was in the place; he sat with me.

8507. You had not sufficient start in the broad daylight to get away clear?—That is so.

8508. But at night, was it different?—Yes.

8509. At night did you think it a better plan to get the start which you did get by escaping through the window?—Yes.

8510. That is your explanation of why you did it in the way you did it?—Yes.

8511. Is there any other ground at all for the suggestion that you acted in that matter as an insane man?—No. The attendants were delighted about the whole thing. They said it was ably planned, and they had not got into any trouble over it.

8512. If you had been with an attendant who had been lax and you had escaped in the day, he would have got into trouble?—Undoubtedly. I liked most of the attendants.

8513. Did you know at that time that if you managed to keep out for 14 days they could not, without re-certifying you, get you back?—I think I wrote to the Commissioners and asked for a copy of the Act.

8514. After you escaped?—No; I wrote in the first place because I knew nothing about the Lunacy Acts. The Commissioners ignored my request. Then I asked the different doctors for it, and they said "No," but eventually I got one from Eyre and Spottiswoode, when I was at Ticehurst. I knew nothing about the Acts at that time.

8515. So you were recaptured in three or four days?—I was too short of money to carry on, and my relatives would not supply me with money.

8516. When you got out during that brief interval from Moorcroft, did you take any steps to protect yourself with regard to any form of certificate?—Yes. I was particularly anxious to get into a nursing home for this operation, which I knew must come, and I rang up Bessie Clapperton, who is Sir Watson Cheyne's nurse, whom I knew quite well, and I asked Bessie Clapperton if she could give me a bed and get me attendants, and she said she would think it over. She eventually said: "I think you had better go down to that place where Nellie Chambers was staying in Lincoln's Inn Fields, or somewhere down in that neighbourhood." I was rather suspicious of her, and I sent one of my old sailormen first to see if there was a trap laid for me, and there was, and they collared him, and they collared my bag of clothes, which was rather embarrassing.

8517. *Mr. Jowitt*: Where did you stay during these three days?—I got into a quiet little hotel at the back of Euston Station. I obtained a doctor's certificate then. A man called McNaughton visited me on the 29th December at the request of a pal of mine, a solicitor. McNaughton came and saw me with Reggie Stilwell, when I was very ill with jaundice, and he accepted Stilwell's view that I was dangerous, and made a perfectly poisonous report.

Mr. Dickens: Dr. McNaughton is dead. I propose to read the report.

Chairman: Would you like it read now, Mr. Stewart?

8518. *Mr. Stewart (to the Witness)*: When was this report obtained—during the period of your escape?—No. McNaughton saw me on the 29th December in Moorcroft.

8519. Dr. McNaughton was known to you personally, was he?—No, I knew nothing of him.

8520. How did he come to see you?—He was sent by a friend of mine called Ritchie.

8521. What was Ritchie's motive in sending McNaughton to see you?—Ritchie had been to see me on the 23rd December.

8522. Did you complain to Ritchie that you were improperly detained there?—Of course I did.

8523. Then was it in consequence of that, that Ritchie got McNaughton to go down to see if he

17 January, 1925.]

Mr. H.

[Continued.]

took a different view of the case?—No, what Ritchie did was this. He said: "It is perfectly absurd that this man is alleged to be insane." He went to my brother and said: "There must be some mistake, the man is ill, but is perfectly sane." He went to my brother and he said he would pay Dr. McNaughton to go down.

8524. So he was only sent down in your interest?—Yes.

8525. You mentioned a friend, Mr. Ritchie, coming to see you. Was there any obstacle put in the way of your friends coming to see you while at Moorcroft?—Not in the first part of my detention.

8526. You were allowed to see anybody?—And before then I think I saw pretty well anyone who came down to see me.

Mr. Dickens: This is dated the 29th December, and it is written to E. H. who is the petitioner: "I visited Moorcroft to-day and examined Mr. W. H. He is certainly deranged and requires to be under care and treatment. This is really ascertained from his conversations, some of his actions and his markedly facile manner. It is not easy to perceive at present signs of organic brain disease, although two early ones are present, namely slight irregularity of the right pupil and a tremulous tongue. These symptoms, along with the normal state, would denote almost invariably the early stages of general paralysis of the insane. It will, however, be two or three months before one can be positive as to the course Mr. W. H.'s trouble will take, but meantime one cannot consider the outlook good."

Witness: That is his report.

8527. Mr. Walter Stewart: And that was addressed, as I gather, to your brother, the petitioner?—Yes.

8528. You told us that your friend had gone to your brother?—Yes.

8529. What had happened behind your back between your brother and him you do not know?—I do not know.

8530. Your brother procured someone to go, and your brother was the petitioner?—Yes.

8531. Did you, during that brief period of time, have an opportunity of getting privately vetted?—Yes.

8532. By whom?—I went to McNaughton under another name.

8533. And under another name what did he give you?—When he saw me in bed, I was in bed extremely bad with a violent pain from gastric or liver colic. He saw me on the 29th December, in Moorcroft with Reggie Stilwell. Then I escaped and I saw him on a Saturday, I think it was.

8534. Mr. Jowitt: How long after?—I escaped on the Thursday.

Mr. Dickens: The date of the escape is the 23rd February.

Chairman: The date I have is that he escaped on the 8th February, and was captured four days later.

(After a short adjournment.)

8546. Chairman: Will you please continue your examination of Mr. H., Mr. Stewart? I think we had reached the point where Mr. H. lost the certificate which Dr. McNaughton had given, which I think you said, Mr. H., was lost in Chancery Lane or taken from your pocket when you were undressed?—Yes.

Mr. Walter Stewart: I am going to call for that second certificate. I do not know whether it is in the possession of anybody present.

Chairman: We have not got it; and, of course, it would naturally not be in any official file. If it was lost in Chancery Lane, of course, it is lost for good.

Mr. Walter Stewart: Mr. H. is not sure whether it was taken from him when he was stripped, or whether it was lost in Chancery Lane.

Mr. Dickens: The case book says 23rd February. "Mr. H. managed to open his bedroom window early this morning."

Mr. Walter Stewart: That may be true, I do not know.

Witness: I went to McNaughton because I had been told about him.

Chairman: It is a mistake in the *précis*. I have got the file in front of me: "Escaped on the 23rd February, 1917, and re-taken on the 26th February." That would correspond with the date of the 23rd.

8535. Mr. Walter Stewart: Now we know how long after the first vetting it was that you were vetted by the same man again?—Yes.

8536. What sort of a bill of health did he give you at that time?—I went to him and said: "I am a man out of the Navy temporarily, and I want to get back again." I said, "I am supposed to be suffering from paralysis of some sort. Will you very kindly examine me and give me a report, so that I may get back into the service?"

8537. And what report did he give you?—He gave me a report qualifying me for light work.

8538. Chairman: Did he not recognise you, when you came into his consulting room again, because he had seen you quite shortly before?—When he saw me in bed at Moorcroft I was jaundiced up to the eyes; it was a dark room. I took the risk, anyhow.

8539. He did not in fact recognise you?—No.

8540. Mr. Walter Stewart: I must take it out of order of date, I am afraid, because my friend objects to secondary evidence. (To the Witness): Tell me, how came you to be deprived of that bill of health as I call it?—Exactly what happened was this: On the Monday morning I was going down trying to collect some money, and in Chancery Lane I was collared. There was a bit of a scuffle there, and either that certificate was lost there or it was taken from me when I was stripped on my return to Reggie Stilwell's place by De Courcy Potterton.

Mr. Walter Stewart: I formally call for it if I may, in case it should be in the possession of Dr. Stilwell.

8541. Sir David Drummond: You mentioned paralysis, that is to say, you asked him to examine you for paralysis. Did you mention anything about mental symptoms?—I suggested the nervous side—paralysis, you see.

8542. But that might have nothing to do with mental symptoms?—I insisted upon him examining my eyes, as I did with all these doctors.

8543. You did not mention anything about mental symptoms?—No; I did not tell him I had escaped from an asylum.

8544. Mr. Walter Stewart: You left it to his acumen to detect any signs of mental disturbance, if any were in fact present?—Yes. He gave me a certificate in a few lines.

8545. What did it say?—In effect it said: "This patient has been invalidated out of the Navy temporarily, and I consider he is fit for light duty."

Mr. Croom-Johnson: So far as my clients are concerned, it may be taken that they have never seen it or heard of it, that it is not in their possession and never has been in their possession.

Chairman: We will take it as simply being what Mr. H. has said: that it certified that he was fit for light duty.

Witness: Then I want to supplement that. I wrote to Mrs. McNaughton. Poor McNaughton was in bad health; he died shortly afterwards; in fact, everybody I was associated with died afterwards. Mrs. McNaughton wrote me to say that she had gone carefully through her husband's notes and she found no certificate about me at all, not even the first one they had, so I imagine he was careless.

17 January, 1925.]

Mr. H.

[Continued.]

I think it is a very reasonable suggestion that he was careless.

8547. However, be that as it may, we have not got the certificate. You have told us, to the best of your recollection, what its contents were?—I had five medical certificates before my final escape.

8548. We have not quite reached that stage yet.—As long as you are in a madhouse you never can get any independent evidence. It is no good sending two doctors, as under the statute. You cannot get it.

8549. Why do you say that?—Because they are coloured with the information which other doctors in the madhouse give them, and the case books. Look at this case book of Moorcroft.

8550. *Chairman*: The point is an important one, and I should like to have your view upon it. In private practice, for instance, when one calls in a consultant, the first thing he does is to see 'your ordinary medical attendant, and say: "Tell me about this case;" and then the consultant forms his opinion upon the information given him, and also upon his own observation of the case. I am a little puzzled by your theory that where the case is a mental illness the medical attendant should not have an opportunity of giving an opinion to the consultant?—Mental illness is a thing entirely outside of any ordinary medicine. There are no rules about it; there is nothing definite at all. It is the most mythical thing you can have. The books these gentlemen write are perfect nonsense.

8551. Do you mean the treatises on insanity?—Yes; and in the medical profession, as I see it—and I have many relatives who are doctors—the consultant who comes in and does not support or hide up the general practitioner is not looked on as a white man. He will not be called in again, if he does not support the general practitioner. That is one of the defects of medical practice; and I am sure *this* gentleman will support me in that. They are taught in their schools that they must support each other.

8552. *Earl Russell*: Right or wrong?—Right or wrong. My friend, Dr. Munro, who is a difficult man, as you know, is a man who puts his patients' interests far and away in advance of any class interest of his own medical profession, and he is an honest doctor. It is the greatest profession we have.

8553. *Mr. Walter Stewart*: The witness was saying that Dr. Munro was an honest doctor. Let me ask you about Dr. Munro. He was a gentleman who at one time was the proprietor of a private mental institution, was he not?—Yes, an institution for 11 ladies.

8554. An institution for gain?—Yes.

8555. And he voluntarily surrendered his licence in respect of that institution, did he not?—He did not surrender it; he cancelled it.

8556. Voluntarily?—Yes.

8557. Why did he do that—has he ever told you?—Yes. He told me he would not accept instructions from a man of the type of Dickinson, of the Board of Control; he objected to being dictated to by a clerk.

8558. Was there any other reason?—There was another serious reason. He was instructed that he was not to release cured patients.

8559. Is he available as a witness to give evidence before this Commission?—Yes.

Chairman: He recently wrote me a letter saying that he desired to withdraw his offer to give evidence, and referring to this Commission in terms which, I regret to say, were anything but polite.

Mr. Walter Stewart: I am sure Dr. Munro would be the first to express his regret.

Chairman: Mr. H. has himself expressed his regret, and I do not associate him with this in any way.

Mr. Walter Stewart: It is the result of an article which should never have appeared in the Press.

Chairman: However, so far as we are concerned, it does not affect us. I do not think we need go into Dr. Munro's position.

Witness: No; but I do wish to maintain that he is an honourable man.

Earl Russell: We do not want second-hand evidence of what he thinks.

8560. *Mr. Walter Stewart*: That is the position as it at present stands, and you know about Dr. Munro. (*To the Witness*): He, I think, at one time actually went a voyage with you?—Yes, I know all about him.

8561. Now come, please, to your enforced return to Moorcroft after your three days' escape. I want you to describe, quite quietly, what were your experiences when you were brought back there. Were you brought back against your will?—Yes.

8562. They were legally entitled to take you back. Just tell us what happened?—I demanded of the police when I was arrested that I should be taken before a magistrate, and the attendants who arrested me produced a letter from John Stilwell, who is the licensee of Moorcroft and also a justice of the peace (which I think is very improper), authorising these men to arrest me.

8563. He was within his legal rights?—Yes.

8564. *Earl Russell*: You are referring to the police on duty in Chancery Lane?—Yes.

8565. *Mr. Walter Stewart*: You make no complaint with regard to the executive officers. Please tell the Commission what happened to you when you were taken back to Moorcroft?—All my clothes were removed, and all my toilet accessories; everything in my room had been cleared out; and I was put into a ward which was not the lowest ward in the place, but the intermediate ward.

8566. What ward was that?—It was not called a detention ward, but it was next to the rough house.

8567. Was there a rough house at Moorcroft?—Yes.

8568. And it was next to that in order of classification?—Yes.

8569. Will you please describe the conditions in which you found yourself?—I had a number of very objectionable people with me.

8569A. In what way were they objectionable?—They were incontinent; they were noisy; they were bad cases—all of them.

8570. In what way were they bad cases?—They had to be under the strictest supervision; there were two warders always in the room with them; and they were the most objectionable neighbours to anyone with any sense of decency.

8571. Had you to live together with those people all day long?—I had to live with them all day long; but I returned to my bedroom at night with an policeman.

8572. Now it is not suggested that at any time you were a violent case, as far as I understand?—Never.

8573. Were any of those people in that department of Moorcroft violent?—One or two were at times violent.

8574. In what way?—Well, they struck the attendants; and they would ramp around. Reginald Stilwell was away at the time; I think he was sick; but Cole did in a way try to take out from that room the very offensive patients who were noisy and beastly and put them in the lower grade room.

8575. Let me ask you this: As far as you are acquainted with the topography of Moorcroft, was there no other place in that institution which would have been safe as a place for your detention?—I was put there as a punishment, because I had a sitting room in the place, but I was not allowed to use it.

8576. Was that the room you had escaped from?—No.

8577. Was that a safe room?—Perfectly.

8578. You say you were put in this place as a punishment?—Yes.

17 January, 1925.]

Mr. H.

[Continued.]

8579. Was the condition of the room different from the condition of the room you had first enjoyed during your stay at Moorcroft?—Entirely.

8580. In what respect?—It was punishment.

8581. Describe in what way it was punitive?—In this way: that I object to associating with the sort of people that were there. It was not a room as big as this one probably, and there were all these people crowded together.

8582. How many of them were there?—14 of them; and the whole thing was an indignity; it was an insult; I resented it.

8583. Your clothes were taken from you, you say?—My toilet things were taken from me. Every night my clothes were removed, so that I should not escape again.

8584. What about your toilet requisites?—The things that I wanted, such as tooth-brushes and things like that, were not there for four or five days, but they gradually drifted back.

8585. It was a temporary derangement?—Yes, purely temporary.

8586. Now tell us with regard to your food at that period. Was it the same as it had previously been, or was it different?—The food was on a different scale. In the morning and at lunch time I had my meals with the keepers and many of these people in a ward. My dinner at night was served on a tray in this big place, with a lot of these people ramping around.

8587. Was it different food or the same food as you had previously had?—It was sufficient, because I am satisfied with very little.

8588. Was it different to that which you had had before?—Yes, it was on a different scale.

8589. In what way was it different?—Was it better or worse?—It was certainly worse.

8590. In what respect?—It seemed to me to be of a poorer quality, and there was not the choice of things.

8591. This was in war time, and you desire to make no meticulous criticisms with regard to the diet, but you say that the food was different when you were under punishment?—Yes.

8592. *Earl Russell*: What did they do with your monkeys? Were you allowed to have them?—When I got there, I told the Curator at the Zoo to send a van and collect them.

8593. Were they collected?—They collected them and took charge of them.

8594. *Mr. Jowitt*: You did not have them back again?—I got them back again when I escaped, of course. I did not have them back at Moorcroft; I thought it was not suitable.

8595. *Mr. Walter Stewart*: As to Moorcroft, is there anything else you desire to say with regard to your second detention there?—With regard to Moorcroft, I do not want to be unfair, but I do resent the bringing of my wife into this. All my letters to her were stopped, and my solicitor, Mr. Steele, collected them after months from the keepers at the place; many of them were opened.

8596. Were you told that your correspondence was being tampered with?—I know I realised it after a time.

8597. You have talked about your toilet requisites. Is there anything you desire to say with regard to towels in this new place where you were detained?—I was not allowed to go into my bedroom, as I did formerly. I had to go into the common wash-place.

8598. Had you your own individual towel?—No; it was simply a dirty place such as you would get in a factory.

8599. You said that some of these patients were incontinent?—Yes.

8600. Did that affect the place at all in which you washed?—I would not like to go into that.

8601. You had to use such towels as were available?—There was one towel for the lot.

8602. Did you ever protest about that?—Of course I did.

8603. With what result?—Nobody took any notice. There is no law in these places.

8604. Did you protest at any time against your detention in that particular ward?—Yes.

8605. To whom?—To my petitioner.

8606. That was your brother, was it not?—Yes, my brother; and he, after some six weeks, wrote to Stilwell, and said, "It is most unsuitable." Stilwell at that time, you see, was beginning to move. I was being served with writs in this asylum; and he then put me back in my sitting-room. I am very grateful to him for that.

8607. There is one other matter I have not put to you. You told us about a will that had been prepared with the assistance of your solicitor before you were certified?—Yes.

8608. Was anything done with regard to that will while you were still at Moorcroft?—Yes.

8609. Could you recollect the date at which it happened and what it was?—Yes. The will was prepared by Mr. Muther in November, and it was in draft when I was imprisoned. This is an admitted document, prepared by Messrs. Speechley, Mumford and Craig. The will was signed in the presence of R. H., my elder brother, and witnessed by Stilwell, on the 30th January.

8610. During the period of your first detention?—Yes. I requested that my solicitor should attend then, because I wanted to make certain minor alterations, and I was refused, of course. If I had died there, which I might very well have done, I do not know what sort of trouble there would have been over the will.

8611. *Chairman*: You spoke of writs coming in. What writs were coming in at this time?—After my consultation with the Chancery barrister, Mr. Paley Baildon, he said, "Well, I advise" so and so. I do not think he knew about the 14 days. "If you get back into Moorcroft, I advise that you must get your wife to enter an action against you for possession of your property." It is rather involved, but it was quite sound. My brothers had stolen all my property; they captured all of it, under the law; and one of my brothers, being the petitioner, took possession.

8612. Are those what you refer to as the writs that were coming in?—Yes. Mr. Steele—this gentleman sitting behind here—was instructed by my brother-in-law, who is a Newcastle solicitor, to serve me with a writ, and I had instructed my wife to writ me. I had managed to get a letter out to her; it was posted by a keeper.

8613. *Earl Russell*: In your own interest, you wanted these writs?—In my own interest I wanted them. I knew that huge sums were being given to anybody who asked for them, and I rather objected.

8614. *Mr. Walter Stewart*: How did the knowledge that all your affairs were under the control of other people affect your mind, and that you had no means of personally controlling your estate—how did that affect your mental quietude?—Well, I am a business man, I suppose, and I naturally resented the position; but I looked on the whole thing from a humorous point of view, because I saw how difficult things were.

8615. You tried to behave as a philosopher?—I think so.

8616. *Chairman*: A laughing philosopher?—Yes.

8617. *Mr. Walter Stewart*: I want to know this: it is alleged that detention is for two purposes: the safety of the patient and other lieges; and also for the purposes of curative treatment. What was the specialised form of treatment which you enjoyed at Moorcroft?—The curative treatment was largely my own, because the head butler, the head attendant, Gray, was favourably inclined towards me, and would give me out of the medicine cupboard or the big medicine room anything that I asked him for.

8618. And you prescribed for yourself?—I prescribed for myself.

17 January, 1925.]

Mr. H.

[Continued.]

8619. Except on the occasion when you were presented with a sedative?—Yes; and when I was desperately ill, after Hale White came.

8620. Now your brother, the petitioner, interested himself with regard to the question of removal to a more congenial atmosphere—was that so?—Yes.

Mr. Walter Stewart: I call for a letter which was written by Mr. E. S. H. to Mr. Steele, requesting that this gentleman should be given an opportunity to be moved to more congenial surroundings. I do not happen to have a copy.

Mr. Croom-Johnson: We will search for this particular letter, if you could give us the date of it.

Mr. Walter Stewart: It would be some time in May, I think, because Mr. H. was moved in June. We can go on while the letter is being found.

8621. *Mr. Jowitt:* Might we just get from Mr. H. what he prescribed for himself?—I had an attendant at that time who was a masseur, and I used a preparation called Elliman's Embrocation, because I had so much pain back and front here. (*Describing.*) This was before the operation. He used to rub me with powder and that embrocation. It is not true that he ever treated me with mercury; because the only mercury that ever came near me was sent by Maurice Craig, and I used it for lighting my fire. I ceased to have any confidence in people. I prescribed for myself in that respect. I had a black draught. Gray used to give me that. I do not think I would have had confidence enough to take anything else.

8622. *Mr. Walter Stewart:* There is a special appropriateness in what you were telling us with regard to mercury. At any time in your life have you ever been subjected to treatment by mercury?—Never.

8623. I ask you that for special reasons?—Yes.

8624. The correspondence not being produced, I pass on. An order, I think, was obtained. Under some authorised procedure you were removed to Ticehurst—is that so?—Yes. I was served with a writ.

8625. And that was on the 8th June, 1917?—No, it was earlier than that.

Earl Russell: I want to know how serving him with a writ led to his going to Ticehurst.

Witness: It was in May some time that the writ was served. Mr. Lovibond telephoned me; Mr. Steele telephoned; it was just before the 18th May. The writer was a fellow with one arm, an old soldier. I told him the facts and said: "I must immediately see the solicitor who has been instructed to act." No one had heard of the suggestion before. Then Mr. Steele telephoned on the 17th May, and came on the 18th himself. He is present here. He was then told by Dr. Stilwell that I was a dangerous case.

8626. *Mr. Walter Stewart:* Who told him that?—Reginald Stilwell. I have it in his proof here. I was a dangerous case. If he was frightened at all, he only had to raise his voice, and the keepers would spring in and protect him.

8627. So it was suggested to your solicitor that you were a dangerous person?—Yes.

8628. So that your independent adviser, as far as you were allowed to have any contact with him, might not also have an independent point of view?—No. The Lunacy Master, Sir David Brynmor Jones, ordered my removal to Ticehurst. I requested Sir David, of whom I knew something and who knew something of me, either to release me or let me attend his court, or, if he could not do either, to send me to a better place.

8629. *Chairman:* May I just interpose for one moment? It is said that your solicitors were informed by Dr. Stilwell that you were a dangerous case?—Mr. Charles Steele was informed in that sense.

8630. I am in a little difficulty about that, because I find a letter of your solicitors, dated 14th May, which says this: "We are concerned for the above named patient" (that is yourself) "and are desirous of making inquiries by direction of the Master

in Lunacy as to whether there is a vacancy in your asylum" (that is Ticehurst). "We may add that the patient is a highly respectable gentleman and occupied a good position in the shipping world. He is not of a dangerous disposition, but it is desired to secure an asylum with better surroundings than where he is at present." I have some little difficulty in seeing how that squares with your statement that your solicitor, Mr. Steele, had been told that you were a dangerous case, because he writes immediately afterwards and says, "He is not dangerous"?—That is because he had several hours' interview with me, and, seeing that the instructions given by the keeper were untrue, he realised that they were untrue.

8631. When you saw Mr. Steele, your own solicitor at this time, and had several hours' talk with him, did you tell him you were perfectly sane and that you ought not to be in a place of this sort?—Certainly.

8632. And did he take no steps?—I told him a good deal more than that. I told him the thing was a conspiracy.

8633. Were you alone with your solicitor then?—Yes.

8634. You were in touch with the outside world and with the means of putting the law in motion then?—I did not know what the law was then.

8635. You believed you were being detained improperly?—I told Mr. Steele and he went to my petitioner brother.

8636. And yet your own solicitor writes and says about you that what is desired is not your release but "better surroundings than he has at present." That does not impress one with the fact that there was a gross wrong being done to his client?—With all respect to Mr. Steele, he had his own interests to consider, of course, and it is a very remunerative thing to have the administration of a lunatic's estate, is it not?

8637. I have never had the pleasure?—Well, Sir, his clerk told me so, anyhow.

8638. You suggest that Mr. Steele, although convinced by you of your complete sanity, nevertheless makes arrangements for your being transferred to a more agreeable asylum?—Mr. Steele went to the petitioner, my brother, and said, "I do not see anything wrong with this chap, and you had better release him," and my brother said "No." You see, there had been a very long standing trouble in my family, which I do not want to go into, and they were determined that I should not be released, and it was no good Mr. Steele trying to release me against the petitioner's interests.

8639. *Mr. Jowitt:* What you say now is that Steele joined the conspiracy?—No.

8640. I have listened to your evidence very carefully, and I attach some importance to what the Chairman is putting to you. I think you ought to realise that you are making a very serious charge against your own legal adviser, if you suggest that in order to benefit himself out of the estate he lends himself to this further detention in the asylum?—No. I say the original arrangement and certification was in the nature of a conspiracy. I think that Steele had all sorts of wrong information before him, and I think when he wrote that letter to the Ticehurst people he wrote it in good faith.

8641. I thought you would mean that?—Of course I do.

8642. *Earl Russell:* I rather agree with Mr. Jowitt. Either when Steele left you he thought you were insane or he thought you were not insane. If he thought you were still not sane, of course, his action was accountable?—I think the powers against him were too great; it was impossible for him to do anything. His proof that I have here suggests that he had been misinformed about many things.

8643. But you do understand the difficulty Mr. Jowitt raises? Here is your own solicitor, instructed by you?—Forgive me; he was not instructed by me; he was instructed by my wife.

17 January, 1925.]

Mr. H.

[Continued.]

8644. Having a long private interview with you, and then going away and not taking action for your release?—He did take action. He went to the petitioner, my brother. That is the easy way. Steele knew nothing about the Lunacy Act, probably.

8645. *Chairman*: One of the things we are much interested in in this Commission is the provision of means of access between patients who are in an institution such as you were in and the outer world, to preserve contact; and a good deal of your evidence is directed to that object. I am rather impressed with some of the things you have told us. For instance, you saw as many of your friends as you liked?—Yes.

8646. Those were people from the outside world. You had a doctor sent down by Mr. Ritchie, and, again, your solicitor sees you, and sees you in private at your wife's request?—But it took about four months.

8647. Be it so. I am impressed with the number of occasions on which there were contacts during the period of this detention between you and the outside world. You were not isolated, were you?—I could give you actually the number of friends who visited me.

8648. How many were there all together?—I am referring to friends outside of the people who were instrumental in putting me in.

8649. Just run down the number you have there.

Mr. Croom-Johnson: I do not know whether the Commission has this list. I have a copy, and I see the witness has a copy of the same thing. It is a detailed list which was got out in one of the litigations for the purpose of showing what the contact with the outside world was.

Chairman: Perhaps you might hand it in; it will save time.

Mr. Croom-Johnson: If you please. (*Handing in a document.*)

Witness: Up to the time of escape, that is between 15th January and 23rd February, I had three outside visitors.

8650. *Mr. Walter Stewart*: Just tell us who they were—whether they were brought into contact with you at your invitation, or how?—There were two boys for whom I am trustee—that was on the 27th December. There was Ritchie on the 23rd. I do not recognise any other.

8651. *Mr. Croom-Johnson*: Dr. McNaughton?—He was a doubtful one.

8652. *Chairman*: Your brother had been the petitioner, had he not?—Yes.

8653. Is that Mr. E. S. H.?—Yes.

8654. I see he came to see you several times?—Yes, it is a statutory duty.

8655. You were on quite good terms with him, evidently?—I had to be. I wanted to keep friends with him, because my keeper told me he would have the power of removing me if he liked.

8656. *Mr. Walter Stewart*: Under Section 72?—Yes.

8657. *Chairman*: So far as that particular brother was concerned, you and he had not fallen out up to that time?—He was induced to take the petition because he had been the most friendly to me and is the one next to me in age.

8658. I merely want to get from you this: Was this brother one with whom you were on friendly terms?—At the time of certification, as far as I know, we were friendly.

8659. He was the brother next to you in age, and he came to see you several times during this period?—Yes, he saw me.

8660. Did you say anything to him about your grievance?—I appealed to him in every possible way, but he got this theory of syphilis and had been assured that I must die within six months, and he did not want to have an unpleasant relative loose in the world. My wife was informed in just the same way. My wife never saw me from October until my operation.

8661. *Mr. Walter Stewart*: Do you know who, if anyone, informed your wife that you were syphilitic?—Yes.

8662. Who?—Dempster.

8663. *Mr. Croom-Johnson*: He is dead?—Yes, I know; but the whole of this trouble arises, if I may put it without traducing the memory of the dead, through having a drunken doctor. I am looking at it after a number of years. I was living in a drunken man's house, and he had an idea that I had information which might be prejudicial. That is as I see it now. Any slander was good enough—any matter to destroy my testimony.

8664. *Chairman*: I could imagine, of course, that it would be a most distressing thing for anybody to be said to be suffering from G.P.I. with the unpleasant implications that that disease has?—Yes; it has broken up my home—it has done that all right.

8665. I am most anxious to appreciate your outlook. On the other hand, one must recognise that doctors may make a wrong diagnosis of a case quite honestly. I am sure doctors are often puzzled by cases?—Therefore they should exercise the greatest care.

8666. Yes. Let us suppose, therefore, that this was a wrong diagnosis in your case, as it seems to have been, because we know you are not suffering from G.P.I. Therefore, it may have been a wrong diagnosis. After all, one must recognise that there is nothing criminal in making a wrong diagnosis. There may be neglectfulness in not making a sufficiently careful examination first of all, but after a most careful examination a doctor may still make a wrong diagnosis?—That is why I honour this gentleman sitting here, Dr. Richardson, who was at Ticehurst. He went most carefully into every detail, and there was not one single thing he or Dr. Newington found that suggested syphilis or G.P.I.

8667. Let us follow that up, because it is a most interesting matter. A doctor called in to a case may be either careless or careful, as the case may be. Of course, his duty to his patient is to make a careful examination before he diagnoses the case?—Exactly.

8668. I think we all know that after the most careful investigation a doctor may err in his diagnosis, because symptoms are often very difficult to identify. Symptoms of one disease simulate the symptoms of another very often, and sometimes a doctor may make an incorrect diagnosis. There is nothing criminally wrong about that; it may have very unfortunate consequences?—In maritime things we have negligence and statutory negligence, and all sorts of different things; and I do suggest it was negligence not to have a series of blood tests taken before accusing a married man of having all sorts of diseases.

8669. It comes to this. You say that a diagnosis of your case was arrived at on inadequate investigation, that there was not sufficient care taken in the preliminary investigation before jumping to the conclusion that you had G.P.I. That is really the whole point of your evidence on this part of the case?—Yes, and, of course, I go a little further. I am satisfied that there was a desire on the part of certain people to destroy testimony.

8670. Let us assume it to be the case, as it has now been established, that you had not G.P.I. It does not follow from that that you were necessarily at that time entirely of sound mind?—I was going to ask you for a definition of "insanity."

8671. If I could give one, I should be a much more gifted person than I could ever aspire to be?—May I put it in a sailor's way?

8671A. If you please?—A man is insane who is a menace to himself or to others, or who is anti-social, and it is only those people who ought to be locked up. Sprigg of "The Lancet" agrees with me. Everybody who has a temperature of a few degrees is certifiable. Our hospitals and our asylums

17 January, 1925.]

Mr. H.

[Continued.]

during the influenza epidemics were simply crowded with patients, who were promptly released, or released after three, four, or six months, if they behaved themselves. I think that came out in the Everett case, a long case which went through three different Courts.

8672. Yes; but I may take it, after we have heard your account of matters, that your real complaint was this, that there was a diagnosis in your case of an exceedingly unpleasant and ill-omened disease, arrived at on an insufficient examination and imperfect data, and that is really the groundwork of your complaint; that there was attributed to you a disease which you did not have, and that was the result of an imperfect or careless diagnosis?—I accept Sir Thomas Horder's view, and particularly Dr. Hugh Munro's view.

8673. But wait a moment. As to Sir Thomas Horder's view, it is recorded for us, fortunately, by Mr. Justice Sankey. What Sir Thomas Horder said about you is this, if one may read it. Sir Thomas Horder himself said that it was "a very suggestive and very suspicious case." That is your own witness.—But you must remember that what Sir Thomas Horder says in the box, having to support his own profession, and what he may tell me, may be quite different things. I can assure you that Sir Thomas Horder said that he would never give a diagnosis of G.P.I. without at least three blood tests, and yet here this thing is done by a man who was not a pathologist.

8674. I should never think of cross-examining you, of course, but I am very anxious to elicit from you the real thing that is in your mind, what you have been suffering from, your grievance?—I have no grievance. I have come here and I have spent of my substance to try to prevent other people from being treated in the same way. The whole thing to me is forgotten in a way. I am an independent witness.

8675. You have come here to tell us that the present system has broken down or is inadequate?—Yes, I am quite satisfied of that.

8676. *Earl Russell*: Still, a wrong diagnosis is a grievance?—Yes. Well, of course, the medical profession really has not advanced at all in the last 500 years, has it?

Chairman: Of course you know also that it is very annoying when your counsel gives you a wrong opinion. A counsel may be mistaken in his view of the law, but you do not say he is a bad man on that account; you merely say he is a badly informed man.

8677. *Mr. Walter Stewart*: It has been put to you by the learned Chairman as to what your grievance is?—I have no grievance.

8678. You say there was a wrong diagnosis. If you had had access to independent opinion and had been told at the time what was the alleged result of the blood test that had been taken, do you think that the diagnosis would have been left undisturbed for twenty-four hours?—No, of course not.

8679. But you had no such opportunity?—I had no opportunity.

8680. Is that your grievance?—I think this secrecy is a dreadful thing.

8681. Do you think that is the overriding and underlying grievance with regard to the whole administration of the lunacy law at the present time?—I am satisfied that is so.

8682. Rightly or wrongly, that is your opinion?—Certainly.

8683. *Earl Russell*: Still, to finish the point the Chairman was putting to you, do you say, apart from that, that you were sane during the whole time you were confined, and were wrongly confined?—I was as sane as I could be with a high temperature and liver disease complicated with pneumonia. When I told the doctor that my father died of a certain disease, that I nursed him and knew the symptoms, and I had exactly the same symptoms as he had, I say that

that doctor ought to have taken that as gospel and worked on those lines, and then he would have found out.

8684. That is not really my question. My question is, apart from this question of diagnosis, do you say you were a sane person wrongfully detained during the whole of your time in the asylum?—I do, most definitely.

8685. *Chairman*: And that the start of the whole thing that resulted in this experience was that there was a diagnosis of your case which was erroneous and founded upon an imperfect and negligent investigation of your case?—Yes.

8686. *Sir Humphry Rolleston*: The question of diagnosis does not enter into it, does it? It might have been left out of the case entirely. The certificate was not based upon that question?—I think that certificate of Dr. Porter Phillips is quite definite which says, "He has the physical signs of G.P.I."

8687. *Chairman*: You might have that and yet not have general paralysis, because you know the symptoms of one thing very often simulate the symptoms of something else?—I think it was a dreadfully wrong thing for him to spend his Sunday afternoon coming down and trapping a poor engineer in a workman's cottage. It was a most deplorable thing. I beg that he should not be allowed to practice outside and do these undesirable things. Here is a man with a big salary in a big place, and he comes out and takes the bread out of other practitioners' mouths, and he does a thing like this.

Chairman: He is a medical superintendent at an institution, and it is suggested that he should not practice outside.

Mr. Walter Stewart: I have not elicited that grievance. It was not in answer to any question put by me. I am so anxious not to occupy Mr. H. too long.

Chairman: I have taken a long time, I am afraid. I was very anxious to get his own view as to what he was feeling himself.

8688. *Mr. Walter Stewart*: I am obliged, Sir. (*To the Witness*): Now let us leave Moorcroft. You were taken, in the circumstances you have told us of, to Ticehurst. You have already once to-day, in this room, expressed your opinion as to the management of Ticehurst. You say that is a place where they tried to be honest?—That is right.

8689. Your experience of the lunacy law being what it is, is it possible for complete honesty to exist with regard to the management of any institution under the existing law, with secrecy as an element?—I would very much doubt it. With due deference to Sir Frederick Willis, I do not think the Board of Control has sufficient power. It has no power to compel a right spirit in these places. I think that his office should be very much strengthened by legislation. They should have a real disciplinary power over these houses of detention. At present it is purely formal.

8690. *Chairman*: What sort of additional powers—more visitation, or what sort of thing do you mean? I want a practical suggestion from you?—If he occasionally were there, and in the case of defective case-books, if he had powers to fine, or where there were false certificates, if he had powers to punish. I think he will tell you that there are not many false certificates, but I seem to have come across a number of them.

8691. *Mr. Walter Stewart*: We must keep strictly to the ambit of the evidence. Now take Ticehurst. Were you in better surroundings at Ticehurst than you had been in at Moorcroft?—Yes; I would like to refer to that. At Moorcroft I was desperately ill, and I requested the management to let me have a proper nurse. That was referred to someone else, and they refused it also at Ticehurst. I found that in the case of all death certificates I have taken out from Moorcroft, of which I have a number, all the attendants at the death of all sorts of nice people were

17 January, 1925.]

Mr. H.

[Continued.]

labouring men. You know the form of death certificate. The man present at death who signed was the most dreadful type of person. I nearly died in Moorcroft myself, and I should deplore at any rate not having the ordinary decency a hospital gives you. These places are merely gaols. I say that Moorcroft was merely a gaol, and I see that many of my letters are dated from "Moorcroft Gaol." That was my way of putting what I found was a fact.

8692. To all intents and purposes that was how you felt yourself situated—as a prisoner?—If there was a distinction it may be indicated by someone else.

Mr. Jowitt: £700 for six months may be one distinction.

8693. *Chairman*: You get board and lodgings free in a gaol, you know?—Yes. I visited Broadmoor. If I had done anything wrong, I would have been very much obliged to one of the Judges to have been sent to Broadmoor rather than to Moorcroft.

8694. Mr. Walter Stewart: If you have committed a crime, there is a judicial inquiry of a true character as to whether you are fit to plead or whether you are of such a state of mentality as to be conscious of the quality and nature of your acts?—Exactly.

8695. You had no benefit of that kind?—I was worse off than a criminal—very much.

8696. What state of health were you in by the time you got to Ticehurst?—On arrival at Ticehurst I was fairly well.

8697. It was in the spring time, was it not?—Yes. I arrived at Ticehurst on the 8th June. It is rather a humorous thing. I tried to get away and I gave my attendants rather too much beer, and the Ticehurst people were very much annoyed to find me turning up with two fellows half tight. There were, in fact, the driver of the motor and two of Stilwell's men.

8698. *Chairman*: All "tight"?—No, the driver was not tight. I did not give the driver any.

8699. You showed your sanity by not giving the driver any?—Hayes Newington was very much bothered about it. He did not like it at all.

8700. Mr. Walter Stewart: Have you a copy of the Ticehurst case book?—It is mostly dealt with in Mr. Justice Sankey's judgment.

Mr. Walter Stewart: I do not know, Sir, whether I might have the original of the Ticehurst case book.

Chairman: It is here somewhere but I really thought we were not going into the Ticehurst matter.

Mr. Walter Stewart: I am not making any complaint. I want the Commission to see what sort of state it was supposed by them he was in.

Witness: This is Dr. Richardson's diagnosis which was entirely favourable to me.

8701. *Chairman*: Was he a doctor in Ticehurst?—He was second to the chief who died.

Chairman: Let us have what Dr. Richardson found out about you.

Mr. Dickens: It is in Mr. Justice Sankey's judgment.

Mr. Walter Stewart: I am asking for the Ticehurst case book.

Chairman: The case book is here somewhere, I believe. We asked for it to be brought here. The Ticehurst people have all gone away now because we understood that nothing was wanted from them.

Mr. Jowitt: The case book is quoted verbatim in Mr. Justice Sankey's judgment.

Mr. Walter Stewart: Would you be good enough to refer to the judgment of Mr. Justice Sankey, if that is a verbatim quotation from the case book?

Chairman: Yes. There is an entry by Dr. Richardson which is quoted.

Mr. Walter Stewart: I think it commences "There was no evidence of general paralysis of the insane." That is what I am seeking to put before the Commission.

Chairman: The passage begins with this, does it not? "This gentleman is of somewhat full habit of body; he has the appearance of a person who has

'lived well.' The eyes are blue, the left pupil is more dilated than the right and is oval in shape, neither is quite circular; both react to light and accommodation. No tripping or slurring is noticeable in his speech; he can pronounce test words and sentences quite well. On closing his eyes and his lips tightly no tremulous or uncertain action of the muscles is seen. Neither of the knee jerks is active and the left is the least so. The pulse is 72 per minute and regular; on auscultation a systolic murmur has been heard in the aortic area. The liver dulness is not increased. The lungs are resonant on percussion and on auscultation the sounds are normal. He walks slightly lame on the right leg." It does not say anything about paralysis in that passage.

Mr. Micklem: Mr. Johnson, in what action was this list made out?

Mr. Croom-Johnson: In the County Court action brought by the witness against my clients.

Earl Russell: That was for the loss of the use of the sitting room, was it not?

Mr. Croom-Johnson: Yes.

Witness: I know it quite well.

8702. *Chairman*: It merely is a description of your physical appearance?—I think there is more than that.

8703. And also certain physical tests that were applied to you?—Yes.

Mr. Walter Stewart: Now, with regard to that I desire to put in evidence any admitted specimen of the handwriting of this gentleman at any date between his admission to Moorcroft and the time he escaped from Ticehurst in August 1917, because that is supposed to present the indication of the existence of general paralysis of the insane. That is one of the things that is looked at in a diagnosis.

Witness: You want some letters?

Mr. Walter Stewart: Your own handwriting at this period.

Mr. Croom-Johnson: We have got any amount of them.

Mr. Dickens: We have got them in the summer or the spring.

Mr. Walter Stewart: Very well, then they will be produced.

Mr. Croom-Johnson: Before we leave this, I think there is present in the room a copy of the Ticehurst case book entries, if the Commission would like to look at them or if my friend would like to look at them. There is an entry on the 13th June, 1917, which contains the entry with regard to his physical condition.

Chairman: Is it by Dr. Richardson?

Mr. Croom-Johnson: This is by Dr. Newington who was the licensee of the Ticehurst establishment.

Chairman: The representatives of Ticehurst have left this morning on the basis that nothing was to be said about it. I understand that the witness, Mr. H., is proposing to say nothing about it but merely to say what was the state of his mind. If the case book entry is an example of their impression of his state of mind, I think we should have it for that purpose.

Mr. Croom-Johnson: This is a complete copy and it was used in the action in which Mr. Justice Sankey gave judgment.

Chairman: If it is a complete copy of the Ticehurst case book, then it can be made available to Mr. Stewart and to us.

Mr. Croom-Johnson: Yes. It is complete.

Chairman: Of course if there is any passage which you think would be useful to us, will you defer it for cross-examination.

Mr. Walter Stewart: I am quite content if I understand that my friend will use it in cross-examination.

Mr. Croom-Johnson: Of course it is no part of my case. I happened to know that it was in the room and I asked for it.

Chairman: It is merely to assist us all, Mr. Croom-Johnson—I quite appreciate that.

17 January, 1925.]

Mr. H.

[Continued.]

Mr. Croom-Johnson: Yes. You were speaking about what was his physical condition and this is simply an entry as to his mental condition. In order to see from the two what the mental condition was, may I read it? It will probably save time.

Mr. Walter Stewart: If my friend is going to make it part of his cross-examination—

Mr. Croom-Johnson: No, it is not part of my case.

Chairman: Mr. Stewart has asked Mr. H. to produce what Dr. Richardson said about him and what Dr. Richardson entered about him in the case book.

Mr. Walter Stewart: We are assuming that this is a correct copy.

Chairman: I have accordingly called for a copy of the case book, in order that I may look at the whole as recording the impressions that were formed of you while you were in Ticehurst by Dr. Richardson and Dr. Newington who were observing you. I shall therefore look at the whole document and not at a part of it only. Do you wish me to put to Mr. H. some of the other passages in it?

Mr. Walter Stewart: If the whole of it is before us, I am satisfied.

Chairman: If it is all here we can look at it and it will save time.

Mr. Walter Stewart: May I have it in a moment?

Chairman: Yes, certainly.

8704. *Mr. Walter Stewart (to the Witness):* I think it discloses that shortly after your admission you again had a relapse and fell ill with jaundice and pneumonia. Is not that so?—Yes, so it is diagnosed.

8705. I think you suggested that a surgeon should be sent for who was to be chosen, I think, by your friend, Sir Watson Cheyne?—Yes.

8706. I think you are making no complaint that that was not done?—No notice was taken of my desire.

8707. But some days later did they bring a surgeon from Tonbridge by the name of Footner?—Yes, Mr. Bulkley Footner.

8708. By the time he arrived were you in a very critical condition with a high temperature?—I think so.

Mr. Walter Stewart: Can you tell us the date?

Chairman: Really I must abbreviate matters. This chapter of the case is not to be opened. This gentleman has no grievance about what happened there, and it does not seem to me to bear upon the real critical matter he is bringing to our cognisance. It is quite a separate matter altogether and it does not really help us.

Mr. Walter Stewart: What I did want to get was this. Our case is divided into four heads. We have dealt with certification. I did want to get in connection with this the element of detention.

Chairman: But we cannot have that with regard to Ticehurst. I understood you acquiesced in the position that so far as Ticehurst was concerned the detention was lawful, but that it all proceeded from an initial mistake as to what was found to be wrong with the patient.

Mr. Walter Stewart: But it was more than that—protracted, because there was no access in a convenient form to an authorised representative who could have gone to Ticehurst and convinced the authorities that a mistake had been made.

Chairman: I think you will agree with me that we have been taking the case very fully. I think you should pass from that.

8709. *Mr. Walter Stewart:* If you please, Sir. (*To the Witness*): At any rate, you had no independent representative at Ticehurst prior to your operation or subsequent thereto?—No—no medical representative.

8710. You were operated upon when in *extremis* and you survived the operation?—Yes.

8711. And as soon as possible after that time, was your wife permitted to see you for the first time since certification?—Yes, my wife had been kept away by some letters.

8712. Now that being so—there being no complaint against Ticehurst—with regard to the Board of Control, did you at Ticehurst seek to obtain any redress from the Board of Control?—At Ticehurst I saw a Commissioner named Trevor.

8713. Did you write letters to them?—I wrote very few, because I had given up the Board of Control as a forlorn hope.

8714. Was notice taken of the letters you wrote?—Occasionally you would get a sort of printed thing saying: "We have received your communication which shall have attention."

8715. You never wrote to the Lord Chancellor, did you?—Oh yes, rather.

8716. With what result?—I wrote to them all. I wrote to the Judges I knew. I wrote to my friends in Scotland Yard, and particularly to the Home Secretary, who at that time was Cave, I think, whom one knew something about. I understand they were received at the Home Office, but they were simply put away.

8717. Have you heard at all of the Health Committees under the Ministry of Health?—No, it is rather since my time.

8718. Now you say you obtained no satisfaction from your correspondence with the recognised constituted authorities; and then, I think, shortly afterwards Dr. Newington died and Dr. Richardson was left in charge of Ticehurst. Do you know whether any communication was made by Dr. Richardson to Captain Bell, a friend of yours?—Yes.

8719. Is Dr. Richardson here?—Yes. I suppose we are allowed to speak about Ticehurst?

8720. Not by way of complaint, but as to what he said about you?—Captain Douglas Bell swore that he had talked to Dr. Richardson, and that Dr. Richardson said: "Oh, there is nothing wrong mentally with H., but, of course, he is recovering from an operation." I think Dr. Richardson rather doubted that, but it was certainly confirmed by Dr. Richardson's wife, with whom I was fairly friendly.

8721. He was, of course, in a position in which he had to act with great caution?—Yes, he was only the second. Newington was the autocrat, and I do not think Dr. Richardson had much power there, really.

8722. You are not in any way blaming Dr. Richardson, as I understand it?—No.

8723. As far as you know at that time there was no independent judicial authority functioning in that way to whom you could appeal?—I was seen by a magistrate called Dixon and a doctor, who were official visitors in connection with the justices.

8724. Tell us about that, in order to see how far the machinery assists a patient in that way?—That was very interesting. These two men came into my sitting-room, and they said they were visitors under some Act of Parliament, so I said: "Well, I wonder if you have got the Act with you, because I have been looking for it a long time," and they said: "No, you are not allowed to have the Act." Then I said to Dixon, who was the magistrate, and who really was the person who counted—I do not think the doctor was official, but he came there to advise Dixon—"I escaped from that place in Moorcroft, was out for four days, was able to look after myself; cannot you give me a release? I am able to look after myself. I have been very badly injured; I am ruptured; I require proper surgical treatment and better medical attention. Cannot you manage to clear me up?" and these two fellows smiled and walked out.

8725. They took no notice?—They took no notice; in fact, one of them was here giving evidence the other day.

8726. Which one?—He was the man who acts for East or North Sussex—Fawcett. He said he never had had a complaint. It was untrue, because I certainly complained very bitterly.

8727. We were not in a position to cross-examine, you see, although we knew that fact?—At present

17 January, 1925.]

Mr. H.

[Continued.]

there is no means. If your family want to keep you in, I do not think they dare release you, and I think Sir Frederick Willis will bear me out in this: that his instructions from his Department are that the medical officer of one of these places is not to release without the petitioner's consent; it is contrary to the Statute, but I am told that instructions have been given—true, it is on the authority of the discredited Dr. Munro, but he said he received such instructions.

8728. *Earl Russell*: Instructions given by whom and to whom?—By a man called Dickinson to Dr. Munro.

8729. *Mr. Walter Stewart*: When Dr. Munro was controlling a private establishment?—He said so.

8730. *Earl Russell*: Instructions to superintendents of private establishments?—Yes. It is confirmed by another man who is running a private establishment that he is not recommended to put a patient out on the doorstep, unless he has got somebody to take him away, but he has done it.

8731. But I understood you to say just now that the Board of Control had issued instructions that a private patient was not to be released unless the petitioner consented?—No, I do not think you got me right. There are two people at the Board of Control; Sir Frederick Willis is the official controller, but the secretary is what the Americans call "the big noise" there; and it is he who whispers instructions in the ears of people. I am satisfied that the Board of Control are rather too anxious to support the licensee against the patient, whereas their duty is to look after the patient and to protect his interests. I speak with some experience of it, and that is what I found, with all due deference to Sir Frederick Willis.

8732. You say these are unofficial instructions then?—Quite unofficial.

8733. But the instructions are that a patient is not to be released even if he is sane?—That is what Dr. Munro said. That is one of the reasons why he gave up his licence.

8734. *Mr. Jovitt*: That comes direct to you from Dr. Munro?—That comes direct to me from Dr. Munro.

8735. *Mr. Walter Stewart*: Of course you know the provisions of Section 83 with regard to the giving of notice of recovery of a patient?—Yes.

8736. As far as you know was any notice ever given by anybody anywhere of your recovery?—Oh no, that would have been contrary to the spirit of the thing.

8737. Let us come straight to the point. When did you escape from Ticehurst?—I escaped on the 28th August.

8738. How soon after that did you submit yourself to a medical examination so that your mental condition should be checked?—I had had McNaughton, and when I was visiting friends in Tunbridge Wells I went to three different doctors there and consulted a solicitor on their advice. I told these three doctors the same story: "I am supposed to be paralysed; I have had a big operation; do you think I can get back into work again?" and they all with one accord (not having the pathological record which I begged them to inquire into then, because Dr. Newington told me something about this) gave me a clean bill of health; and the night I escaped I went to Dr. Allen up in Hampstead and Allen sent in his report to my solicitors. The consequence was that Dr. Richardson was up there the next day looking for me.

8739. *Chairman*: You had provided a clue yourself?—Yes.

8740. *Mr. Walter Stewart*: By that time you knew about Section 85?—Yes, I knew the whole thing then.

8741. Is that the easiest and most expeditious way for a patient who has any money,—to escape, if he is wrongfully detained?—I have specialised in escapes.

8742. That is your deliberate opinion on personal experience?—Yes. If my friend, Maurice Craig, had not died, we should have had half-a-dozen out by this time.

8743. *Earl Russell*: Had you more money this second time than you had on the first occasion?—I got £10 from my club; I had got £12 in hand.

8744. *Mr. Walter Stewart*: You had the good fortune to be known as a member of a London club, where they would cash a cheque?—Yes. I bought two cheques there for 2d. each.

8745. *Sir Humphry Rolleston*: When did Maurice Craig die?—Did I say "Craig"?

8746. Yes.—I meant Drake—Maurice Drake; he died about a year ago.

8747. *Mr. Walter Stewart*: To show your personal anxiety, as soon as you had the opportunity to face the music, did you voluntarily submit yourself to a spinal puncture in order that a series of Wasserman tests of your blood might be taken?—You see getting into these places is easy, but getting out you have got to have all sorts of sworn documents; and Sir David Brynmor Jones, who is Master in Lunacy, insisted on blood tests and insisted on sworn statements from the doctors—quite different things from what you go in on—casual sort of documents. He realised my state almost at once. He said to me, "There has been gross contempt of Court here."

8748. With regard to what?—With regard to this escape. I said "Do you call it contempt of Court escaping?" I said "It is the legal way of getting out. It is the one legal way in which you can get out without perjury."

8749. Who took the tests with regard to the Wasserman reaction that was sought to be obtained?—A Scotsman. Sir Frederick Mott told me he was the best man in London—at the London Hospital.

8750. Was it Dr. Spitta?—Harold Spitta did the first one.

8751. Are those certificates in existence?—Yes.

8752. Were they filed with the Master in Lunacy in order that you might be enabled to recover control of your estate?—Yes.

8753. And with the dossier of the Master in Lunacy they will be found, if that is found?—That dossier is very interesting. I think you ought to have it, and I think you will be amused at the difference in the affidavits before escape and after, my family being anxious to keep me in when Sir David took over the estate.

Chairman: I am afraid I cannot call spirits from the vasty deep. If the thing does not exist I cannot get it.

Mr. Walter Stewart: Surely it must exist; it could not have been destroyed. I ask that a search should be made, because it contains, among other things, the opinion of Dr. Crichton Browne and Dr. Munro. These gentlemen went into it directly after his escape, and I want you to find that he was of mental normality while he was at Ticehurst, and that Section 83 ought to have been put into operation.

8754. *Chairman*: I am told, as the latest report, that a search is being pursued in the Master's office, and I hope the dossier will come to light. One can do no more than call for it and try to get it; they are making a diligent search for it. If it is recovered, it will be put before us. Might I say just one word to you, because I am quite sure you do not want to exaggerate things. You said that the only effective way of getting out of asylums nowadays is to escape, but you must remember that statistics show a recovery rate at present of about 30 per cent. of persons who are discharged recovered?—Who should never have been put in; most of those people were simply toxic cases. I would like to have from Sir Frederick Willis how many wealthy people are discharged.

8755. Do you suggest that no one recovers and is discharged from an asylum who has been quite properly detained, and that his only way out is to escape?—No; the statistics show that a great many wealthy people are not discharged.

17 January, 1925.]

Mr. H.

[Continued.]

8756. You do not want to overstate the case?—Not at all, but I do say that there is a tendency, if there are big fees attached to it, for a man to be hung up in these places.

8757. *Mr. Walter Stewart*: On that point, are you prepared, if the Commission think it useful, to express your personal view with regard to what is the difficulty, for instance, with the medical superintendent in the matter?—The difficulty the medical superintendent has in discharging?

8758. Yes—in availing himself of the power that is ultimately with him more than with anyone else. What is the difficulty as far as you know?—I think if the medical superintendent is pressed by the relatives to keep a person in, of course the tendency is for him to obey the demands of the relatives. He has got the legal formula for detaining the person and the relatives do not want that person out.

8759. *Chairman*: This observation would have no application to pauper cases, which form the great majority of cases in public asylums?—I have only visited pauper cases in Devon, at some of the local places.

Mr. Walter Stewart: May I say it is a different difficulty there.

Chairman: I merely wanted to make it clear that this gentleman's testimony to-day relates only to private institutions, where there may be pecuniary or patrimonial interests involved.

Mr. Walter Stewart: I am not suggesting it is wickedness, but people do not like insane relatives brought home, if they are alleged to have been syphilitic.

Witness: They are very anxious to avoid the stigma of insanity. I do not know why there is a stigma, but there is a dreadful one.

8760. *Chairman*: We are hoping that something may be done to mitigate that?—I hope so.

8761. *Mr. Walter Stewart*: You say there is a stigma?—Yes.

8762. You are a man of fair means and good social position. Since you came out have you ever been conscious of a different attitude on the part of your various acquaintances and friends towards you from that which they assumed before you were certified?—

I think the difficulties of living in a small village are rather great. One always has to have a solicitor employed because the voice of slander goes about. One is always being troubled with objectionable people. Of course you get slander in any small village, but it is more marked where a man has been subjected to the indignity I have been subjected to.

8763. It is difficult to conceal, if you have been certified?—I have never concealed it. There is nothing to be ashamed of.

8764. It was not your fault?—No. I think it is a very grave thing and I think it should be removed.

8765. Since you escaped and were certified to be of sound mind have you devoted a great part of your life and a great deal of your private fortune to an attempt to bring about a reformation in the law as it exists?—I have done everything I know. I have myself been a petitioner.

8766. You have no motives whatever of an interested character except to try to prevent other people suffering as you have suffered?—I should be very glad if I could do that.

8767. We know that lunatics have neither a vote nor control of their property?—That is so.

8768. There is just this point in order to show that a mistake may be made. Immediately after your escape, is it a fact that in the case book at Ticehurst the entry with regard to you was that you were discharged on the 8th June, 1917, "not improved." Is that the record that exists in that case book regarding you to-day?—That is the record in the case book and I suppose with the Board of Control. My solicitors wrote to the Board of Control and said: "There have been so many slanders about my client that I suggest there be an apology or that the details be altered because it is untrue."

8769. *Chairman*: I do not think we can go into a question of that kind. Your point is really as to the formula, that in this case you had escaped and you resent the official file saying that you were discharged "not improved"?—Yes.

8770. *Mr. Walter Stewart*: Of course you were well enough off to get an independent opinion?—Yes.

Chairman: We cannot go into the Ticehurst point, without some explanation from them.

Cross-examined by Mr. H. C. Dickens.

8771. I gather from you, Mr. H., that in your firm belief you have never departed from sanity during the whole of this time?—I have said that I have never been in any way a menace to myself or others, or insane.

8772. I gather you were always anxious to get out of these institutions and to regain your liberty?—Yes.

8773. It would naturally be to your interest to keep a careful guard on your words and actions, so as not to give anybody the impression that you were mentally deranged, would it not?—Yes. I had to adopt a humorous style in dealing with things because they were such frightfully dull places.

8774. A humorous style, but no style that would suggest any sort of derangement?—I think not.

8775. What puzzled me was that you wrote a few letters during this period. One was on the 23rd of April to Dr. Cole and others. Dr. Cole is the gentleman about whom you told us that the less said the better, and that you accept nothing he said. But I take it you will accept the fact that you wrote to him a letter dated the 23rd April, 1917, addressed from Moorcroft Asylum to Jack Stilwell, J.P. Mr. Stilwell, Senior was not a gentleman you knew very well, was he?—He was the licensee. He never was there, but the keepers all called him "Jack." We were all a happy family in that way.

8776. He was an elderly gentleman. How often had you seen him?—I think I saw him in the kitchen once.

8777. "Bill Ashton, J.P." He was the Justice of the Peace from Uxbridge?—Yes.

8778. That is Mr. William Ashton, whom you had only seen on one occasion?—Yes; he was the ex-grocer.

8779. "Bob Cole, M.D."; that is Dr. Cole, is it not?—Yes.

8780. The gentleman about whom the less said the better?—He was the gentleman against whom I had the slander action.

8781. And "Tom Petterson, M.R.C.S., Dublin"?—Yes.

8782. This is the letter written in these terms to Robert Cole: "I have warned you to be most careful as to your statements *re* my mental health. I find that you have been to my brothers and misled them, and it will be up against you later on to eat your words. Two of the highest Harley Street specialists gave me in writing an absolutely clean bill of mental health on the 24th February, and yet you are fool enough to stultify yourself." Now what does that mean?—That was referring to my visit to Dr. McNaughton.

8783. Who was the other one?—I did not go to anyone else, or to any other doctor.

8784. I think that Dr. McNaughton lives in Lower Belgrave Street, as a matter of fact?—I do not know where he lives.

8785. So Dr. McNaughton alone is what you describe as the two Harley Street specialists?—I know how that came about—there was somebody else with him in the room.

8786. What, in Lower Belgrave Street, Eaton Square?—No; that is where Bob Cole lives, is it not?

8787. I do not know?—I cannot remember the addresses.

17 January, 1925.]

Mr. H.

[Continued.]

8788. That is the address at which Dr. McNaughton lived. It was somewhere in the neighbourhood of Eaton Square or Pimlico, was it not?—Yes.

8789. And those are the two highest Harley Street specialists—they gave you an absolutely clean bill of mental health. I understand from you that what Dr. McNaughton gave you was a certificate that you were fit for light work?—I should say that was the best certificate. That is a clean bill of health, is it not?

8790. Would you describe that as a clean bill of mental health?—You must not take it too literally.

8791. "And yet you are fool enough to stultify yourself. It must have been the fault of the She Hun that bore you." Do you think that amusing? Do you think that a reason for mirth?—In the light of my researches about this man, I think he was a deplorably bad man.

8792. "Your behaviour *re* my wife's letters proves you to be nothing better than a corpse boiler. Don't come near me or there will be trouble. (Signed) W. H. Certified a lunatic by an ex-grocer."—Do not you think there is an element of humour about that?

8793. Perhaps you will point it out to me?—You will remember this man had been slandering me. He had told my visitor Ritchie—

Mr. Dickens: We will come to that in a minute.

8794. *Mr. Walter Stewart*: He had told your visitor Ritchie what?—That I was syphilitic. "But do not tell him or he will have a fit."

8795. *Mr. Dickens*: Did Mr. Ritchie allege that Dr. Cole had made some sort of statement about you on the occasion when Mr. Ritchie went down to visit you at Moorcroft?—Yes, on two occasions.

8796. On two occasions on the same day?—Yes, in the train going home. You have seen the pleadings, have you not?

8797. Yes. Did you commence an action for slander against Dr. Cole?—Yes.

8798. Was that action tried?—No.

8799. Was the action dismissed for want of prosecution?—I had to abandon it because Ritchie became ill and I could not prove my case. I had to abandon it under counsel's advice.

8800. At all events the action was dropped?—Yes, it was dropped. It cost me £600, but I got some valuable information.

8801. Then did you write another letter to Dr. Cole on the 9th May, 1917?—Yes; I objected to that man very much.

8802. Is it addressed to "Bob Cole, M.D."—"Dear Cole, I have just had a wire from the Kaiser to submit to you his new design of shako for the new corps Kadener Tollerin Legiment 67 st Antim 4 that he is raising for you to commence, known in English as the Body Boilers' Corps." What are they?—I think this is just an imaginary thing. This is a jest that was got up by the keepers.

8803. "That he is raising for you to commence, known in English as the Body Boilers' Corps. Kindly suggest any alterations after fitting the cap, and it does fit. Perchance Jack Stilwell or Bill Ashton can help you. Yours, (Signed) W. H." What is this jest about body boilers?—You will remember that certain people started the idea that the Germans were making glycerine from boiling down human bodies.

Mr. Dickens: Tell us about Dr. Cole and the body boilers.

Mr. Walter Stewart: Let him explain.

Mr. Dickens: I understand that I have got exactly half an hour to finish my cross-examination of Mr. H.

Witness: These letters were written at a time when one was under considerable irritation with this man. He was a very offensive chap. He married a Hun wife, and all the keepers in that place hated him. They used to come round and say, "Let us give

him a new helmet" or something. It was a very dull place. I am not sorry I wrote those letters. I should write them to-day.

8804. *Mr. Dickens*: I do not understand why you call him "Bob."—Everybody called him "Bob."

8805. Do you call most people by their Christian names?—No, I do not.

8806. "Bill Ashton," "Jack Stilwell."—Yes.

8807. These letters were addressed to them, you know?—Yes; they were carrying on a dishonest business. I was not going to call them "Esquire."

8808. That is your way of qualifying the dishonesty?—Yes.

8809. Was this a good joke in your opinion to send these letters by post a few years ago? (*Producing the same*).—Yes. It was a very suggestive thing. Do you understand the symbolism?

8810. To whom did you send them?—I do not know; I sent them to several people.

8811. To a lot of them? You sent one to Dr. Porter Phillips, did you not?—I hope he liked it.

8812. And Dr. Percy Smith and several others?—I sent them to several others.

8813. You sent many others—unsigned—I think they have "the best wishes of a village in Devonshire"?—I do not know. They knew who they came from. You know it is a symbolic way that sailors have of describing what they think is rather a bad business, and it is a bad business.

8814. I want to know with regard to the other medical gentlemen in this case?—Whom do you represent?

8815. I will answer that. I represent Dr. Percy Smith and Dr. Porter Phillips.—Did they get these letters?

8816. They did.—Did they like them?

Chairman: I do not think that is a proper question.

8817. *Mr. Dickens*: Tell me about these two gentlemen. I do not understand whether you make any allegation against them. Do you allege against them that they made these certificates in your case fraudulently, knowing that they had no business to make them?—I am glad you have mentioned that. The three people who certified me have admitted that they were sent down to certify. They admitted that to Dr. Munro, when he went round to see them.

8818. Perhaps you would answer my question without any reference to Dr. Munro, who, I understand, is not willing to give evidence here?—He may be.

8819. Perhaps you will tell me what you think yourself. Did those gentlemen, in your opinion, give those certificates fraudulently, knowing that they had no business to give them?—If you read the certificates in the way a critical man does—

Mr. Dickens: Cannot you answer?

8820. *Chairman*: I think you must answer that. It is a question put to you quite straightly. Do you think these are dishonest certificates?—I certainly think so now.

8821. *Mr. Dickens*: You have said so before, have you not?—I think so now, in view of what has transpired since in a number of cases.

8822. You have accused Dr. Percy Smith of giving a fraudulent certificate in some other cases, have you not, in conjunction with your friend, Dr. Munro?—I took this thing to "Truth."

8823. Did not both you and Dr. Munro accuse Dr. Percy Smith of giving a fraudulent certificate in the case of a man called B.?—In the case of H. B.

8824. Was not that matter tried out in a suit for nullity of marriage?—It was the most disgraceful thing that ever happened.

8825. What was the result of the trial?—I have a docket here—

8826. The fact is that the result of the judgment in that case justified the certificate that Dr. Percy Smith had given?—I think that certificate should never have been accepted. I think it is an absolutely dishonest certificate.

17 January, 1925.]

Mr. H.

[Continued.]

8827. And the judgment?—And the judgment. I think from what B. has told me and what his poor wife has told me that it was disgraceful.

8828. And the judgment was a dishonest judgment, possibly?—Are you suggesting things?

8829. I want to know what you suggest. Who was the Judge?—Mr. Justice Shearman.

8830. At all events, Mr. Justice Shearman decided that the certificate was a proper one?—No; he did not decide it was a proper one.

8831. We know the name of the case?—It was a disgraceful case.

Mr. Dickens: It was *B. v. B.*

Mr. Walter Stewart: Is it reported?

Witness: I have all the details.

8832. *Mr. Dickens:* Dr. Cole gave evidence in the case, and was cross-examined?—Of course he did. He is one of the gang.

8833. Let us know who the gang are?—That I would rather not say.

8834. Perhaps you would be good enough to tell me, because you must. Is Sir Maurice Craig one of the gang you alluded to?—Yes. I do not think the people connected with Bethlem do work in a gang.

8835. And Dr. Percy Smith?—Yes.

8836. And Dr. Porter Phillips?—Yes.

8837. And Dr. Cole?—No, he is not; but he is so objectionable.

8838. Is he one of the gang?—No.

8839. Is Dr. Stoddart one of the gang?—Yes, he is one of them.

8840. Dr. McNaughton, in the light of what you have heard this morning and the report he made in your case, do you suggest he is one of the gang?—No.

8841. He is an honest man?—He acted according to his lights; he acted under instructions.

8842. And honestly?—Stilwell is one of the gang; but I do not like his methods.

8843. Are there any doctors with whom you have been brought into contact in this case, except Dr. Munro, who are not members of this gang?—I told you I have many relatives who are doctors.

8844. Are any of the doctors with whom you have been brought into contact in this case, apart from your relatives and Dr. Munro, members of the gang?—I think you have already heard me speak of Dr. Richardson.

8845. He is not a member of the gang?—No, he is an honest man.

8846. But not a member of the gang?—No.

8847. I understand this gang exists for the purpose of getting people into asylums by fair or foul means?—No, that is not so.

8848. What is it?—They work in a series. One instructs the other to go down and certify, and they work round in a circle of that sort. They all have their special houses which they feed. Dr. Percy Smith has got a very good house; he put his own wife and sister-in-law there. I have met the sister-in-law. They work in a series supporting these places. Medical men should not do that kind of thing.

8849. Do you mean that these gentlemen are sending people to asylums for the purpose of putting money into one another's pockets? Is that the suggestion?—I say that a medical man has no business to do this sort of thing. It is a priesthood, and they should have nothing to do with the corrupt practices of business.

8850. Will you kindly tell the Commission whether you suggest that these gentlemen are sending people to asylums with a view to putting money into the pockets of their relatives?—I say they are supporters of vested interests, and they live by putting people in and taking them out. Now you have mentioned one eminent gentleman, I would like to show you a cheque of his. You may like to see it.

8851. I do not want to see it. I have quite enough questions to ask you; but if you have anything you would like to put forward, I will not stop you.—You will get them one day, perhaps.

8852. *Mr. Walter Stewart:* What was the name connected with the cheque?—There were two people. I think perhaps we had better leave it, then.

8853. *Mr. Dickens:* You understand, do you not, that Sir Maurice Craig, as he now is, Dr. Stoddart, Dr. Percy Smith and Dr. Porter Phillips all expressed a view—whether it was honest or not—during this month of December, 1916, that you were suffering from the symptoms of the early stage of general paralysis of the insane?—Yes.

8854. You know that, do you not?—Yes; they all follow one another. It is the etiquette of the medical profession. You do not understand the etiquette of medicine.

8855. I do not understand anything like as much about it as you do; but I do not want to go through all those certificates; it is waste of time. I want to get the facts. You agree that all these gentlemen were agreed with one another in their diagnosis whether it was an honest diagnosis or a dishonest diagnosis?—There is some sort of evidence that they were sent down to do a certain thing, and they faithfully did it; they did it very well.

8856. And they all purport to agree in their diagnosis, you will agree with me there, whether it was honest or not?—I say it was dishonest.

8857. But you will admit the fact that they all agreed?—That is quite likely.

8858. And that subsequently Dr. Cole, Dr. McNaughton and other doctors in this establishment came to the same conclusion, whether honestly or dishonestly I do not know.—Dr. Richardson did not.

8859. That was later. I am talking about this winter. Is it not also the fact—I am sorry to have to put these things to you—that your own wife appeared to be under the impression that you were mentally deranged at this time?—I do not want to say anything that would traduce the memory of a doctor that I am very fond of—I have some medical friends who are honest people—and that is Dr. Hayes Newington. My wife's statement to me is that Dr. Hayes Newington invited her to write that letter, and when it was brought to my knowledge I was furious about it, and I got hold of her and said, "Who told you to do this?"

8860. May I first of all put to you what she did say, otherwise the Commission will not understand. This was written on 12th June, 1917. "Dear Dr. Newington,—Very many thanks for your kindness in writing to me re my husband; he writes me twice since being with you and seems very pleased with everything. Any details you can give of his condition I shall be grateful for. Is there any chance of his ultimate recovery of brain power? I just want to tell you that I have for some years past had a very trying experience with him, and since the war twice or thrice my life has been in danger, so that I have quite lost my nerve. He writes me he wants to come down and see me here. I take it this would not be allowed." Your wife did write that?—Yes, she wrote it, and since, when it was put to her, she wrote to Mr. Steele, my solicitor, and said that it was untrue. I was ill at the time.

8861. This is the result of a plot between her and Dr. Newington?—No, I do not say that. Newington was very anxious to collect information to entitle him to retain me as a prisoner.

8862. *Chairman:* I noticed this letter, and it strikes me as rather a serious matter?—Mr. Justice Sankey dealt with that.

8863. You and your wife, no doubt, were on excellent terms, and as you say you had had some serious illness; but when a lady writes about her husband that her life has been twice or thrice in danger, and that she has quite lost her nerve—if that were true, it would be very serious. Are you suggesting that your wife was not telling the truth when she wrote that letter?—She admitted it. She wrote to my solicitor to say that it was not true.

8864. Why do you think she would write what was not true about her own husband?—My wife's mind

17 January, 1925.]

Mr. H.

[Continued.]

had been very much poisoned by the stories that I had been unfaithful to her and had acquired syphilis, although we were always devoted friends up to this time. She was prevented by letters of Reginald Stilwell from visiting me.

8865. All that I can understand as possibly altering her attitude, but it does not seem to me to refer to a matter of fact?—Might I put something in writing to you which will explain it?

8866. If you please. But I am on a very simple issue; it is merely whether she spoke the truth or not?—She admitted she spoke a lie.

8867. Why should a wife want to tell a lie about her husband?—Shall I put it in writing?

8868. Yes. Take a sheet of paper, if there is anything you do not want published. We do not want anything brought out in public that is distressing to you. (*The Witness wrote an answer and handed it to the Chairman.*)

8869. You do not want this handed round, of course?—Quite so.

8870. *Mr. Dickens*: Now I just want to get one or two admissions which I think I can get from Mr. H. (*To the Witness*): Dr. Maurice Craig, as he was then, you had seen on a number of occasions?—Yes; I looked on Craig as a faithful friend.

8871. He had been attending you, in fact, from January, 1915, on and off?—No; I used to go up to his consulting room when I was in town, have a talk with him, and come away.

8872. At all events, it was he who suggested the blood and spinal fluid test which was subsequently taken?—He it was who suggested to me that it was a remedial test, and I permitted it.

8873. Do you suggest he said it was a remedial test?—Yes, absolutely. I should certainly never have permitted a searching of my body in that way, otherwise, knowing that I had never had an infection of that kind.

8874. Do you suggest that he told you it was going to cure you?—It was remedial.

8875. Of what?—He told me afterwards that there was a good deal of pressure in the spinal column, and they had found the pneumo-cocci in the spinal column.

8876. What were you suffering from?—The gall sac just *here* had been injured on a ship down at Dover, and this thing used to swell up and bind the starboard lung.

8877. We do not want to go into details about this. All I want to get is that Sir Maurice Craig told you that what Adler was going to do was to cure you of this trouble, whatever it was?—Yes.

8878. Then you also saw Dr. Stoddart, and you had an interview with him on the 20th November?—Yes. Dr. Stoddart is a man in a very much higher social position than the rest of these men. He was extremely pleasant. He told my medical adviser that he never had such difficulty in certifying in his life, so my medical adviser said: "Why certify?" He said: "Because I was told to."

8879. Are you again alluding to Dr. Munro?—Yes, I am; he is an honest man, mind you.

8880. *Mr. Jowitt*: Munro or Stoddart was honest?—Munro.

8881. *Mr. Dickens*: Stoddart was honest, was he not?—I have had trouble with Stoddart.

8882. I gather that all these gentlemen went out of their way to tell Dr. Munro of this dishonesty?—No, not dishonesty. They said they were sent down to do it. I was Craig's patient, and they had to help him. There is a considerable revenue from these things.

8883. A considerable revenue?—There is a considerable revenue to be derived from the incarceration of people in these places.

Mr. Dickens: I do not know whether you heard that, Mr. Chairman?

Chairman: No, I did not.

8884. *Mr. Dickens*: He says there is a considerable revenue to be derived from the incarceration of these people, I gather, and therefore they do not look upon it as dishonest?—It is business.

8885. When they certify patients they are sent to certify?—That is the position.

8886. I am bound to ask you this about your interview with Dr. Percy Smith on, I think it was, the 9th December, when he certified you and gave one of the certificates to which you take such exception. You have not, I think, given us the whole of that interview?—Well, he came into my room—

8887. Just answer the question. Have you given us an account of the whole of that interview?—I am not sure. There may be something else.

8888. I am afraid the details are extremely offensive?—It is always so in the gang's certificate. They always put in something offensive so that no decent person can face it—no decent woman, anyhow.

8889. *Chairman*: The question we are considering now is whether there was sufficient investigation by this doctor before he gave the certificate, the certificate to which you take exception. The question put to you is, have you told us all that passed between you and Dr. Percy Smith, or was there more?—I think there was more.

8890. That is all Mr. Dickens is asking up to date. If there was more, can you tell us what more did pass, or is that the matter which Mr. Dickens says is unpleasant?—I should be delighted to hear it. I expect it would be something very unpleasant, from what he says.

Chairman: I am in your hands, Mr. Dickens. You know the audience we have here. Are these matters which should be brought out?

Witness: They are not true.

8891. *Mr. Dickens*: The details are extremely unpleasant and offensive. May I put it in this way: Did you notice that Dr. Percy Smith was taking down your remarks in shorthand at the time?—He is a very clever man.

8892. *Chairman*: Did you notice he was taking them down in shorthand?—No, he was not doing so. If he says so I do not believe it.

8893. *Mr. Dickens*: This is the transcript of the shorthand notes?—He is a legal expert. He is always knocking about the Courts. I see him always there every day when I am up there.

8894. *Chairman*: Who is Dr. Percy Smith?—A little chap with a beard.

8895. He is not here?—We know him.

Mr. Dickens: I am going to put to the witness something which Dr. Percy Smith says he said to him.

Chairman: I understand you are going to call Dr. Percy Smith who is going to produce his contemporary shorthand notes of what passed at this interview. (*Witness*): Do not you accept them, Sir.

Mr. Walter Stewart: At present the evidence of the witness is that they were not made in his presence, and therefore could not be produced in any ordinary judicial proceedings, either as evidence which was brought to the notice of the witness or as a note made at the time from which the witness could refresh his recollection, if at the time they were made. At present my friend has laid no foundation for the production of these notes in evidence.

Chairman: He could not very well have laid any foundation, except this, that he is going to bring a witness who is going to prove the notes and who says he took the notes at the time.

Witness: But do not you believe them, Sir. The room was too dark, for one thing, at the time. I had been asleep. He came in and told me that he was a heart specialist, and he is an intolerably untruthful man.

Chairman: You are apparently going to prove it yourself?

8896. *Mr. Dickens*: I must put it to him, Sir. There is a suggestion against Dr. Percy Smith that he took no trouble in this matter. (*To the Witness*):

17 January, 1925.]

Mr. H.

[Continued.]

Did you tell him that you had a nervous breakdown in October, 1914, after the beginning of the war?—We have had all this. This is the certificate.

8897. Do please listen: "Says he had a nervous breakdown in October, 1914, after the beginning of the war, had had a very strenuous year. Says his assistant had joined the Army." You will stop me when it is untrue?—Yes.

8898. "Says his heart has been a trouble to him the last year or two, it wakes him up just when he is going to sleep, it flutters or races or stops, it is regular now. Had just been having a sleep (3 p.m.). Says he does not sleep more than about four hours. Thinks this is because he has been to sea. Had a nervous breakdown at Teignmouth. Says he was in a hotel and was put in a nursing home by the local doctor or Dr. Dempster. Says he has got a cut on the arm (shows a scar)." Did you show him a scar?—Yes, I have a small scar.

8899. "Before going to the nursing home which was called Hermosa. Thinks it was a very rummy place. Says he was put in charge of four men, three of whom were infernal blackguards, they were temperance male nurses. Says he has left one 50 guineas in his will, he was a good one, says that this one told him that Jenkins, another attendant, was not doing right by him. Says he got 'every vile delusion that a man could have.' Thinks this was produced by drugs. Thinks he was very violently and improperly treated. Says Dr. Dempster used to go down to see him. Says that Jenkins had a filthy disorder and that he could smell it." Did you tell him that?—Yes, that is in the certificate, I think.

8900. "Says 'the dirty —' "—I think I will pass this—May I see it? (*Document handed to Witness.*) I will see whether it is true or not.

8901. You see where those pencil marks are? Will you just read that and say if it is true. The members of the Commission, I am afraid, will have to read it.—(*After reading*) This at any rate is true.

8902. You said that?—It was true that these things were done, but I did not say it to him. It is a mixture of a statement of Dempster and his.

Mr. Dickens: Will you hand that to the Chairman, please—(*same handed to Chairman*).

Mr. Walter Stewart: May I see it also?

Chairman: Certainly. (*Document handed to Counsel.*)

8903. *Mr. Stewart (to Witness):* You will notice it says, "Says—" so and so. Whether that is a contemporaneous shorthand note you will judge.

Chairman: Yes.

Witness: This is very largely untrue. This is in the nature of the unpleasant certificates that are given.

8904. *Mr. Dickens:* "Thinks the treatment in that place was vile. Says that on four occasions he removed pieces of surgical dressing from the meat-pies. Says it has all been taken down in the last two years because he feels it is a matter of personal honour that these matters shall be put right even if he dies; does not want to take any action himself at the moment. Says he was seven-eight months in the home."—That is untrue.

8905. "Thinks the treatment improved from the moment Dr. Craig saw him at Teignmouth. Now has been here since 11th October. Dr. Craig has kindly seen him from time to time, also has seen Dr. Newton Pitt about pneumonia. Says he is bothered about his heart, but is really rather indifferent. Laughs a great deal. Says his wife was married twice, and her first husband did not consummate; he had phthisis, and told her that she would be very well off."—That is a lie.

Mr. Dickens: "But it was not clean money and she should use it for charities."

Mr. Jowitt: That is quite untrue?

8906. *Mr. Dickens:* Have you ever said anything of that sort?—No, I am not in the habit of discussing things of that sort. I disliked the man so much. He could not have written the shorthand.

8907. Did you or did you not say this to Dr. Percy Smith?—Certainly not.

8908. "Says his house in Devonshire is an ideal home for soldiers and sailors. Says it is her idea to turn the house into a hospital. Thinks his wife was vilely treated. Has a strong desire to get back to Brighton to his flat and his wife. Says she drinks at times." Did you tell him that?—No, certainly not.

8909. *Mr. Jowitt:* May we be told if the part about the hospital is true?—The part about the hospital is true to a point, namely, that during the time I was at Ticehurst I certainly did make designs for something of that sort for amusement; but I discussed nothing with Dr. Percy Smith.

8910. *Mr. Dickens:* There was some truth about the hospital, but it is mixed up with somebody else?—Yes—this is all Dempster.

8911. "Says his property, which became his and his wife's in 1913 on his aunt's death, has been stolen from them by his first cousin, Bill H. Says he 'jumped' their claims with his brother's consent."—That is true.

8912. Is Mr. H.'s name "William"?—Yes.

8913. Did you mention Bill H.?—I do not know. I called Dempster "Bill," always.

8914. Did Dr. Smith know him as "Bill H."?—I did not discuss it with him. This is all Dempster.

8915. "Says he 'jumped' their claims with his brother's consent. Thinks this is all frightfully amusing, so that their claims are much curtailed and made more expensive. Says Bill H. has spent on his and his wife's property about £2,000, and has 'crabbed their claim.' Says he feels weak and crooked, but does not know when he has been so well mentally; now finds he can write very freely." That is all, I think.—I am glad you have read that, because that is so typical of the man. I think it is very fine and good evidence.

8916. You did not like Dr. Percy Smith at all?—No. I was only with him quite a few minutes.

8917. You got a very bad impression of him from the start?—Yes, I disliked him.

8918. That is not exactly what you told us this morning?—I have a shorthand note being taken, and that will show.

8919. With regard to Dr. Phillips, he was a charming man?—Yes.

8920. And he was also one of the gang?—He has left them now.

8921. He gave an untrue certificate in your case because he was sent down to do it?—It was grossly untrue.

8922. It must be a dishonest certificate?—Yes.

8923. He says he took you in his car to Moorcroft at your request. There is no suggestion that you were taken off by stealth. You asked Dr. Porter Phillips to take you in his car?—No.

Mr. Walter Stewart: I formally object here to what my friend has put in the form of a question. "You were taken by Dr. Phillips to Moorcroft at your request." The evidence of the witness is that he never knew he was being taken to Moorcroft, but that he was told by Dr. Phillips that he was being taken to Dr. Phillips' house, and yet my friend, having heard that, puts that question in that form. I ask you not to allow it, Sir.

8924. *Mr. Dickens:* I will put it to you again, Mr. H.?—I did not.

8925. Did you ask Dr. Porter Phillips to take you in his car?—No, certainly not.

8926. You did go in his car?—It was not his car.

8927. Was the only stipulation that you made before you went to Moorcroft in the car that you should take your monkeys with you?—No, it is quite untrue.

8928. Did you take your monkeys with you?—I took a small cage with two monkeys.

8929. You took no winter clothes, but you took your monkeys?—I packed up everything I had, but somebody forgot to put them in the car.

17 January, 1925.]

Mr. H.

[Continued.]

8930. *Mr. Jowitt*: The monkeys were in the car?—These little things were in the bottom of the car.

Chairman: Have you any questions, Mr. Croom-Johnson?

Mr. Croom-Johnson: I have a great deal to ask this witness about several matters, if I am to go into everything, but I am wondering about the time, and whether I could be of any assistance to the Commission.

Chairman: Just remind us for which particular party you appear.

Mr. Croom-Johnson: I appear for Dr. Stilwell. The accusations, as I understand it, against Dr. Stilwell are first of all that he is one of the gang, and secondly that the result of the escape was that this witness was improperly confined and in improper quarters. These are two of the points.

Mr. Walter Stewart: I do not know whether you will rule now, Sir, at this stage, whether that document which is being circulated amongst the members of the Commission is admitted by you in evidence. It is alleged to be a note, denied by the witness, taken in his presence or communicated to him, and I submit it is not admissible at this stage at any rate as evidence in this case.

Cross-examined by Mr. Croom-Johnson.

8931. *Mr. H.*, I want just to see where we are about some of these matters. The action which was tried by Mr. Justice Sankey was in respect of the Ticehurst place?—That was an action brought by me against Ticehurst.

8932. In that action, as I understand it, your complaint was that you ought to have been released earlier by the Ticehurst people?—That is on the pleadings. That is one of the things.

8933. That is really what the fight was about when it came to trial, was it not?—No. The reason why that thing went to trial was this. We wanted evidence, and we wanted as much untrue evidence as we could get. We wanted to know exactly the condition of lunacy as it stood in the Courts. It really was only £200 that it cost.

8934. I have read, and I suppose we have all read, the judgment of Mr. Justice Sankey, and it proceeded apparently on the basis that your claim against the doctors was a claim in negligence, because they had not taken the proper steps and ought to have released you before?—That is the substance of it; that is the pleadings.

8935. Somewhere about the same time you were in litigation with my client, Dr. Stilwell, were you not?—I had put him in the County Court, yes.

8936. And in Dr. Stilwell's case your complaint against him was that he had improperly deprived you of the benefit of your sitting room at Moorcroft, and as a result ought to repay to you money which had been paid to him upon the basis that you were entitled to the sitting room?—Yes; grave overcharges was I think the general charge.

8937. You made no complaint against Dr. Stilwell in the action against him that he had been guilty of any negligence, or ought to have let you out?—I think my counsel suggested that. As a matter of fact the action was brought to obtain documents in the slander action against Cole.

8938. The action was brought in the Uxbridge County Court, and you sued Dr. Reginald Stilwell; and Mr. Steele, the gentleman of whom we have heard, was the solicitor who acted for you in those proceedings?—Yes.

8939. And was the accusation there that you had been deprived of the use of your sitting room for a certain length of time and certain necessities, which you said were provided by you in order to supplement what you said were insufficient supplies?—Yes, that is in the pleadings.

8940. You made no complaint in that action that Dr. Stilwell had done anything that was wrong, other than with regard to the sitting room and the food?—I do not think you are right there.

Chairman: No, it is not proved yet.

Mr. Walter Stewart: That is what I mean. Unfortunately it has already been circulated. I am sure that if it is not ultimately proved, the members who have seen it will dismiss it from their minds.

Chairman: Mr. Dickens' duty was to put it to this gentleman, because if he was going to prove ultimately what was a contemporaneous note it would have been most important. Therefore it would be very unfair to have let Mr. H. go away without putting it to him.

Mr. Walter Stewart: I am not complaining at all. It may remain in your custody with pleasure as far as I am concerned.

Chairman: Mr. Croom-Johnson, you were telling us about your position.

Mr. Croom-Johnson: That is my position. Charges, and very definite and deliberate charges are made against my client, and I must cross-examine about them, but it is now half-past four, and the intention was expressed this morning of rising at that time.

Chairman: At all events we would all sacrifice a further half hour to finish the case.

Mr. Croom-Johnson: If you please, Sir.

Chairman: We have the pleadings here.

8941. *Mr. Croom-Johnson*: In that action did your two brothers give evidence on your behalf?—My two brothers were called by me.

8942. Were you represented by a leading counsel of considerable experience, Arthur Powell, K.C., and a junior counsel? Was the action heard by His Honour Judge Scully at some length? Did your two witnesses go into the box and acknowledge in the proceedings that they were entirely satisfied both with the terms and with your treatment?—Yes, untruly.

8943. And did the learned Judge say in giving judgment that he would say as little about it as he could, but that in his opinion the action was one which ought never to have been brought?—He did, on the testimony before him.

8944. And was your complaint in that case about the non-use of the sitting room substantially the complaint which you have put before the Commission here to-day, that you were put into this other room with a number of other patients?—That is what I strongly objected to; it was an infamous thing to do.

8945. That is that part of the proceedings. Was that the room which you have characterised at my client's premises as, I think, the last room but one?—Yes, the last from the roughest.

8946. Is that a large apartment, comfortably furnished, with carpets, smoking-room chairs, periodicals, pictures, large unbarred windows—five large unbarred windows—overlooking the garden?—No, that is not true; they are barred windows. You cannot open them more than about that much—(describing).

8947. That is a photograph of one end of the room, is it not. (Handing photograph to Witness)?—Yes, that is right. This is the place we used to hold divine service in, which I stopped. It is a beautiful place—lovely! I should like you to be there.

8948. Now dealing with the place generally, it is a large house, is it not?—It is a big rattle-trap building of about five different periods.

8949. A real old-fashioned house with large grounds?—Yes, well walled.

8950. Of 13 acres?—Yes.

8951. A park?—No, a cricket ground.

8952. I do not propose to proceed any further with that, unless the Commission think that I can give them any further assistance about it. Now just tell me this. During the time you were at Moorcroft you were visited repeatedly by different persons?—Yes, we have a list of them, and I agree with the list.

17 January, 1925.]

Mr. H.

[Continued.]

8953. We both, I think, have the same list. Is it right that you were visited during the time you were at Moorcroft no less than nine times by Sir Maurice Craig?—If you say so, yes. I do not think it is nine, is it? Have you counted them?

8954. I have counted them.—Very well

8955. Were you visited by both your brothers?—Yes.

8956. Were you visited by Dr. Hale White?—Yes.

8957. We have not heard about him?—Of course, he was the one who saved the operation in the first place.

8958. Were you visited by your partner in business, Mr. Burls?—Yes, he took out letters for me.

8959. And altogether during the five and a half months that you were there, were no less than 43 visits paid to you by people from the outside world?—I have dealt with this.

8960. Would you mind giving me the number? You may object to my expression "the outside world." In this list of outside persons who paid you visits there are in fact 43 visits in about five and a half months, other than the persons who were connected with actually running the home?—Outside of officials, of friends there were about 12, I think, not 43.

Earl Russell: We have got the list.

8961. *Mr. Croom-Johnson*: If you please. (*To the Witness*): As I understand it, you make no complaint at all against the attendants at this place so far as regards the way in which they waited upon you personally?—The attendants behaved quite nicely.

8962. So far as Dr. Stilwell is concerned, you have been good enough to say this afternoon that Dr. Stilwell is one of the gang?—Yes.

8963. Were you on terms of considerable friendship with Dr. Stilwell?—I was on terms of considerable friendship with Dr. Stilwell?—I was on terms of considerable friendship up to the time of the escape, when he started doing the dirty.

8964. Not after?—No

8965. Did you persistently write him letters addressed "My dear Reggie"?—Yes.

8966. Even after the escape?—Oh, certainly.

8967. And you were accustomed not only to write to him very lengthy letters, but also to other persons?—My letter book is really a diary; that is the way I look at it.

8968. Just let us see what state you were in after the escape and had come back again. Is that one of your letters, addressed to Dr. Stilwell, "My dear Reggie" (*handing letter to Witness*)?—Yes.

8969. I am only going to read this one out of many dozens as a specimen of the letters which you wrote. It says: "My dear Reggie,—As I am not writing to Control or other of my distinguished pals, I am going to give you a treat. As usual, there are several things I wish to draw your kindly attention to." Then you made statements with regard to other persons, attendants, which I do not propose to read. Then you discuss the waste arrangements to the bath, and, suggest the application of buckets of boiling caustic soda. Then you say this: "The whole system must be rearranged after the war, and lots of other things, old chap. Why not float this place as a limited company (you will not then have all your eggs in one basket)? I will write 66, Victoria Street"—did you know what was to be found at 66, Victoria Street?—Yes, that is the Board of Control.

8970. "I will write 66, Victoria Street, and get permission, and perchance plant some shares on the unsuspecting Commissioners"?—You are spoiling the market.

8971. Did you know—before I read the rest of the letter—that an application was being made for your transfer to another home?—At this time?

8972. Yes?—What is the date of that?

8973. 7th May, 1917?—Yes.

8974. Let us see what you say about that application in your letter. "I am quite sure the Lunacy

Master won't be able to dispense justice at 11 a.m., Tues. 8th, without my assistance. Remember £50 a week is a large sum for even a certified insane marine engineer. So we will all go with a luncheon basket on the top of the car. Perhaps Brynmor Jones will let us picnic in his court. I know all the attendants and can arrange to have a few palms put round the corridor end in west wing. I used to go and worry the Treasury Solicitor in the happy days beyond recall about damages by merchant ships to warships; their office is near Jones P.C., so I will take you in and introduce you. I wonder if you could find a nice snug corner here for my brothers Herbert and Richard, one large bedroom and that s.w. sitting-room affected by Major ——. They will want most favourable summer terms, three months certain. Both troubled with delusions. (*Coliana*) (*Maurice Craig's patients*). Were they patients of Sir Maurice Craig?—Oh, yes; they paid him 100 guineas. They were patients all right.

8975. "If you keep me much longer here I shall want to get married again." Then there are some expressions which I do not propose to soil my lips by reading. "Apparently reading between the lines C. recommends the mixing of the sexes in these sanatoriums and the sterilization of one of the parties, etc., etc., then a long quotation in Latin which he cut out of Malthus. Bob's native language is 'Lithuanian Hunn.' Kind regards to Mrs. Reg and the family. You and I are a pair. Cheer up, Reggie—Yours ever, W. H., R.N.R."?—Yes.

8976. I want to ask you just one question about this. I do not want to put it offensively at all, but in face of letters of this description, would you say it is impossible for anybody to take the view that yours was, to say the least of it, a doubtful case?—Do not you think that is a humorous letter? It is not a madman's letter. There is nothing mad about it. It is simply amusing.

8977. *Mr. Walter Stewart*: What is the date of that letter?—7th May, 1917.

8978. *Mr. Croom-Johnson*: I want just to clear up one little point. Mr. Steele, you have told us, was your own solicitor?—No.

8979. He had acted as your solicitor?—No, he was not my solicitor until after my escape.

8980. Had you confidence in Mr. Steele?—I knew nothing of him. He was a very useful man to know.

8981. You have told the Commission that you were served with writs in this place. Did Mr. Steele first of all come down and serve you with a notice of application under Section 116 for the appointment of a receiver of your property?—A writter came down—a man who serves writs.

8982. Was this document an application under Section 116, the document which you refer to when you talk about writs being served upon you?—I daresay; I cannot say definitely.

8983. Was that on the 30th April, 1917?—Yes.

8984. A few days after that did Mr. Steele himself come down to see you?—Yes, on the 3rd May.

8985. Did you understand from Mr. Steele or from the document which was served upon you what the application was that was being made?—I had instructed my wife to make the application.

Mr. Jowitt: What was the application?

8986. *Mr. Croom-Johnson*: It was an application under Section 116 for the appointment of a receiver, on the ground, of course, that this gentleman was incapable of managing his own affairs?—No, no; do not put wrong constructions upon it; that is not true.

8987. How many times do you think you saw Mr. Steele?—Three times at Moorcroft. I do not know, Sir, what sort of suggestions are made against Steele. He is a perfectly honourable man.

8988. *Chairman*: There is no suggestion made, as I understand. Mr. Croom-Johnson is asking you whether Mr. Steele is a solicitor of repute in whom you have confidence?—He is my brother-in-law's agent.

17 January, 1925.]

Mr. H.

[Continued.]

8989. *Earl Russell*: The only suggestion I have heard against Mr. Steele is your own?—I say nothing about Mr. Steele.

8990. *Mr. Croom-Johnson*: You discussed this matter with Mr. Steele and perfectly well knew the grounds of the application?—Yes.

8991. I suggest to you that at that time, and indeed at all times as far as Dr. Stilwell is concerned, you were not taking the point as against Dr. Stilwell that he ought to have seen that you were released from this place?—This action was an effort to get release, and a very costly one. I think that application cost me £1,100, but it was worth it to get out of this place.

8992. I just want to test your recollection about this by one other fact. You have told the Commissioners that after your escape when you were put into this general apartment at Moorcroft the food was different?—Yes.

8993. I must call evidence about this?—Why trouble about it?

8994. Do you know in fact that the food was identically the same, except that it was served at a different time from the food you had when you were in your own room?—That is quite untrue. Of course, with regard to that beautiful photograph of yours, you ought to have the patients in there as well. It is not really complete.

8995. You put that upon me. I suggest to you that the patients in that room were about six or eight, and that some of them were not as ill as you were yourself?—That is untrue.

8996. That they were all of them gentlefolk?—It is untrue.

8997. That when you were brought back from your escape you were not stripped, but that you were searched?—I was stripped to my under-things.

8998. Not entirely stripped. By whom?—By Potterton and some man in the oak room.

8999. That you were visited in this very room by your brother, the petitioner?—No.

9000. And also by Sir Maurice Craig?—No. I insisted upon my petitioner brother going to the place to see what sort of a place it was, and he unfaithfully reported as to the condition.

9001. He reported on oath in the County Court action that it was a perfectly proper place for you to be in?—It was so much perjury. The perjury in my own family is perfectly vile.

9002. Your brother was called by you or by your own counsel as a witness?—I had to call somebody. It was an action to get information so as to prosecute Cole. I would like to put in Reginald Stilwell's letters to my wife, but they are perfectly abominable.

9003. *Chairman*: Before you re-examine, Mr. Stewart, I want to add one fact. (*To the Witness*): As you know, we have called for the file of the papers relating to various litigations you have had?—Yes.

9004. There is one we have got the papers of, an action by you against Dr. Dempster, to whom you referred, do you remember?—Yes; Dr. Dempster's action has only just been settled.

9005. It was an action brought in 1923, I see, and I understand you have a decree for a sum of money against him?—No.

Mr. Croom-Johnson: Dr. Dempster's action was discontinued.

Witness: I got an offer of a settlement, and it necessitated my withdrawing any charges I made against Dr. Dempster.

9006. *Chairman*: The action I have before me is one in the King's Bench Division, and it appears to be between W. H. and William Thomas Dempster?—Yes. He owed me a large sum of money, and he pleaded the Statute of Limitations. I had not the means to carry on earlier, and the Statute barred me.

9007. But it is not for that purpose I am referring to it; it is because of what is stated in the pleadings.

I understand that your claim was in respect of moneys which he had obtained from you while you were staying with him?—Yes.

9008. Now here is the paragraph that I must say caught my eye when I read the pleadings: "When the plaintiff made the several payments referred to in paragraph 5 hereof he was not in a fit state, physically or mentally, to appreciate the nature of his acts." Is that true? Were you "not in a fit state, physically or mentally, to appreciate the nature of your acts"?—My counsel drafted those things.

9009. On your instructions?—Dempster had been all the time saying that I was not mentally right, so that was put in to make him say the other thing, really. Mr. Batt, who drew the pleadings, is here. It was put in to find out what this man really meant.

9010. This was a statement made to the Court in the claim submitted to the Judge, and I understand it was made on your instructions. Do you say it was not a sincere statement?—I would not go as far as that, but it was a statement to draw a denial, as I remember it, but I would rather ask counsel. He is here. I should certainly have objected to it if I had known of it.

9011. It has been my duty to look through those pleadings, and that caught my eye?—I think counsel was very much influenced by the fact that he wanted to avoid the Statute-barred thing. I understand that if a person is insane the Statute does not run. I think it was a little piece of chicanery; I do not know.

9012. It struck me when I read it as being a remarkable statement in the case?—It is tactics, rather.

Mr. Walter Stewart: Might I look at those pleadings, Sir, in case I desire to put a supplementary question? Of course, it is clearly understood by the Commission what this is. This is not evidence, and in pleadings alternative and mutually destructive averments are put in very often.

Earl Russell: One generally assumes they are to be supported by evidence in the box.

9013. *Mr. Jowitt*: May I ask: Whilst you were at Moorcroft a considerable number of people, you have told us, came to see you?—Yes.

9014. Some of them were your own personal friends?—Yes.

9015. One of them is a gentleman I know very well—Mr. Burls?—He did everything he could to get me out.

9016. Did these people take any, and if so what, steps to secure your release from Moorcroft?—The Rev. F. W. Sandwich visited me once or twice and consulted a solicitor, and did everything he could to get me out, because he was quite satisfied that I was sane. None of the people I met on escape noticed that anything was wrong. Mr. Burls went so far as to go to my brother and say, "I have known H. all my life," and he said, "It is a perfectly wicked thing to say that he is insane." Mr. Burls would confirm that. It is a criminal libel to suggest that a man has got that disease. But you see my family desired my incarceration, and on the Master's docket I think you will find why it is so.

9017. None of them seem to have written to 66, Victoria Street?—I think they left it all to the expert. Maurice Craig is the "gaoling" expert, and he worked the whole thing.

9018. These are the counter-espionage people; these are the anti-Maurice Craigs, and except for the fact that one of them wanted to consult a solicitor, they do not seem to have taken any effective steps to get you out?—I was in touch with Paley Baildon, and Baildon could not make head or tail of it. He took the view that the whole thing was fraudulent, and he has dealt with the matter very, very strongly in opinions and so on since. He was satisfied, as all my friends who saw me were, that there was nothing abnormal about me. With regard to the documents that our friend here has read, anything of course in a mad-house is under suspicion.

17 January, 1925.]

Mr. H.

[Continued.]

9019. Did you notify anybody after you had escaped finally from Moorcroft as to where you were?—Yes; I had my friend Wylie.

9020. Did you communicate with any of the official bodies, the Board of Control, or anybody?—One of my friends sent them a humorous telegram, or something of that sort.

9021. Is this the telegram—did you help to compose it?—I think it was a general composition.

9022. I will just read it: "H. found dead in bed this morning. Deny report. My cooking brandy cause relatives (sic). No inquest. Bury in garden with your permission. Pushen."—I remember something about it. I think it was sent by Charlie Wylie, who was a painter, but he thought it was a good idea to hide up everything and bury me in the garden.

9023. You see we may have our own views about whether it is funny or not; but as you were alleged to be insane, does not it occur to you that it was not a time at which you ought to indulge in sending this sort of telegram to the Board of Control?—I did not send the thing. This thing was a joke

around a table in a restaurant. They said, "I am sure the Board of Control will be interested to hear about it."

9024. It is handed in at 8.30 a.m. on the 23rd February, which is the date of escape?—Yes, I remember it.

9025. *Chairman*: There cannot have been a restaurant meeting before 8.30?—I was in a restaurant; I was in St. James' Restaurant. It is opened about 7 o'clock, and I had got on the telephone to some friends.

9026. *Mr. Jowitt*: Where were the friends coming from?—They came from St. John's Wood.

9027. And they met you at breakfast?—They came down, because they did not know where I was.

9028. It is a time of day when most people's humour is not at its brightest?—I think it was a mistake, but we looked upon the whole thing as so dishonest that nothing could make it worse.

9029. I candidly cannot see why it makes you send humorous telegrams?—I have said I did not send it.

Re-examined by Mr. Walter Stewart.

9030. I do not want to occupy time over small matters, so I pass from the humorous telegram, so long as it is understood that it was not your production. The humour was that of somebody else?—Yes. I did not want it to be sent, but it was sent.

9031. Now with regard to this pleading, I think I ought to go into that, as the learned Chairman has been impressed with it. Paragraph 5 alleges that from time to time during your stay in the house of Dr. Dempster, he asked you to supply him with money, and that you did supply him with no less a sum than £1,203. That is not stressed as evidence of insanity, although of course it was a sign of great confidence at the time in Dr. Dempster. Just recall to mind the period at which he plied you for these loans. What was your state of physical health and your temperature at those times?—Those loans were doles that were handed over, as I had money. I was physically not too well; mentally I was all right.

9032. Can you recall at any of the periods when you were pressed to advance these sums, whether your temperature was other than normal?—I cannot say that; it is so long ago.

9033. You were a sick man at the time?—Yes.

9034. What was the nature of the sickness?—Trouble with the gall.

9035. And suffering as you were from some disturbance in connection with the gall bladder, was your temperature from time to time affected by it or not?—Yes, one gets a bit toxic.

9036. Being toxic, as you put it, would you be at that time in your normal mental condition with regard to clarity of mind, or what was your mental condition, quite apart from lunacy?—I think I was sick and not too well.

9037. Does the body, when the temperature is not normal, sometimes re-act temporarily upon the mind?—Yes, I should think so.

9038. And was it with that in view that you authorised paragraph 7 of this pleading to be drafted by Mr. Batt, who sits here, and who is in a position to accede to or contradict it, if any question is raised?—Yes.

9039. I have sought to put that explanation. If it is pressed any further there is the explanation. I am only going to take you through one or two passages. With regard to the alleged shorthand notes, which are alleged to have been made at the time, I would like to draw your attention first of all, in order that the Commission may be in a position to see if it is what it purports to be, to the form of it. As for the intrinsic character of this, which pretends to be a shorthand note made at the time—that is how it is put forward—look at it. "Says he

was cut on the arm." "Says he was put in charge of four men." "Says he left 50 guineas in his will." What say you? Supposing this had been a genuine contemporaneous shorthand note, alleging something that you had yourself said, do you, as far as your experience of such matters goes, think it would have been in that form, or that it would have been in *oratio recta*, especially as I am reminded it was taken in shorthand?—It is an untrue thing.

9040. I think I can show on the face of it that it is. This purports to be the family history: "Said to be nil." That obviously was communicated by someone other than yourself?—Yes.

9041. "Previous history." Was Dr. Dempster acquainted with your previous history?—He never was my medical attendant until I went to stay with him in June, 1915.

9042. And at that time had he your confidence?—No. He attended my wife. I did not care about him.

9043. But he had been in contact with your wife?—Yes.

9044. He was present in the house on the occasion of this gentleman, Dr. Percy Smith's visit?—Yes.

9045. And Dr. Percy Smith had access to him?—Yes.

9046. As far as matters that are in this strange document are concerned, I call your attention and that of the Commission to the fact that very few of them appear in the certificate of Dr. Percy Smith as being matters which he had personally observed concerning you?—Yes.

9047. As regards facts communicated by others, I call the attention of the Commission to this passage, that somebody, and that must have been Dr. Dempster, says that you were restless and garrulous. So that Dr. Dempster was telling Dr. Percy Smith that you were a great talker?—Yes.

9048. You had talked a great deal to Dr. Dempster, had you not?—I had very few occasions to talk, because I was alone mostly, with the exception of a nurse; and when anyone came in one was fairly chatty.

9049. It is always difficult to see ourselves as others see us, but tell me, as far as you are aware, was your mental condition on that occasion when Dr. Percy Smith came the same as it is to-day, or was it different?—I think that as regards my mental condition, I was perfectly alive to everything. I was certainly a sick man.

9050. Of course you had just recently been suffering from a somewhat serious physical sickness?—No doubt.

Mr. Jowitt: Would you get this from him: I appreciate that he did not say any of this to Dr. Percy

17 January, 1925.]

Mr. H.

[Continued.]

Smith, but he said he did say a good deal to Dr. Dempster. I have not got this in my mind, and I want to know it. Did he say to Dr. Dempster at some time or other the substance of what is in that statement, particularly that part of it which was handed to the Chairman to be read?

9051. *Mr. Walter Stewart*: Is it present to your mind?—Yes.

9052. The learned Commissioner desires to know this: Did you ever say what is actually there, either to Dr. Dempster or to Dr. Percy Smith?—No, certainly not.

9053. *Mr. Jowitt*: I do not mean the actual words, but the substance of it?—The substance of it, in some respects, I believe I have said to Dr. Dempster.

9054. *Mr. Walter Stewart*: With regard to what you said to Dr. Dempster, you may tell us what it was you said to Dr. Dempster on that point with regard to the attendant whose name I think was Jenkins. Repeat again, if you will, what it was you said to Dr. Dempster about Jenkins. Was there anything you then said that was not fit for publication?—No.

9055. Then say it?—This man had to use a thing called a catheter, and I thought it was an extremely risky business. I think no attendant is allowed to use that instrument except the doctor is present, or something of that sort.

9056. Use it on whom?—On me. They had been giving me a drug called paraldehyde; it is a thing to make you sleep, and that produces a difficulty—I think doctors will correct me if I am wrong—in natural function.

9057. And that being so, a catheter had to be utilised?—Yes, and the catheter was not sterilised.

9058. Was lint used in connection with the use of that instrument?—The catheter was not sterilised, and that was the danger. It should never be used except by a medical man.

9059. Was lint at any stage of that attempted operation a necessary adjunct?—I think so.

9060. Was some reference made by you to Dr. Dempster with regard to that service which Jenkins was required to render you, as to the use of the catheter?—Which he should not have rendered but which he did.

9061. Was that what you mentioned to Dr. Dempster?—I think so.

9062. Is that the true nature of the communication relating to that matter which you made to Dr. Dempster?—I think so.

9063. By the time it has filtered through to Dr. Percy Smith it has assumed this disgusting form, and you are saying what you tell us on oath, with the knowledge of what it was Jenkins wanted to do?—Yes.

9064. Now just follow that up. You had an objection to Jenkins using that instrument upon you?—Yes.

9065. Why had you that objection with regard to Jenkins?—I thought he was an infected man.

9066. And that is the foundation of all this filth?—Yes.

9067. Is that a fair sample of the way in which, according to you, these statements were—

Mr. Jowitt: The other detail about walking up hill you might want, Mr. Stewart.

9068. *Mr. Walter Stewart*: I am greatly obliged, Sir. (*To the Witness*): Will you refer to that matter and explain it, if you desire to do so, to the Commission?—Yes. I think on our looking into the drug accounts and things at Teignmouth, my adviser was very much concerned about the drugs that were used, and he thought very improper drugs had been used; and they certainly had on me, a man who had never had to use any drug, an extraordinary effect, and I think any hard physical exercise did bring about some condition of that sort, due to the extreme use of those drugs. I think that is true. I might have discussed it with Dr. Dempster, never with Dr. Percy Smith. I say here deliberately it is gross perjury if he says he took those notes in shorthand. He is a liar.

9069. He will be able to prove that if he can?—Yes.

9070. Just one other matter about the razor: Does that call up anything to your mind. (*Document handed to Witness*).—That is not mine.

9071. Have you ever said anything to justify that?—No.

9072. You said in cross-examination that some of these people when they make reports do insert matters which patients would be very anxious to keep from public scrutiny?—Yes.

9073. Have you had experience of that?—Yes. I would refer Dr. Stilwell particularly to the certificates of a very distinguished gunner officer, another inmate at Moorcroft while I was there.

Chairman: This is just the very question we must not have, because we do not know what attitude these people may have about it at all.

9074. *Mr. Walter Stewart*: The witness is ready to show that this is not an isolated instance of the introduction of something into a certificate, the object of which he says, rightly or wrongly, is to prevent a person from using it. (*To the Witness*): If desired you could have brought them, so that they could have been produced?—Yes; they are most grossly offensive.

9075. Now Mr. Croom-Johnson produced a photograph of the room, and does that photograph convey at all the actual impression which that room would present to the senses of a person who was an occupant of it?—It is a dressed up photograph, to show what a pretty place it is.

Mr. Croom-Johnson: Is my friend suggesting that it is a dishonest photograph.

Mr. Walter Stewart: I do suggest that.

Mr. Croom-Johnson: I would rather like to have this matter made perfectly plain.

Mr. Walter Stewart: My suggestion to the Commission is that that is a photograph taken for the purpose of making the room look very different from what it looked when Mr. H. occupied it together with 14 people, some of whom were violent.

Witness: It is a dishonest photograph.

9076. That is what you say, and are prepared to stand by?—Certainly.

9077. You have at some period of giving your evidence expressed yourself in terms, that were somewhat strong and without qualification, with regard to certain doctors?—Yes.

9078. I am only going to ask you about one of them. The name of a Dr. Stoddart has been mentioned as one of the gang?—Yes.

9079. Do you say that all the doctors whose names are mentioned in connection with Dr. Stoddart are in frequent communication with him?—My information (and I have fairly well watched these people and their lives and careers) is that they seem to be very much associated. I have had to take very great exception to Dr. Stoddart's certificates.

9080. Are you aware that Dr. Stoddart was the defendant in the recent action of Campbell against Knight and Stoddart?—I have heard about it.

9081. An action in which it was alleged that he had defamed, in the form of a certificate, a Mr. Campbell, a member of my profession?—I have heard about it.

Mr. Croom-Johnson: Judgment for the defendant.

9082. *Mr. Walter Stewart*: Do you know that in that action Dr. Stoddart did not hesitate to certify that gentleman as insane, and that the relieving officer who was there for the purpose of removing him absolutely refused to remove him on the ground that he was a sane man?—Yes, that is right.

9083. And, although the doctor escaped on the ground that there was only one claim, namely, a claim for defamation, and the jury found there was no express malice on his part, was it a finding—indeed, was it admitted by everybody in the course of the case that the gentleman was perfectly sane at all times?—Yes.

Mr. Croom-Johnson: Some people might characterise that as a leading question.

17 January, 1925.]

Mr. H.

[Continued.]

Mr. Walter Stewart: It was a leading question, but it is a matter of record.

Chairman: I do not know that that is very impressive. It means that Dr. Stoddart has in this case been found to be wrong.

Mr. Walter Stewart: And we shall ask you, Sir, to find that that is not the only case in which he was wrong.

Chairman: I wonder how often we professional men are wrong. I wonder how many professional opinions I have given have been wrong. I should not like to have them all brought up against me.

Mr. Walter Stewart: They are in writing as a rule, and we can be faced with them; but these methods of dealing behind the backs of the people concerned with their lives and their condition, the making of these allegations, which they have no champion on their behalf to check, I suggest is a very different state of affairs to the open function of counsel.

Chairman: That is quite a good point on the question of whether these things should be communicated to a person, but I am not sure that one is entitled to attack the medical profession or any other profession because they have been wrong in certain instances. It is not Stoddard's want of publicity you are attacking him for, but because he was wrong in this case.

Mr. Walter Stewart: No; he was so wrong that he misled all the others; they all followed him like a flock of sheep, and if there had been the protection which we are hoping for some day that people may get, it would have been checked at the outset, and these mistakes would not grow.

Chairman: That is quite a proper point to make. I think there should be more publicity about these things and more communication, but the fact that a doctor may be occasionally wrong in his diagnosis must of course happen.

Mr. Walter Stewart: I shall not ask you to say that that is a *mala fides*, but I shall seek to show that he was wrong.

Chairman: I accept the position that he was wrong.

9084. *Mr. Walter Stewart:* If you please, Sir. (*To the Witness*): Now, certain cheques have been referred to—have you got those cheques?—Yes, I have them here. I think the suggestion about the cheque was that it proved my contention that the arrangements for certification had been started some days before.

9085. How do the cheques support that view of yours?—The cheque for 90 guineas I was asked for several days before my incarceration, and it evidently showed a guilty knowledge on the part of the person who asked for it.

9086. Who asked you for it?—I will not mention names; I would rather leave it to the Commissioners. I can show them the cheque. It was supposed to be for medical attention while at Dr. Dempster's house.

9087. Was that before you had received medical attention other than Dr. Dempster's?—No; this was four days before certification. It proved to my mind that certification was then definitely arranged, long before these other documents were written. Shall I show the cheque to you, Sir?

9088. *Chairman:* If you think it is important we should see it.—I think it is.

9089. *Mr. Walter Stewart:* Did you draw the cheque?—Yes.

9090. Were you told for what purpose the money was required?—He said he had been going about there a good deal and thought he would like some money.

Chairman: Is the point that he was sane enough to sign cheques, but not sane enough to retain his freedom?

Mr. Walter Stewart: Yes.

Witness: I think the condition of the writing and that sort of thing is important.

Mr. Jowitt: Is the point this, that after he was certified he would not be able to sign cheques, so

before he was certified they hustled up and got a lot of money out of him?

9091. *Mr. Walter Stewart:* Yes; they made up their minds beforehand. (*To the Witness*): It is a matter of inference, but I think you are entitled to draw attention to it?—Yes.

(*Cheques were handed in.*)

9092. With regard to the cross-examination by my learned friend, Mr. Dickens, I have in re-examination to put a few questions upon that. The expression was used in a letter you wrote on, I think, February 24th, "Your behaviour *re* my wife's letters"—what does that bring to your mind? Would you explain what you want to say with regard to that and how that throws light on the truth of your contention or otherwise?—My petitioner, that is my brother, gave orders that all letters to my wife were to be forwarded, but she never got them and Mr. Charles Steele recovered 40 of them, many of them opened. Instead of forwarding these letters, the licensee of Moorcroft was writing what I think were perfectly wicked letters to her.

9093. I am only going to read two of them to show what he was doing behind your back.

Mr. Jowitt: Will you not put the letters to the gentleman when he comes?

Mr. Walter Stewart: May the witness identify them?

Witness: These are copies from my wife's solicitor; she is very bitter about the whole thing, of course.

9094. *Mr. Walter Stewart:* Will it be possible to secure the originals of those letters from your wife?—Yes, they are in my possession.

9095. At any rate, they were letters which you say were shameful, keeping her misinformed?—Keeping her misinformed, but particularly keeping her away from me.

9096. If I am given the opportunity I will put them to that gentleman at the proper time. Now you have made a very strong statement that I want to give you an opportunity of enlarging upon. You say with regard to these gentlemen, who are frequently engaged in this particular practice of certifying, that they are supporters of vested interests?—Yes.

9097. What vested interests do you there allude to?—I allude to the large capital that is invested in these madhouses. At Ticehurst, for example, I have the details.

9098. Have you had an opportunity personally to search the register with regard to a particular madhouse called Camberwell House?—No. I have often visited it, but I have not searched the register there.

9099. It has been done to enable us to see whether the witness who appears as a medical superintendent is a witness altogether independent of the pecuniary side of it?—Yes.

9100. I can not pursue that with you further. You say they are supporters of vested interests?—No doubt.

9101. You say that these are very valuable properties. Do you know that from your own personal investigation?—Ticehurst is certainly.

9102. What is the highest rate of interest you have heard of being paid by one of these private companies?—I have heard it is about 30 per cent. as an average.

9103. Of course, you cannot ascertain the rate of interest by searching at Somerset House?—No, it is all hidden.

9104. But you can find out how many shares anybody has got?—Yes.

9105. Now about your wife's statement that Dr. Hayes Newington invited her to write that rather dreadful letter that has been put to you. Up to the time that you were certified had your wife ever expressed to you the slightest fear of you or nervousness with regard to being associated with you?—Never.

17 January, 1925.]

Mr. H.

[Continued.]

9106. What was the attitude of your wife after it was alleged that you were suffering from G.P.I., and the other thing?—I think she was vindictive; I think she took it as true although she knew in a way it was not true.

9107. She knew perfectly well that if you were suffering from that, it must be owing to some infidelity on your part?—I think so.

9108. It had that effect at any rate?—At any rate the women in my family were going about telling her, "Do not you associate with him."

9109. Did you know at all, so as to have a chance of removing the effects of the poison, when it was first injected into her mind?—I never knew about this until I met Dr. Munro after my final escape.

9110. The damage was done then as far as your wife was concerned?—Yes.

9111. You had nobody who at the time could deal with it for you, because nobody knew outside—nobody on your side knew?—No.

9112. Did your brother petitioner ever apply for your release under Section 72?—No. He was thinking about doing it but a fresh lot of evidence was being collected.

9113. At any rate the Ticehurst people were not assisting your discharge?—No. They were doing everything to prevent it, but I think if it had gone on another month or two he would have done something, at least he said so. I have letters from him which said, "I have never noticed my brother Bill any different in these places from what he has always been."

9114. You say you can produce those letters?—I have certainly got them somewhere.

9115. Will you make a note to look for those letters so that they may be put to your brother if he is called?—There is a letter to Hayes Newington from E. H. which rather supports that; at any rate, I have the correspondence.

9116. You can let me have them at the proper time?—Yes.

9117. Now is the time as far as you are concerned?—Yes.

9118. Of course if communications are made to laymen by doctors, unless their confidence has been

shaken in doctors as yours has been, you would expect them to act upon them?—I have never taken a doctor's opinion because I do not think they are scientific; I think they are prejudiced.

9119. I am not going into the detailed matters put to you, but with regard to this I think it is right that you should be given an opportunity to express a view about it. You say that with your experience of doctors who deal with mental disorder, you think they are not always very reliable, in your opinion.

Chairman: I am not going to allow this to be pursued further. Really we have had Mr. H.'s experience at great length. Is it really very important whether he thinks doctors are reliable or not?

Mr. Walter Stewart: On this point I do not think it is.

Chairman: Some people say lawyers are not reliable.

Mr. Walter Stewart: Some are, Sir.

Chairman: And so are some doctors.

9120. *Mr. Walter Stewart (to the Witness)*: Is there anything further you wish to say, Mr. H., on what has been put to you in cross-examination? I do not want to put any further specific questions to you?—I would urge the Commission to do everything they can to destroy this condition of secrecy. I do not think these vested interests at places should be allowed. I do not think doctors have any business to be mixed up with finance; it is not desirable; it is contrary to the ethics of their profession.

9121. Particularly for the medical superintendents?—Yes, I think it is most wrong. I think they are often led into error by their desire to make money.

9122. Many people are?—We all are. I should like to thank you, Sir, for the courtesy of your Commission in listening to me at so great a length. I do hope that my experiences will improve the conditions of certification, and I hope make honest men of some of the gentlemen who are engaged in it.

Chairman: We thank you for your attendance here to-day, and for all you have told us. I trust you will be none the worse for the ordeal you have had.

Witness: Thank you, Sir.

(The Witness withdrew.)

(Adjourned to Monday, 26th January, at 10.30 a.m.)

5, OLD PALACE YARD,
WESTMINSTER, S.W.1.

SIXTEENTH DAY.

Monday, 26th January, 1925.

MEMBERS PRESENT :

THE RT. HON. H. P. MACMILLAN, K.C. (*Chairman*).

THE EARL RUSSELL.

SIR HUMPHRY ROLLESTON, BART., K.C.B., M.D.

SIR THOMAS HUTCHISON, BART.

SIR ERNEST HILEY, K.B.E.

SIR DAVID DRUMMOND, C.B.E., M.D.

MR. N. MICKLEM, K.C.

MR. H. SNELL, M.P.

MRS. C. J. MATHEW.

MISS MADELEINE SYMONS.

MR. P. BARTER (*Secretary*).

MR. W. FAIRLEY (*Assistant Secretary*).

MR. WALTER STEWART and MR. CREMLYN (instructed by the National Society for Lunacy Reform) appeared on behalf of Mr. H.

MR. H. C. DICKENS (instructed by Messrs. Hempsons) appeared on behalf of Sir Maurice Craig, Dr. Robert Percy Smith, Dr. J. G. Porter Phillips,

Dr. William Henry Butter Stoddart and Dr. Robert Cole.

MR. R. P. CROOM-JOHNSON appeared on behalf of Dr. Reginald John Stilwell and Dr. Bulkeley Footner.

Chairman: Mr. Stewart, you may recall that when Mr. H. was before us on Saturday, a week ago, you made an application that we should endeavour to recover the papers relating to the discharge of the receiver of Mr. H.'s estate. I have a letter from the Chief Clerk in the Master's office informing me that he has obtained copies of certain of the documents. I am sorry to say they are not yet complete; but, such as they are, I think they should be in your hands. I have a copy of the order appointing the receiver, a copy of the order restoring Mr. H. to the management of his affairs, a special report by Lord Sandhurst (who was then the Honourable John Mansfield), of the 24th May, 1917, and a special report also by him of the 9th October, 1917. I am sorry we have not the three documents to which you naturally attach much importance, namely, the certificates produced in the High Court proceedings, not by Dr. Crichton Browne, I want to correct you about that, but by Dr. Crichton Miller, Dr. Spitta, and a third doctor. But as far as we are concerned, I think you may take it that we shall hold it established that these three certificates were to the effect that at the time of their examination they found Mr. H. of sound mind.

Mr. Walter Stewart: The only certificate to which I attach great weight and importance was the bacteriologist's certificate of Dr. Spitta, to show that the Wassermann test was negative.

Chairman: We have been doing our best as you can see, to recover these documents, and that is what we have so far; possibly some more may come to light, and the Chief Clerk has instructions to send us everything he can recover; but I ought to say this, in fairness to them, that I am told that there has been in the office a complete reorganisation of their papers

and some have been difficult to recover, but the instruction still stands that if the papers are found to be recoverable they are to be produced.

Mr. Walter Stewart: I know there is a difficulty; we have found it in other cases.

Chairman: Quite so; I thought it right to let you know about it. Then I regret to say that Mr. H. has addressed a letter to us which I venture to think should not have been sent, in which he refers in advance to Dr. Percy Smith's evidence. I do not propose to say more about it, but I think it is very undesirable that witnesses before us should comment upon other witnesses who have not yet been examined.

Mr. Croom-Johnson: May I say in that connection that my client, Dr. Stilwell, has received a letter also from Mr. H., and we do not desire to receive these communications. I will not say anything more about it than that. At a later stage probably the letter will be available for the Commission.

Chairman: Yes. We have received a number of letters. In ordinary circumstances, in a Court of Law, one would of course take very serious action in such matters, but we do not desire to lay undue stress upon these matters in this Inquiry. I merely say that it is quite improper that any such communications should be addressed to us or to any of the parties concerned in the case.

Then I think before we resume this morning, it might be convenient if the Commission were to indicate the points to which they attach importance in connection with Mr. H. It seems to us that we should be much assisted if Counsel appearing before us were to devote attention to two topics which have emerged, and upon which we should like assistance. The first is the circumstances in which it

26 January, 1925.]

Sir MAURICE CRAIG, C.B.E., M.D.

[Continued.]

was thought proper that an urgency order should be pronounced in Mr. H.'s case; the justification for an urgency order instead of the more deliberate procedure of a reception order is a matter upon which we should like to hear some evidence. The other topic is also of some importance, namely, the circumstances of the certification. Mr. H. alleged that the examination was insufficient, and indeed, he went further and said negligent; and we should like to have evidence indicative of the circumstances of the examination—that is to say, the care with which it was conducted. I think that all present will realise that from our point of view the important question is whether the existing system provides adequate safeguards against improper certification of patients; and therefore it is of importance to us in this particular case to receive assurances that in Mr H.'s case, the examination was sufficient to justify the making of a certificate that he was of unsound mind. These two matters seem to us of importance. My colleagues are also anxious that if possible we should see Mr. Steele, who was referred to in the course of the previous proceedings, and address one or two questions to him with regard to the making of Mr. H.'s will. If Mr. Steele is present this morning, perhaps he will be good enough to remain with us for a short time in order that we may ask him a few questions. If not, I shall direct that he be invited to come. There is one other matter, rather for Dr. Stilwell, and that is in connection with the treatment of Mr. H. in Moorcroft after his escape; he complained that when he was brought back to Moorcroft he was punished, in the sense that he was sent to or kept in another part of the building where he had to associate with undesirable fellow patients, and his complaint was that his escape entailed those unpleasant consequences. Possibly you, Mr. Croom-Johnson, might give us a little assistance upon that matter. You will see, of course, its importance.

Mr. Croom-Johnson: Precisely.

Chairman: Now those seem to be the points of interest to us that emerge in our investigation, and if the evidence were directed to those topics it might, I venture to think, considerably shorten the proceedings, and at the same time give us all the assistance which is necessary for us in our task. Is Mr. Steele here this morning?

No reply.

Sir MAURICE CRAIG, C.B.E., M.D., sworn.

Examined by Mr. H. C. Dickens.

9123. Sir Maurice Craig, you practise at 87, Harley Street, Cavendish Square; you are a registered medical practitioner, a doctor of medicine, Cambridge, a Fellow of the Royal College of Physicians of London; you were the holder of the Gaskell Gold Medal in Psychology, Lecturer in Mental Diseases, and Demonstrator in Psychology in Guy's Hospital; the author of a work on "Psychological Medicine," and you have been a contributor of various articles for the medical journals upon these subjects, and you have had an extensive practice in mental cases for many years?—Yes.

9124. Now you first came into contact with Mr. H. in January, 1915, I think, at Teignmouth?—Yes, the 16th January, 1915.

9125. You have kept and you have here the whole of the notes that you made from time to time as you saw him with regard to his case?—Yes. I did not make notes on every occasion I saw him.

9126. But you have all the notes here that you did make?—Yes.

9127. And you did, in fact, see him off and on from January, 1915, to January, 1917?—That is so.

9128. I do not want you at the moment, although you can do it in cross-examination, to go into the whole of the details, but I think it would be more convenient if you gave the medical history of Mr. H. as you knew it from January, 1915?—I have my

Chairman: He is evidently not here. The Secretary of the Commission will communicate with Mr. Steele, and ask if he will be good enough to attend later in the day. Now Mr. Dickens, have you anything to say this morning?

Mr. Dickens: I should like to call some witnesses who will be able to deal satisfactorily I think with the points you have raised. The witnesses I propose to call I will call in chronological order as far as the history of this case is concerned. There will be Sir Maurice Craig, Dr. Stoddart, Dr. Percy Smith, Dr. Porter Phillips and Dr. Cole. The only other witnesses whom I should have called and who would have given relevant evidence, are Dr. Adler, Dr. Dempster, Dr. McNaughton and Mr. Ashton, who are all dead, so I think I am satisfying the Commission that I am calling everybody I possibly can.

Chairman: Certainly. I am sure you will study economy of time in the matter.

Mr. Dickens: I will do my best.

Chairman: We cannot, of course, try out every case as if we were in a Court of Law.

Mr. Dickens: Of course you will understand that my clients feel very strongly the attacks that have been made against them. They do not desire in any way to skim this matter, and they are very anxious to go into every detail to show that they have done and said nothing which they cannot justify in this case, and if they should go into it at greater length than you think necessary, perhaps you will be good enough to stop it.

Chairman: We will leave the matter in your discretion to a large extent, but we are really concerned to keep our attention focussed upon the matters which will assist us in our inquiry.

Mr. Dickens: If you please, Sir, but at the same time these gentlemen have been attacked, and you will give them every opportunity of thoroughly defending themselves.

Chairman: No doubt.

Mr. Dickens: Then I will call Sir Maurice Craig first. I should say that I have now been instructed to represent Sir Maurice Craig, Dr. Stoddart and Dr. Cole, as well as the other two gentlemen I represented last time, in view of the fact that attacks have been made upon them personally.

Chairman: Very well.

original notes here, Sir, but I have made a copy of them, so that I can read them more easily, if I may use the copy.

9129. Chairman: If you please?—I saw Mr. H. first on the 16th January, 1915. I then saw him in consultation with Dr. Johnson at Teignmouth. That gentleman unfortunately has since died. I was informed that Dr. Dempster of Croydon was also his medical attendant, and I also met him on that occasion, and I met Mr. E. H., so far as I can make out. Then I was informed that Mr. H. was a consulting engineer, naval architect and shipowner, and that his age was 48. I was given certain family history, but as it brings in other persons' names, I do not know whether the Commission would like me to go into it.

9130. Chairman: Has it any relation to the history of the case?—Yes, it is with regard to the history. There were certain persons of unsound mind in the family.

9131. We need not have the names of the persons, but it is relevant from the medical point of view?—Yes. I am dealing, as the Commission will appreciate, with confidential matters, which I certainly should not have disclosed except under conditions such as these, and I presume that Mr. H. himself wishes me to disclose them; but if at any time I am stopped from disclosing things, I shall appreciate what you

26 January, 1925.]

SIR MAURICE CRAIG, C.B.E., M.D.

[Continued.]

as Chairman ask me to do. Of course, some of these points to which I shall have to refer, or perhaps ought to refer, are confidential matters regarding other persons.

9132. *Earl Russell*: Is it not enough for us that there was an undesirable family history?—Yes.

9133. *Chairman*: It is a position of some embarrassment for you, as I understand?—It is more a professional matter. I have nothing to keep back, but I do not want to disclose anything which would hurt other persons' feelings.

9134. It is quite sufficient for us if you say that the facts indicated to you disclose a certain hereditary element?—I was informed he had been to Leys School, was "a great antiquarian; very talkative and brainy man; hard working; very musical." That is the description of him that was given to me. On that occasion I may say straight away that I diagnosed him as a "chronic nerve exhaustion." But I was given certain information regarding him, that he had been "worried by the war. He signed for a German friend for naturalisation. He had been excitable and talkative for two or three years. Ordering things and requiring things to be done quickly. Sleepless." That would be since the beginning of the war. In September he was worse, and "one night in the Royal Hotel, Teignmouth, he tried to get out of the window. His wife and a clergyman held him until some officers came in—"

Mr. Walter Stewart: Now, Sir, before this sort of evidence goes any further, may I take your ruling upon it. You will observe, as far as my recollection goes, that nothing was put to Mr. H. with regard to any such escapade as is now being spoken of, and unless Sir Maurice Craig is prepared to say that these communications were made to him by Mr. H., I submit it is a little going outside the ordinary rules of evidence.

Chairman: I think we have gone outside the rules of evidence pretty flagrantly hitherto. Mr. H. has told us plenty of things which were said to him by other people which we did not stop.

Mr. Walter Stewart: Not on my invitation, Sir.

Chairman: On his own. The difficulty is that the diagnosis of this case is attacked. Of course the diagnosis of a medical man necessarily proceeds upon information he receives regarding his patient, and therefore I am afraid one cannot stop this.

Mr. Dickens: I am not putting this forward as being proof of these facts, but as evidence of what the doctors had before them.

Mr. Walter Stewart: It would have been fairer that the matter should have been put to Mr. H. when he was in the chair, so that he could either accept them or deny them.

Chairman: But even if he had denied them, it would still have been one of the circumstances in Sir Maurice Craig's mind when he dealt with the case.

Mr. Walter Stewart: I do not desire to say any more, Sir.

9135. *Chairman*: We will take your caveat, if we may so call it, on this subject. (*To the Witness*): Will you please proceed, Sir Maurice?—He regarded himself as a strong man. "He was taken to a nursing home, had cut himself very badly on the left arm. It took eight officers and men to hold him. He was only once difficult in the home." That was before I saw him. "His memory was said to be quite clear and he was now beginning to take interest in things. He thought people had thought that he was a German spy, delusions come and go. Gets depressed at times and believes that he is to be executed. At other times normal. At times more excited after seeing wife." There was no incontinence or any suggestion of that. Then "Illusions"—I have put a query against "illusions"—that I was not certain of. "Voices were not definite." I was not satisfied that they were. "No one had ever noticed any change in his speech. Three weeks ago used to read less than he is reading now. Most depressed in the evening and late afternoon. He had

a sense of fullness and being over-fed. He never refused food. He had not attempted self-injury. Once got his brother down on the floor in early morning." That was in the home. I have not got a note about that. "His sleep at first was on certain sedatives, and he complained of feeling confused on waking." On the 20th December he "writes a letter, a statement re a murdered girl and raped first. He was the cause."

9136. *Mr. Dickens*: What is that statement of the 20th December?—I was just looking. I saw him on the 16th January; so 20th December must have been the date on which he wrote the letter, of 1914, I take it, about a murdered girl. "Raped her first and he was the cause. Really not in London, and re German spy." I am afraid these notes are rather disjointed, but they have been copied from the originals. And he "was in bed one month and since then walks twice daily. No interest. Only speaks if spoken to. Will play a game but gives little attention to it." There was no history of any bad habit. There was a suggestion that there was something about his wife. I will write it down or give it out, as it is wished.

9137. *Chairman*: If you will hand us a copy of your notes or your original notes?—I will hand you the notes by all means, but I am afraid they will be a little difficult to read.

9138. If you will give them to me that will be the best plan?—Certainly. (*Handing same to the Chairman.*)

Mr. Walter Stewart: May we have a copy of them?

Mr. Dickens: We have not another copy.

Mr. Walter Stewart: These are new to us, made behind our client's back.

Mr. Dickens: I object to this sort of insinuation.

Chairman: Surely a surgeon or a doctor does not make his notes in front of a patient's face?

Witness: These are all notes made at the time, but the history would not be, of course, Mr. Stewart. Of course, when I wrote about what the patient told me, that would be written in front of him. I took notes at that time. Now this is the patient's own statement: "He says he has got no headaches, no noises in his head. Lost one stone in weight. Sleeping better. Wakes up very frightened. Says that he is able to read a little. Feels that he is physically wrong. Bowels will not act every day. Normally constipated. His memory is good. Feels that he has treated his wife badly financially. Has had fear of disease. Tendencies to obsessional condition—doubts. Converses freely." Then there is a query about a collision re one of his fleet and a warship. I was not able to follow quite what he was talking about with regard to that matter. Then there is a complaint of another physical nature. "Eyes and all reflexes normal, but he feels he may have committed crime."

9139. *Mr. Dickens*: You do not remember whether that fear of disease was any specific disease, do you?—No. I examined him physically.

9140. *Chairman*: What date are we on now?—We are still on the 16th January, at Teignmouth. I have gone back to the first page, 1915. I put it in chronological order because it comes on my card a little in front of the mental history, but it really belongs to that time. He says he had retention of urine on several occasions. I put it down. I am not certain that that is really an organic condition, but it might have been a fear in his own mind—one of the fears he complained of. His knee jerks were normal. His pupils were equal and normal.

9141. Might I interrupt you to say that it is important to know how you came into contact with the case? Who called you in?—I have not an absolute record. I should have been called in by Dr. Dempster or Dr. Johnson, I should think. It was probably Dr. Johnson, because he was the doctor in charge at that time. I knew Dr. Johnson; I had met him in consultation before.

9142. *Mr. H.* professed to regard you at first in a friendly light, and one wanted to know how you

26 January, 1925.]

Sir MAURICE CRAIG, C.B.E., M.D.

[Continued.]

came into contact with him. You were called in in consultation?—Quite right.

9143. You saw Mr. H., and what was his reception of you?—Very friendly. It always has been you will see, as I go through the case. It is one of those cases in which the legal requirements of certification embarrass the relationship of physician and patient, and you will see that the change comes about after that took place. I have evidence even that after he left Ticehurst he wrote me quite a friendly card; but the trouble arose over the legal position in which he thought I was a party.

9144. In his detention?—Yes. The pupils were normal on that occasion, which is very important, because there was a change then. It was one of the points you made at the beginning, Sir, to know why there were doubts as to the diagnosis in the medical opinion. There were changes and physical signs during the course of the illness itself. I have a record that on the 16th January his pupils were normal. Now later there is a change in that, and that really, as I hope I shall be able to show the Commission, led to my being in doubt, and also led to the question of having further consultation and examination. Then on the 9th March, 1915, I saw Mrs. H. I had recommended that he should remain on in the home. There was a history here of a great deal of mental disturbance, but I should like the Commissioners to notice that I made no recommendation of certification here. I do not know whether I was absolutely legally correct in what I did—I mean here was a gentleman who had attempted his life very seriously in a nursing home by getting out of a window, on which occasion it had taken eight people to hold him. There was no hurry in sending this gentleman to a mental hospital.

9145. *Mr. Dickens*: Did you do your utmost from beginning to end to keep him, if it were safe, out of a mental hospital?—Yes, as I always do, feeling as I do after 30 years of work what a strain it is upon a patient. I have always taken the human side, even if at times I get very near the legal obligations placed upon me as a professional man. Now on the 9th March Mrs. H. said her husband was "improving steadily," and she arranged then with Dr. Munro to be with him. The wife is evidently apprehensive of being with him alone and living with him. The patient used to be afraid that the Germans would get hold of her. "Still worrying about how unkind he was to her. Patient is apt to slip out of the tram. If he is concerned in a case he had in Court, he would be up all night talking it over with her." This was merely a note that she said he was such an apprehensive man that if he had any problems he would be up all night talking them over, thinking that he may have taken the wrong view.

On the 13th May, 1915: "Came up with Dr. Munro and Dr. Dempster." At this time he was with Dr. Dempster. Dr. Dempster was a friend of his and had been for some long time, apparently, because he was very friendly with Dr. Dempster at that time, and he lived with him on and off long before the question of certification came along. It was not only a question of a month or two.

9146. *Chairman*: Did he come to London on this occasion?—Yes, he came up to my house at 87, Harley Street with Dr. Munro and Dr. Dempster. He told me he had taken up golf. "Still upset by vibration. Was taking no hypnotics. Was sleeping well. He was a timid man. When well a great talker. Had talked to Dr. Munro about his wife's"—the other point I referred to. That was told me by Dr. Munro. "He can read with ease. Undecided. Sleep was bad and said he had been nervy for two years. Depressed on waking. Has had to go to Hindhead to his brother's house with Dr. Munro." On the 9th June, 1915: "Patient came up with Dr. Munro and Dr. Dempster" and it was a question then of Dr. Dempster taking him away; also a question of him giving up business, and it was suggested that if he

returned to his wife it would be wise for him not to give up business. "Wife began bombarding him with letters *re* money matters and this has upset the patient." That was what Dr. Munro told me.

9147. *Earl Russell*: Was that a fact, or was that a delusion?—I think there were letters. I think Mrs. H. had been very worried, and I have no doubt she did write to him on several matters.

9148. We do not want any details?—No; that was the case. "Mr. H. H. found the engineer man"—that was in the place of a male attendant, somebody to go about with him, or to relieve Dr. Dempster. "Is not depressed now, and is certainly better. Brother dealing with wife's matter. Patient told me he would like to go to Dr. Dempster, and I have suggested the engineer man staying with him during the week end." That is, so that he should have an opportunity of seeing him. "The wife denies writing letters on money matters."

Then on the 13th July, 1915, Mr. H. again came with Dr. Dempster. "He is better in many ways, more natural; still thinks he has no money. Now staying with Dr. Dempster of Croydon." That was as early as July, 1915, so that he was on and off 18 or 19 months with Dr. Dempster, and he was with Dr. Dempster at his own request when he was at his best, and more or less in quite a normal condition. "He eats and sleeps well. His weight was 11 stone 13½ lb. Can read with comfort. His pulse was normal."

Then on the 30th September, 1915: "The wife called this morning. The patient told his wife that he felt that he had been mentally afflicted all his life. Used to take everything to heart. He is now much better. Goes to Shoreham week ends. He is worrying about the Zeppelins. He is living with Dr. Dempster, and wife agrees that this is the best. Wife still is haunted by the incident and is evidently afraid of having him back again." The Commission will note that this fear on the part of the wife was antecedent to any tests that were made or any other point that came up in the medical history subsequently. I have a letter about this, and some notes.

9149. *Mr. Dickens*: We will come to that later on? Yes. "He wishes to have a flat. His wife feels that her confidence will never return. Her brother feels that they should not live together again. She does not even stay with him at Dr. Dempster's. (Before marriage he once took offence at the dentist and he was going to take an action.)" Some one told me that. "Dr. Dempster came with patient later. Patient wished to travel, but war on—no desire. Sleep good; not depressed. Feels too lazy. He is willing to stay if Dr. Dempster can put up with him. I told him his wife's nervousness was a factor *re* his going back." That is, the patient himself knew about the difficulty of the wife's nervousness following the incident referred to.

On the 23rd December, 1915, he is very much better. "Said that the Zeppelin raid had done him good. Inclined to talk too much and spending money more freely." Then I have a note that the wife lost her nerve. I do not know whether you would just wish me to read the next sentence, Sir.

Chairman: Yes, I think so. "The last time he was in bed with her he had on his boots, hat and overcoat."

Mr. Stewart: If this is read I must again point out that none of these matters affecting Mr. H., which he must have known of if they were true, were put to him in cross-examination. I submit that it is a gross evasion of the ordinary rules of fairness that this sort of thing should be allowed to be done, when Mr. H. was not given a chance either to admit or to deny it. It must have been known to those who are instructed on behalf of this gentleman.

Chairman: I have already expressed the view of the Commission. Sir Maurice is now giving us the information upon which he proceeded in his diagnosis of the case.

26 January, 1925.]

Sir MAURICE CRAIG, C.B.E., M.D.

[Continued.]

Mr. Walter Stewart: Does that affect what I am raising by way of objection, Sir, namely, that no opportunity was given to the person most concerned either to deny or to admit this—something alleged behind his back which was not even called to his attention?

Earl Russell: Still that makes no difference to the effect upon the doctor's mind at the time.

Mr. Walter Stewart: I am dealing with the procedure here. Would it not be right that Mr. H. should have the chance either to deny or to admit these matters?

Chairman: I have already pointed out that, if he had denied them, it would not in the slightest degree have affected the question we are considering now.

Mr. Walter Stewart: Would it not be fairer that he should have the chance either of admitting or denying them?

Mr. Dickens: If it is an attack upon me, which it seems to me to be, all I can say is that I was not Sir Maurice Craig's counsel last time, nor had I seen these notes.

Witness: I may say that these notes have never been used. I am forced to disclose these notes by Mr. H. himself.

Mr. Walter Stewart: Have they ever been disclosed to Mr. H.?

Chairman: I think, Mr. Stewart, you must restrain yourself. This is exactly an illustration of the class of embarrassment which the Commission will experience when we come to investigate particular cases. We have thought that we ought to hear a few individual cases. The atmosphere of litigation is being imported into them which we desire to exclude. Matters are brought before us by individual witnesses relating to their experience in this matter, and we have decided to hear them; but it is quite impossible to conduct this inquiry as if we were in a Court of Law. We can only take witnesses' statements, and we shall proceed to value them. Will you just proceed, Sir Maurice?

Witness: "Doing secretarial work at Croydon Hospital." That is, Dr. Dempster was encouraging him to do work. "He sees his wife regularly. Sleep good, pulse normal. Does not feel so active as he was. Wife lost all nerve and cannot face having him at home."

On the 28th July, 1916: "Has been away with wife and with Dr. Dempster. Not resumed marital relationship. Now appreciates his former cloudiness. Every five years had nerve storm. At one time dread of enclosed spaces or railway carriage. Still with Dr. Dempster, but anxious to get away. (Wife had been married before and had infinite worries.) He had been working at very high pressure and all his assistants left. No desire to return to business." You will see here that he admits now that he had appreciated he had been ill in the early part, because he says: "Now appreciates his former cloudiness."

Now we come to the more important time. On the 21st October, 1916: "I saw the patient at Dr. Dempster's, 94, Brighton Road, Croydon." The history was that: "He has been very excitable and over-active. Writing very florid letters to comparative strangers. Sexual excitement; and wife would not live with him. Had an attack of gastritis."

Earl Russell: Was he in bed when you saw him at this time?—Yes, I think he probably would be, because he was just back from an attack of pneumonia at Brighton; so I am almost certain he would be in bed; at any rate, he would be only sitting up in his room. "Dr. Bates, Brighton, wrote to Dr. Dempster saying patient had gastritis. Wife with him. Dr. Dempster went down and found him down with pleuro-pneumonia. Met Dr. Bates; could not look after him. Returned to Dr. Dempster 10 days ago. Pneumonia is better, but got very *exalté*, litigation, big schemes. Talks incessantly. Sleeping four hours or less. Cut off his moustache and shaved his head" (he was quite bald). "The right lung was dull. Now calling his wife a drunken woman. Very

fond of her, but mother alcoholic, and now she was, and had it all his life." This is what he told me. Of course, his manner had quite changed. He had always spoken very kindly of his wife, but now, owing to his mental condition, was speaking in a more uncontrolled way. "Never resumed marital intercourse. Chatters on; but wife got drunk in the Pullman car. Wanders from subject to subject. The pupil was not re-acting well to light."

9150. *Mr. Dickens:* Was that significant?—That was a change from what had taken place before, and it attracted my attention. "Knee jerks also were dull and unequal, and pulse was normal. Speech normal."

9151. Now at that stage did you get a letter, dated the 22nd October, from Mrs. H., and have you the original there?—Yes.

9152. Is that in these words: "Dear Dr. Craig. I am glad to hear you have been to see my husband at Croydon. Please write me to above address and tell me what you really think of him, his brain, etc. I felt nervous about our living together again, and the excitement for him I feel was too much. This is a very painful subject to discuss. I feel I cannot take up the life together again, though I love him as much as ever. Sincerely yours, (Signed) A. E. H." Was there any suggestion at that time that Mr. H. was suffering from a disease which he was afterwards suggested to be suffering from?—There was none at that time, no.

9153. Then did you write a report on the 22nd October, addressed to Dr. Dempster?—Yes, I wrote one.

9154. That is to say, the next day?—Yes. That was the same day as I expect his wife wrote to me.

9155. "I saw this patient in consultation with Dr. Dempster on 21st October, 1916, at 94, Brighton Road, Croydon. I found him just recovering from an attack of pneumonia; the lung condition is clearing and there is no anxiety as to his complete recovery from this. As regards the mental condition, he is excitable and loquacious, wandering from subject to subject in a somewhat irrelevant manner. This excitement is the opposite phase of his former state of depression; on the other hand, there are one or two symptoms which would suggest more serious trouble, that is, that the condition is due to some organic disease of the brain. The symptoms that would suggest this are fortunately confined to one or two, therefore I hope that they may pass away, but in order to help the diagnosis I should suggest that the blood be examined and, if possible, a test of the cerebro-spinal fluid; if it is decided to do this, it would be advisable to get someone like Dr. Adler, 10, Bryanston Square, Portman Square, to make these investigations, and I would gladly arrange for it if so desired."—That is so.

9156. Did you know Dr. Adler?—I knew Dr. Adler; he had done a good deal of work on and off. I first got to know him through Lord Dawson.

9157. Just tell the Commission something about the doctor.—He was quite a recognised man for this sort of work. He had done a good deal of work for me. If you notice, I only say "it would be advisable to get someone like Dr. Adler"—I was not advising Dr. Adler.

9158. But he was a gentleman of repute in bacteriological examinations?—Yes.

9159. Did you speak to Mr. H. about Dr. Adler's visit? Did you tell him that Dr. Adler would come when it was arranged?—I do not know whether I have got anything on record about that. I may have told him that I wanted Dr. Adler to make an examination of his blood for me. Whether I would tell him why I wanted it examined is another matter. I mean a medical man does not convey every fear in his mind to his patient.

9160. No, but he has said that you told him that Dr. Adler was coming to do a small operation on him which would cure him of his trouble?—I certainly would not do that; it would be totally untrue,

26 January, 1925.]

Sir MAURICE CRAIG, C.B.E., M.D.

[Continued.]

and I never make an untrue statement to a patient in any sense that way.

9161. *Earl Russell*: It is not the kind of statement a doctor ever makes?—No, it is an unnecessary statement.

9162. *Mr. Dickens*: Subsequently was it arranged that Dr. Adler should go down?—It was. Then there is a note before he does go down on the 4th November, that the patient told me he was going to build a hospital. "His lung was not quite clear yet. He was in very great spirits." He was talking in a very jocular way about everything. "Pupils: the left is not so good as the right." I put a query there which expresses a doubt in my mind as to whether it is owing to the rapidity of the re-action that I cannot see it. It was in my mind that there was something in that; therefore I was not omitting to appreciate anything that might be happening, and therefore was on the look out for it; but I was satisfied, as other medical people were later, that this was not the case. Then he told me that, "When ill he felt that his testamentary affairs were not right. On the 12th October Dr. Dempster advised him waiting on this matter, but patient feels uneasy. The will was made in 1904. Query, drawn up by brother's firm or somebody named Harvey. Patient used to live in Croydon. White, Lodge, S— and Drummonds were one of the leading firms." There is a word there I cannot read. "He telephoned to Drummonds and a man named Muther, I think it was, came. He instructed the nurse to telephone." I may say that these matters with regard to the will were that he wanted me to say that he was in a fit condition to make a will. Therefore I had to tell him that if he was going to use me in that way he must disclose to me in what way he was altering his will, or why he was altering it, or some main facts; or I should be in a peculiar position, being a medical man, especially one who was on the nerve side, if it ever came to my having to give evidence; I should be asked certain questions about matters which, if I was going to protect his will, I should have to be in a position to know. He told me these facts.

9163. *Chairman*: Then you make a statement about his testamentary dispositions which we need not go into. Then you say: "His memory is lucid to a degree."—Yes.

9164. Memory is excellent. Left pupil is very little affected by light.—That means it does not re-act to light.

9165. "To see Adler on Monday."—Yes, in two days' time.

9166. Then I notice "Wassermann" and two crosses. What does that mean?—That is double plus—plus plus. That means that it is a "positive." Of course it ought not to be positive at all; it ought to be negative. Dr. Adler reported—

9167. *Mr. Dickens*: You have that there, have you not?—Yes.

9168. Will you produce it to the Commission?—There is one on the 7th November in which he gives me a short report. "Hecht's modification of the Wassermann blood. Re-action markedly positive. Cerebro spinal fluid. Re-action positive." Then I wrote to him. As you will hear it was not complete. I did not know about the cell content of the cerebro spinal fluid, whether that was altered, so I wrote to him. Though what this report told me was very disquieting, it did not tell me all. At any rate he writes me then and says: "Cerebro spinal fluid. Wassermann re-action moderately positive." "The cytological count shows comparatively few leucocytes. Differential count however goes to show that the lymphocytes number about 86 per cent." which is in fact distinctly high, in fact, pathological. That would indicate something mental.

9169. *Earl Russell*: Would you give us something we could understand, Sir Maurice?—I am very sorry.

Chairman: It is very technical, of course.

Witness: Yes. It points to what is known as general paralysis, or it might be some other form of specific disease, and that of course, taken with the

physical signs as observed by myself, were very disquieting; because you see the clinical side had already led to something in my mind, therefore when I got this, saying that there was a bacteriological change, it was of much more serious import; in fact it would have been very wrong for me to have done anything else than to take count of it.

9170. *Mr. Dickens*: What does it denote?—If that is true, it points to the case being one of general paralysis. I mean of course you may say that this account of Dr. Adler was wrong, in what he had done, but I am not responsible for it in any way; I am taking it as it is.

9171. I think the Commission would probably like to know a little more about general paralysis of the insane, and what it denotes?—Of course it has passed through many phases, but it has at last reached a stage at which it is known that it only arises under certain conditions—that is, the person must have had already a specific history.

9172. *Mr. Walter Stewart*: What specific history?—"Specific" is a technical term for syphilis.

9173. *Mr. Dickens*: I need hardly say that the syphilitic infection may have been innocently come by?—Exactly.

9174. *Chairman*: Can it arise in a case where the syphilis is secondary, inherited syphilis?—Well, it would be a little late. It can, of course, but this might be a little late here.

9175. It does not necessarily indicate that the particular person has himself received contagion?—No; all it indicates is that the syphilis occurs.

9176. *Earl Russell*: But the patient may have been innocent?—Absolutely, may not even know he ever had it. Oh, yes, that frequently happens.

9177. *Chairman*: It is now recognised, is it, as definitely associated with syphilis, whether transmitted or acquired?—That is so; it is a syphilitic disease.

9178. *Mr. Dickens*: Syphilitic or post syphilitic?—Well, it is syphilitic. Everything must be post if once syphilis is there.

9179. *Chairman*: Perhaps you might enlighten us a little further, Sir Maurice. Has medical science reached the stage of being able to diagnose it easily? I mean is it one of those things the symptoms of which are readily detectable or is it one of those things in which the symptoms may be difficult of ascertainment?—Sometimes very difficult. If you have a large number of physical signs, of course it is easy, but if you have only a few, then it is more difficult; being a syphilitic disease, it must be curable in that sense, if you could only find the cure; and certainly I should be blameworthy if I had not given him every opportunity of getting a cure or of having a treatment for it.

9180. I hope I am not anticipating Mr. Dickens, but might I just ask this also: Is the Wassermann test supposed to be conclusive in medical science?—Yes, we accept it.

9181. Would you regard it as a conclusive test?—I believe there are certain other conditions, mostly oriental diseases, where it may arise. I dare say Sir Humphry Rolleston would help the Commission better on that, because it is a general question of medicine; but, broadly speaking, it becomes an absolute test, especially if you get it, as in this case, in the cerebro spinal fluid as well as the blood. You see you have it in two places here. Of course, the earlier you can attack a disease the more likely you are to stop it. Therefore it was absolutely essential that he should have treatment, and he had treatment as a matter of fact. Therefore from the neurological standpoint it is quite conceivable that what was done might have stopped the disease. You could not say medically and scientifically that that was not true. Directly this report came in, Dr. Dempster was informed at once, to give specific treatment.

9182. *Mr. Dickens*: Mercury?—Yes, mercury and iodide of potassium.

26 January, 1925.]

Sir MAURICE CRAIG, C.B.E., M.D.

[Continued.]

Sir David Drummond: We heard that he never had mercury in his life.

9183. *Chairman:* Mr. H. told us he never had mercury, and he threw it in the fire.—I was under the impression he had it from Dr. Dempster. Dr. Dempster would be carrying out what I asked in that sense. I understood he was treated.

9184. *Mr. Dickens:* How would it be given?—It might be given by the mouth, as ordinary medicine.

9185. A patient would not necessarily know, would he?—Not necessarily.

9186. At all events you prescribed it?—I advised Dr. Dempster.

9187. Then perhaps the Commission would like to know a little more about the subsequent course of this disease of general paralysis. Does that remain?—It usually runs a course of a varying period of from one to six years, but of course there are cases on record in which it apparently has ceased and has never advanced any further. Being a definite poison, the tissue cells may stop the progress of the poison.

9188. Have you heard anything about the subsequent history of this case which excludes the possibility of that diagnosis being correct?—I may say here as a clinician—I am leaving out entirely the bacteriological side of it and the fact that his physical signs were not very marked—it has always been a doubt in my mind as to whether it was or was not; but I was forced into this position, of course, by the bacteriological examination. Medical people have appreciated right through the whole case that there was a good deal to be said against it being general paralysis.

9189. *Earl Russell:* And just to complete Mr. Dickens' question, do I understand that apart from the bacteriological test there would still be a doubt in your mind?—Yes, certainly, apart from that; but I have always made it perfectly clear. I have a letter here which I wrote in 1918 in reply to one in which the brother mentioned something about "you medical people are sometimes wrong," and I put at the end here, "I quite admit that the medical profession are by no means always right, and I am always glad when I am wrong if it means that the patient gets well." It was always in my mind.

9190. *Mr. Walter Stewart:* May we have the date of that letter?—27th February, 1918.

Mr. Stewart: May we have the letter as soon as convenient?

Mr. Dickens: You shall have it in the course of time.

9191. *Mr. Snell:* Should I be right in assuming, Sir Maurice, that general paralysis of the insane is not invariably progressive?—Not invariably. Of course it is a disease we have been learning very much more about during the last 10 years. In the old days if once one diagnosed G.P.I. you would say a person ought to die of it, but at that time it was thought to be something else. Now, however, it is known to be due to a specific organism; therefore it comes into the whole group of diseases caused by organisms. Therefore, scientifically, we are bound to come to the conclusion that it might be recoverable.

9192. *Mr. Dickens:* I have a book here on mental diseases, by Dr. Cole, in which he says that "about 7 per cent. of patients, however, improve marvellously and appear to get well, the disease being arrested for a period of months, or even a few years"—do you agree with that?—Yes.

9193. *Sir Humphry Rolleston:* What is the longest period of remission in your experience?—I have known of a case of certainly 15 years.

9194. *Earl Russell:* While we are on the Wassermann test, would you consider the one test sufficient?—There is a question whether he had another test, but you must remember it was during war time, and one was very heavily pressed for keeping notes. But I do refer in a letter here to "the last test." I can, however, find no record of it having been taken as another test. If it had been a test unsupported by clinical or physical signs, then I should certainly

say one test was not sufficient; but when you get a test which corroborates physical signs, it is very much more usual not to take a second one. It is a very difficult thing to take. It is to some patients extremely painful, and gives them a terrible headache; therefore it is not a thing that you would do lightly. You would not make it merely from academic reasons. When you have clinical signs supporting a bacteriological examination, I should say it was a proper and sufficient test.

9195. *Chairman:* But suppose, Sir Maurice, that the only history of the case you had was that a single Wassermann test had been taken of the patient, and that that test gave positive results; would you consider that sufficient to pass judgment upon the case?—It would be commonly done, yes.

9196. Do you think it would be reliable—that is what we want to know?—Yes, it ought to be quite reliable. The only point would be that if treatment were given, there must be a further test made later as to whether the treatment had been in any way successful, or whether there was an improvement taking place in the condition of the patient.

9197. But for the purposes of getting an indication of the nature of the disease, would you in practice just rely upon one Wassermann test?—Certainly. In a diphtheria case you do not go on taking tests; you treat the patient at once.

9198. *Chairman:* One positive swab is sufficient in that case?—Yes. You might get into very serious difficulties in certain conditions if you did not.

9199. I was asking that because one of the points Mr. H. made was that he considered one test was inadequate, and that three tests should have been made before a considered judgment upon his case was pronounced?—That is contrary to medical practice, certainly.

9200. That is not the only question, whether it is contrary to medical practice or not. The question is really whether one test is reliable and ought to be relied upon?—Certainly.

9201. *Mr. Dickens:* Then if during one of these remissions a Wassermann test is made and turns out negative, what effect has that on your mind? That the first test was wrong?—No, not necessarily.

9202. During a remission would a report of this sort be negative?—It might be negative; but there is an implication here that it might be thought that I had still in my mind that Mr. H., whom I have not seen for some time, might be in a remission stage of general paralysis. I do not want to put that in his mind. He has burden enough owing to his illness. I should not like in any way to suggest that to him, that he may be still suffering from that disease. I can only hope that he may have recovered; but the fact that a test was made and found negative would not indicate in the least degree that the first one was wrong.

9203. *Chairman:* I have found the passage about the mercury; it is in question 8621. Mr. H. said: "It is not true that he ever treated me with mercury; because the only mercury that ever came near me was sent by Maurice Craig—"that is you, Sir Maurice—"and I used it for lighting my fire."—At any rate it was prescribed.

9204. That is the important point?—Yes.

Chairman: Shall we just go on with the notes?

9205. *Mr. Dickens:* You, Mr. Macmillan, used an expression about a confirmed judgment as to the nature of the disease. I understand Sir Maurice, you never came to a confirmed judgment as to his disease?—No.

9206. You were suspicious, and this gentleman presented all the symptoms of this particular disease?—Yes.

9207. Then your next note is a note of 20th November, 1916, when you met his brother-in-law?—Yes, with Mr. E. H. "He was full of libel actions. Imaginary wrongs. Stoddart went with me. He felt that patient was probably certifiable but had very great difficulty in obtaining facts to make a certificate upon." I might say here that

26 January, 1925.]

Sir MAURICE CRAIG, C.B.E., M.D.

[Continued.]

of course this does not mean that he did not think Mr. H. was a person of unsound mind, but there are two points that a medical man is always faced with; one is that his certificate has to bear on the face of it evidence conveyed by another person that the person is of unsound mind. You may see and know a person, and from your own observation say he is a person of unsound mind, but it might be quite impossible to write anything down on a certificate that would convey to another person that that person was insane. Of course, in this case the difficulty was very great. It was much more by his general behaviour and conduct, and by the way he was writing huge numbers of letters. His views were much changed towards people and things. He was charging people whom he had not apparently charged before. He was now saying that the nursing home he had stayed at, which he had always spoken quite friendly of, had given him certain diseases, or at any rate he got diseases there—

Mr. Walter Stewart: Really, Sir, I submit that this ought not to be permitted. Mr. H. has never been suggested to have said anything of the kind. What he did say you know.

Witness: I am only saying what he told me.

Mr. Walter Stewart: We know what was written down.

Chairman: Mr. Stewart, you must really recall that Mr. H. had the utmost latitude from us; in fact the longest sitting of the Commission was given to him in order that he might put his case fully before us. I think we are also entitled to hear his medical advisers at the time.

Mr. Stewart: We have got this in writing, and the gentleman is being allowed to give evidence of something quite different from what is in writing.

Chairman: He is telling us what was in his mind as to Mr. H.

Mr. Walter Stewart: I have not been able to get access to the documents.

9208. *Mr. Dickens:* Will you go on with your notes please, Sir Maurice?—It was on that occasion that Dr. Stoddart signed his urgency certificate.

9209. *Earl Russell:* That is the 20th November?—20th November, 1916.

9210. *Chairman:* No, that is not right. He did not sign an urgency certificate on the 20th November, did he?—Yes, but it was never put in force.

9211. *Mr. Dickens:* As a matter of fact, you were in a position on the 20th November to send Mr. Holman to an asylum?—I would have been, yes.

9212. The legal formalities had been completed, and if you had been anxious to certify him and to send him to an asylum you could have done it there and then?—Yes. Mr. E. H. signed the order. He met us down there and signed the order, and Dr. Stoddart gave the certificate. But it was never put in force, as I will show you in one moment.

9213. *Chairman:* I think you might read the next sentence in the note of the 20th November: "He felt that patient was probably certifiable, but had very great difficulty in obtaining facts to make a certificate upon."—Yes, "but finally decided that, as he was threatening to go, he ought to be restrained." The difficulty that we were in at this time—indeed, it became more so ten days later—was that he was threatening to leave Dr. Dempster's. If he had left Dr. Dempster's in the state he was in—you must remember here was a gentleman who had shaved his head bald and taken his moustache off—he would most certainly have got into the hands of the police, and we should have had to deal with it after he had been taken up as a person of unsound mind wandering at large. Therefore it was improper for us to allow him to run the risk of this.

9214. *Mr. Dickens:* Would you read the note at the bottom of the page?—"Seen by Stoddart and he decided to certify, but felt that there was a difficulty." Now, there is a report by Dr. Stoddart.

9215. Dr. Stoddart will produce it. I do not want to read it twice.—If you please. On the next day,

the 21st November, there is a note: "Last evening patient talked matters over with Dempster and said that he appreciated that he was doing foolish things and writing far too much, and said that he would be willing to follow any rules laid down if he could remain on with Dempster." He knew there was a question of him leaving; indeed, I told him about the position he was putting us in. "When I talked to him he was quite clear, and asked me to frame any rules, and he would sign them. This he did, and took a copy for himself. I told him that both Stoddart and I were doubtful whether he was fit to retain his liberty unless he were willing to be guided." In the case of a patient of this kind who understands things, I always tell them absolutely the plain facts. I mean there are certain persons who, of course, would not understand if you told them, but with a patient in Mr. H.'s state I always inform the patient of the difficulty he is placing his medical advisers in if he does certain things, and why, and what it means. Now you will see that immediately afterwards, on the 21st—

9216. First of all, did he understand that it was a question of his liberty?—He certainly did.

9217. Did he write you two letters on the 21st?—Yes. He wrote me one before I saw him. This is his letter: "I feel I owe you an apology for bringing you and Dr. Stoddart down yesterday, especially when you are so busy. I have perhaps taken this illness too lightly, at any rate it is nothing to the 1914 trouble. In my stupidity I have been too ready to talk rather than to listen. I will in future write your instructions, and they will be honourably carried out. As a matter of fact, I have ever since I could smoke and eat ravenously been trying to harden myself. I feel now" (then there is a word I cannot read) "and have been about a good deal. I suppose it is the mercantile marine stubbornness. I feel rather bad about the nursing sister, but it is better to part, and will make it up to her later. I am afraid you think that Topsham Hospital a vision, but I do really mean to get on with it when you ease off the cables. With kind regards, I remain, yours sincerely, W. H. I want you to see my letter to 'Western Morning Post.'" I went down and saw him, and then I drew up this in front of him while we were talking.

9218. *Chairman:* What is the date of that?—This is dated the 21st, the same date as that letter. I went down at once. Dr. Stoddart signed that urgency paper on the 20th November. He talked the matter over. The patient knew perfectly well what Dr. Stoddart's view was and what my view was: that he was not fit to be retaining his liberty. Therefore he lost no time. He writes this letter himself. He gets Dempster to ring me up to get me to come down again, which I did. Then we talked it over, and I wrote this: "I am willing whilst I remain at 94, Brighton Road, to write only to my relatives and if I write to anyone else I will submit the letter to Dr. Dempster or to my brother Ernest"—that is, he will not write to strangers, without asking about it. "I shall be willing to stay in bed and fall in with any rules Dr. Dempster makes. I am willing to give up the hospital scheme and I shall take no further action about going to Brighton at the present time."

9219. That is sensible enough?—Yes.

9220. *Mr. Dickens:* That is signed by him; it is drawn up by you and witnessed by you?—Yes. That is dated the 21st November, 1916. Now he keeps that letter, and he writes to me on that evening, after I had left: "Dear Dr. Craig. I enclose your original draft of agreement and have handed copies to Dr. Dempster. So many thanks for all the trouble you have taken. I am writing to advertise in Notes and Queries. Gentlemen of antiquarian tastes or otherwise will receive every possible care and attention in house of medical man living in Torquay. Box 570, 11, Bream's Buildings, Chancery Lane, E.C." You will notice that this letter is not quite normal; it is a little distraught, but there is a good deal of it. "It looks fairly promising as a second string to my bow;

26 January, 1925.]

Sir MAURICE CRAIG, C.B.E., M.D.

[Continued.]

will submit replies later. Personally I feel at peace with all the world with the exception of Arms matter. Will you please consider what is best to be done. I am giving up flat at Brighton at the soonest possible date, viz., 30th December, 1916, I cannot under lease relet. Again thanking you." Then I write—

9221. There is a note first on the 21st November: "Patient expressed willingness to do anything we asked"?—Yes, I have read that.

9222. "Said he knew he had been abnormal"?—Yes. "I told him that both Stoddart and I were doubtful whether he was fit to retain his liberty."

9223. Did you make up your mind then that it was not necessary to send him to an asylum?—Yes; I was most reluctant to do so. I never wanted to do it. It is the last thing one wants to do, to send a patient into a mental hospital unnecessarily. All my difficulties were that if he was not going to be guided by me I was forced into the position, but he once more said to me: "I will be guided"—and here of course I was on very thin ice and on slender grounds, because I should like the Commission to appreciate that an independent medical man had now said he was a person of unsound mind and ought to be under care, therefore my legal position, or Dr. Dempster's legal position, was getting very doubtful. I was prepared even then to cancel, as I did cancel, the certificate, and never used it. I will read you the letter I wrote to his brother as to why I did it.

9224. That was on the 22nd, was it not?—Yes. That was the brother I had met with the doctor and who had signed the urgency order of the 20th November: "After leaving you on Monday I made all necessary arrangements for your brother to go down to Moorcroft; but yesterday morning Dr. Dempster rang me up saying that your brother had written to me and also spoken to him to the effect that he was perfectly willing to fall in with any recommendations and keep any rules that we made, and that he thought before anything was done it would be wise for me to go and have another talk with him, which I did yesterday afternoon. I put matters very clearly before him as to the difficulties he was placing us in by his want of judgment in writing letters, etc., and that I felt the responsibility so great that I had advised that further opinion should be taken, and that this opinion supported the view that he should be protected from doing unwise acts. Your brother fully appreciated the position and promised that he would sign any rules that we wished and keep them. These I drew up and he signed them. Under these circumstances, I felt that it would be improper to take any further action in the matter as to putting the certificates in force and sending him under care at the present time." So that as I say, it was the reverse of wishing to place him under care. I was most anxious to keep him out, as I had been all the way through.

9225. What happened between that date and the 9th which necessitated the urgency order?—Unfortunately I do not seem to have many notes about that time, but the point was that things fairly improved for a time—that means for a day or two; but of course Mr. H., with all sincerity and intent to keep an honourable undertaking—I am not saying he did not keep it, but his illness did not permit him to keep it, so that he was unable to keep it—passed straight away again into doing the very things about which he said he would be willing to abide by our decision, and the difficulties increased as to the number of letters that he was writing and the way he was writing. He had then got two monkeys in his bedroom, and the whole thing was getting impossible, and Dr. Dempster said he could not honourably keep him there because he was of unsound mind, and he felt he was doing some illegal act by detaining him.

9226. *Chairman*: He was paying, of course, for his keep?—Yes, and therefore I had to do something further in the matter to relieve him. Mr. H. himself was saying he was going to leave and go on his own.

9227. *Earl Russell*: No objection was taken to the monkeys, because they were allowed to accompany him to the asylum?—Yes. That is why I said Moorcroft, where I could send him with his monkeys. He was very attached to his monkeys. We were trying to meet him in every direction possible.

9228. *Chairman*: There is nothing necessarily wrong in a person having pets of that description?—No, except in a small room; with the monkeys living constantly together, the room was not altogether quite in a sanitary condition.

9229. I do not think the fact that a person has even a peculiar taste in pets is indicative of an upset mind?—Taken by itself it was nothing, but taken in conjunction with everything else it was a new factor.

9230. *Earl Russell*: Were the monkeys bought after the 21st November?—No, I think he had ordered them just before.

Mr. Walter Stewart: No, because it is in the certificate of Dr. Stoddart, "Mr. H. told me he had bought a monkey from the Zoo, and showed me the parrot cage he intended to keep it in."

Chairman: What was the date of that?

Mr. Walter Stewart: The 20th November.

Witness: He had not got them yet.

Chairman: I must say I do not attach much importance to the monkeys.

Mr. Dickens: I do not think Sir Maurice does.

Chairman: He might have had a parrot or something else, which might have been quite proper.

Witness: It was a new factor with him in that sense.

9231. *Earl Russell*: But not new since the 21st?—No, I am not saying that; but the real position was that Dr. Dempster said he considered he could not legally detain him.

9232. *Chairman*: That is a different point. An urgency order had been signed, and therefore Dr. Dempster's position became legally embarrassing?—Yes; that was the real point.

9233. *Mr. Dickens*: Will you read your note of the 9th December, Sir Maurice?—"Last night was abusive to Dr. Dempster and accused him of having him ill-treated at Teignmouth; he has written charges of all kinds. Last night threatened to leave. Still writing. I came down with Robert Percy Smith. Writing not affected." Now it was then Dr. Dempster had telephoned to me and said the position is absolutely impossible, and could I not do something. That I must take certain steps to have him either removed or have something done. I got into communication with his brother and decided that further opinion should be called in. Now, in calling in further opinion, I thought it would be unfair to call in Dr. Stoddart, or the patient might think it unfair, a person who had already prejudged the position; so I decided that I would call in somebody else, someone quite free, who knew nothing at all about it. Therefore, I called in Dr. Percy Smith, another physician of well-known repute. That was the reason Dr. Percy Smith was called in, and not Dr. Stoddart, on the second occasion.

9234. Did you see Dr. Percy Smith before he examined the patient?—No. I met him down there.

9235. Did you tell him the medical history of the case?—I gave him my history of the case, yes.

9236. And then he saw the patient alone?—Of course, yes, and had a very long interview with him.

9237. After that he drew up a certificate which you have seen, no doubt?—I have seen it, yes.

9238. Was that a certificate which was justified by circumstances as you knew them?—Absolutely.

Chairman: I think that is the certificate of the 9th December?

9239. *Mr. Dickens*: Yes. (*To the Witness*): What sort of length of time did that interview last?—A long time. It is a long time ago, and I could not say definitely. It certainly would not be under three-quarters of an hour or an hour.

26 January, 1925.]

SIR MAURICE CRAIG, C.B.E., M.D.

[Continued.]

9240. In your judgment did Dr. Percy Smith have sufficient information at his disposal to make that certificate?—Certainly.

9241. And in your view it was thoroughly justifiable under the circumstances?—In fact, it was the only alternative, unless we were going to allow him to wander outside and be taken up by the police.

9242. I was going to ask you why it was an urgency order and not a reception order?—The reason was that a reception order takes a longer time—that is, you have to get another medical man to see him, and also get a justice's order. Therefore he might have said: "Well, I am going; I am not going to stay any longer," and he might have left, and we should have had no power to restrain him, of course. Urgency is essential when a person is not under proper control.

9243. Then did Dr. Porter Phillips come on the scene?—Yes. Dr. Porter Phillips made the other certificate. He was another medical man.

9244. Have you seen his certificate?—I do not know whether I have; I could not say whether I have or not.

9245. You had better see it, Sir Maurice. Dr. Porter Phillips is also a gentleman of repute?—Yes. He is resident physician at Bethlem.

Chairman: We have it; it is dated the 10th December.

9246. Mr. Dickens: I want Sir Maurice to see it, and to say whether he thought it was justified under the circumstances. (To the Witness): Have you got it there?—Yes.

9247. "He was abnormally excitable, restless and loquacious. He was unduly effusive and communicative to me, a stranger to him, *e.g.*, he told me about his private affairs and invited me to his country house. He exhibits the physical signs of general paralysis." All that was true, and Dr. Porter Phillips had an opportunity of seeing and talking to the patient?—Yes. I did not go down; he saw him alone.

9248. Under the circumstances his certificate was justifiable?—Absolutely.

9249. And you yourself, if you had not been otherwise in charge of the case, but had been called in for the purpose of making an examination, would have come to the same conclusion?—Yes, absolutely.

9250. You had made up your mind that he was a person of unsound mind?—Yes.

9251. And then he went to Moorcroft, as we know?—Yes.

9252. There are some subsequent letters. I see you went to see him from time to time at Moorcroft—in fact you often went?—Yes; I saw him from time to time.

9253. And then he treated you as a friend?—Yes.

9254. I see you wrote a letter to his brother on the 3rd February, 1917—have you got that letter?—Yes.

9255. "I went down to see your brother yesterday. I have received many letters from him, but I was so glad to find yesterday that he was quieter and much more settled down. When I asked him about going away, he said that the weather was very cold, and that he thought it was fully early to get off yet." Do you remember in February talking about him going away, and his saying it was fully early to get off yet?—Yes, I do.

9256. "And under the circumstances it would be better to wait before giving him a change. He talked quite cheerfully and did not make any complaints at all."—Of course there was Dr. Macnaughton's report between that, on the 29th December. You saw that?—Yes. There was a letter from his brother asking that he should be sent down. There was a letter from Mr. E. H.

9257. Mr. Walter Stewart: What would be the date of that?—The 24th December, 1916. "I have just had a call from one of my brother W.'s greatest friends. He is very anxious that G. W. F. Macnaughton of 33, Lower Belgrave Street, Eaton

Square, should be asked to advise whether he considers there is organic disease (I understand you were not quite definite on the point yourself) and if there is no organic disease what treatment he would recommend." So that I had been perfectly open to the friends, as I was to everyone. "Unless you see good reason to the contrary will you get this done promptly." Of course one was only too glad to have anyone and it was arranged that he should go down. I did not meet him.

9258. Chairman: Will you tell us whether Dr. Macnaughton is an expert in this branch of medicine, or was he a general practitioner?—I suppose he was in general practice. I do not know very much about him in that way, but he was asked by his own friends and relations.

9259. Mr. Dickens: At all events you saw his report, and it was a justifiable report?—Yes. He wrote to me "I am leaving this envelope open and perhaps you would be so kind as to forward it after you have seen it as I do not know the address." He had not got the address of the brother, so he forwarded the letter through me. He puts as a post-script: "I had a very kindly and courteous reception from Dr. Stilwell and Dr. Cole"—that is at Moorcroft. Then he wrote this report, of which I have a copy here; perhaps the Commission have already had it.

Chairman: Yes, I think we have had that.

9260. Earl Russell: Just before you read that report, you said you saw him at the asylum, and that he made no complaint. Did he make no complaint of detention?—No, he never made any complaint that I am aware of, to me. I think a little later on there was a complaint; I would not like to say definitely without looking at my note, but it was nothing of any serious point at all. Even when he was taken back he made no complaints on that occasion.

9261. He did not tell you that he was wrongfully detained at that time?—No, even when he escaped and had gone back.

9262. Mr. Dickens: You saw him after that?—I saw him after that. He was in a very happy condition and made no complaints whatever, either about his treatment or of his detention. This letter of Dr. Macnaughton's is from his own friend—nothing to do with any expert persons at all. "I visited Moorcroft to-day and examined Mr. H. He is mentally deranged and requires to be under care and treatment. This is readily ascertained from his conversation, some of his actions and his markedly facile manner. It is not easy to perceive at present signs of organic brain disease, although two early ones are present, namely, slight irregularity of the right pupil and a tremulous tongue. These symptoms along with the mental state, would denote almost invariably the early stages of general paralysis of the insane, it will, however, be two or three months before one can be positive as to the course Mr. H.'s trouble will take, but meantime one cannot consider the outlook good."

9263. Mr. Micklem: Was that in December?—That was on the 29th December, very shortly after he got there.

Chairman: Yes, we have that report already on the note in last Saturday's proceedings.

Witness: There is a report that he had an attack of jaundice when he went in. He was subsequently operated upon at Ticehurst.

Mr. Dickens: Does the Commission want to go any further with Sir Maurice?

Chairman: No, I do not think so.

Witness: There is one medical point there. He does rather suggest that we were not careful enough and ought to have done that operation earlier.

9264. Chairman: Now there is one question I would like very much to ask you, Sir Maurice. The reports contain what is no doubt from the point of view of the patient a very serious matter, namely, that he exhibits physical signs of general paralysis. Mr. H. subsequently came to know that these certificates contained that statement. Of course, you

26 January, 1925.]

Sir MAURICE CRAIG, C.B.E., M.D.

[Continued.]

will appreciate that from the point of view of a patient such a diagnosis is a very grave matter?—I think I have already said so this morning.

9265. I want to follow out with you what we are thinking on the subject. It is naturally a very grave matter because of the implications of that disease?—Certainly.

9266. It might indeed have unhappy social implications in many cases?—It is a difficulty we are faced with in many cases.

9267. What I want to know is this: Was that statement, that the patient exhibits physical signs of general paralysis, essential to the finding which is the important finding in such certificates, namely, that the patient was found by the medical examiner to be a person of unsound mind. Let us assume that the sentence, "He exhibits physical signs of general paralysis," were deleted altogether from the certificate. Were the other circumstances of the case, the clinical record of the case with which you were familiar, sufficient in your opinion to warrant the pronouncement that he was of unsound mind, apart from the signs which had been noted and were said to relate to general paralysis?—I wish to give a fair account of this. It is to convey to some other person something, that is the intent of the certificate, and to give the Board of Control a fair opportunity of knowing and appreciating what is said in the other part of the certificate in a case like this. I should say that it was really the right action to take in putting it in. I fully appreciate that in law it would be unnecessary, because detention is not necessary for the organic disease—that is, a person suffering from general paralysis would not necessarily be detained as a person of unsound mind. I take it that is your point, Sir.

9268. It is not quite that so much as this: one recognises that a medical man may make a mistake in the diagnosis of a disease, just as any other expert person may, and one recognises also that certain diseases are very difficult to diagnose apart from mental disease. One disease simulates the symptoms of another, and so on. Hence the possible inaccuracy of the diagnosis, the name attached to the symptoms, may be wrong. But what is of much more concern is this—whether the patient's conduct and condition, as clinically observed by you, was such as in your opinion to justify a detention order being pronounced in this case.—Certainly; his conduct was quite sufficient.

9269. Certain symptoms were seen to which the name of general paralysis was attached; but it is much more important from the point of view of deciding whether a person should be detained, whether his conduct is such as to merit detention. One might say that the case was a case of dementia præcox, shall we say, which was not the fact at all; but still was a case of unsound mind. Therefore the actual name applied to the symptoms may be wrong, but the mental unsoundness may be present?—Yes, I see your point; but of course you must remember that medical people can be attacked from either side, for sins of omission, or sins of commission.

9270. Certainly.—A person wants to convey as much to the person who reads the certificate as he himself knows, or, at any rate, thinks he knows, at that time.

9271. He ought sincerely to set out the matters which seem to him to be important?—It is a private matter. One fully appreciates that the law permits that when a person recovers he shall get the certificate. Therefore is the medical man to write the certificate in such a way that it shall be acceptable to the patient when he recovers, or shall it be written in such a way as to contain full information to those in Government Departments who are responsible for saying whether his detention is wrong?

9272. Plainly the latter. He must sincerely set down the things he has observed, and the inferences he has drawn.—I quite see your point.

9273. *Mr. H. C. Dickens*: Would it be fair to say this, that the certificate purported to say two things, first that the patient is of unsound mind, and, secondly, to explain what in the certifier's opinion is the cause of that?—Yes, it may be superfluous, or may be regarded as superfluous.

9274. But it is helpful?—Of course in the majority of cases I am thankful to say that in medicine we make more correct diagnoses than bad ones. I see the point. In many other cases it might be very helpful.

9275. *Earl Russell*: Is it not more than the Board of Control—do you not want to convey to the people who will be responsible for his treatment what his treatment should be?—I quite agree—that is another point.

9276. *Mr. H. C. Dickens*: And there is also the question of the justice of the peace?—I do not know so much about him.

9277. But should you not give him all the information in your power?—Oh, certainly, but it might be arguable whether that would help him. Certainly it would be very helpful to medical people, or might be.

9278. *Chairman*: What I really wanted to know was this, whether the diagnosis that those symptoms were the symptoms of general paralysis was vital to the pronouncement that this gentleman was of unsound mind?—No, but there are two factors here. One is drawing attention to the condition itself. It is the data upon which the case is sent in to other persons. It may be regarded as superfluous, but in some cases it might be very important. I can quite imagine cases in which this would be of infinite importance, in the case, for instance, of some legal or criminal trial in which it was a question of having it on record that medical men appreciated a certain disease at a certain time. It is not only this you are dealing with; you may have many, many other factors coming in.

9279. *Mr. Croom-Johnson*: Sir Maurice, you know Moorcroft?—I do.

9280. It is apparent from the record of the attendances in this case that you saw Mr. H. at Moorcroft on many occasions?—Yes, I did.

9281. And you have also, I take it, seen other patients from time to time in the course of your practice?—I have.

9282. Do you recollect seeing him in what was described as the large room at Moorcroft?—Yes; after he had returned. Of course, he had his own room, but then he had used his own room in order to escape; therefore when he returned, in order to give him a certain amount of liberty, as much as they could do, they put him in what you call there the large room so that he could go about; but he would always be under the observation of some person.

9283. Rather more supervision of the attendants?—Quite.

9284. Do you know that room well?—Quite well, and he made no complaint.

9285. I was going to ask you that. Did he make any complaint when you saw him in the large room of his being there?—None at all; in fact it rather interested him to study the cases of other persons.

9286. He made no complaint. Was there anything when you were there which would indicate that that room was not a fit and proper place for him to be in?—No, nothing at all.

9287. Just look at that photograph, if you know the room. (*Handing photograph to the Witness.*) Is that the room as you know it?—Yes.

9288. A suggestion has been made here by counsel that that is a dishonest photograph dressed up for the occasion.

Mr. Walter Stewart: What was said was that the people who occupied it, 14 in number, were not represented in the photograph. That was what was said by counsel.

Mr. Croom-Johnson: It is Question 9075 at page 36. "It is a dressed-up photograph, to show what a pretty place it is."

26 January, 1925.]

Sir MAURICE CRAIG, C.B.E., M.D.

[Continued.]

Mr. Walter Stewart: It was my friend who put it about the dishonesty. What I complained of was that it did not show the people who were in it.

Chairman: That is running away from the point. The answer made by Mr. H. was: "It is a dressed-up photograph to show what a pretty place it is. (*Mr. Croom-Johnson:* Is my friend suggesting that it is a dishonest photograph? (*Mr. Walter Stewart:* I do suggest that. (*Mr. Croom-Johnson:* I would rather like to have this matter made perfectly plain. (*Witness:* It is a dishonest photograph.")

Mr. Walter Stewart: But there was a reason given as to why it was suggested, namely, that the people were not shown in it.

Chairman: That may be.

9289. *Mr. Croom-Johnson:* Sir Maurice, is that a photograph of the room as you know it?—Yes, I have known it many years.

9290. And have you interviewed other patients in that room from time to time?—Yes.

9291. In your view was it a proper thing to put Mr. H. in that room?—Yes, I think it was the kindest thing. He was allowed much more freedom there. Otherwise it would mean that he would have to sit in a room with a male nurse; whereas in that room he could wander about. It was a much larger room and he had much more freedom.

9292. He would have other people to talk to and something to interest him, to take his mind off the fact that he had escaped and had been brought back again?—Indeed he told me so.

9293. *Chairman:* But another point which is important is that Mr. H. says that the persons who were with him in that room were unpleasant. "I had a number of very objectionable people with me. They were incontinent; they were noisy; they were bad cases—all of them. They had to be under the strictest supervision; there were two warders always in the room with them; and they were the most objectionable neighbours to any one with any sense of decency." I can quite imagine that if the people were of that description, it would be very unpleasant for Mr. H. to find himself in a room, however well furnished and however pleasant the room might be, if the occupants of the room were disagreeable persons?—I have never seen a noisy person or a person of that type in that room; he would not be there in that case. A person of that type would be in his own room entirely.

9294. We can only ask you for your own observation. You visited this gentleman on several occasions. On the occasions when you were there, were there persons of a noisy, incontinent and objectionable type in the room with him?—I have never noticed in that room any objectionable smell at any time.

9295. *Mr. Croom-Johnson:* Or objectionable people?—No; in fact I have known patients a good deal more normal than Mr. H. was at that time.

9296. In that room?—Yes, in that room; sitting drawing and doing things, amusing themselves.

Chairman: The real question is just this: Whether when brought back after his escape he was put into a place where he had to associate with disagreeable and nasty people, which might be regarded by him as a form of punishment upon him for having tried to run away.

9297. *Mr. Croom-Johnson:* Did you observe anything of that kind?—Nothing at all.

9298. Did he make any complaint of anything of that sort?—Never. He regarded it in an amused way, as he did everything. He knew me fairly well; I had looked after him for a long time; he had never kept anything from me that I was aware of. He was always very friendly. If he ever had difficulties he would always write or tell me about them, and I would certainly have seen that it was put right.

Chairman: Have you got all the material you want, Mr. Stewart? Have you got a copy of the notes?

Mr. Walter Stewart: I have not the letter of the 17th February, 1918, yet, Sir.

Chairman: I want to see, first of all, that Mr. Stewart has the proper materials to put his questions upon. Have you got a copy of the witness's notes?

Mr. Walter Stewart: Oh dear no, Sir. I had no idea of all this notetaking.

Mr. H. C. Dickens: You can have all my letters.

9299. *Earl Russell:* Just before we leave the subject of this room I want you to direct your mind to this. Mr. H.'s escape was made by night from his bedroom. During the time he was occupying this room, he was allowed to occupy that bedroom at night from which he had escaped; so we would rather like to know whether this room was not in fact rather a punishment than a protection against escape?—Moorcroft, you know, is one of the most open of all these mental hospitals; the doors are not locked, I mean. There is an obligation upon them to see that a person does not keep repeating these things, and they are responsible to the friends. If a person does it by night it does not mean that he will not do it by day.

9300. Still he continued to occupy the room from which he had escaped. The two things are not quite consistent?—I see your point. He was not placed in a dormitory, you see.

Earl Russell: I daresay we shall hear about it from Moorcroft.

Mr. Croom-Johnson: We might as well tell the Commission that the evidence that will be given will be that after the escape he had a man with him at night, which he had not before.

Chairman: Now, first of all, there are the notes which Sir Maurice Craig made of Mr. H.'s case. Unfortunately the copies of them seem to be very few, I have one here; perhaps Mr. Stewart will use my copy.

Mr. Walter Stewart: As this is the first opportunity I have had of seeing these notes, perhaps I might postpone any cross-examination arising directly upon them to a more suitable occasion.

Chairman: Mr. Dickens made exactly the same complaint, that you had not formulated your charges against the doctors, and he was in a difficulty in cross-examining. However, he put his questions that day and allowed us to get on. I think you can quite well put your questions to Sir Maurice upon the material you have, and I am very anxious that you shall have everything.

Mr. Walter Stewart: All I desire to say with regard to Mr. H.'s evidence is that his *précis* had been circulated to every member of the Commission many days before he gave his evidence, and copies had somehow or other got into the hands of the other side, if I may so express it; so that it is not quite a parallel position.

Chairman: Perhaps it is not. If I have done you an injustice I am very sorry, but I want you to have just now all the material you ought to have. If you have any difficulty in getting any paper, please let me know, and I shall see you have it.

Mr. Walter Stewart: I am greatly obliged, Sir.

Mr. H. C. Dickens: I think Sir David Drummond wanted to see the handwriting of Mr. H. There were two original letters I handed in addressed to Dr. Cole. We have another one here addressed to Sir Maurice Craig in September, 1917. (*Handing in the same.*)

Witness: This was very much later—nearly nine months later. He sent me a postcard: "Dear Craig, —Will try and see you shortly. You were ill-advised to make a confidant of the late H. H. Newington. You must realise what professional jealousy is. Cole is also 'censored.' Kind regards, W. H. (*Handing the same to Sir David Drummond.*)

Mr. Walter Stewart: Before I begin my cross-examination, Sir, I would desire to call your attention to the terms of Section 28 with regard to certification: "Every medical certificate under this Act shall be made and signed by a medical practitioner. (2) Every medical certificate upon which a reception

26 January, 1925.]

Sir MAURICE CRAIG, C.B.E., M.D.

[Continued.]

order is founded shall state the facts upon which the certifying medical practitioner has formed his opinion that the alleged lunatic is a lunatic, distinguishing facts observed by himself from facts communicated by others; and a reception order shall not be made upon a certificate founded only upon facts com-

municated by others." So that it requires that the facts should be disclosed.

Chairman: I think that is clear, and the statutory form of the certificate shows that also. We quite have that point.

Mr. Walter Stewart: If you please, Sir.

Cross-examined by Mr. Walter Stewart.

9301. Sir Maurice Craig, I want to ask your opinion on this. I do not think you were present, were you, at the early sittings of this Commission?—No, I was, unfortunately, laid up.

9302. Do you agree with this view which was expressed by Sir Frederick Willis: that, after all, the real safeguard of the patient depends upon the appointment of upright and responsible men as heads of institutions?—Certainly.

9303. And do you agree that as far as possible there should be no conflicting interests between the duty which the upright and responsible person owes to his patient and his own interests with regard to money?—Certainly.

9304. You agree with that?—Yes.

9305. I thought you would. So that you would be prepared, I take it, to agree to one of our recommendations, at any rate, namely, that as far as certification is concerned the remuneration of no official functioning should be dependent upon the nature of the certificate?—I mean a person who at the present time may have or has any financial interest, if you use the word, is barred; no such person could certify.

9306. Does a doctor get the same fee, whether he certifies or whether he does not?—Certainly. You are asked your opinion.

9307. So that the certificate is paid for, in any event, at the same rate. Now I noticed that you laid stress on the fact that Mr. H. was what was termed unduly loquacious; that means that he talked a good deal and rather fast, and did not always confine his answer, when he was answering a question which was susceptible to a plain Yes or No, to Yes or No?—I would not like to say that at all. When you speak of a person in his state you must remember he was wandering from subject to subject, as you may note in his letters; they are not altogether in sequence.

9308. It would not, in your view, necessarily be a sign of mental derangement if a person who was asked a question, which was susceptible to the plain answer of Yes or No, answers at some greater length?—Certainly not.

9309. But may I ask you, if I put a question to you which is susceptible to the plain answer Yes or No, that you would answer it by saying Yes or No?—Certainly. I am the person of unsound mind!

9310. I ask you to do that if you would kindly, just to shorten the proceedings?—Certainly.

9311. Are you acquainted with the institution known as the Medical Research Committee of the National Health Insurance?—Yes.

9312. I am going to invite your opinion on something that appears in their publication dated 1918, and reprinted in 1921 with regard to this Wassermann test. You have said already to the members of the Commission that it is contrary to the medical practice to make more than one test. Now just listen to this, which is at page 5 of the Report in question: "Quantitative investigations of this kind have already been undertaken in the Local Government Board laboratory under the general direction of Lieut.-Colonel Harrison, but it can hardly be hoped that these will bear fruit before the end of several months. The Medical Officer of the Local Government Board has kindly undertaken to communicate to the Committee the results of this work as it proceeds, and if necessary it will be supplemented by additional work undertaken elsewhere on behalf of the Medical Research Committee. Therefore, while convinced that the Wassermann test when properly performed affords most reliable information, the Committee are of opinion that, for the protection of the individual,

in all cases, where the only evidence of syphilis is a positive Wassermann reaction, the serum should be retested before a diagnosis of syphilis is based on this sign alone." What do you say to that? Do you agree with it?—It was done twice in this case.

9313. I ask you do you agree with that?—I should say it is very proper. It was done twice in this case. They are only referring to blood here. The blood was tested, and subsequently the cerebro-spinal fluid.

9314. Listen. "The serum should be retested." Was the serum retested in this case? You can answer that, Yes or No.—You want the truth?

9315. I want you to say whether it was retested.—I am going to give you the whole truth, and that is that the cerebro-spinal is an infinitely finer test than the serum.

9316. I ask you was the serum retested?—The serum was tested once, as far as I know.

9317. Then we will pass on. What was recommended here in this case was not done?—Something more important was done.

9318. Listen to this: "In the present state of our knowledge the Wassermann reaction is an empirical one. There is every reason for hoping that it may eventually be brought within the domain of exact physical chemistry and reduced to a simple chemical test. But it is the opinion of the Sub-Committee that, until this is so, the original Wassermann test, with its full controls, is the best adapted for general use, though it may be supplemented, for the control of treatment, by more sensitive short-cuts, that is, by those admittedly likely to yield a larger percentage of positive reaction. The Committee would go further and recommend that in tests made for official returns only those methods shall be accepted which conform with the original Wassermann test as defined below, and that the so-called 'short-cut' methods are only to be accepted by way of voluntary supplement to the official tests." Do you agree with that?—The test that we went upon was not the Wassermann pure and simple; it was the cell content in the cerebro-spinal fluid, which is a very different thing, very much more important and more conclusive.

9319. Will you now answer my question? Do you agree with what I have just read?—This is technical. I am afraid I am not a bacteriologist.

9320. Would you rather express no opinion?—I am not a bacteriologist.

9321. At any rate, as to practice I will ask you this question, founded again upon this document: "The responsibility attaching to any imperfection or slovenliness of technique is so great, and the results of a false diagnosis may bear so heavily upon a patient and his family, that the Committee believe that the whole weight of responsibility for the reports made should be borne by a fully-qualified pathologist."—They were in this case.

9322. You have told us there was no retest.—Here we fulfilled what they ask, that is, it was done by a bacteriologist. It was not done by me or by any general practitioner; it was done by a bacteriologist of known repute.

9323. "The report of a pathologist that a given blood-serum has shown a positive or a negative Wassermann test has a greatly diminished value for statistical purposes, unless the report is coupled with a statement of the particular method employed."—It is in this case.

9324. Very well. "It is well known that no statement of this kind is commonly provided." Show me in connection with Adler's test, what was the method employed?—Hecht's modification of the Wassermann blood. That was on the blood side. There were two

26 January, 1925.]

Sir MAURICE CRAIG, C.B.E., M.D.

[Continued.]

tests made at the same time, one of the blood and the other of the cerebro-spinal fluid. It was the cerebro-spinal fluid that carried weight with us and not the blood. All that you have been reading there has relationship to blood, and to blood only.

9325. You do not appreciate—it may be my fault—what is the purport of my question. The question is: Does that show what the technical method of the test was?—Yes, Hecht's modification. He tells us here.

9326. Now I understand you have committed yourself to the view that once syphilitic always syphilitic?—You mean as far as the test is concerned?

9327. No—as far as the patient is concerned?—I have not committed myself to any such thing. A person can be cured of syphilis.

9328. Very well. So that a person might on one occasion, according to you, as I understand, show a positive reaction and on a subsequent occasion a negative reaction?—That is true.

9329. Owing to what?—Owing to the change in the toxin.

9330. Due to treatment do you mean?—It is generally due to treatment but over an extended time; that is, a person without treatment can become negative over a length of years; that means that the blood cells can themselves correct the poison. It is the tissue cells that really do the destruction of the poison in the end, and all these other things are only to assist the tissue cells to eliminate the poison.

9331. Does that mean that in your view this very unpleasant disease may run its course and the patient become free from it?—Yes.

9332. I am glad to hear you say that. You do not suggest that you know of your own knowledge that Mr. H. ever underwent any treatment after Adler's certificate, do you?—I say that I prescribed it.

9333. Have you got a copy of the prescription?—I did not write it. I only spoke to Dr. Dempster.

9334. But he left Dr. Dempster immediately, did he not?—No, he did not.

9335. Within a very short time?—Within five weeks.

9336. And Dr. Dempster is dead. You know Mr. H. has sworn that he never in his life was subjected to mercurial treatment or to any treatment for syphilis?—Yes.

Mr. H. C. Dickens: He said it was given to him and he put it on the fire?

9337. Mr. Walter Stewart: Yes, sent to him. (To the Witness): But if he was with Dr. Dempster there would be no occasion, would there, to send it?—Dr. Dempster would get it from the chemist.

9338. Now let us come back to this gentleman who was the distinguished medical gentleman, as we have agreed to call him—Adler?—He was a known pathologist.

9339. Was he a friend of yours?—No.

9340. One of the unpleasant things that Mr. H. has said with regard to some of you gentlemen—you know the expression he used—we will call it a coterie for the purposes of this case.

Chairman: Do not flinch from it. Call it a gang.

9341. Mr. Walter Stewart: That is what he called it. (To the Witness): Were you on the mere relationship of a medical man working in conjunction with somebody whose name you knew as a bacteriologist?—Dr. Adler was very little known to me; he had never had a meal in my house, or anything of the kind; I did not know his relations. I do not know what further I can tell you to show that I had no intimate relationship to him.

9342. Were you collecting the 15 guineas on his behalf?—I was responsible for it.

9343. I am asking you whether you were collecting the 15 guineas?—Dr. Adler died. He got pneumonia very shortly after doing this. Dr. Adler, I understand, had six sisters who were dependent upon him, and when I called in Dr. Adler I was responsible for the fees, and therefore I should see that the money was sent to the sisters; indeed Mr. H. knew about the death of Adler, and he knew about the sisters.

9344. From you?—From me, I suppose, yes.

9345. Did you write to him saying that Adler was an old friend of yours?—No. I do not think so. I cannot imagine I did.

9346. Let us just see. 30th November, 1916: "Dear Mr. H., I herewith enclose memo. of fees." Was he dead or alive then?—I am afraid I cannot tell you that.

Mr. Walter Stewart: "I herewith enclose memorandum of fees as you ask. I am also sending you the memorandum of Dr. Adler's fees for going to Croydon and testing the blood and spinal fluid. You will be sorry that he has died after a few days' illness. It is all too sad, as he had six sisters, who lived with him and were dependent upon him. I will get a receipt from his executors and send it to you. The weather is very cold, so be careful. With kindest regards"—and so on.

Earl Russell: Where is there anything about an intimate friend in that?

Chairman: Do you think that helps us in the least in our inquiry, Mr. Stewart?

Mr. Walter Stewart: That is not the only answer.

Chairman: One knows that when your private practitioner calls in a consultant, you pay the fee in that case. There are some very important matters, Mr. Stewart, which I think you ought to attend to.

Mr. Walter Stewart: I only want to see what was the relationship between Dr. Adler and the witness.

Chairman: We are not impressed with the expression "the gang."

Witness: I have the answer here; it is dated the 1st December, 1916.

Chairman: Please remember, Mr. Stewart, that all this has to be recorded at the public expense, and we must really keep a check upon our notes.

9347. Mr. Walter Stewart: Certainly, Sir. I am passing from it at once. I only wanted to see what Dr. Adler's position was. (To the Witness): Now that being so, you have told us that you indicated. I gather, to Mr. H. with what object this test was being taken. Is that so?—Not necessarily at all.

9348. Did you tell him or not?—I do not remember that I did; I could not say, it is so long ago.

9349. On the contrary, did you not indicate to him that it was a matter connected with curative treatment?—No; certainly I did not do that. I may have said that I wanted his blood examined because there were certain symptoms I should like cleared up.

9350. At any rate you never thought it necessary to tell him why?—If there is any reference to curative treatment it would be in this way, that the curative treatment would be dependent upon what I discovered. It is conceivable that I put it in this way, but it would not be put as the primary reason for the investigation. Treatment would be the proper proceeding after any discoveries were made.

9351. Then from first to last did you ever indicate to Mr. H. what was the object with which he was asked to submit to this test?—I have no record of what I said.

9352. Have you no recollection of it?—It is eight years ago. I should not like to say what I said at that time. I certainly would not tell him a lie.

9353. You would not be a party, I mean, at all to any practice of deception upon any patient of yours?—Not knowingly.

9354. Who sent Dr. Porter Phillips down?—Dr. Porter Phillips would be asked to go down—

9355. By whom?—It might be by myself or by Dr. Dempster.

9356. I put it to you it was by you, and also Dr. Percy Smith?—Very well.

9357. Tell me this: On whose behalf were you acting?—I had been acting for the relations of Mr. H. I was acting for Mr. H. himself. You must remember that Mr. H. had been coming up voluntarily, willingly, at his own request, to see me, for over 12 months.

26 January, 1925.]

SIR MAURICE CRAIG, C.B.E., M.D.

[Continued.]

9358. On whose behalf were you acting when you sent down Dr. Percy Smith and Dr. Porter Phillips?—I should be acting then probably on the brothers' behalf.

9359. Did you ever tell your patient, Mr. H., that?—That I was acting on his behalf?

9360. Why do you repeat the question unless it is inaudible? Did you ever tell Mr. H. at this critical period that you were acting on behalf of his brother?

—No, I was not acting on his behalf in that sense. As you know, I have already read out that I told Mr. H. very definitely why he was having a further consultant called in.

9361. Now, will you answer my question: Did you ever tell him you were acting on behalf of his brother?—I was not acting on behalf of his brother. I was acting on my own behalf, as a medical man, to do my best by him.

9362. You have told the Commission that you were acting on behalf of Mr. H.'s brother. I ask you as a further question whether you ever told him that?—You take part of an answer, take it out of its context, and turn it round. You asked me on whose behalf I was acting. I told you I was acting on the patient's behalf and on the patient's brother's behalf.

9363. What you told me a moment ago was that you were acting on behalf of the brother?—And the patient.

9364. I know you were. Did you ever tell the patient that you were acting on behalf of his brother? Did you ever tell him that?—That was general knowledge. I do not think I ever should have told him.

9365. Do you mean to say it was within the knowledge of Mr. W. H. that you were acting on behalf of his brother, who was the petitioner?—That all depends upon the sense in which you are using the word "behalf." W. H. knew that I was seeing his brother.

9366. I daresay he did. But what you have not answered yet is: Did you ever tell Mr. H. that you were acting on behalf of Mr. H.'s brother, who was the petitioner?—Do you mean individually, and for nobody else? I never was acting on the brother's behalf.

Chairman: Please wait a moment. Is this of any value to you? A doctor does not act on written instructions as a solicitor acts for a particular client. A doctor who has a patient in a difficult situation is acting in the interests of all concerned. He is called in on behalf of the family. It is of no assistance to us.

Mr. Walter Stewart: With respect, Sir, what I want to show is that in these cases the system permits the medical man to act in an inconsistent capacity, to hunt with the hare and run with the hounds. This witness has just said that he was acting on behalf of Mr. H., who was his patient, and on behalf of the petitioner, and I want to show you that so long as that is clear, the importance of it is for you to determine. We think that is not right.

Witness: You are referring to some system. I do not know what system you are referring to.

9367. I think it is clear to the Commission. Just listen to this letter, if there is any doubt about it. It is dated February 27th, 1918. It is the one I have had such difficulty in getting. "Dear Mr. H.,—Although your brother asked me on several occasions to see him, I was not taking my instructions from him as to visiting, but from you and Mr. E. H.; therefore it would be improper for me to send in my account to the patient, as it dates from the time when he was regarded as being a person of unsound mind." So that you sent in the account to Mr. H.'s brother?—The point was that the brother had asked me to forward the account to his brother, and I refused for the simple reason that, as he was considered to be a person of unsound mind, I thought it was improper to debit him or to have negotiations with him. Therefore I say that I only can send it to him to deal with, and he can deal with it as he likes.

9368. When did you begin to act for the petitioner H.?—I never did begin to act for the petitioner.

9369. From what point did you begin to take instructions from him?—When a person is placed under care, then his liberty is transferred to his brother. That is what the legal documents mean. You are transferring the liberty of the subject to some other person, usually a relation. From that time on I deal with the relation only.

9370. Was that the reason why you were so anxious to get that cheque for £90 odd, which was given by Mr. H. a day or two before he was taken away to Moorcroft?—Let me explain that. I quite appreciate the inference.

9371. *Mr. Dickens:* It is a very offensive inference?—It is a principle that I myself have always strongly held, that one should not be having monetary relationship with a person who is of doubtful sanity. Now in this case Dr. Stoddart saw Mr. W. H. on a certain date.

9372. *Mr. Walter Stewart:* 20th November?—Yes; and I sent Dr. Stoddart's account to his brother. His brother sends on the account, Dr. Stoddart's account, to W. H. himself, and W. H. pays that account; and he had been pressing me for some weeks before to let him have my account.

9373. You know he says you pressed him?—Let me tell the story, anyway.

9374. Certainly?—I had been attending him throughout the year, and he had asked me for his account and I had put it off; but when Dr. Stoddart was paid he said, "You ought to be paid too." And you must remember that after that incident in which I accepted his word—that is the document in which I said, "I am going to treat you as normal as nearly as I can if you will only abide by certain conditions"—it would have been an insincerity on my part; I wished to treat him absolutely sincerely according to his own signature; and that document in which he said, "I will abide and will behave as you feel I ought to"—it was on that condition only that I received money from him.

9375. Do you regard that as a simple and straightforward answer to my question?—Absolutely. I think it is borne out by the correspondence.

9376. You thought Mr. H. was unduly loquacious, you told us. Was he, or was he not, in your view, of unsound mind on the 20th November, 1916, when Dr. Stoddart gave that certificate?—Yes.

9377. And after that you asked him for a cheque and got it?—Yes.

9378. Did you do anything else after that with regard to his will?—A good deal had happened before that. With regard to his will, he told me all about his will.

9379. Were you one of the legatees?—I was just going to tell you about that. He talked to me about the will, and he said, "I propose to put you in this for a sum of money." I said to him: "Now you are placing me in a very serious position. I can only ask you not to do this. Remember I am in a fiduciary position." We never let him do it; at any rate while he was under my care the will was never made, and I besought him not to.

9380. He says he told you, "I will put you down for £3,000"?—He told me he had put me down for £1,000.

9381. He told you that?—Yes.

9382. When did he tell you that?—I could not tell you the date. He did not tell me he had put me down; he told me he was going to, and I besought him not to.

9383. And up to what time was this will the subject of his solicitude?—I could not remember. As I have already read out, Dr. Dempster had asked him not to make this will. He told me that himself. I urged him not to make the will, and as a matter of fact as long as he was under my care he did not make the will. Mr. W. H. will remember that I told him that while I was in the fiduciary position in which

26 January, 1925.]

Sir MAURICE CRAIG, C.B.E., M.D.

[Continued.]

I was, I must beseech him not to do anything of that kind.

9384. Was not the will actually the subject of further consideration when he was afterwards at Moorcroft?—Never, as far as I was concerned; in fact I did not know about that until I saw it the other day. I never knew it was ever made.

Earl Russell: Which is the answer in which Mr. H. said that Sir Maurice Craig was pressing him to pay his fees?

Mr. Walter Stewart: It is quite at the end, in the re-examination.

Witness: You know there is a letter here in which he said: "Many thanks for your skilful attention." I mean he himself wrote to me in that way.

Mr. Dickens: "The cheque for 90 guineas I was asked for several days before my incarceration, and it evidently showed a guilty knowledge on the part of the person who asked for it."

Chairman: That is Question 9085.

Mr. Dickens: He deliberately says he does not mention names.

Mr. Walter Stewart: Here it is in writing, 30th November, 1916: "Dear Mr. H.,—I herewith enclose memo. of fees."

Witness: Yes.

9385. Was that the memo. in return for which a cheque for £90 odd was sent?—Yes.

9386. Then you did ask for it in writing.

Earl Russell: That is not pressing him for it.

Chairman: Why use epithets of that sort, which convey an impression?

Witness: He asked for it himself. I never asked for it; he asked me to let him have it. You must remember I could not go on refusing.

Mr. Walter Stewart: At any rate there is the letter, which I put in.

Earl Russell: That is all very well, but nobody regards his tailor as pressing for his account, simply because he sends it in once a quarter.

Chairman: We are really all concerned in some very important matters here, and one of them is the important question of the diagnosis of your client's case. We really are not getting on.

Mr. Walter Stewart: The way I put it is this, Sir, that it shows that the witness did not believe him to be insane.

Witness: I have given my reasons. If you do not accept them I can only state them as they are.

9387. Do you mean you would send in an account for a sum of fees to a man whom you knew to be insane?—No; I should never have sent them in.

9388. But you got your 90 guineas for this, and subsequently you got 100 guineas from the brothers for what you did for them?—It was for subsequent work, you must remember.

Chairman: I am not going to have this gone into. We are not in the least concerned with this part of the case, whether he received 500 guineas or 100 guineas.

Mr. Walter Stewart: I put it as a faithful discharge of duty, and I want to show how Moorcroft was conducted. Mr. H. has said that these people worked together, and I am in a position to prove that, if I am allowed to.

Chairman: I am quite aware of the fact that a number of medical men called in to a case work together, as you choose to put it. They profess to be acting in the interest of the patient. We are also aware that medical men are remunerated for their services. Beyond that I do not think this evidence is assisting us at all. What I want to point out is that there really is an important matter in your own interest which one is very anxious to get on to, namely, whether there was any necessity here for an urgency order, and also whether the diagnosis of this gentleman's case was carried out with sufficient care. Your questions about the Wassermann test seem to be of importance. This question of investigating the remuneration that Sir Maurice Craig received is rather personally offensive.

Mr. Walter Stewart: I am putting it to show that there was no need of an urgency order. If there had been, surely an honourable gentleman would not have been sending in an account and taking a cheque. That is what it is directed to, if anything at all. I submit that as cross-examination on that point it is relevant. Surely, with respect to any ruling of yours, Sir, is not that so? Are we not entitled to see how the witness treated him?

Chairman: I think you bring out the point quite well without any heat. You say that a certain cheque was drawn by Mr. H., which was offered in payment of a certain debt, before which date an urgency certificate had been written by Dr. Stoddart. You have your whole facts there. You know them; I know them. It does not advance it very much to press it any further. I mean I see the point. I generally see points, I hope.

Mr. Walter Stewart: As long as it is clear to the Commission.

Witness: I may say I see the point, and I fully appreciate it.

Chairman: Please let us get on.

9389. *Mr. Walter Stewart (to the Witness)*: Now that you do see the point, do not you agree that it is undesirable that that financial interest should be existing between the person sought to be certified and the medical man who is taking steps to get him certified? Do not you agree now that that is undesirable?—It is very difficult if medical men are to do certain things. Medical persons are paid for their opinion on certain things; and what you are putting here is not fees for certification, but for certain work done, and it is very difficult, of course; it cuts both ways. That is, if you say to a person that they are to be treated for charity, and no medical man is to charge a fee for doing certain things, he places an obligation upon the patient or the patient's friends which might be very unpleasant, if such were done.

9390. *Chairman*: But there is a point there, Sir Maurice, that is quite worth examining. The point is this: of course, a patient requires attendance often, and the case may be one in which there are mental symptoms. I suppose a medical practitioner who attends a mental case is remunerated, just as if he attends any other case; but when you come to the question of certification, which has certain legal consequences, I think the point we are on is whether the medical attendant who is remunerated, very properly, for his services, should be participant in the act of certification. There is a point of principle there, you see?—I think I should accept that absolutely, and I have tried to explain to the Commission the peculiar difficulties I was in, that I was still treating him as a normal person. We discussed this question as to whether he was fit to retain his liberty.

9391. Do you think as a matter of principle it would be better that when the stage of certification comes on?—The certification should be made by the relations, I quite agree.

9392. And should be conducted by some person other than the regular medical attendant?—The law is very particular on that, that he should participate, because I take it the legislature considered that the medical attendant who knew the patient well, was the person who was more likely to protect that patient than a person who might be called in for some other specific purpose.

9393. There is this difficulty also: somebody must take the initiative. Let us assume the case of a patient who is really suffering pretty acutely; someone always has to take the initiative.

Mr. Walter Stewart: Mr. H.'s brother had already taken that.

Chairman: Someone has to take the initiative, and if the patient himself is disabled from taking the initiative, as he frequently is, it is very difficult to get some means whereby there is adequate protection for that patient. Take the case where there are relatives who might have an interest, for example,

26 January, 1925.]

SIR MAURICE CRAIG, C.B.E., M.D.

[Continued.]

to have a patient put away. We are really touching the heart of the question here. We are very concerned to see that a person should not be detained in any circumstances of suspicion, and how one can get a solution for the difficulty, because someone must take the initiative. Suppose my brother becomes insane, I take the initiative. The retort is: "You are interested in getting him into an asylum." If I take no action who is to take action?

Witness: Of course, that question does constantly arise. It may seriously arise in the event, for instance, of a son who is going to look after his father, in which case, if the father recovered after certification, he might disinherit his son; and indeed it has happened, because of the action the son took at that time. Therefore I have known sons say to me: "I am not going to do it." I appreciate the difficulty.

9394. How is one to get the initiative taken in the matter?—Certification has nothing to do with medicine, I may say. It is an embarrassment, as it is in this case, of the relationship of patient to physician. Therefore it is never sought so far as the medical people are concerned. It is an obligation placed upon the medical persons by the State, that they are to do certain things under certain conditions. If they do not do it, they may be brought up for not doing it.

9395. But I am on the question of initiative?—I am only saying that medical people get more and more shy of doing it, because it is a legal obligation placed upon them, and they say: "We do not understand it; therefore we will go on with medicine; but we do not understand the legal requirements." It comes in seriously here, because it shows to the Commission the difficulties the medical profession is constantly in.

9396. The point is rather this: the initiative must, of course, lie with somebody. Up to a certain point the patient is sane and is able to ask the doctor to come and see him. It is very difficult to say at what point the capacity to ask for the attendance of a doctor has really ceased?—I hope it will be shown to the Commission that everything should be done in the early stages to avoid certification as far as possible, both in the patient's interest and the medical people's interest, and everybody's interest. It is something which is put upon us by the State. It is the liberty of the subject which is really the difficulty. If you are going to interfere with the liberty of the subject you must take certain legal remedies in order to safeguard it, and if this Commission can in any way discover something it would be very valuable. In this case Mr. H., up to a point, was perfectly willing to be guided; indeed, I had arranged that he should go to another doctor's house; but the difficulty is that the law says you are not to do so, that you must not send people here and there without taking certain legal steps.

9397. But the question is about getting an independent medical opinion upon the case?—Here you have four or five independent opinions in this case.

9398. But it is suggested that it was not independent, because first of all you were called in by Mr. H., and then the relatives ultimately employed you, and then that you suggested Dr. Percy Smith?—But these are all recognised men. I mean if it is suggested that the medical profession is such an unworthy profession that even when you get into the upper layers of it, so to speak, the men are not to be trusted and are not honourable men, I do not think you will ever get a solution of anything.

Chairman: I am afraid that is the suggestion that was made to us.

9399. *Earl Russell:* Your trouble is that apart from Section 315 you could not continue to treat this patient?—I was not allowed to.

9400. Apart from that he would not be treated?—He himself said, "I am going to leave."

9401. A voluntary system would not have helped you here?—No.

Chairman: I am sorry to have interrupted your cross-examination, Mr. Stewart.

9402. *Mr. Walter Stewart:* I want to get this case of ours admitted, and the witness has admitted one of the chief points in it. Let us follow that up. (*To the Witness:*) Do not you see that in the peculiar position in which things are, the patient is not always in a position properly to look after his own interest?—Yes.

9403. Supposing in relation to such a crucial question for him as certification or non-certification, he was not himself in a condition to look after himself, would not you welcome the intervention of an upright independent authorised agent to act on his behalf with you?—Where are you going to get such a person?

Chairman: There is a difficulty there, Mr. Stewart. What sort of agent do you mean?

Witness: I have no feelings on this matter. Anything that helps you, you must remember, helps the medical profession.

9404. *Mr. Walter Stewart:* Let us go by steps. If I could get him, would you welcome the intervention of such an agent?—I should welcome anything which made the position easy both for the patient and the medical profession.

9405. Whether that authorised agent were a lawyer or layman, if he were honest?—I should like to hand over the whole thing to the lawyers.

9406. So that you would not be opposed to the patient being represented by an authorised agent at the moment of certification?—Personally, certainly not.

9407. Be it so?—But you must remember the financial position. You know the difficulty.

9408. I am not suggesting that the doctor would have to pay—the patient would have to pay?—You must remember that I, as a physician, look to the patient's interest much more than at the moment you think I do. I am only saying that the more payments you have to make, the more difficult it is for the patient.

9409. It is provided for in the case of paupers who commit crimes. Do you think it would be equitable that it should be provided in the case of non-criminal people who are in this dreadful position?—I am only saying that the more publicity you give, the more evasion of the law you will get.

9410. Supposing it were at the option of the patient or his representatives that this interview on the occasion of certification should be a public or a private one, there would be no difficulty there, would there?—Very great difficulties in some cases. I mean the places where they used to hold public inquiries were much complained about, because it was complained that they were treating a person as if he were a criminal.

9411. If there were an option on the part of an authorised agent that it should be public or private, it rests with him; there would be no objection on that ground, would there?—No. The difficulty would be who is going to exercise the option?

Mr. Walter Stewart: That is all provided for in our case.

Mr. Dickens: I put Sir Maurice Craig into the box, not to give his views upon the administration of the Lunacy Acts, but to answer the charges made against him.

Chairman: I believe Sir Maurice is going to give evidence on general questions later. It is quite true, Mr. Stewart, that you are really dealing with general questions of principle, and not with Mr. H.'s case at all at the present moment.

Mr. Walter Stewart: That is what I thought I was invited to do. This is the first opportunity we have had to put our general case to any medical man.

Chairman: You are going to have your general case put to us by Mr. Parker. In the meantime this witness is dealing with Mr. H.'s case. There are limits, you know.

26 January, 1925.]

Sir MAURICE CRAIG, C.B.E., M.D.

[Continued.]

Mr. Walter Stewart: I thought it was on principle that you asked me to cross-examine Sir Maurice?

Chairman: I asked you to cross-examine him upon whether it was necessary that an urgency order should be made in his case, and whether there were sufficient

precautions taken in his case under the existing system. I think it would be a good time now to adjourn for lunch.

Mr. Walter Stewart: If you please, Sir.

(After a short adjournment.)

Mr. Walter Stewart: Mr. Steele is now here, Sir, if you desire to see him.

Chairman: There are just one or two questions which Lord Russell wanted to ask him. We will finish with Sir Maurice first.

Mr. Walter Stewart: May I take your ruling, Sir, before I put any further questions? Am I in order here before this Commission to put to this witness or to any expert, what his view is with regard to the proposals that we ask you to adopt for the reform of the administration of the Lunacy Laws?

Chairman: No; that is not our contemplation in dealing with these particular cases.

Mr. Walter Stewart: Very well, Sir; if I may not I may not.

Chairman: We hope to have that matter explained to us very fully by Mr. Parker.

Mr. Walter Stewart: One of the most effective ways of establishing a case is to get the other side to admit it.

Chairman: I quite appreciate that, but what we propose to do is this: We are going to have evidence possibly from Sir Maurice Craig and other witnesses later on. Before that evidence is received, we shall have had Mr. Parker's points, and I propose myself to put those points to a number of those gentlemen in order to see what their view upon them is. I must maintain the control of these proceedings in my own hands.

Mr. Walter Stewart: I quite appreciate that, Sir, but if at that time any particular points have not been put fully before you, would you allow me on just those points to supplement questions which are put? This is our child, and we want to see that at any rate it is led out into the daylight.

Chairman: I think in the previous part of the proceedings you frequently favoured me with suggestions, and I adopted quite a number of them.

Mr. Walter Stewart: You did, Sir. 60 admissions were obtained.

Chairman: The course which I propose to take of examining certain gentlemen later on will take this form: I shall then have been apprised by Mr. Parker of the points to which you attach special importance. Then in conformity with the usual practice of Commissions such as this, I shall have an opportunity of putting those points to the witnesses who come afterwards, and see how they look in their hands.

Mr. Walter Stewart: I must not put them this afternoon?

Chairman: No, if you please.

Mr. Walter Stewart: I am always anxious to avoid any insubordination. What I wish to do is to ask this gentleman questions with regard to the actual circumstances surrounding the certification and conveyance to and detention at Moorcroft.

Chairman: I do not think this gentleman had much to do with the actual conveyance or detention. He was a party to the earlier history of the patient, and he took part also in the preliminaries of the certification.

Mr. Walter Stewart: I assure you it went a great deal further than that, Sir, if my information is correct.

Chairman: Just go ahead with your questions, and we will see if any point arises.

9412. *Mr. Walter Stewart:* If you please. (To the Witness): You were not the certifying physician in this case?—No.

9413. Do you, as a consultant, in these circumstances ever certify at all?—Yes.

9414. In about how many cases in a year?—I am not a great certifying person. I do not know that I certify perhaps more than 12 or 14.

9415. You very often put the matter in the hands of some other qualified person?—No.

9416. But you do sometimes. Both the certifying doctors were introduced by you in this case?—Yes.

9417. You do not suggest that any of them told the patient what they were there for?—These gentlemen are of the same standing as myself.

9418. Eminent, we will agree, but did they, whether eminent or otherwise, ever let him know what they were there for.

Mr. Dickens: They are going to be called.

9419. *Mr. Walter Stewart:* You did not let him know what they were coming for?—Certainly.

9420. That they were coming to certify?—A question had arisen (I distinctly said so in my notes) whether his mental state was such that he should retain his liberty. There is correspondence with Mr. H. himself on that matter, in which he agrees.

9421. We know what the letters say, but we have to see what happened. You sent Dr. Porter Phillips down, did you not?—Yes; that is the last doctor.

9422. I am dealing with him at the moment. Was it on instruction by you that he was sent to represent, if he was told to represent, to Mr. H. that Mr. H. was to go and stay with him at his (Dr. Phillips') place?—All Dr. Phillips would be asked to do would be to see Mr. H. and enquire into his mental condition, and to see whether he was a fit person to retain his liberty, or whether anything else should be done.

9423. I may take it that you did not suggest to Dr. Porter Phillips that he should get Mr. H. away from Croydon by a suggestion to him that Mr. H. was to stay with the doctor?—Certainly I never made any such suggestion.

9424. Mr. H. said that he was led to understand that he was going to a doctor's house, but that Moorcroft was never mentioned.—The suggestion is quite untrue, as far as I am concerned.

9425. As far as you know.—As far as the statement by me. You asked me whether I made the statement.

9426. I asked if you knew of it.—I know nothing of it.

9427. I did not venture at that stage to say that you said it. Tell me this: Had Mr. H. all along regarded you as a personal friend?—Mr. H. was a very delightful patient, a very nice man, and I had a regard for him, as I have to-day.

9428. And you were always very nice to him?—I tried to be, the same to him as I should be to anybody.

9429. You do not suggest, do you, that you ever told Mr. H. that he was suspect of such a disease as syphilis?—I should never inform a patient of a doubt I had in my mind; I should never do it.

9430. Let us test it. If you were consulted by a person as a patient, would you not tell him if in fact you discovered that he was suffering from such a thing?—It might be necessary.

9431. In order that he might know where he stood?—Quite.

9432. You never told him that. Was it not your duty to tell him, in your conception of your duty as a medical man of standing, acting on behalf of the patient?—He was not opposing, as far as I know, being treated in any way. You see the point here is a very subtle one. Here is a gentleman disturbed in mind already. I had got a history of him, in which he said he was full of fear. I had a history which showed that he was afraid of disease as you know, at the very earliest date. Now for me to convey something to him that was not quite necessary, or may not have been necessary—

26 January, 1925.]

SIR MAURICE CRAIG, C.B.E., M.D.

[Continued.]

9433. Do you tell the members of this Commission that where a doctor finds that a patient of his gives definite signs of being a sufferer from such a disease as that, it is not the doctor's duty to tell him?—All the circumstances must be taken into account.

Chairman: You will certainly not convince the Commission of that duty.

Mr. Walter Stewart: I do not know what the Commission's view would be.

Chairman: Let us put this point for a moment: supposing an unhappy patient has indications of cancer, and the patient is in a low state of health at the time. You surely do not suggest that the doctor's duty is to walk into the patient's bedroom and say, "I am very sorry, but I suspect you of having cancer; you are going to die shortly." He might say, "We have examined your case and have come to a certain conclusion, but we think that a change of air and new surroundings may help you to recover." But to tell a patient straight out that he has a very dangerous disease would surely have a most detrimental effect upon the patient.

Mr. Walter Stewart: With deep respect, Sir, the case you put is not analogous. Cancer is an incurable disease, but the witness has said that general paralysis is recoverable.

Witness: You are now taking it very much further. I said it is a condition which, up to a certain point, may be recoverable.

9434. *Mr. Walter Stewart:* In dealing with your question to me, Sir, you have included in that a number of terms which I do not suggest. For instance, "You are going to die shortly." What I am putting is a very definite point. (*To the Witness*): Is it or is it not in your view the duty of the medical man, if he diagnosed the disease of syphilis, to inform the patient?—It may be, in a primary condition, yes; because of course the man is then in an infective condition; he may injure others; but in the later stages, especially as I say this man had fears, you must remember that to tell a person he has got a disease is to increase his illness seriously, and unless there is going to be some benefit derived from the medical side, you would not tell him.

9435. Is it according to the ethics of your profession, as you understand them, to treat a man for syphilis without telling him that he is suffering from it?—I should say each case has to be taken on its merits.

9436. Mercury is a deleterious drug in some respects, is it not?—It all depends on how it is employed.

9437. Do you say it is a drug you would give if you could avoid giving it?—One would avoid all drugs if possible.

9438. Therefore it is to that extent deleterious. Is it not a drug which, administered over a long period of time, produces very undesirable consequences to the patient?—If improperly employed.

9439. Do you say that you prescribed mercury or iodide of potassium for this patient of yours, without telling him what the prescription was intended to effect?—I might or might not.

9440. Did you?—I do not recall that I did.

9441. You never told him that?—I have told you as far as I can tell you. I have no memory that I did tell him.

9442. Then we will accept his story on that point. That being so, of course he had no representative except you; you were his friend, upon whom he relied?—Dr. Dempster was a personal friend of several years' standing.

9443. His general practitioner?—But more than general practitioner.

9444. You have said to the learned Chairman already that the usual medical attendant should be one of the certifying doctors. Why was Dr. Dempster not in this case?—Because he was a personal friend.

9445. Does the Act, as far as you know, contain any exception in favour of personal friends?—Per-

sonal relationship of some time standing is an important point.

9446. Is not the relationship between the usual medical practitioner and the patient always a personal relation?—Not in the close relationship of Dr. Dempster and this gentleman.

9447. Do you mean that he was a beneficiary under the will of the gentleman?—No.

9448. What do you mean?—He and his wife used to go and stay together, and stay in each other's houses; they were personal friends. He was down there the first time I saw Mr. H. at Teignmouth. Dr. Dempster was not attending him then. Dr. Johnson was the doctor in charge at that time, but Dr. Dempster was there as a personal friend and representative of the family—as a friend.

9449. Dr. Dempster would know more about this gentleman, perhaps even than Dr. Percy Smith?—He would know it in a different way. Dr. Percy Smith would be of more value a good deal from an expert's standpoint, and I understand that is one of the points that you would like. There may be a good deal to be said for it. That is, that persons who understand about mental disorders should always be the persons who certify, and not the general practitioner. I have seen that put forward as an important point, and in this case it was done.

9450. On that day when he was certified, did Mr. H. speak at any greater length in answer to questions that were put to him than you are doing now.

Chairman: Mr. Stewart, would you kindly refrain from insinuations of that sort, or else I shall stop this cross-examination at once.

Mr. Walter Stewart: I cannot get a proper answer, Sir. If you protect me by asking the witness to answer my question, I will not make any observations.

Witness: I am doing my best. If you tell me I have not answered it or have misunderstood it, I will gladly do my best to answer it. You must remember that I am looking at this as a medical man, and you as a lawyer. We may have a different appreciation.

9451. I will put it to you. What was there about the relationship which existed between the usual medical attendant, Dr. Dempster, and Mr. H. that justified his not being made the certifying doctor, or one of them?—I think it is a question you ought to have asked Dr. Dempster. Unfortunately he is dead. I mean I cannot say. Dr. Dempster did not wish to certify. I only know that he preferred that. He was a close friend.

Mr. Walter Stewart: So I will not ask you why it is not on the certificate.

Earl Russell: He really has answered your question three times. We are not getting on at all.

9452. *Mr. Walter Stewart:* I am afraid it is my incapacity to follow the witness's answers. (*To the Witness*): Now with regard to whether he was in a fit state on the 16th December, did you go down to Moorcroft after they had got him there?—On which date is that?

9453. On the 16th, that is the day I come to?—I should not see him that day, no.

9454. On the 18th I think you went down?—You may have the dates; I know they have been supplied.

9455. You paid him no less than nine visits at Moorcroft, did you not?—I know they asked for those, and they would have them.

9456. You had more than one patient there; I think several patients at Moorcroft were patients of yours, were they not?—The patients are not mine when they have passed under the care of others.

9457. I mean patients whom you have recommended?—Yes.

9458. I suppose you visit them, too?—Not necessarily. I sometimes never see a patient again. Patients go to different institutions.

9459. How is that arranged? How is it arranged, how often a consultant of your eminence should, once a man is certified, continue to pay him visits?—That is entirely the desire of the relations on the one hand, or it may be, as in this case, the expression of a wish

26 January, 1925.]

Sir MAURICE CRAIG, C.B.E., M.D.

[Continued.]

from the patient himself. He wrote to me, asking me to come and see him.

9460. Is it ever anything to do with the expression of a wish of the consultant to the person who keeps the establishment?—No, never.

9461. That has nothing to do with it?—No, certainly not.

9462. I suppose in an establishment like Moorcroft they are supposed to have first class medical men attached to the institution?—Some institutions have and some have not.

9463. Were the charges 15 guineas a week, including medical attendance?—The superintendents are always medical men, of course.

9464. They are supposed to be efficient medical men, I suppose?—They have their own medical attendants attached to the institution.

9465. Do you suggest that on the occasion of these visits you were examining Mr. H. as his medical attendant?—I was doing my best to help.

9466. What I put to you is that you merely conversed with him in a casual sort of way for a few minutes?—If that is your outlook on professional business it is not mine. You make the suggestion.

9467. I am asking you if you did that?—No; I never do such things. I carry out my work, as I hope I have been able to show to the Commission by the records I have got. We were right in the middle of war time. We were working 15 or 16 hours a day. I do not think it shows great negligence.

9468. I was asking if you had any records covering this period of the nine visits to Moorcroft?—No, I have not.

9469. Then that rule was not applied to those visits when there were nine of them?—No; he was out of my immediate care.

9470. Why were you visiting him?—I was asked to; I was asked on one occasion. He had got this jaundice, and then he saw Sir William Hale White.

9471. But you are an alienist, are you not?—My special line is in functional nervous disorders.

9472. Not for such a complaint, simple as it may be, as jaundice?—That comes in medicine. I hope I am a physician before I specialise.

9473. I am sorry to have to go into it, but it has been challenged in the case put to you in examination in chief, about this large room, or whatever you agree to call it. There were 13 other patients in that room, were there not?—Not to my knowledge.

9474. You would not know them all personally I agree, but you would know some of them. Were any of your patients in that room?—I could not say; they may or may not have been. I do not know at what date, or at what time, you are alluding to when these 14 persons were there.

9475. At the date in February when he was recaptured, and put in that long room instead of being allowed to use his own private room for which he was paying?—That you must get from Dr. Stilwell, I am afraid I cannot answer it.

9476. If any of them happened to be patients of yours you would know it?—Yes, but when you say patients of mine do you mean patients I have seen? I have seen a very large number of people in 30 years. Do you call all these people patients of mine?

9477. How many of the patients who are now in Moorcroft have you recommended?—I could not answer that question; I have no knowledge.

9478. But you are constantly there?—No. I only go when I am asked.

9479. I am looking to the number of visits in this period?—At that time I was going down more frequently—not now.

9480. Of course you have no personal?—At that time I was consulting physician to Moorcroft.

9481. You were in a sense a relation of Dr. Stilwell?—Not a relation. I had known Dr. Stilwell originally when he was a house physician, when I was at Bethlem Hospital.

9482. Were you not connected at all?—I was going to tell you. That was the first I knew of Dr. Stilwell, and subsequently my brother, who lived with me, got to know Dr. Stilwell and got to know his family, and he ultimately married Dr. Stilwell's sister.

9483. So that it would be more natural that you would go there more frequently, perhaps?—No. At the time I recommended Mr. H. to go there, one of the reasons, amongst others, was that if he could get into Moorcroft they were much freer in their liberty, and also that I had certain influence owing to the fact that I was consulting physician there, and that I could get him certain amenities which would not be given in other places. For instance, to take his monkeys down might not have been allowed in other places.

9484. Not even at 15 guineas a week?—No.

9485. Not even in a private room?—No.

9486. You know he was to have a private room?—Yes.

9487. I notice that it is put in Dr. Stoddart's certificates as one of the grounds for finding him to be of unsound mind. Do you know, having known the gentleman long before he was certified, that for years he had always kept those sort of pets?—I know that for 18 months prior to his going there he had not done so.

Chairman: We attach no great importance to the fact of this gentleman having a *penchant* for monkeys any more than a *penchant* for parrots.

Mr. Stewart: If it is in the certificate, I want to show the stuff the certificates are made of.

Chairman: If you think it is important, go on.

9488. *Mr. Stewart (to the Witness):* Now with regard to the condition of this gentleman I am bound to ask you the question: Do you now say that Mr. H. is suffering from general paralysis of the insane or not?—I have not seen Mr. H. for many years; I could not answer that.

9489. It would be a very remarkable case, would it not, if after 10 years from the onset, assuming 1916 to be the date of the first onset of the symptom, he should still be in the condition of physical health that he now enjoys?—It would be very unusual, and I think Mr. H. can be happy in the belief that the medical opinion, or any expression of opinion, at that time that he was suffering from general paralysis was probably wrong.

9490. I am greatly obliged to you for saying that. Is not this at the bottom of it all, that that is the underlying circumstance in this case that really turned the balance against him?—No. The question of his mental disorder and the reason why his liberty was taken away from him have in fact nothing to do with the general paralysis.

9491. Do you mean that all the doctors would have certified him just the same if that had not been there?—Certainly.

9492. Then we shall be able to deal with the certificates on that basis?—That is the proper basis. The question of behaviour and conduct is the whole proposition.

9493. Very well; then I must deal with that and that alone. He wanted to go to Brighton, did he not?—He threatened to leave.

9494. Do you know that he had at that time a tenancy in a furnished flat which still had three months or thereabouts to run?—Yes.

9495. Is Brighton a place less salubrious than Croydon?—It may be much more salubrious.

9496. If he were well enough to be taken away to Moorcroft in a motor car at short notice, was not he well enough to go to his own flat at Brighton if he wanted to?—That was the whole problem. We considered that he was unfit to retain his liberty of movement.

9497. Because he wanted to go to Brighton, amongst other reasons?—No.

9498. Did you not say a moment ago that that was the whole trouble—his conduct; he would insist on going away?—Yes.

26 January, 1925.]

Sir MAURICE CRAIG, C.B.E., M.D.

[Continued.]

9499. To Brighton. I put it to you therefore: What was the difference between his going on the 10th November to Moorcroft in a motor car with a small handbag to what would have happened if he had gone to Brighton, accompanied, of course, by someone?—That was the whole problem—that he refused to be accompanied.

9500. How do you know?—That was the whole problem. I think every witness will tell you that.

9501. Alone?—Alone. He would not stay with Dr. Dempster. He refused to have any supervision whatsoever, and we had to decide whether he was fit to go alone and live his life alone and under these conditions.

9502. Will you venture to swear that that gentleman ever said to you that he intended to live alone at Brighton?—I presume—

9503. Did he ever say it?—Will you let me finish? If you say alone, I presume he would have maids, in that sense; I did not presume he was going to lead a hermit's existence. He would not take a nurse with him, for instance.

9504. Up to this time Mr. H. had been allowed to enjoy his personal freedom, had he not?—Up to that time.

9505. And after he once succeeded in effecting his escape he enjoyed it without special detriment to himself?—He was very much better, you know; he was steadily getting better. Your inference is that he was the same when he left as when he went in.

9506. Does a general paralytic generally get better?—Even if he were a general paralytic he can have a full remission. I have known a man, a captain of a ship, who took his ship to Australia, and brought it back during a remission.

9507. Was he under any treatment as far as you know; as you put that case on me?—It is not only one case; there are plenty of them.

9508. You have put it upon me, but you know nothing about the circumstances of that case. You put it upon me as an anonymous case; I cannot test it?—It is very difficult to test it. I daresay you may get that case from Dr. Percy Smith as well; but every one of us knows cases where a man returns to his work and does his ordinary work after he has once been taken ill with general paralysis; that is a common experience; you will find that in any text-book.

Earl Russell: You cannot ask a witness: "Does a thing ever happen?" and when he tells you that it does, complain that it is an anonymous case.

Mr. Walter Stewart: It is very rare.

Witness: No, it is very common; you will find it in every text-book.

9509. I have got one or two of them, but I am keeping them for their authors. What is your text-book?—I have written a book on psychological medicine.

9510. It does not include general paralysis of the insane?—Yes.

9511. What is the title of it?—"Psychological Medicine"; it has run through three editions. You will find it all there about remissions.

9512. When was it written?—1904 was the first edition, and there have been two subsequently, and you will find all about remissions there.

Mr. Walter Stewart: Subject to the ruling of the Chairman, I ought to go into that question. Do you agree to the usual course? What do you say to this?

Mr. H. C. Dickens: What is the book?

Mr. Walter Stewart: This is an article by one Percy Smith. I am in your hands, Sir.

Chairman: I have not noticed it conspicuously. What material are we at present receiving to assist us in recommending amendments of the law? I do not see that we are receiving any. There seem to me to be points upon which I am so sympathetic to your point of view, that it is a great pity you should injure your case by conducting it as you are doing just now.

Mr. Walter Stewart: I will not proceed with it another single sentence.

Chairman: I am sure you will not, but I should like you to appreciate that we are fully sensible of the important points that have arisen in connection with Mr. H.'s case. We are exceedingly sorry if those points are to lose their importance and value by being covered up by a great deal of irrelevant matter which is of no assistance whatever, and which is being recorded at the public expense, and at waste of time to important public persons, yourself included. Has not this eminent gentleman just said that in his opinion the suggestion that in 1916 Mr. H. had general paralysis of the insane was a misreading of the facts? Can you want anything more than that?

Mr. Walter Stewart: Very well, Sir. I leave it, never to return to it.

Chairman: Please.

Mr. Walter Stewart: Now I want to deal with this question of Mr. H. being treated as an urgency case. I think, Sir, that is important.

Chairman: That is a point we were wanting to consider: Why it should be treated as an urgency case and not dealt with by the more leisurely form of procedure?

9513. *Mr. Walter Stewart (To the Witness):* Dr. Stoddart had been down on the 20th November?—Yes.

9514. Was the reason that his certificate was not acted on that it was so thin that even a judicial authority would not pass it?—No; that is suggesting something which is entirely proved otherwise by a letter. Circumstances changed, and it was those circumstances that altered the necessity for putting it in. There was no question whether that certificate was good or bad, or whether it was a poor one. The whole question turned on Mr. H.'s own agreement to be guided by his medical advisers, and he wrote me the letter himself. Here is the letter (*producing the same*).

9515. You put it to me. I want to put the opposite view and to test it. You say that was nothing to do with it?—No, nothing.

9516. Let us see what the certificate says, and then point out whether you regard this as a strong enough certificate to deprive a man of his liberty?—Dr. Stoddart is a recognised man. If on receipt that document was not considered satisfactory the question would be raised instantly by the Board of Control, and properly raised. I may say it is not infrequently raised.

Mr. Walter Stewart: If I am taking longer than I had wished, it is not my fault. Listen to this: "Dr. Stoddart, The most important symptom in this connection is his intention to remove himself to Brighton beyond care and control when he is obviously not fit to be at large, as will be hereafter seen. He was rather garrulous in conversation, so I am told; and still more so in writing. He writes letters all day long. He told me this himself; and Dr. Dempster showed me piles of letters written by the patient—about three inches thick daily." How many inches thick do you think would be an indication that the person writing was insane? That is what I cannot understand. These were three inches thick.

Mr. H. C. Dickens: It depends upon the thickness of the paper.

9517. *Mr. Walter Stewart:* "Many of these were to comparative strangers, and Mr. H. had to explain them away by saying he had nothing else to do." He had not much else to do at that place. "His nurse told me"—(so much of this is what is told)—"that Mr. H. was liable to uncontrollable fits of temper again, quite unlike his normal self, and that he had the desire to visit a matrimonial agency despite the fact that he was already married. Mr. H. told me that he had bought a monkey from the Zoo and showed me the parrot cage in which he intended to keep it in his room. In so doing he showed defect of reason for the circumstances were quite unsuited to the keeping of such a pet. He

26 January, 1925.]

Sir MAURICE CRAIG, C.B.E., M.D.

[Continued.]

appeared also to have developed a litigious frame of mind respecting (1) some property belonging to himself and his wife conjointly, (2) a false accusation by his sister which was never made, and (3) his treatment at a nursing home in Devonshire a couple of years before where he claims that he was insulted by being massaged. He was also full of 'schemes' which, in his circumstances, bordered on being unreasonable. For example, he wished to convert his wife's house into a hospital for sailors." At that time, 1916, was not everybody who could help in any way trying to render the utmost assistance that they were capable of rendering to the cause of this country, and had not his wife, down in that part of the world where they lived, a house eminently suitable for conversion into a small hospital?—I have not any knowledge of it.

9518. You agree, do not you, that not any one of these things ought by itself to be regarded as an indication of insanity—do you agree with that?—Each thing separately probably would not be.

9519. It was only because in the same individual there was a desire to keep a pet monkey.

Chairman: Or to go to a matrimonial agency when he was already married.

Mr. Walter Stewart: That was what was told to Dr. Stoddart.

Chairman: So were the other things.

Witness: This gentleman was very much more of unsound mind to anyone seeing him than was capable of being written down. A patient's actions are extraordinarily difficult to describe.

9520. *Mr. Walter Stewart*: Would you call the surroundings in that long room with 12 or 14 persons ameliorative or not? I want to see what made him better?—They certainly would not do him any harm.

9521. It would do him good perhaps?—He had to be with somebody until he recovered his mental balance. The body puts itself right.

9522. Then there is no need for this highly specialised alienist and treatment—"the body puts itself right"?—But it has to be placed under such conditions that it will get right.

9523. It takes a long time in some of these specialised institutions?—It depends upon the conditions.

9524. What conditions?—The body may not be able to put itself right.

9525. Have you noticed at all that people who are private patients seem to have a longer average duration of detention than patients who are pauper patients?—No.

9526. We have figures on that. You do not know, or you do not agree?—I do not agree, most certainly from my experience. I have worked in every class of institution.

9527. Can you give us the figures? What is the percentage rate of discharge in the first three months in the case of private patients?

Chairman: Do not answer that question, Sir Maurice. I have already indicated that what we are concerned with is Mr. H.'s case—not the question of the rate of discharge from different classes of institutions.

9528. *Mr. Walter Stewart*: Very well, Sir. (*To the Witness*): Now have you told us all you wish to

tell us with regard to why this was an urgency case? Is there anything more you would desire to say as to why this should be treated as an urgency case?—The urgency was that he was not under proper control, and he refused to remain under control.

9529. He had not done anything wrong, had he?—He was not allowed to; he had treatment.

9530. But if he had done nothing wrong, what was the necessity for the control and treatment?—But you are not going to wait till murder is done before preventing it, or suicide before preventing it! A person who is suggesting suicide may have to be looked after.

9531. Did he suggest suicide?—No.

9532. Why treat it as urgent?—He threatened to leave.

9533. Do you say you had the right of preventing him from going to Brighton if he wanted to?—I had the right to question if he was fit to go.

9534. You say that made it a proper case for an urgency order?—Then the law gives certain powers for dealing with those cases, and it places the obligation upon the medical man to see that it is carried out.

9535. And that was what made you regard this as an urgency case?—That is so.

Earl Russell: You are forgetting that Sir Maurice said in examination-in-chief that if Mr. H. had done this he might have been taken up by the police for wandering at large.

9536. *Mr. Walter Stewart*: That is his surmise. (*To the Witness*): What earthly evidence have you to base that upon?—In many cases they have done it.

9537. Had he ever been taken up at that time?—No.

Chairman: Of course not. The whole thing was an apprehension of what might happen.

Mr. Walter Stewart: Is this the way we must regard it: Is any patient who expresses himself dissatisfied with his immediate surroundings and who desires to go elsewhere liable to be made the subject of an urgency order on that ground—even if he has accommodation elsewhere?—*Witness*: No.

9538. You do not put it as high as that?—You know perfectly well I should never dream of it. It is almost insulting me to ask the question.

9539. In this case what was there to differentiate this patient from any other patient?—Because he was of unsound mind.

Chairman: You will not get it any further, Mr. Stewart.

Mr. Walter Stewart: If you please, Sir—not with this witness.

Chairman: And not with any other.

Mr. Walter Stewart: I accept your intimation, Sir.

Re-examined by Mr. H. C. Dickens.

9540. I only want to put one question that I ought to have put before, Sir Maurice. What was your exact connection at Moorcroft?—I was consulting physician.

9541. Excuse me putting it to you. Were you paid a salary?—Yes.

9542. Do you or have you ever had any financial interest in any of these institutions?—None.

9543. Moreover is it against the rules of the Royal College of Physicians to have any?—Certainly.

Chairman: Thank you, Sir Maurice; we are obliged to you for attending here to-day.

(*The Witness withdrew.*)

Mr. CHARLES RICHARD STEELE, sworn; examined by THE CHAIRMAN.

9544. Would you give us your full name in order to get it on the note?—Charles Richard Steele.

9545. You are, I think, a solicitor practising in London?—Yes, at 6, Finsbury Square.

9546. We shall not detain you more than a moment or two, but there are one or two questions which arise relating to work you had done for Mr. H.

Were you solicitor for Mr. H. at any time?—For W. H., yes; I ultimately became his solicitor.

9547. Was he a client of yours?—When do you mean? He became a client of mine, after I had acted for his wife in connection with this matter.

9548. What one wants to know is when did you first act for him in the sense of opening an account in your books against him—when did you first act for

26 January, 1925.]

Mr. CHARLES RICHARD STEELE.

[Continued.]

Mr. H.?—I really do not know that, but I was acting in his interest in May, 1917.

9549. But, as you know, he became an inmate at Moorcroft in December, 1916. Had he been a client of yours before that?—No.

9550. I thought you had prepared a will for him?—No, I prepared the codicil which revoked that will; that was about the first thing I did.

9551. When did you prepare that codicil?—I prepared that codicil in May, 1917.

9552. Then was that the first piece of professional business you had done for Mr. H.?—Yes, I think so. He was never a client of mine. My client was really his brother-in-law and his wife. They were my clients when I went down to Moorcroft. I have a draft will dated December, 1916, and an executed engrossment of it dated 1917, and the first thing I did was to revoke those documents.

9553. *Earl Russell*: You were here when Mr. H. gave evidence about the long interview with you at Moorcroft, were you not?—No.

9554. I thought he said you came there to execute a will?—I am sorry, but there is a misapprehension. I was not here when evidence was given about me, and I certainly did not get any document executed in Moorcroft.

9555. *Mr. Croom-Johnson*: There was an appointment you may remember in connection with the appointment of the receiver which started in May, 1917?—Yes, those proceedings were initiated by me.

9556. *Earl Russell*: This is what Mr. H. said. He had a long private interview with you at Moorcroft?—That, as it stands, is true.

9557. That is so?—Absolutely.

9558. What date is that?—I believe it is the 3rd May, 1917.

9559. And no testamentary document was signed then?—Of course not; it was the first time I had ever seen the man.

9560. There is one other question I want to ask you, if we are wrong about the will—some of my colleagues are looking it up. You had this interview with him alone at that time?—Oh, rather.

9561. Were you told by the Superintendent that he was a dangerous lunatic before you went to see him?—I was absolutely, and I was told I need not be nervous, because a man would be stationed on the mat outside the door, and all that I need do was to raise my voice and he would come in at once.

9562. So that Mr. H.'s evidence on that is quite correct?—That statement is correct.

9563. Did you find him at all violent during that interview?—No, I remarked upon the ordinary tenor of his appearance when I went in.

9564. About how long did the interview last, one hour or two hours?—I should say an hour and a half probably.

9565. At that time when you saw him you were acting, you say, for his wife and his brother-in-law?—Yes.

9566. He was not your client?—I had never seen him before that day.

9567. Did you, when you left him, form the opinion that he was a sane man or an insane man?—Well, my feeling was that if he was insane I might go there myself one day, because he seemed perfectly normal; and I remarked upon it to the medical officer, to whom I had been introduced when I had arrived, and who had taken me along.

9568. *Mr. Croom-Johnson*: Who was that?—I do not know. He was the gentleman who was in charge of the place at the time.

9569. *Earl Russell*: You formed the opinion that Mr. H. was not insane?—I was startled that a man so apparently sensible should be there.

9570. Did he, among other things, complain to you of being improperly detained there as an insane person?—Mr. H.?

9571. Yes?—Of course he did.

9572. He did?—Absolutely.

9573. Did he ask you to take any steps for his release?—Absolutely.

9574. Did you take any steps?—No.

9575. Why not?—I had no instructions to take any steps for his release.

9576. Because he was not your client?—He was not my client, added to which I should have thought it a very improper proceeding on my part in the face of the statements made to me. The limit to the man's life was given to me. I was told that they already saw a difference in his walk.

9577. So that although you thought he was sane, you thought you must be wrong; is that what you mean?—Yes.

9578. The question about the will has been found. It is this. I would just like to put this to you:

"Was anything done with regard to that will while you were still at Moorcroft?—Yes," says Mr. H. Then he goes on to say the will was prepared by Muther in November, then there was a document prepared by Speechley Mumford & Craig. That has nothing to do with you, has it?—No.

9579. "The will was signed in the presence of R. H., my elder brother, and witnessed by Stilwell on the 30th January." That was not a day on which you visited?—It was prior to the third of May.

9580. The number of the question is 8609.—The will is made on the 30th January, 1917, and it is signed by Reginald Stilwell and witnessed by Reginald John Stilwell and others. I had nothing to do with that. I had recovered possession of these when I came to act as his solicitor.

9581. Yes; that was the misapprehension I was under. I thought it was you who had done it?—The first thing I did was to get the codicil dated 17th June, 1917, which revoked that will.

9582. *Mr. Micklem*: May I ask you this, Mr. Steele: when you saw this gentleman in May, 1917, at Moorcroft, did you consider that you were acting for him, or that you were acting for somebody else?—I was acting for somebody else.

9583. For whom?—For his wife and brother. I think I put the brother in. The thing originated in this way—

9584. By whose instructions did you visit him?—Answering that question strictly and technically, by the brother-in-law, who is a solicitor for whom I have acted for a number of years. He wrote to me and said: My brother-in-law is unfortunately an inmate at Moorcroft, but my sister wishes you to go and see him and see what arrangements you can make for his welfare, and do whatever you think is right in the man's interest. Accordingly I went down and spent an hour there talking with him, and I came away amazed.

9585. Did you then take any instructions from him at that interview as to his codicil?—No.

9586. You simply had a talk with him?—I simply had a talk with him.

9587. And you say you formed the conclusion that he was not of unsound mind?—I do not like to put it that I formed any conclusion about it. I went there. The position was staked out for me. I understood that the man would not be put there if he was not of unsound mind, but still it seemed to me—

9588. It seems a little strange, if you came to that conclusion, that you took no subsequent steps to try and get him removed?—I am afraid I do not follow that.

9589. If on seeing him, and acting as a solicitor for somebody, you came to the conclusion that he was wrongfully detained there, one would have expected that you would have taken some steps to get him out?—I had no authority.

9590. *Chairman*: You had been sent down in his interests?—I had no possible means of setting up my opinion against the opinion of the medical faculty.

9591. *Mr. Micklem*: But you could have given information to his relations?—But his relations knew all about him, more than I did; I had never seen the man before.

26 January, 1925.]

Mr. CHARLES RICHARD STEELE.

[Continued.]

9592. Did you take no steps after you had seen him?—I took steps to get him more comfortably placed.

9593. You appear to have written about his removal from Moorcroft?—Very likely.

9594. I see there is a letter from you which was referred to by Mr. Justice Sankey in a previous action.

Chairman: It is printed in the proceedings at Question 8630.

9595. *Mr. Micklem*: Thank you. (*To the Witness*): In that letter, which is dated 14th May, you say this: "We are concerned for the above-named patient." Then at that time you were acting for him, were you not?—That I do not know. I was using his name.

9596. You observe how your letter runs: "We are concerned for the above-named patient and are desirous of making enquiries by direction of the Master in Lunacy as to whether there is a vacancy in your asylum?"—Yes.

9597. I suppose before writing that letter you had communicated with the Master in Lunacy?—I should not think so for a minute.

9598. You would not think so?—I should not think so.

9599. You see you say: "by direction of the Master in Lunacy."—I was determined to move him away from Moorcroft.

9600. *Mr. Steele*, I do not want to press you unduly, but you say in this letter: "We are concerned for the above-named patient and are desirous of making enquiries by direction of the Master in Lunacy as to whether there is a vacancy in your asylum." Do you now tell us that that was a mistake, that you had not received any directions from the Master in Lunacy?—Certainly there was no order in the ordinary sense of the word.

9601. I did not put that to you for a moment. You say he was not your client. I put it to you whether you had any direction, not whether there was an order?—No, I had not any direction in any specific terms, but it was a waste of time to go and issue a summons before the Master in Lunacy and ask for permission to remove the patient from Moorcroft to Ticehurst, then to find out when you got the order that Ticehurst had not got rooms for him, or rooms you could not accept.

9602. Is this what you really meant: I think I shall become concerned with the patient, and I am sure if I ask the Master in Lunacy he will give me direction?—No, I was *dominus litis* at that time; they were my proceedings.

9603. Then you go on: "We may add that the patient is a highly respectable gentleman and occupied a good position in the shipping world. He is not of a dangerous disposition, but it is desired to secure an asylum with better surroundings than where he is at present." You had been told that he was dangerous?—Yes.

9604. Why did you write "He is not of a dangerous character"?—Because he obviously was not dangerous in the sense in which it would be understood there he was a dangerous man, likely to do anybody an injury.

9605. You told us that you did not think he ought to be in an asylum at all?—What I meant to convey was that I was surprised that a man having such clear perception and an active brain should be the subject of the disease or complaint, or whatever it was, I was told he suffered from.

9606. Referring to your letter of the 14th May, 1917, is it not quite clear that at that time you thought he ought to be in an asylum, and that the asylum should be changed from Moorcroft to some rather more comfortable place?—Officially, yes. Personally, I had no opinion about it.

9607. *Earl Russell*: Why do you say you were determined that he should be removed from Moorcroft—why determined?—Because—I do not want to say anything—

9608. We do want you to say it.—I sat for an hour and a half in that miserable little room in Moorcroft looking out on the lawn, and it occurred to me that

if anything were wanted to drive a fellow dotty it would be imprisonment for the whole of his days, and I wanted a sailor to have the sea to look upon, and that is what I went down to Ticehurst for.

9609. Can you see the sea at Ticehurst?—There is a fine view over the country, and you are supposed to get the air from the sea. I do not know whether you can see the sea. But at Moorcroft the patient was on the ground floor and the only sign of life was an occasional gardener going by with a mower. At Ticehurst I got him rooms where he got a view of the sun.

9610. Is that your only objection—that the view was restricted?—You may call it the only objection. It was depressing.

Mr. Walter Stewart: He had said it was a miserable room.

Earl Russell: We have heard that.

Mr. Croom-Johnson: May I ask a question of this witness on this part of the case, Sir?

Chairman: On the question of the room that he visited?

Mr. Croom-Johnson: I wanted to ask him a question about his evidence on the 3rd of May when he went down there.

Chairman: Would you mind telling me to what purpose your question is to be directed?

Mr. Croom-Johnson: Really for the purpose of seeing whether he could not form the impression which he says he formed of the sanity of Mr. H.

Chairman: I do not think we can enter into that.

Mr. Croom-Johnson: If you please, Sir.

Chairman: On the other hand, you can ask him about the question of the room.

9611. *Mr. Croom-Johnson* (*To the Witness*): How many times did you go down and see Mr. H. at Moorcroft, do you think?—Three or four times.

9612. Did you always see him in the same room?—I do not think I ever saw him anywhere else.

9613. I would rather like to have your impression about it. You have characterised it with epithets?—I only used one.

9614. Have you any idea of the size the room was?—No, I have not. It was a very small room.

9615. You saw him in a very small room. May that have been the room where you were interviewing him?—No, it was what was called his room.

9616. *Chairman*: His sitting room?—Yes.

Mr. Walter Stewart: Might I ask as to what was said to this gentleman by the people at Moorcroft? *Earl Russell* has got part of it, but not quite the whole.

Chairman: I do not know that we need pursue it. Of course, this gentleman's views upon the sanity or insanity of Mr. H. are not of much importance. He has said that he was told Mr. H. was dangerous.

Mr. Walter Stewart: If I may help you it will show you how patients are kept in these places.

Mr. Croom-Johnson: That is the very point upon which I was stopped.

Chairman: Let me hear the question, Mr. Stewart.

Mr. Walter Stewart: Did the medical superintendent, or whoever the gentleman was that you saw at Moorcroft, say that he had no hesitation in saying Mr. H. was suffering from general paralysis of the insane and that the end would come in 18 months' time—did he say that?

Chairman: First of all, we have to consider whether the question is to be put.

Mr. Walter Stewart: I beg your pardon, Sir.

Chairman: No, I do not think we shall allow that question.

Mr. Walter Stewart: Very well. Then with regard to the will. If the state of Mr. H.'s mind is still a matter the Commission desire to know about, there is something written on the document itself which bears a date, a scrutiny of which may throw some light upon it.

Chairman: Will you show me the document, Mr. Steele? (*Document was handed to the learned Chairman.*)

26 January, 1925.]

Mr. CHARLES RICHARD STEELE.

[Continued.]

Mr. Walter Stewart: May the will be regarded as evidence? I tender it.

Witness: That is a draft.

Mr. Walter Stewart: There are certain instructions by way of alteration of that document.

Mr. Croom-Johnson: Bearing in mind the case book, I should have thought my friend could not have had it more plainly than on the last occasion—the entry on the 30th January, 1917. May I read the entry?

Chairman: If you please.

Mr. Croom-Johnson: "Mr. R. H. visited his brother to-day and brought the patient's will with him, which the patient had recently altered. At Mr. R. H.'s request and with the consent of Mr. E. S. H. (the petitioner), after the patient had read through the will, I witnessed it with attendant Brewer. I considered that the patient is mentally well enough to do this and to thoroughly appreciate the contents of his will." That is signed by Dr. Stillwell.

Mr. Walter Stewart: So long as it is so regarded by the Commission, I am content.

(The Witness withdrew).

DR. WILLIAM HENRY BUTTER STODDART, SWORN.

Examined by Mr. H. C. Dickens.

9617. Dr. Stoddart, you practise at Harcourt House, Cavendish Square. You are a registered medical practitioner holding the degree of Doctor of Medicine, London, you are a Fellow of the Royal College of Physicians, London, and a Member of the Royal College of Surgeons, England, you obtained the Gaskell Gold Medal in Psychology and Mental Diseases in 1901, and since then you have been Examiner to the Medico Psychological Association?—Not all the time—just for a few years, five years.

9618. You are a Lecturer in mental diseases in St. Thomas's Hospital, Consulting Physician in mental diseases to the War Office, Examiner in psychology and mental disease to the University of London, and you hold a variety of other appointments in connection with the study and treatment of mental diseases and psychology?—Yes.

9619. You are also the author of a book entitled "Mind and its Disorder," and other books on the subject, and you are the author of a variety of articles on mental diseases, and the like, which have appeared in the medical journals from time to time, and you have for a great many years made a study of mental disorder and psychology?—Yes.

9620. You first came into contact with Mr. H. on the 20th November, 1916?—That is right.

9621. You made certain notes at the time, which you produce?—Yes.

9622. I think you made an examination of Mr. H. and had a conversation with him—how long were you with him, roughly speaking?—About three quarters of an hour, I should think.

9623. Whereupon you drew up a report which you produce, and does that accurately and sufficiently represent the result of what you heard for yourself, and what you were told by other people that day?—Yes, I think so.

Mr. Dickens: I do not know if I should read it, Mr. Macmillan.

9624. Chairman: Perhaps you might just put it in. (To the Witness.) Where was this?—At Dr. Dempster's house at Croydon.

Chairman: And have we got who had invited Dr. Stoddart to go there?

9625. Mr. Dickens: How did you come to go there?—Dr. Craig asked me to go and see Mr. H.

9626. For what purpose?—For me to give my opinion on the case.

9627. Chairman: But you had not known the case of Mr. H. before?—No.

9628. Mr. Dickens: Did you speak to Sir Maurice Craig beforehand?—Sir Maurice Craig gave me something of the previous history of the case.

9629. Did you see Dr. Dempster?—Yes, I saw Dr. Dempster.

9630. Did he give you any information about the patient?—Yes; he showed me some of his letters, a pile of letters as a matter of fact, about so high. (Describing.)

9631. You looked at them, so that you got the general nature of them?—Yes.

Chairman: Then I think this report which was made is of importance; it was a report made at the time.

Mr. Dickens: Yes, it was made at the time; it was a report to Sir Maurice Craig for the benefit of the relations of the patient.

Witness: Yes.

Mr. Dickens: Shall I read it, Sir?

Chairman: Is it very long?

Mr. Dickens: It is two pages. "I beg to report that I have to-day examined Mr. W. H., a retired Consulting Naval Engineer, at the house of Dr. W. T. Dempster, 94, Brighton Road, South Croydon, with whom he is residing as a patient. I was informed that Mr. H. had an attack of pneumonia about five weeks ago, but he now appears to have recovered completely from this and to be well and strong in so far as his physical health and condition are concerned. There are, however, many signs of mental disorder, some of which are sufficiently serious to raise the question whether he ought to remain any longer on the footing of a voluntary patient in a doctor's house or to be certified and sent to an institution for the insane. The most important symptom in this connection is his intention to remove himself to Brighton beyond care and control when he is obviously not fit to be at large, as will be seen hereafter. He was rather garrulous in conversation—unlike his normal self, so I am told, and still more so in writing, for he writes letters all day long. He told me this himself, and Dr. Dempster showed me piles of letters written by the patient about three inches thick daily. Many of these were to comparative strangers, and Mr. H. had to explain them away by saying that he had nothing else to do. His nurse told me that Mr. H. was liable to uncontrollable fits of temper, again—quite unlike his normal self, and that he had the desire to visit a matrimonial agency, despite the fact that he is already married. Mr. H. told me that he had bought a monkey from the Zoo and showed me the parrot cage in which he intended to keep it. In so doing he shows defect of reason, for his present circumstances are quite unsuited to the keeping of such a pet. The patient appears also to have developed a litigious frame of mind, respecting (1) some property belonging to himself and his wife conjointly, (2) a false accusation by his sister, which was never made, and (3) his treatment at a nursing home in Devonshire a couple of years ago, where he claims that he was insulted by being massaged. He is also full of 'schemes' which, in his circumstances, border on being unreasonable. For example, he wishes to convert his wife's house into a hospital for sailors in opposition to the wishes of his wife and family. Although any one of these symptoms by itself might be of little consequence, their combination in the same patient is suggestive of the disease known as 'general paralysis' or 'dementia paralytica.' This diagnosis is rendered more probable still by certain physical signs, although these again are not unequivocal. They are an increase of the knee-jerks, failure of the left pupil to react to light and (as I am told by Dr. Maurice Craig) a positive Wassermann reaction in the blood and especially in the cerebrospinal fluid of the patient. Moreover, certain changes in the cell content of the latter fluid are also

26 January, 1925.]

Dr. WILLIAM HENRY BUTTER STODDART.

[Continued.]

suggestive of general paralysis, though again not unequivocally. I understand that Mr. H.'s mental symptoms, although slighter in degree, date from January, 1915, or earlier. Despite the fact that such a protracted duration militates against the diagnosis of general paralysis, I can come to no other conclusion than that this is the disease from which the patient is suffering. In typical cases of general paralysis there is progressive mental and physical deterioration, ending fatally in about a couple of years; but Mr. H.'s case is atypical, and it is therefore impossible to attempt a prophesy as to its duration—even assuming the diagnosis to be correct."

Witness: Yes.

9632. Then did you sign a certificate which I think you have?—Yes.

9633. I think that has been read to the Commission; it is dated the 20th of March, and I need not read it again, but it embodies some of the facts that you put in your report?—Yes.

9634. There is no mention at all of the diagnosis of general paralysis?—No.

9635. But the facts that you put in your certificate are merely facts with relation to his mental derangement at the time?—That is so.

Chairman: Is that the one, Mr. Dickens, that was never used?

Mr. Dickens: That was never used.

Chairman: And there is not a word in it with regard to general paralysis?

Witness: No.

Chairman: We have not had that one; it was never used, and therefore did not go on the file.

Mr. Dickens: Sir Maurice Craig had it; I thought he had put the original in.

Earl Russell: It has been read.

9636. *Mr. Dickens:* This was a certificate intended to accompany an urgency order, and to be the foundation of an urgency order?—Yes.

9637. Was it a case, in your opinion, that necessitated an urgency order rather than the delay of proceeding by a reception order?—Yes.

9638. Why?—I have put it in here, as a matter of fact. "The most important symptom in this connection is his intention to remove himself to Brighton beyond care and control, when he is obviously not fit to be at large." That is the reason for urgency stated there.

9639. Whatever the correctness or incorrectness is of the diagnosis, have you any doubt that on that day he was insane and certifiable?—No doubt whatever.

9640. There are one or two more questions, Dr. Stoddart, which I should like to put. Had you been brought into contact with the late Dr. Adler?—No, I am afraid I never met him, I knew of him.

9641. Had he a reputation as a skilled bacteriologist?—Yes, certainly.

9642. One more question with regard to private asylums?—Have you any financial interest in any institution of this sort?—Not a penny in one of them.

9643. Do you ever certify patients on the orders of other medical men, apart from your own judgment?—No, certainly not.

9644. Can you produce your notes—I am not going to read them—the notes you made at the time on which you founded your report?—Yes.

9645. I see your final word is "diagnosis. General paralysis, litigious."

Mr. Walter Stewart: I will ask my friend Mr. Cremlyn to cross-examine this witness.

Cross-examined by Mr. Cremlyn.

9646. Dr. Stoddart, I understand that you have a very vast experience in dealing with lunatics and certifying them?—Yes.

9647. I think for some considerable time you were medical officer at the Bethlem Hospital, were you not?—Yes.

9648. Would you mind telling me when it was that you were at the Bethlem Hospital, and how long you were there?—From 1898 until 1914.

9649. And you were also, I think, an Examiner in mental diseases, and so forth, at the University of London?—Yes.

9650. Are you still an Examiner?—My time is just up.

9651. What I wanted to ask you was this, and I do not want to be offensive at all, I have to put a few questions to you: Have you changed within recent years the entire basis upon which you previously used to deal with mental cases? Have you changed your mind as to the basis of dealing with mental cases?—No, I do not think so.

9652. May I ask you this: I see you wrote a book a little time ago, which has run into several editions, "Mind and its Diseases," I think, or "Mind and its Disorders"?—"Disorders," yes.

9653. Now that book is largely based upon what is known as the Freud system, is it not?—Yes, the latter editions.

9654. In the latter editions of that book you appear to have adopted the Freud system, which is diametrically opposite to the system which you adopted before, dealing with mental cases?—Yes, that is a different question. I gather that you meant the way in which I dealt with mental patients, not the pathology. I do hold different views as to the pathology of mental disorder.

9655. I put it to you erroneously, but holding that different view about pathology as you do, has not that coloured your mind and altered the whole view that you take, and the way you look at cases now?—Yes, I suppose it has.

9656. Now did you submit Mr. H. to any of the Freud tests?—Certainly not; he was not capable of that.

9657. May I put this general question to you: you know that the view that you take of the mind was very severely criticised by "Guy's Magazine"—you know that review on your book?—Yes.

9658. I do not want to be offensive at all, but you know the view you take is not generally accepted, is it, by the medical profession—I leave it at that?—Quite right.

9659. May I now put this first question? What was the most important thing about Mr. H. which led you to the conclusion that he was not fit to be at large?—A number of little things that I have specified here in the report. I was going to say here that we have to state in a report, and on a certificate, facts, but very often the general demeanour of a patient and the expression, and the way in which he behaves, which cannot be described on paper and put down as facts, influence one very much indeed; and so it very often happens that you cannot make a strong certificate although you are quite certain that the person is very insane.

9660. You suggest, then, with your vast experience of it, that it is practically impossible to carry out Section 28 of the Act?—Sometimes, yes.

9661. Section 28 says that you must state the facts in the certificate—you think it is almost impossible to carry that out on the material facts?—Sometimes it is, yes.

9662. Now arising out of that, taking this report by itself—you have told us there were other things you could not reduce to writing—do you suggest that this report in itself would not be a sufficient ground for certifying Mr. H. insane?—No, I would not say that. I thought it was sufficient.

9663. You see, you, say that it is impossible to reduce to writing many things that you see in a man, which would warrant you in finding that he was not only insane, but sufficiently insane to be dealt with under an

26 January, 1925.]

Dr. WILLIAM HENRY BUTTER STODDART.

[Continued.]

urgency order. Are there any of those material things that are not down here in this report?—There was one which just caught my eye here among the notes, "A delusion that his sister had been slandering him some years ago."

9664. Now let me deal with that, because that is a point that would arise on my examination. How do you test that that was a delusion and not a fact?—I made enquiries after he had told me that his wife had been slandering him. It was something that sounded improbable, and then I made enquiries afterwards, I think from his brother, and he said that it was a delusion.

9665. Then I take it that, generally speaking, you cannot test whether a statement is a delusion or not a delusion, except by asking other people about the matter?—Unless it is something quite obvious; as, for example, when a person says he is God Almighty or the Emperor of China.

9666. Then may I take it as a general rule that you cannot test the state of a man's mind at all except by his conduct?—Including what he tells you.

9667. I want just to take these things. First of all, take the numerous statements that you have put down here in this report. I take it from you that by themselves, isolate those statements every one of them by themselves, and they would not warrant you in certifying him as insane?—I think so, I think not a single one by itself.

9668. Not even the general paralysis of the insane?—No, there are many general paralytics in the early stages that are not insane.

9669. Exactly; so that taking each of these statements by themselves they would not warrant you, but you say that collectively, because you have a number of them, that would warrant you in certifying him as insane?—He was garrulous in conversation. By itself on paper that means nothing, but as I heard his garrulity he was obviously insane.

9670. Now you are putting something different to what you then said. You told me just now that taken by themselves they would not warrant you. Do you say one particular form of garrulousness will warrant you?—Yes; taken by itself on paper it is not sufficient.

9671. That seems to me rather contradictory. I do not want to trap you at all. You see, the certificate that you give is the warrant on which a man is to be certified, is it not?—Yes.

9672. And on the face of the certificate itself there must be a sufficient warrant for finding a man insane, especially under an urgency order?—Yes.

9673. And on the face of it, can you say that this statement is not a sufficient one?—Not that one, but I put half a dozen.

9674. I am coming to the lot; I have disposed of that, and I have disposed of the general paralysis of the insane. You say that is not sufficient?—Yes.

9675. Now take the statement which you have put down here as a most important symptom—"the most important symptom in this connection is his intention to remove himself to Brighton beyond care and control." How do you come to the conclusion that that is a very important symptom as a test of the proof of insanity?—Perhaps I am wrong in having used the word "symptom." "The most important reason for giving a certificate," I think, would have been more correct.

9676. You agree it is not a symptom?—It is not a symptom, no.

9677. And did you think when he was going to Brighton that he was going to Brighton, to use a vulgarism, I mean it explains it, "on the burst"—he was going there on a sort of joy ride, or jollification, or something of that sort?—No, but I was quite sure that he would behave in some eccentric manner if he were outside.

9678. Do you say that you are entitled to certify a man as insane if you think that he will behave in

some eccentric manner?—Yes, such an eccentric manner as will attract the notice of the police.

9679. Was there ever any evidence put before you by anybody that Mr. H. had behaved in such an eccentric manner as to attract the attention of the police?—No.

9680. That was not communicated to you by anyone, that he had ever behaved in that way on any occasion?—No. There was the history of the year before, of course, when he was suffering from nervous depression: "he attempted to injure himself." One has to bear that in mind.

9681. Yes, and bearing that in mind, is it not a fact that he had never behaved in that way from that time to the time you saw him?—Not that I know of, no.

9682. Was there any symptom about him which would lead one to the conclusion that he would be violent to anyone?—No, I do not think so.

9683. Nothing at all?—No.

9684. You see what I have to suggest to you, Dr. Stoddart, is this—please understand that I am not suggesting any dishonesty of any kind on your part—what I am suggesting is that the methods by means of which you arrived at whether he was insane were not scientific—that the tests applied were not sufficient to warrant you in signing an urgency order. That is my suggestion—that is what I have to put?—I do not know what other tests I could have applied.

9685. That is rather what I want to get at, if I may ask you, as to what are the tests by means of which you can tell that a man is likely to be violent, or ought to come under an urgency certificate. What general tests are there. You say he talks a lot—a good many people do that. A good many people might want to go to Brighton, if they were in a voluntary home; therefore I put it to you that it might be possible that he might suffer from everything you have said in this certificate, and yet there would be no grounds for an urgency certificate?—Do I gather the suggestion is that he was not insane?

9686. Yes, the suggestion is that he was not insane?—Well, I am sorry, there is a difference of opinion.

9687. Well, you see, I am putting to you that it is a very difficult matter, as I think you will agree, really to find out if a man is insane—very difficult?—It may be, but not always by any means.

9688. Let me put one case to you: Supposing a man came to you and he wanted to bluff you, and he talked to you and said he was perfectly sane, and he suddenly told you he was the Apostle Paul—how could you say whether that man was really sane, or whether he was really for some purpose or other trying to bluff you that he was insane?—I think one can gather that by the person's general demeanour—again a thing that one cannot put on paper.

9689. But you have to put on paper under the Act, before you certify a man, proper warrantable grounds for certifying him?—Yes. A person is not necessarily certifiable because he says he is the Apostle Paul. He may be able to carry on quite well in the outside world.

9690. Exactly, and the case I want to put to you is that a man might be entitled to go down to Brighton, although he was garrulous, although he had general paralysis of the insane, and although he told you he was going to bring some action, which as a matter of fact he did bring afterwards?—I did not know that.

9691. Will you take it from me that that is so? I submit to you therefore that there is not a single thing in the whole of this document of yours which either collectively, or taken by itself, is any proof at all of insanity or violence; it is merely eccentricity, at the highest?—Eccentricity can be very extreme.

9692. Did you come to the firm conclusion that he was suffering from general paralysis of the insane?—No, I did not; I was doubtful.

26 January, 1925.]

Dr. WILLIAM HENRY BUTTER STODDART.

[Continued.]

9693. Would that weigh with you at all?—No, it would have made no difference.

9694. So that you do not regard that as being a very serious matter in this case?—Yes, certainly, a very serious matter.

9695. In his case?—It did not matter as regards certification. Of course to the patient it is a very serious matter indeed.

9696. But I gathered so far as Mr. H. was concerned it did not weigh with you one way or the other in certifying?—It did not make any difference as to whether I should certify him or not.

9697. Can you tell us really what did turn the scale, so to speak. What did make the difference, and why did you certify?—Well, as I say, the chief thing was that he was going to remove himself from care and control, and go to Brighton, where he would not be under control.

9698. He was not under care or control, was he not there as a voluntary patient?—Yes, but Dr. Dempster was willing to look after him, and as soon as he took himself away from Dr. Dempster he would not be under care and control.

9699. Did you see any signs of any uncontrollable temper about him?—No, he did not show any temper while I was there.

9700. There is one other point: When you had a conversation with him about his condition did you tell him that he was up against the medical profession?—Certainly not. He was not up against the medical profession. I went there to do what I could to help him.

9701. And you helped him by certifying him?—Certainly.

9702. You thought that was the proper way to help him?—Certainly.

Re-examined by Mr. H. C. Dickens.

9703. And you think so now?—Yes, certainly.

9704. It is suggested that a gentleman called Munro came to see you later on, and that you told him that you had difficulty in certifying, and that he said to you, "Why certify?" and you said,

"Because I was told to." Is there any truth in that suggestion?—Certainly not. I was asked for my opinion, and then I said he ought to be certified.

Chairman: Thank you, Dr. Stoddart.

(The Witness withdrew.)

Dr. REGINALD JOHN STILWELL, sworn.

Examined by Mr. Croom-Johnson.

9705. What are your qualifications, Dr. Stilwell?—M.R.C.S., M.R.C.P.

9706. Are you now one of the licensees of "Moorcroft"?—Yes.

9707. Were you a licensee in 1916?—Yes.

9708. I think the property belongs to your father?—Yes.

9709. That is Mr. John Stilwell, a Justice of the Peace, who has been referred to?—Yes.

9710. Were you there in 1916 and 1917?—I was.

9711. And did you see Mr. H. from time to time?—I did.

9712. Was he on friendly terms with you?—Yes, very.

9713. Did he frequently write you letters?—He did.

9714. Long letters?—They were.

9715. And were they expressed in friendly language?—They were.

9716. Now I want to come down to the point of time when Mr. H. escaped—the 23rd February. Do you remember his being brought back to "Moorcroft" on the 26th February, 1917?—Yes, I do.

9717. Was he brought back by one of the attendants at "Moorcroft" who had found him in Chancery Lane?—He was.

9718. On his return, was he searched?—He was.

9719. Have you any knowledge of his being stripped?—No, I have not.

9720. Did you give any orders that he should be stripped?—No.

9721. Is it any part of the ordinary routine of the institution that he should be?—No.

9722. And, so far as your knowledge goes, do you think he was?—No, I do not think he was.

9723. Now after his return he was placed by day in what is known as the large room?—He was.

9724. I will deal with that specifically in a moment. With regard to the night time, did he continue to occupy the bedroom from which he had made his escape?—Yes.

9725. But with the difference that there was an attendant who slept in the room with him?—Sat up with him.

9726. Was that, in your opinion, a necessary precautionary measure?—It was.

9727. Now with regard to the large room, first of all, do you recollect how many patients there were in the room during the time that Mr. H. was there?—No, not precisely.

9728. About how many would there be?—Generally from eight to ten patients.

9729. And two attendants?—Two attendants.

9730. We have seen the photograph. I might perhaps just ask you this general question about the photograph. Has the photograph been taken comparatively recently?—Yes, last week.

9731. For the purpose of putting before the Commission?—Yes.

9732. Is there any truth in the allegation that that room was dressed up in any way in order to convey a wrong impression to the Commission?—No—just as it always is.

9733. Now just tell me this: What was the object of putting Mr. H. in the large room?—There were two points; chiefly to have more special observation and, secondly, from a medical point of view, he would associate with others more, and the intention was that he would lose the idea of always trying to escape.

9734. Had it anything to do with any notion of punishment?—No.

9735. Is it any part of the treatment of these afflicted people, either in your establishment or, so far as you know, in any other establishment of a similar nature?—No, certainly not.

9736. In your judgment, would it have been a suitable thing to place a man who had recently escaped and had been recaptured in a room by himself?—Well, it would have meant that he would have been shut up, you may say, all day long with one man.

9737. You would have had to have an attendant there in order to see that he did not escape again?—Yes, in the room again.

9738. And in the exercise of your judgment and your knowledge of these cases, did you think it was better for him to be in this large room?—Certainly.

9739. Now just a word about the patients who were in that room with him. First of all, with regard to their social position, were they people all of a similar social position to himself?—They were.

9740. Were they noisy people or not?—No, probably not so noisy as Mr. H., or not so talkative.

9741. Were they well-behaved patients?—Yes, in my recollection of them, as far as I remember. They would not have been there if they had been very troublesome.

26 January, 1925.]

Dr. REGINALD JOHN STILWELL.

[Continued.]

9742. Were all of them as bad as Mr. H., or were some of them worse?—There was no one there more talkative.

9743. And what about their general condition; were some of them more normal or less normal than Mr. H.?—I think there were some more normal.

9744. More normal than Mr. H.?—Certainly.

9745. Now next with regard to their habits. Were any of them from your own observation people of dirty habits?—No, certainly not; they would not be in that room if they had been.

9746. One other small point: after he came back was there any difference made in the food which Mr. H. received?—No, certainly not.

9747. [He suggests that some sort of difference was made, and that he was not as well looked after?—No, the food was all the same; the only difference was that most of the gentlemen in that large room have* their main meal in the middle of the day instead of the evening; they dine at 2, and the patients who are more normal have luncheon and dine later.

9748. Do you recollect how long it was that Mr. H. was in this room?—I think it was four or five weeks.

9749. We have got the information from Mr. Steele, at all events, that when he came on the 3rd May he did not interview Mr. H. in this room.

Earl Russell: Would you ask about Mr. H.'s toilet articles?

9750. Mr. Croom-Johnson: I am much obliged. (To the Witness): With regard to Mr. H.'s toilet articles, is it true that he was deprived of those?—No, it is not true. His bedroom was exactly the same as it was before.

9751. And so far as his bedroom was concerned, would he use his bedroom in the same way; although he would sit in the day-time in this large room, would he have exactly the same bedroom?—Absolutely.

9752. And the amenities?—Absolutely.

9753. And his washing and shaving, and all that sort of thing, would be done in his bedroom, presumably?—Not his shaving. We have a barber's shop.

9754. Was he visited in that room by his brother, the petitioner?—Yes.

9755. And also by Sir Maurice Craig, as we have heard?—Yes.

9756. Until the proceedings in the Uxbridge County Court, had you ever heard of any complaint by Mr. H. or by anybody on his behalf, about being put into this room?—No.

9757. Then, in the County Court proceedings, was the complaint there about the room, that he had been paying still at the rate of 15 guineas a week, but had not been allowed the use of his private sitting room in the day-time?—That was the charge.

9758. Was that the only complaint made ultimately in the County Court?—As far as I remember, it was.

9759. Just tell me one thing about the place generally. Have you from time to time a number of patients who come there voluntarily?—I have.

Cross-examined by Mr. Walter Stewart.

9775. Have you a prospectus of any sort relating to "Moorcroft," Dr. Stilwell?—No, I am afraid I have not.

9776. Are none issued at all to interested people? No, we have never had one.

9777. How do you arrange for the supply of certified patients to be delivered at "Moorcroft"; I mean if the public are not in any way circularised, who feeds you?—We have been at it some time, you know; our name is fairly well known.

9778. Who sends the cases?—Most of the doctors, and ex-patients.

9779. Tell us about the doctors. Are you supplied with patients by several London consultants?—Yes.

9760. Patients who are not certified at all?—Yes.

9761. And do some of them repeat their visits and come again and again?—They do.

9762. What was happening in Mr. H.'s time?—I cannot remember whether I had a voluntary boarder at that time, but I nearly always have.

9763. And have you them there to this day?—I have several, yes.

Earl Russell: While you are on charges, will you ask him how the £700 for six months was made up?

9764. Mr. Croom-Johnson (to the Witness): I do not know whether you have got a copy of the account. It has been suggested that £700 for six months was the amount that was paid you. Your charge was 15 guineas a week?—Yes.

9765. Was that an inclusive charge?—No, anything he wanted we got for him, you know.

9766. For example, who would pay Sir Maurice Craig's fees for coming down? Would those go through your accounts or not?—I do not think so.

Mr. Walter Stewart: Those were paid by the brother, the petitioner, out of the estate. We have evidence of that.

9767. Mr. Croom-Johnson: Have you any recollection about £700 being charged at your establishment for six months?—I do not remember what the amount was.

Chairman: It would come to 60 guineas a month at 15 guineas a week.

Earl Russell: It is about half the figure that was mentioned to us.

Witness: I do not think our account could have come to that.

Earl Russell: Very well, so long as you put it to him.

9768. Mr. Croom-Johnson (to the Witness): There was a Receiver appointed afterwards in the lunacy proceedings, was there not?—Was that while he was at "Moorcroft"?

9769. Just about the time he was leaving. Do you recollect whether you sent up your accounts to the solicitors in London for the purpose of their being examined and checked for the lunacy proceedings?—No, I do not recollect that.

Chairman: There is one thing—"the miserable little sitting room"—what was the size of the sitting room?

Mr. Croom-Johnson: Yes, the private sitting room.

Witness: It is a very nice sitting room. I think it is about 14 feet square; it has got two good windows and it looks out on to the garden.

9770. Chairman: Is it on the ground floor?—Yes, on the ground floor.

9771. Mr. Croom-Johnson: Is it well furnished?—Yes.

9772. And very well appointed?—Yes.

9773. Is that sitting room very much the same to-day as it was at the time Mr. H. was with you?—I think it is very much the same.

9774. So that if any Members of the Commission care to go and see it they could see it in very much the same circumstances in which Mr. H. inhabited it?—Yes.

9780. Sir Maurice Craig being one of them?—Yes.

9781. About how many in a year does he send you?—I have not the faintest notion.

9782. But you can find out quite easily?—Yes.

9783. As I understand you will be here to-morrow, perhaps you will make a note of that. Now tell me this: they are not all on the same basis of payment, are they?—No.

9784. What is the highest scale?—Our terms now are roughly from 8 to 15 guineas a week.

9785. Are none as high as 20 guineas. What about that American gentleman—I do not want to mention names—did he pay 20 guineas?—I should think it is very likely he did. He had three rooms.

26 January, 1925.]

Dr. REGINALD JOHN STILWELL.

[Continued.]

9786. How many of these paying guests had you at this time—in 1916?—We generally have about 45 or 46.

9787. At an average of about how much? You could look that up too, I daresay. Have you not prepared yourself at all to give evidence in regard to these details?

Chairman: I am not surprised he has not, because the question is how was Mr. H. treated while he was in the establishment?

Mr. Walter Stewart: But the whole range of the inquiry, I thought, was as to what was provided and on what terms, at these private places, and as to whether they were properly run?

Chairman: I thought the question was whether Mr. H. was badly treated when he was at "Moorcroft."

Mr. Croom-Johnson: It was all gone into in the County Court action.

Mr. Walter Stewart: Surely my friend has been seeking to show how good it all was.

Chairman: I do not see that the number of patients he has and how much he makes out of them has any bearing at all upon the matter in question.

Mr. Walter Stewart: I submit that the question of what is got for the money is strictly relevant to the ambit of the inquiry. I want to get the general conditions. This is a typical case.

Chairman: Please go on. The only question I want to deal with is the question of how Mr. H. was treated while in this establishment.

9788. *Mr. Walter Stewart*: If you please, Sir. (To the Witness): Now as to the general nature of the establishment, this is a place for the reception and cure, if possible, of mentally ailing patients, is it not?—Yes.

9789. That is what you hold yourself out to do, and you charge up to 20 guineas per patient. What do you purport or profess to provide in return for that payment—not only meat and drink and lodging, but what else?—Medical treatment.

9790. Including what? I will put something specific to you to indicate what I mean. We have heard, amongst the items of ameliorative treatment, massage and psycho-analysis specially stressed as proper in dealing with this class of patient. Do you provide either of those things?—Yes, both of those.

9791. Is either of them included in the ordinary charge or are they charged as extras?—No, ordinary charges.

9792. What—massage? In the Uxbridge case did you not actually claim additional payment because Mr. H. had massage?

Mr. Croom-Johnson: We claimed nothing in the Uxbridge case.

Mr. Walter Stewart: But was not that part of the claim which he disputed?

Witness: I do not remember it.

Mr. Walter Stewart: I have the shorthand note.

Chairman: I am not going to have this gone into.

Mr. Walter Stewart: Very well, Sir. (To the Witness): You say it included massage—you swear that.

Chairman: I do not care whether he swears it or not. Will you kindly address yourself to the question, how was Mr. H. treated?

Mr. Walter Stewart: I am dealing with the massage.

Chairman: I do not see that he is ill-treated because he is charged for massage or if he is not charged for massage.

Mr. Walter Stewart: I thought it was bad treatment.

Chairman: It may be bad financial treatment, but it has nothing to do with his ill-health.

Mr. Croom-Johnson: I should like to add that there is not a word of this in the County Court claim.

9793. *Mr. Walter Stewart*: No, it is in the evidence; it was complained of. (To the Witness): Now let us come back to the point. Mr. H. was charged 15 guineas a week, we know. What sort of

room was it? My friend has been allowed to ask you about this room; was it on the ground floor?—Yes.

9794. Was it infested with mice?—No.

9795. Was it an old crumbling panelled room?—No.

9796. Is it panelled?—No.

9797. Was it any less safe than the large room?

Mr. Croom-Johnson: Do you mean with or without an attendant?

Witness: It is an ordinary room just as safe as any other room.

9798. *Mr. Walter Stewart*: Then why was he removed, after he had escaped, to another room, if that was just as safe as any other room?—I explained that before. I moved him there because I thought it was good for him to be with other people, better for him than to be alone in a room with one man.

9799. What about the old gentleman who came and sat down in an aggressive way on that day that he arrived? That is how he first knew he was in an asylum?—I can assure you that before Mr. H. escaped he had practically the run of the house, and he was all over the house, too.

9800. Do you profess to provide sufficient guards for the 15 guineas, to guard a man who is in a private room if necessary?—As a rule, we charge extra for a man at night.

9801. It was only in the day time that he was put in the large room?—Yes.

9802. Then it was not necessary to put him in the large room for safety?—For actual safety, no.

9803. Do you seriously suggest to the members of this Commission that the conditions in the large room were better adapted to ameliorative treatment than in his own room?—Yes, I do.

9804. Why did you not put him there at first?—He was, as I say, in every room when he first came there.

9805. Why did you not put him there first? There is an extra charge for a private room which you made, and continued to make throughout?—Yes.

9806. Why did you not put him in the large room at first?—I have no doubt he went there.

9707. He had his own room at first, and he was put back because of the complaint; that solicitor came down, did he not?—It was nothing to do with him.

9808. There was a complaint, was there not?—No, there was not.

9809. Did not his relations complain of his being put in that long room?—No.

9810. Very well, you are swearing all this. You understand, when I say that the photograph does not honestly disclose the conditions, what I mean is that it does not show the sort of people who were in it?—Of course not.

9811. I am not going to put any name to you for obvious reasons, but I am going to put on slips of paper the names of people who were in that room, what they were suffering from, and how they behaved. Just take, if you please, *that one (handing a slip of paper to the Witness)*. This is the only way in which I can show what this room was like. I do not want publicly to mention any name. Do you recognise that name—aged about 32?—Yes, I remember him.

9812. Did he suffer very badly from scales on his skin?—No, I remember the gentleman very well.

9813. Was he constantly picking his skin?—I do not remember.

9814. Was he strapped up with bandages and put in the oak room?

Mr. Croom-Johnson: May I see that slip of paper? (The same was handed to learned Counsel).

Witness: What do you mean by strapped up?

9815. *Mr. Walter Stewart*: With bandages over the sores?—He may have had.

9816. And was he eventually so bad that he had to be put in the oak room?—Yes.

26 January, 1925.]

Dr. REGINALD JOHN STILWELL.

[Continued.]

9817. And he was put in there with a man called Priestly—that is the attendant?—No. You are getting rather mixed, I think.

9818. Was another man of that name with him?—Yes.

9819. Was he a persistent blasphemer?—No, I am sure he was not.

9820. Do you remember this gentleman who was also in the room at the time (*handing another slip of paper to the Witness*)?—May I mention that the first gentleman you gave me the name of got quite well in about five months.

9821. I dare say he did, but I am dealing with the condition he was in when Mr. H. was sharing the room. I do not care what happened five months afterwards. What about that gentleman (*handing another slip of paper*). Do you recognise the name?—Yes.

9822. Was he one of those people who indulged in loud prayer in season and out of season?—I think that is rather exaggerated, you know.

9823. What is wrong about it, the loudness or the fact that he prayed in and out of season?—As a matter of fact he used to say rather a prolonged Grace before meals, but I cannot agree that he was a loud prayer.

9824. Did he vary it by reciting erotic verses?—No, I never heard of it—not erotic verses.

9825. You have references in your case book to all these people, I suppose?—Yes.

9826. That is what I am told was his peculiarity. He constantly recited erotic verses. He had been with you many years, had he not?—Not in 1916.

9827. Is he still with you?—Yes.

9828. Then you know whether he is like that?—He is certainly not like it now.

9829. He is better?—No, he is not.

9830. No better?—No.

9831. I am very sorry to have to put this sort of question to you, but is it a fact that these sort of people at times smell very badly? Mr. H. said that that particular man did. Is there any ground for that?—No.

9832. Do some of them smell very objectionably at times?—Some cases do, but they would not be in the large room.

9833. Mr. H. says that one was?—No.

9834. Do you remember the case of a solicitor of that name (*handing another slip of paper*). He was also in that room?—Yes.

9835. He was one of the violent resisters to feeding, was he not?—He had to be constantly forcibly fed by attendants, had he not?—That again would be in your case book, would it not?—It would be, if he was.

9836. Do you deny it?—No, I do not remember it.

9837. Would he be one of those patients who was frequently very tearful, weeping, melancholic—do you remember him?—I remember him very well.

9838. Was he a patient of that kind?—I do not remember that he was very depressed—no.

9839. On instructions, I am told that that was his condition. You will not deny it, will you?—I should like to look it up.

9840. I should be obliged if you would. I should welcome a verification of these particulars because I want to be fair. Now had you an attendant named Jacobs to look after a particular patient?—Yes.

9841. Did he look after this patient in the long room. (*Handing a slip of paper to the Witness.*) Do you remember the patient?—You have written down the Christian name, I think.

9842. He was a violent man, was he not? He used to kick the attendants, did he not?—No.

9843. I put the name of Jacobs to you. Perhaps that will enable you to verify it, but that was the name of the keeper. He kicked him and was struck in return?—If he is the patient I think you are referring to, it is very unlikely.

Chairman: I think, Mr. Stewart, Mr. H. made his point to us that he found these patients very disagreeable. Is not that almost enough?

Mr. Walter Stewart: It is suggested that they were worse than he was and I am showing what they were like, and the case book will show.

Chairman: I think he said that some were worse and some were better. Really I think the contents of this room eight years ago have ceased to interest, beyond the fact that the patient did not like being there, and thought the company was objectionable.

Mr. Walter Stewart: I have nine of them. (*To the Witness*): Do you consider that to share a room with people like that is likely to be ameliorative of the condition of a patient who according—

Chairman: Please stop. Cannot you ask the simple question: Do you think it would be nice to be in a room like that?

Mr. Walter Stewart: For a patient in that condition specially—even at that moderate rate of pay.

Chairman: Put your question in your own way, if you prefer to introduce parentheses of that sort.

9844. Mr. Walter Stewart: I am bound to, Sir, if I am to get the whole circumstances. (*To the Witness*): Do you think that that is likely to be a suitable environment to produce a cure?—Yes, I do. You see, I do not think you have got the hang of this thing, if I may say so. In this large room there are certain patients who go in there; if they are well enough they go in there. If they are not well enough they go into another room; they vary from day to day.

9845. It has nothing to do with whether they can afford to pay for a single room, has it?—If they can afford to pay for a private single room, they can have one, but it does not follow that they will always be in that room.

9846. For five weeks Mr. H. was kept out of it. Was that because he was not well enough, or because you wanted to punish him?—No, I did not want to punish him.

9847. Was it not for the purpose of punishment that he was made to consort with those people whose cases I have been putting to you?—No, certainly not.

9848. How came he to be put back again into his room?—I thought he was well enough to return.

9849. Is it not because complaints were conveyed to you in writing by his relatives as to the conditions by which he was surrounded?—I do not remember it in writing. I think Mr. E. H. said he would like to have his brother back into his own room as soon as I thought fit.

9850. And did you then put him back and not tell him?—I do not think so at all.

9851. You did not put him back before, did you?—No.

9852. What form of mental treatment did you give him to cure his diseased mind? Just describe it, so that we can know what he got?—He gets at the start a routine life.

9853. You can get that outside, cannot you?—Yes.

9854. What other advantages had he?—Occupation of a suitable character.

9855. What occupation did you find for him?—It was unnecessary to find him any.

9856. Very well; then that was not provided. What else did you provide for his mental amelioration—think, and tell us?—We devoted a good deal of time to him.

9857. What did you do to improve his mind?—I am not aware that I did anything particularly, except his general health.

9858. That is exactly the process; you do not do anything particularly. You provide them with food and lodging and let them cure themselves if they can. Is not that the actual basis and bedrock of the whole thing?—No, it is not.

9859. Was there any process of psycho-analysis in order to improve their minds?—Not in his case.

9860. I invite you now to take the opportunity to tell the Commission what there was in the way of special treatment?—I do not think Mr. H. had any special treatment.

9861. Very well. No special regular exercise, for instance?—He had plenty of exercise.

26 January, 1925.]

Dr. REGINALD JOHN STILWELL.

[Continued.]

9862. I say no specialised exercise?—No.

9863. Then with regard to the bathing—baths are said to be such a great subject of this treatment. Had he an ordinary slipper bath in his room?—I cannot remember what bath he had.

9864. As far as you are able to say, was there any other special kind of bath ever provided in this special establishment?—There are the baths.

9865. Was there any other bath ever provided for him except an ordinary slipper bath filled from a can?—I do not know whether he used one of the bath-rooms or not.

9866. Anyhow, you do not know whether he had one of the baths for curative purposes?—I cannot say.

9867. Simple diet—I dare say he had that. I am not complaining about that. You say it is the same all through; there is no difference?—Not in the quality of the food.

9868. In other words, the highest paying patients get no better food than the lower paying patients?—No.

9869. That is a matter to be noted. What were the amusements provided? We know he had his own pets to amuse him, and a very good thing too. That is highly recommended nowadays by people connected with these establishments, is it not—that people should be allowed to have pets?—I have not heard of it.

9870. What amusements would you provide for 15 guineas a week, or whatever it was?—Mr. H. was so busy; I do not think he had time for amusement.

9871. He amused himself?—Yes, to a great extent.

9872. Be it so; I only want to see what the establishment is capable of doing. Now tell me this, as distinguished from amusement—occupation. He provided his own, did he not?—He did.

9873. Regulated employment—you did not provide that, did you?—No.

9874. There was no regulated employment provided. General care of bodily health; let us see what you provided in that way. What was the general care of bodily health?—Did you prescribe medicines for him?—Personally do you mean?

9875. Or anybody. You are a doctor, are you not?—Yes.

9876. Who is the medical superintendent in this place?—I am.

9877. Very well then. Who regulates the prescriptions for your 40 odd patients?—Either I or my partner.

9878. Then let us deal with you, you are here. What medicine, if any, did you provide for this gentleman?

Mr. Croom-Johnson: Do you expect this gentleman to give a list after this period of time?

Mr. Walter Stewart: Unless the Chairman stops me, I am disposed to do it in my own way.

Chairman: I have almost despaired of trying to stop you.

9879. Mr. Walter Stewart (to the Witness): Tell me what medicines you provided him with?—I really do not know what medicines he had. He might have had something for his bowels, or a tonic, or anything.

9880. But your case book is kept for the purpose of indicating what drugs are supplied, amongst other purposes, is it not?—Yes.

9881. I happen to have a copy of it. Have you your case book here?—Yes.

9882. I challenge you to show any member of this Commission that he ever had mercury or iodide of potassium at your establishment, if that be a relevant question?—I never said he did.

9883. I am much obliged. You are not in a position to suggest that he did. I put to you that you actually did on 2nd January prescribe this prescription.

Mr. Croom-Johnson: You must not take it that I accept that. I have the case book before me.

9884. Mr. Walter Stewart: Very well. (To the Witness): Is that what you prescribe (handing book to the Witness)?—That I prescribe?

9885. What was prescribed on 2nd January? What was the prescription; was that for the jaundice?—Yes.

9886. What is that?—This is calomel.

9887. Then what is the drug on the 2nd January?—That was on the 28th January. On the 2nd January I think it was for his temperature.

9888. Do not you know what it was?—Yes.

9889. What was it?—Salicilate of soda.

9890. That is what they give you for rheumatism?—Yes—temperature.

9891. Quite an ordinary tabloid drug. Anything else?—I see he had some capsicum.

9892. Do not you know what that is?—Yes.

9893. What is it?—It is a very useful drug.

9894. What is it for?—For the bladder, as a rule.

9895. He was suffering from some trouble with the gall-bladder. Had you diagnosed that?—Not the gall-bladder.

Chairman: The urinary system.

9896. Mr. Walter Stewart: Very well. How many medical attendants do you provide for these 40 patients?—There were two of us, resident—Dr. Potterton and myself.

9897. Which of those two was it who made the entry in the case book about the fact that he was suffering from general paralysis of the insane—an entry under date January 10th—"month's report, January 10th"?—That is Dr. Cole.

9898. Was he your visiting physician?—Yes, he helped me a great deal.

9899. And he placed that on record, did he not?—Yes.

9900. Do you know that shortly after that entry was made in your case book, Mr. H. managed to get a peep at it?—So he says.

9901. After that his attitude towards your medical confrère—the other gentleman you have told us of—I think his name was De Courcy?—Potterton.

9902. Mr. H.'s attitude towards him changed; he took a very great dislike to him?—Very likely, yes.

9903. With that entry in the case book, do you wonder, assuming Mr. H. thought it was Potterton who made the entry, that he took a dislike to him?—He says he was a general paralytic.

9904. Yes. You would not like the person who said it?—No.

9905. Especially if you knew it to be untrue?—No.

9906. Then you do not suggest that that dislike which he took to the doctor was in any sense a proper symptom upon which to diagnose that he was insane, or to emphasise his insanity?—It is a way people who are insane often have, is it not? They take likes and dislikes.

9907. But I am putting to you the reason for it—to show there was a reason for it?—There may have been.

9908. I see you have got this entry: "January 23rd, 1917. The patient spends most of the day in his own room playing with his monkeys and writing letters to various people. He has expressed a great dislike to me personally, and is best left to others for the time being. D.C.P."—that is Potterton?—Yes.

9909. Now I call your attention to the fact that he gained a peep at the entry in the case book. You do not wonder, in the circumstances, that he took a dislike to the medical practitioner if he thought he was responsible for that. It is reasonable, is it not?—I see the point.

9910. I hoped you would. It is a very serious thing, everybody agrees, and that was the first knowledge he had of it as far as you know, was it not?—Yes.

9911. Did he ever protest to you against it being said that he was suffering from it?—I do not think so.

26 January, 1925.]

Dr. REGINALD JOHN STILWELL.

(Continued.)

9912. That is as far as you are prepared to go?—I do not think it was ever mentioned.

9913. I put it to you that he objected very much?—To being called a general paralytic?

9914. Yes?—To me?

9915. Not to you being called that, but to his being called that?—I do not remember it. I did not know he even thought about it.

9916. Did you ever tell the solicitor, Mr. Steele—was it you who saw him first of all?—Yes.

9917. Did you ever tell him that Mr. H. was suffering from general paralysis of the insane, and that he would not last 18 months?—I do not remember telling him.

9918. Try?—I will not say that I did not.

9919. Is that the sort of way that you doctors who run these places—you are a part-proprietor of this place?—Yes.

9920. Is it a limited company?—No.

9921. Do you think that is a justifiable thing to say to a solicitor, who comes to make inquiries about a man's condition and as to how he is being looked after?—I do not know. I think so, yes.

9922. You justify it as being a thing that doctor proprietors of establishments should do. Would it tend, do you think, to induce relatives to keep the patient in your establishment—the knowledge, for instance, that the patient in question was suffering from G.P.I. and would not last more than 18 months? They would not be likely to withdraw

the patient so readily, would they, if they thought that were true?—If the patient was well enough, they would, I take it.

9923. If a patient is going to die in 18 months?—If he got a remission, as they often do.

9924. You never told anybody that he got a remission?—Not that I know of.

9925. On the contrary, did you write a series of letters to his wife?—I have heard you say so.

9926. Perhaps if I read a little passage—

Mr. Croom-Johnson: Perhaps if you will produce the letter, it will be the best way of settling this point.

Mr. Walter Stewart: Very well, if my friend takes the point. Mr. H. is not here. I do not know, Sir, whether you think I am entitled to put the passages from the copies which are before you.

Chairman: I do not think that this is in the least contributing to our deliberations. I do not want to stop you, because I am so reluctant to make you feel that I am in any way wishing to stop evidence that you wish to bring.

Mr. Walter Stewart: But I am putting the reason why.

Chairman: Surely it is a question I have put to many witnesses. We are quite aware of the fact that where a person is an inmate paying them large sums weekly, they have an interest to detain that person.

Mr. Walter Stewart: Very well. If I am speaking to the converted, I will cease.

Re-examined by Mr. Croom-Johnson.

9927. Just on that last point: Your establishment has been constituted for a number of years now?—Yes.

9928. Is it over a hundred?—Well over a hundred.

9929. Is it a very well-known establishment?—I think so.

9930. And, speaking generally, have you more applications for patients to come in than you have vacancies into which to put them?—It very often happens that we cannot take patients.

9931. I must ask you this general question: Whatever you said to Mr. Steele or anybody else in connection with Mr. H.'s case, did you honestly believe what you said to be true?—Yes, I did.

Mr. Walter Stewart: A little bit leading perhaps.

9932. *Mr. Croom-Johnson:* With regard to the oak room, is the oak room different from the large room we have been talking about?—Yes, it is.

9933. After Mr. H. had been given the use of his own private sitting room again, did he frequently go back to the large room of his own accord?—He did.

9934. For the purpose of talking with the people who were in that room?—Yes.

Mr. Walter Stewart: If this is of any value, I do submit that my friend is dealing with this witness—

9935. *Mr. Croom-Johnson:* Indeed, there are considerations of time, Mr. Stewart. (*To the Witness:*) Did Mr. E. H. give evidence in the Uxbridge County Court?—He did.

9936. Did he give evidence with reference to the existence of this room?—Yes.

9937. Did he say one way or the other whether he agreed to his brother being put in it?—Yes.

9938. What did he say?—He agreed with everything I had done.

9939. And was he called on behalf of his brother in the Uxbridge County Court?—Yes.

9940. And was there a second brother also called, and did he give evidence to the same effect?—He did.

Mr. Croom-Johnson: I think that is enough.

Chairman: Thank you, Dr. Stilwell.

(*The Witness withdrew.*)

(*Adjourned to to-morrow morning at 10.30.*)

5, OLD PALACE YARD,
WESTMINSTER, S.W.1.

SEVENTEENTH DAY.

Tuesday, 27th January, 1925.

MEMBERS PRESENT :

THE RT. HON. H. P. MACMILLAN, K.C. (*Chairman*).

THE EARL RUSSELL.

SIR THOMAS HUTCHISON, BART.

SIR HUMPHRY ROLLESTON, BART., K.C.B., M.D.

SIR ERNEST HILEY, K.B.E.

SIR DAVID DRUMMOND, C.B.E., M.D.

MR. W. A. JOWITT, K.C.

MR. N. MICKLEM, K.C.

MR. H. SNELL, M.P.

MRS. C. J. MATHEW.

MISS MADELEINE SYMONS.

MR. P. BARTER (*Secretary*).

MR. W. FAIRLEY (*Assistant Secretary*).

MR. WALTER STEWART and MR. CREMLYN (instructed by the National Society for Lunacy Reform) appeared on behalf of Mr. W. H.

MR. H. C. DICKENS (instructed by Messrs. Hempsons) appeared on behalf of Sir Maurice Craig, Dr. Robert Percy Smith, Dr. J. G. Porter Phillips,

Dr. William Henry Butter Stoddart and Dr. Robert Cole.

MR. R. P. CROOM-JOHNSON and MR. GEOFFREY MOSELEY appeared on behalf of Dr. Reginald John Stilwell and Dr. Bulkeley Footner.

Mr. Geoffrey Moseley: Mr. Croom-Johnson has asked me to express his regret to the Commission

at his inability to be here to-day. Perhaps you would allow me, Sir, to carry on in his absence?

Chairman: Certainly.

DR. ROBERT PERCY SMITH, sworn.

Examined by Mr. H. C. Dickens.

9941. You are Dr. Robert Percy Smith, practising at 36, Queen Anne Street, and you hold the Degrees of Doctor of Medicine, Bachelor of Surgery, Fellow of the Royal College of Physicians, Member of the Royal College of Surgeons, and Licentiate of the Society of Apothecaries?—Yes.

9942. And, among other appointments, you were Assistant Medical Officer to Bethlem Royal Hospital, under the late Sir George Savage, and on his retirement in 1888 you became Medical Superintendent for 10 years, and, of course, as such, had an enormous experience in mental cases?—Yes.

9943. You left there in 1898, and since that date you have been practising as a consultant in mental diseases and nervous disorders?—Yes.

9944. And, without egotism, you are looked upon in the profession as a great authority on this subject. You have been President of the Medico-Psychological Association, President of the Mental Section of the Royal Society of Medicine, and of the Neurological Section of the Royal Society of Medicine, Examiner in mental disorders to the University of London and to the University of Leeds; you are the author of various books on the subject, and have done a lot of public gratuitous service in the matter. You acted

as Government delegate to the International Committee for the Care of the Insane, which was held in Vienna?—Yes.

9945. A member of the Council of the Mental After-Care Association, and a member of the General Committee of the Lebanon Hospital for the insane in Syria?—Yes.

9946. In fact, the whole of your life has been devoted to this branch of your profession?—Not the whole of my life, but the whole of my life since about 1885. Before that I was a student at St. Thomas's and Resident Assistant Physician at St. Thomas's, and I held appointments there.

9947. Have you any financial interest of any sort or kind in any mental asylum or similar institution?—No financial interest, except a salary as visiting physician.

9948. It makes no difference to you and to your position—

Mr. Walter Stewart: Would Mr. Dickens kindly not lead the witness?

Chairman: Just go on, please.

9949. Mr. Dickens: It makes no difference to you, to your financial position whether a patient is certified or not in any case?—No, none whatever.

27 January, 1925.]

Dr. ROBERT PERCY SMITH.

[Continued.]

Mr. Dickens: There is one other question, before we deal with the facts of this case, which I think Mr. Macmillan will allow me to put to you. It has been given as hearsay evidence with regard to a certain Dr. Munro that he has expressed a continued opinion as to Mr. H.'s sanity. Dr. Smith has an original letter from Dr. Munro here, in which he expresses a totally different opinion, and I ask the Commission, in fairness to Dr. Smith, to be allowed to read the passage out of the letter.

Chairman: It is rather collateral to our direct evidence, is it not?

Mr. Dickens: It is, Sir, but if the Commission have paid no attention whatever to the evidence of Dr. Munro, well and good.

Chairman: I should not like to say that, because we must, of course, attend to all evidence which is brought before us; but if it is a letter addressed to Dr. Smith, you might read it.

9950. Mr. Dickens: It is a letter addressed to this witness, dated the 16th December, 1917. You have the letter there, but I will just read one passage from it. "It is with surprise and regret that I learn that my attitude towards this patient does not altogether meet with your approval, and I am sure you will allow me to correct what I conceive to be a slight misunderstanding on your part. I am so far from believing that the patient was not certifiably insane at the date of your certificate, that I have been doing my utmost, and I think at last with success, to dissuade both Mr. H. and his advisers from any attempt to traverse the opinion of such an eminent authority as yourself." Now with regard to Mr. H., you saw him on the 9th December, 1916?—Yes.

9951. Was he then in bed?—Yes.

9952. And were you with him a considerable time?—Yes.

9953. Had you previously spoken to Dr. Maurice Craig, as he was then, about the patient?—Yes.

9954. And to Dr. Dempster?—Yes, I had the full history from Dr. Craig giving practically all the dates that he gave yesterday, and all particulars.

9955. Did you take down in shorthand what Dr. Craig told you?—Yes.

9956. And what Dr. Dempster told you?—Yes.

9957. And what the patient himself told you during your interview with him?—Yes, I have it all here.

9958. Did you on the same day transcribe your shorthand into that book which you have before you—those notes?—Yes.

9959. And have you furnished us with exact copies of those notes?—Yes.

9960. And are they correct?—Yes.

Earl Russell: Transcribed in longhand or shorthand.

Mr. Dickens: Transcribed into longhand, and we now have typewritten copies, which I propose to hand round to the members of the Commission. I do not propose to go through these notes again, and I will leave it to my friend to cross-examine. Dr. Smith has compared the copies with the original notes, and that is a correct copy of the interview. (*Handing in the same.*)

Witness: I made it myself.

9961. Chairman: You transcribed your own shorthand?—Yes.

9962. Mr. Dickens: Mr. Stewart has a copy, Sir. (*To the Witness*): Now I do not propose to ask you more than this: On that information, the information contained in those notes as received from Dr. Craig, Dr. Dempster, and the patient himself, what conclusion did you come to as to his state of mind?—I came to the conclusion that he was insane, and unfit to remain in a doctor's house.

9963. The Commission would like to know, I think, why you recommended the method of an urgency order in preference to the more dilatory method of a reception order?—There was his whole mental condition, and his whole conversation, and then he had developed what I considered to be dangerous ideas about Dr. Dempster, in whose house he was, and who was an old friend with whom he had been on very friendly terms.

9964. Did you think that there was danger in leaving him at liberty for any further time at all?—Yes; he was a case which one would call potentially dangerous.

9965. Was it in his own interests as well as in the interests of the people he was with that he should be confined?—Yes.

9966. And did you then make the certificate which the Commission have before them?—Yes.

9967. That was on the 9th?—May I look at the certificate?

9968. There is one thing I ought to say about that. We have a certified copy of this certificate, and it does appear that the words "for the public safety" are struck out?—The original certificate is attached to the urgency order. The date of my interview is on the 9th December, and then I set out the facts observed by myself and the facts communicated by others, by his brother and Dr. Dempster, and that is dated the 9th December—that is the same day—and, of course, the brother also made the urgency order the same day. The urgency order is in force for seven days, but the patient must be admitted within two clear days of the date of the medical certificate. The urgency order continues in force for seven days until the petition for the reception order and the reception order are made. That is to enable the patient to be placed under care without delay, and then the justice's order is obtained when he is under care. 9th December is the date of the original certificate, and I think the date of my duplicate certificate which is presented is the 12th. The date of my examination of course is the same, but the date that I signed that second certificate is the 12th. That is only a detail.

9969. Now there is only one question more I want to ask you: It is suggested that you told Mr. H. that you were a heart specialist, and had come to examine his heart?—I never did anything of the kind.

9970. There is no foundation for that?—Not the slightest.

Mr. Geoffrey Moseley: There are just one or two questions I should like to ask on behalf of Dr. Stilwell.

Chairman: If you please.

Examined by Mr. Geoffrey Moseley.

9971. Do you know Moorcroft well?—Yes, I have often been there.

9972. You have been there many times?—Yes.

9973. And have you been able to form an opinion as to the manner in which it is conducted?—I think it is conducted extremely well.

9974. Have you seen the rooms in Moorcroft?—Yes, I have seen a good many of them. I do not know that I can identify any one particular room from memory.

9975. Do you know the room that is called the "common room"?—I am not sure that I do; I have generally seen patients in their own room, or in a separate room.

9976. From your experience have you heard that Mr. H. escaped on the 23rd February, and that he came back on the 26th?—Yes.

9977. Have you heard that he was then placed, not in his private sitting room, but in the common room?—Yes.

9978. Have you heard the reasons for which he was put there?—Because he was more safely guarded, I gather; I think that is the only reason I have heard.

9979. The other reason put forward was that he was associating with other people, which would take his mind off the fact that he had returned?—Yes.

27 January, 1925.]

Dr. ROBERT PERCY SMITH.

[Continued.]

9980. In your experience would it be a proper thing to do, to put him with other people on his recapture rather than put him alone in his private sitting room?—If a patient has escaped, you have to take more care of him when he is brought back, naturally.

9981. The other reason is that it is suggested it is better for him to be with other people than to be

alone in his own room?—It depends upon the case. There are some patients who do much better with others, and there are others who will do better by themselves. That is a matter for individual judgment at the time.

9982. You would not say it is an improper thing to put him in a room with other people?—No, certainly not.

Cross-examined by Mr. Walter Stewart.

9983. Dr. Smith, you say that for many years you have been engaged in this professional activity in relation to certifying people of unsound mind?—In relation to certifying? I have been engaged in the treatment of mental diseases for 40 years, I think it is.

9984. Let us come to more recent times. About how many patients do you think you certified in the year 1916?—I am sure I could not tell you without looking through my case book to see how many.

9985. Could you give us any idea?—No, I could not.

9986. Would it be 20, 30, or more?—I cannot tell you. I do not keep statistics in my head as to how many patients I certify.

9987. You have no idea how many?—I could not give you a guess; I could count them up if you wish me to.

9988. I would like you to give us an idea, if you will note that as a question I put to you?—May I say there are far more patients that I do not certify than I do.

9989. I want to know how many you did certify?—I cannot tell you unless I look them up.

9990. It is quite an ordinary incident in your professional life to certify a patient?—It is one of my duties from my knowledge.

9991. And you have certified a very great number in the course of your professional history?—A great number we may say—not a very great number.

9992. Do you appreciate that the fact that the patient has been certified is bound to cast a blight on his life, from the time of his certification to the end of his life?—No, I would not say it is bound to cast a blight on his life.

9993. It does, does it not?—It does in some cases, but not in all.

9994. I want to test you by a question, which is quite a general one: Would you do everything in your power to avoid anyone who was near and dear to you being certified?—Certainly, as long as it was safe for the patient.

9995. Let us come now immediately to the facts of this case. Have you ever until to-day, in any public court, or on any public document, alleged that Mr. H. was dangerous, either to himself, or to the public? I am speaking of public documents and public places?—What do you mean by public documents?

9996. On a certificate, or on any document which it would be your duty to prepare in connection with your professional duty?—I do not think I have had to prepare any document in relation to Mr. H. except the certificate originally signed.

9997. Let us deal with that. On that you do not suggest that you have anywhere stated that he was dangerous either to himself or to the public, do you?—I did not state in so many words that he was dangerous, but it was my opinion that he was potentially dangerous.

9998. You are quite familiar with the requirements of the section dealing with certification?—Certainly.

9999. May I call your attention to Section 28, requirements of reception order and medical certificates?—Is that the Lunacy Act?

10,000. It is?—May I look at it? (*The Act was handed to the Witness*).

10,001. Sub-section (2) I read yesterday, and I will not repeat it, that it must set out the facts upon which the certifying practitioner has formed his opinion?—Yes.

10,002. Now look at sub-section (3): "The medical certificate accompanying an urgency order shall contain a statement that it is expedient for the welfare of the alleged lunatic, or for the public safety, that he should be forthwith placed under care and treatment, with the reasons for such statement." Did you observe that condition in the certificate you drew?—Certainly. You have my urgency certificate here; the urgency clause is there.

10,003. Show me what is the statement in your urgency certificate?—You have a copy of it.

10,004. I have a copy of the certificate of Dr. Robert Smith dated 12th December, 1916. Is that your certificate?—That is not the urgency certificate.

10,005. That is the only one I have?—I do not know anything about that. That is not the urgency certificate, that is the second certificate.

10,006. That was the certificate upon which he was certified, together with the one prepared by Dr. Phillips, and sent to Moorcroft, was it not?—No, it is not. That is the certificate upon which the reception order was made by the justice after he went to Moorcroft. He went in on the urgency certificate.

10,007. Just call my attention to the passage in the urgency certificate that says that he is dangerous to himself or to the public.

Earl Russell: Those are not the words in the section you read.

10,008. *Mr. Walter Stewart:* I beg your pardon. (*To the Witness*): "Expedient for the welfare of the lunatic or for the public safety"?—This is the statement accompanying the urgency order. This is on the statutory form. "I certify that it is expedient for the said W. H.," and the words "or for the public safety" are put in brackets. I struck those out.

10,009. Why did you strike that out?—Because I did not think it was necessary to put it in.

10,010. Have you not just told us that the reason why you certified him?—I said he was potentially dangerous.

10,011. What is the difference between dangerous and potentially dangerous in your mind?—I should say a man is dangerous if he is hitting people or breaking windows, and that sort of thing. He is potentially dangerous if he has delusions about a man in whose house he is, showing hostility to him, and accusing him of being a vile instrument.

10,012. Did you say that he was potentially dangerous in the certificate?—I say it now.

10,013. On the contrary you struck it out—that he was dangerous?—No, I struck out the words "or for the public safety." It was not a question of the public safety.

10,014. It means danger, does it not?—If you like.

10,015. Very well, then I do like. Let us pursue that a step further?—And then I gave my reasons for the conclusion why it was expedient that he should be placed under care immediately, in the proper clause, which is here.

10,016. Have you ever seen Mr. H. until that day when you went down on the instructions of Dr. Craig?—Not on the instructions.

10,017. Who told you to go?—On the invitation of Dr. Craig—in consultation with Dr. Craig. I am not under his instructions.

10,018. Very well, on the invitation of Dr. Craig?—Or at the request of Dr. Craig.

10,019. Listen to what I am saying. Before ever you saw that patient you had, as you have told my friend, a long talk with Dr. Craig about him?—

27 January, 1925.]

Dr. ROBERT PERCY SMITH.

[Continued.]

Certainly; he gave me the whole history, which is always necessary.

10,020. So that you went down with your mind, at any rate, to some extent, coloured. You could not go with a perfectly open mind, having heard a lot of things that were said before you saw the patient?—In every case where one is called into consultation, one has the history of the case; you do not go down blank.

10,021. That is given in the absence of the patient?—Certainly.

10,022. So that he has no chance of knowing what has been said about him?—Very often.

10,023. Now when you got down there, how did you introduce yourself to Mr. H.?—Dr. Craig, as he was then, introduced me to him, and left me to have what is the proper statutory separate interview.

10,024. Although you had all the discussion with him beforehand, and everything you have put in that report had been communicated to you?—I have said so. Every physician who is called in consultation has a history of the case given him.

10,025. Now you arrived for your interview in that frame of mind?—Knowing the history of the case.

10,026. Did you tell Mr. H. the purpose for which you had come?—I do not remember what I said to him in that respect. I mean, one began to talk to him in the ordinary way as a physician.

10,027. I do not know what that means. Just tell me this: Did you in any way warn him that anything that he did, or anything that he said to you, might be used as material for the making of a certificate to shut him up?—No, not as far as I remember.

10,028. I mean, that is done in the case of a criminal. You do not think that is desirable, perhaps, in the case of a person whom you suspect of being a lunatic?—Very often it would be a most detrimental thing to the patient. A patient is not competent to judge.

10,029. Mr. H. has said he would like to have been told, so that he might have dealt with you properly. Now he did not very much like you personally, did he—he showed some impatience?—Not the least. He talked freely the whole time; he did not show the least dislike. He talked so freely to me; and the details of his conversation, which are shown in the notes and which, of course, one would not like to read out in open Court, show the sort of confidential things that he said to me, which are hardly imaginable if he had taken any hostility to me, or unfriendliness.

10,030. Now you said the "whole time." How long was the "whole time," according to your recollection?—It is rather difficult to tell.

10,031. About?—I should say I was with him at least three-quarters of an hour, or probably longer.

10,032. He does not quite agree with you?—I know, he said 10 minutes.

10,033. It is his recollection against yours?—His recollection is entirely faulty about that.

10,034. This is a less common occurrence in his life than in yours. Is there any truth in the suggestion that is made by some people that very often patients are certified after an interview that only lasts for 10 minutes?—I do not know; I do not do it myself.

10,035. You think you were there three-quarters of an hour?—Yes.

10,036. Mr. Jowitt: In a very obvious case, surely you could tell a man is mad in a couple of minutes?—If a man is breaking up furniture and tearing his clothes, and that sort of thing, it is a matter of sight.

10,037. Mr. Walter Stewart: There is nothing of that kind here?—No, he was not tearing his clothes or breaking windows.

10,038. Now you said, of course, you would not wish to read things that are in the private note, nor do I. I want to see what you put on the certificate

and to test it by that?—Yes, the certificate of the 9th December.

10,039. It is paragraph 3: "I formed this conclusion on the following grounds, namely, facts indicating insanity observed by myself at the time of the examination." This is something you observed, according to you. Then you go on at once to say: "He told me that while in the nursing home for a nervous breakdown two years ago he was vilely and improperly treated." Is that right?—That is what is written here. Yes.

10,040. Is that what he told you?—Certainly.

10,041. Did you take any step with him to test whether there was any ground for that?—I could not go and see the attendants two years ago in the nursing home.

10,042. Dr. Smith, pay me the compliment of listening to my question. Did you take any step with him personally to test that, to see what the nature of the vile treatment was?—But it is two years ago he refers to.

10,043. But still he could tell you if you questioned him?—He told me what he considered they had tried to do. He has no signs of it now, of course.

10,044. Did he say—I must put his version of it to you—was it he or Dr. Dempster who told you about one of the attendants named Jenkins?—He told me; it is in my notes here.

10,045. Jenkins had an unpleasant illness, he said?—He said so.

10,046. Can you suggest that such a thing as that could not happen in the sort of place that he was in?—He said that Jenkins had a filthy disorder, those are his remarks, and that he could smell it.

10,047. Is that impossible? I mean, did you test in any way whether it was likely to be true?—How could I test it? The attendant was not there, I could not smell the attendant.

10,048. You could ask him?—He told me this himself.

10,049. You could put further questions to him to see if there was any probability of it being right?—If a man said he had something the matter with him, I could not test smell at the present time.

10,050. For instance, you could have asked him: Did that attendant ever have occasion to try and pass a catheter in your case?—On the patient?

10,051. Yes.—He did not tell me so.

10,052. You did not ask him anything about the relationship between him and that attendant?—He continued to make a great many statements about Jenkins. There are other things which the Commission may have read of what he said about Jenkins, about when Jenkins shaved him, and so on. I do not like to read it out.

10,053. I am asking you about facts observed by yourself under this paragraph. I notice under that very paragraph you put this under the head of "Facts observed by yourself." "I am informed and believe it is a delusion"—that is about pieces of dressing having got into the meat pies?—Yes, that on four occasions he removed pieces of surgical dressing from the meat pies.

10,054. And then you say, "I am informed and believe that it is a delusion," under the head of "Facts observed by myself"?—Yes, because I questioned Dr. Dempster, who had been constantly seeing him at that time.

10,055. Behind the patient's back, or in his presence?—Behind his back.

10,056. So he had no chance of saying, "Well, doctor, I will tell you how it was"?—No.

10,057. Now he says, "The property which became his and his wife's on his aunt's death had been stolen from him by his first cousin"?—Yes.

10,058. Did he indicate what property, or did you ask him?—Let me look at the note. I think you have got there everything he stated to me.

10,059. You will know it, and I would like you to tell us?—"The property which became his and his wife's in 1913 on his aunt's death had been stolen from him by his first cousin, B. H."

27 January, 1925.]

Dr. ROBERT PERCY SMITH.

[Continued.]

10,060. That is the very man against whom he subsequently had a litigation?—Yes.

10,061. Did you take any steps at that time (further than to put it in a certificate) to see whether it was a delusion, or whether it was founded on a fact?—I did; I asked his brother about it.

10,062. You did not ask him?—He told me. How could I ask him?

10,063. I am trying to test you now by asking you questions to see whether what you say is correct?—I say he told me. I asked his brother if there was any truth in it. I tried to ascertain whether it was a delusion or not.

10,064. Do you think that is quite a fair way to treat the patient, behind his back, to be asking people, who may be interested on the other side, if what the patient says is true?—I think it is perfectly impossible to hold a court before an insane patient.

10,065. Let me ask you this: Do not you think that in matters affecting the liberty and the whole status and life of a person, it would be fair that there should be some real judicial enquiry at which the patient might be represented, even if he could not be present himself?—I think it would be quite impossible to carry out any such course.

10,066. Would it be desirable, if it were possible, in your view that there should be a fair judicial enquiry on this all-important occasion?—There is a judicial enquiry, because there is a justice's order. The papers are presented to the justice.

10,067. We know about the present judicial enquiry, I do not want to discuss that with you, but I do propose to put something to you with regard to the material upon which certificates are based. I will do it now, if I may. I am quoting, it is fair to tell you, from the judgment of a former Chief Justice of the Realm, Lord Chief Justice Coleridge, in the case of *The Queen and Whitfield*, at page 136, and I invite your criticism of this statement of the learned judge.—How many centuries ago is that?

10,068. This is in the year 1885.

Mr. Micklem: What is the reference?

Mr. Walter Stewart: Page 136, of XV Queen's Bench Division.

Mr. Jowitt: The Lord Chief Justice, you mean?

10,069. Mr. Walter Stewart: The Lord Chief Justice, Lord Coleridge. "I am here, I know," says the Chief Justice, "speaking for myself, and I will own that the experience I have had of the flimsy stuff on which perfectly sane men are sometimes incarcerated in lunatic asylums makes me perhaps a severe critic; but I am not content to consider this sort of thing an examination under the Statute." What do you think of that dictum? Do you think it is justified?—I do not think that the judge had had any practical experience of lunatics.

10,070. He is talking of certificates, you know, not of lunatics.

Chairman: Just one moment. The date of that is 1885.

Mr. Walter Stewart: Yes.

Chairman: Then after that the code which we now have in the Act of 1890, whether successful or not, was designed to accomplish the reforms which the learned Lord Chief Justice had in view. I do not say whether they were effective or not.

Mr. Walter Stewart: May I say, first of all, that the Act of 1890 specifically declared there was no alteration of the law thereby. There was a certificate to that effect by Mr. Theobald. Secondly, this very judgment was cited by Lord Justice Atkin the other day in the *Everett* judgment which he gave, and cited with approval, and I can call your attention to the passage.

Chairman: I was only pointing out that defects in the Lunacy Law before 1890 had been the subject of much discussion and a Select Committee had been appointed, as I understand, for the purpose of investigating these matters. I have had the advantage of reading a considerable amount of the Report, in which many criticisms were levelled at the existing

system. What we are considering now is whether the code of 1890 has efficiently met the difficulties of a very controversial topic. But it is important, I think, to have in view, when one is referring to matters before 1890, that they were made under a different régime from that which we have now.

Earl Russell: While we are on this subject, I should like to know what your authority is for saying that the Lunacy Act of 1890 made no change in the law.

Mr. Walter Stewart: My authority is that on the face of the Act itself there is a certificate by Mr. Theobald declaring that the 1890 Act incorporated nothing new—my friend, Mr. Parker, will show it to you.

Witness: I was superintendent of Bethlem Hospital when the 1890 Act came into operation. It introduced in the case of the patients of the private class, the magistrate's, that is, the justice's, order, which was not in existence before. Therefore, it was a very material alteration of the law.

10,071. Chairman: We are very fully alive to the very material alterations have been made.—May I make just one more point, and that is that I was a Superintendent at the time, it trebled at one blow, all the reports and certificates and returns that the Medical Superintendent has to make and sign for patients of a private class.

10,072. Chairman: Of course, we are still concerned in getting to what extent the efforts of 1890 have been successful. It is that which we are really exploring—how far the code in its operation has been successful in meeting all cases?—It seems to have worked very well.

Mr. Walter Stewart: May I answer Earl Russell's question? Here is the report of the Minutes of Evidence on the Statute Law Revision Bill in the House of Commons, 1890, on the 25th March in that year. "We understand," says Mr. Solicitor, "that you are the draftsman" (that is addressed to Mr. Theobald), "and responsible for the arrangement of this Bill?—(A.) Yes. (Q.) Is it a Consolidation Bill in which will be contained, subject to the exceptions shown in Clause 340, all the law with regard to lunatics?—(A.) Yes, I believe it is. (Q.) And does it reproduce the statuteable enactments which have passed in previous years?—(A.) Yes, it does. (Q.) I wish to direct your attention to Section 322; with the exception of that section, is there any divergence from the language used in previous statutes as to which you desire to inform the Committee?—(A.) No, I believe there is nothing in the Bill, so far as I know, that can be fairly said to be an alteration. It has been considered by all the Government Offices, the Home Office, the Local Government Board, the Commissioners, and they have all criticised it, and here and there they have suggested alterations; they have pointed out little things that have been alterations, and these have all been altered back. I believe now there is nothing that can be said to be an alteration of the law."

Mr. Jowitt: What tribunal was that before?

Mr. Walter Stewart: That is the Select Committee on the Statute Law Revision Bill, Lunacy Consolidation Bill, the proceedings of the Committee, and Minutes of Evidence.

Mr. Jowitt: That is the 25th March, 1890.

Mr. Walter Stewart: Yes.

Mr. Jowitt: That is only four days before the Royal Assent is given to the Lunacy Act of 1890.

Mr. Walter Stewart: That is my point, and Mr. Theobald saying there is no alteration.

Earl Russell: That does not in the least answer the question I put to you. The question is, do you say there was no alteration of the law subsequent to 1885, and to tell me this is itself a Consolidation Act and makes no alteration is not an answer; because this Act repeals and re-enacts two Acts which are set out in the Fifth Schedule, and particularly the Lunacy Act, 1889—that was new legislation.

10,073. Mr. Walter Stewart: But the Act of 1890 was nothing new. With regard to that, I must not

27 January, 1925.]

Dr. ROBERT PERCY SMITH.

[Continued.]

argue, I know, but I can call the attention of the Commission to what Lord Justice Atkin said with regard to that, but I do not want to be accused of wasting time. Listen to this: "It seems to me the merest travesty of an examination; and the elaborate system of protection and careful enquiry prescribed by the statute, if this is a legal compliance with it, is, to use old and famous words, 'a mockery, a delusion, and a snare.'" "This case with which I absolutely agree" (he cited a case), "shows to my mind that the statute requires that there should be a real inquiry, a real weighing and sifting of evidence, a real examination with an unbiased mind, a real serious and solemn exercise of judgment." (*To the Witness*): Now, do you think that the kind of enquiry you held answers that definition?—I think I took every step to ascertain what was the patient's mental condition, and to verify from those who were closely associated with him how far his statements were delusions or otherwise, and in what way these ideas were likely to influence his conduct.

10,074. Let me ask you this: In the light of what you now know, do you wish to express any regret for the fact that you certified Mr. H. on this day?—Not at all; I think I should have been very wrong not to have certified him.

10,075. That is your view in spite of all you know?

Chairman: If you are going to take up that line, I am afraid it will be my duty to make public certain communications which we have received from Mr. H. since. We have received communications, which, if they were made public, would be very serious. You are asking this witness to express his regret for his action with regard to this gentleman.

Mr. Walter Stewart: Justifying his certification.

Chairman: Well, I am not going to take a step which I might take. Would you wish me to read the telegram which we have received this morning?

Mr. Walter Stewart: No, I do not ask you to do anything. I ask the witness something in view of what he knows and what I know. That is, the term of the disease.

Chairman: Very good.

10,076. *Mr. Walter Stewart (to the Witness)*: The general term of the dreadful malady that you call general paralysis of the insane is a period of about two years, is it not?—It varies very much in different cases.

10,077. But in your article in Quain's Dictionary of Medicine have you not expressed that view, that the term is about two years?—That is an average, but some cases last only three months; others last 10 or 15 years.

10,078. I think it fair to ask you, do you personally still say—I know what other people say—that Mr. H. is suffering from general paralysis?—Did I ever say so?

Mr. Walter Stewart: I do not know.

10,079. *Mr. Dickens*: He has never said so here, and he has never said so in any certificate.—I said he had symptoms pointing to the early stage, and I think I should have been wrong not to put it down for the guidance of those under whom he was going.

10,080. *Mr. Walter Stewart*: Did you ask Mr. H. or not what it was that was his grievance against Dr. Dempster?—I do not know that I asked him, but he told me.

10,081. What was it?—He volunteered these things; they came bubbling out, as it were.

10,082. What did he say?—I will try to find it, if you will give me time.

Mr. Dickens: "says he was in the hotel, was put in a nursing home by the local doctor, or Dr. Dempster."

Earl Russell: "Dr Dempster said that yesterday the patient was accusing him."

Mr. Dickens: That is what Dr. Dempster told him.

Witness: Yes, that was "facts communicated by others." Dr. Dempster says "that yesterday the patient was accusing him of being a vile instrument

in ill-treating him at Teignmouth." The attendant tried to inoculate him with syphilis, and so on. "Three nights ago called Dr. Dempster names, said he had found him out."

10,083. *Mr. Walter Stewart*: I am asking what Mr. H. said.—Yes, if you will give me one minute.

10,084. As many as the Commission think right?—It is in the last part, I think. When Dr. Craig came back, that is, after I had had my separate interview with him for the purpose of certifying, Dr. Craig came back to see if I had finished.

10,085. And the patient said that Jenkins—?—"When Dr. Craig came back" (this is a copy of my note), "patient said that Jenkins"—this is the man whom he had accused of trying to give him venereal disease—"is going to turn round and say that Dempster organised the thing." That is the thing Dr. Dempster told me, of course, that the patient had accused him of initiating vile treatment at Teignmouth.

10,086. "Says Mrs. Dempster is the ruling power and he is willing to stay as long as she likes"?—Yes, as long as she likes, but he was hostile to Dr. Dempster.

10,087. And that is all, then, that he said with regard to Dr. Dempster?—Yes, it was very important.

10,088. You said it came bubbling out. There was no accusation by him against Dr. Dempster, except that he said that Jenkins was going to turn round and say that Dr. Dempster had organised the thing?—Yes; it seems to me ridiculous.

10,089. At any rate, there is no accusation by Mr. H. ?—It is all part of the statement of Mr. H.

10,090. Well, the Commission can judge for themselves how far that is an accusation by Mr. H. against Dr. Dempster. Did you know at that time that, quite shortly before, his will had been prepared in draft and submitted to him?—I think he said to me that he had prepared a will.

10,091. Did he tell you that he had left considerable sums of money to this very Dr. Dempster?—No, he did not say that.

10,092. And to Dr. Dempster's wife?—No; the only reference he made, I think, to a will in my interview with him was this—it is on page 3: "Says he was put in charge of four men, three of whom were infernal blackguards; they were temperance male nurses. Says he has left one 50 guineas in his will, he was a good one, says that this one told him that Jenkins, another attendant, was not doing right by him," and Jenkins was the man who was afterwards to turn round and say that Dr. Dempster had organised the whole thing.

10,093. That is what Mr. H. said, that Jenkins was going to turn round and say that Dr. Dempster organised the whole thing?—Yes, although Jenkins was the very man who was accused of vilely treating him.

10,094. Do you know whether Dr. Dempster, in fact, had anything to do with Mr. H. being taken care of in that place two years before, where Jenkins was?—I understood that Dr. Dempster had been down to see him at Teignmouth. Dr. Craig told us all about that.

10,095. Was it true that Dr. Dempster had organised that arrangement—organised that thing?—Organised? Dr. Dempster was a doctor who was, I think, or had been his medical attendant. When you say organised, he naturally took part in the arrangement for him to be under treatment.

10,096. Then that was true?—But not in the vile treatment, not organised vile treatment, he organised his going to a nursing home.

10,097. May I put it to you as a question: If an attendant in a place like that had got an objectionable disease of the kind indicated, it would be vile treatment to allow such a person to come in contact with a patient?—It was not the mere statement that he came in contact, but that the

27 January, 1925.]

Dr. ROBERT PERCY SMITH.

[Continued.]

attendant was going to inoculate him with a vile disease, which Mr. H. said the attendant had.

10,098. Mr. H. has given his version of this, it differs from yours?—This is the version he gave me.

10,099. Do you know that Mr. H. said here?—No, I do not.

10,100. He said it was necessary that a catheter should be used upon him, and he objected to Jenkins using that instrument; that is what Mr. H. said to us?—Yes. I will tell you what he said to me.

10,101. I will not go back over that, because you have already dealt with it. I put it to you whether he had had occasion to use any instrument?—

10,102. Mr. Jowitt: Apart from this case, is it a delusion which you have come across before, that patients imagine that endeavours have been made to infect them with venereal diseases?—Yes.

10,103. It is very common, is it?—Yes.

10,104. Mr. Walter Stewart: That is not confined to the insane, is it? I suppose you have heard that patients complain that people have infected them?—Have tried to infect them.

10,105. Very well. Now I pass over the fact that he was garrulous, because that is quite a common symptom, is it not?—Very common in maniacal cases and excitable cases.

10,106. And in some other cases. Now, "The said W. H. appeared to me to be in a fit condition of bodily health to be removed to an asylum." How long was it before that that he had recovered from pneumonia?—Several weeks.

10,107. Was it? He was still in bed, was he not?—He was not in bed from pneumonia. He was in bed.

10,108. What was the reason of his being in bed?—I should think partly to keep him in one room and to keep him out of mischief.

10,109. Now I want to ask you this. Are there not at Brighton many very eminent and efficient medical people?—Oh, yes, a large number.

10,110. You know now, do not you, that he had, in fact, a furnished flat there?—Yes, I believe he had.

10,111. Would there, in your view, have been any harm at all, if he was well enough to have been taken a long motor drive to Uxbridge, even in going by train to Brighton to his own flat?—The drive to Uxbridge does not compare with the drive from Croydon to Brighton, to begin with, it is only just over the bridges to Middlesex, it is from Surrey to Middlesex.

10,112. It was the difference in the distance?—It is 40 miles to Brighton from Croydon.

10,113. It was too far, you think?—I do not raise that point.

10,114. I thought you did?—I think he was unfit to stay in his flat at Brighton, quite unfit.

10,115. Would it not have been possible, if it was only the welfare of the patient that was being considered, that somebody might have attended him there?—I do not think so. In his condition nobody could tell in what way that man might suddenly develop in the next day or two.

10,116. He had never, as far as you were able to ascertain, while he was at Croydon, been guilty of any overt act of violence, had he?—I do not think he had, no.

10,117. And have you ever heard that since he left Croydon on that 10th December, if that was the right date, that he ever was guilty of any overt act of violence towards anybody?—No, he was put under care, of course.

10,118. You have been asked about Moorcroft. It was sworn yesterday by Mr. Steele, who was not Mr. H.'s solicitor, that Mr. Steele was told that Mr. H. was dangerous. From all you know regarding Mr. H.'s conduct at Moorcroft and elsewhere, can you point to any single act indicating that he was dangerous?—In the history of

Mr. H. there is evidence that he at one time was extremely dangerous; and, therefore, as he had got now a development of excitement following what had been a depressed condition, there was every reason to anticipate that he might be dangerous.

10,119. You are talking of something that had happened two years before?—Yes, but it is all part of the man's history.

10,120. It is put in your note, but not in the certificate?—Quite so. It was not a fact I observed myself; that is a fact of previous history. You do not put everything in the previous history in "facts communicated by others"; you put the things that are relevant at the time.

10,121. Was that not relevant at the time?—It was relevant in his history that he had had a very dangerous attack, in which it took eight men to hold him, in which he broke through a window and cut his arm. He showed me the scar on his arm.

10,122. I think I am accurate in saying that that suggestion that he at any time required eight men to hold him was never put to Mr. H.?—That I do not know about. I did not put it to him. You do not always ask a patient about everything that has happened in his past life. He showed me the scar on his arm.

10,123. Did you ever see him again?—Not till the other day in court here.

10,124. I want to put, if I may, this general question to you. Bearing in mind that these people whom you are called in to certify are, *ex hypothesi*, in a condition in which they are not well able to look after their own interests, do you think it fair that there should be some neutral authorised representative to see that they get fair play?—I think the patient does get fair play. I think all doctors who approach these matters take a very serious view of it; certainly all physicians do, and the whole thing is not so simple. There are patients who will not speak if what you may call a Commission is held over them. There are others whom it would excite and make worse.

10,125. You do not quite follow what I am putting. I am putting that there should be someone to watch the interests of the patient, who is unable to watch his own?—In the ordinary way the relatives of the patient and the family doctor are watching the interests of the patient.

10,126. Have you never known a case in which relatives have desired to put a patient away because he was awkward for them, rather than dangerous to himself or the public?—Certainly, there may be such cases. On the other hand, there is nothing more distressing and more wearing to the relatives of the patient than to have an insane patient in the house, there is nothing so dangerous and so exhausting.

10,127. For the first time I find myself in complete agreement with you, but let me ask you, do not you think even in the case of such a patient that it would be expedient, desirable and just, that there should be someone to separately represent the interest of the alleged lunatic?—I think there is. There is the justice, to whom the papers are presented.

10,128. The justice—think you?—It is a most difficult question, introducing any condition of that sort.

10,129. Earl Russell: I would like to clear up one point that has been bothering me a little. Did you hear Sir Maurice Craig's evidence?—Yes.

10,130. You heard him say that this patient had a bad family history?—Yes.

10,131. I notice at the beginning of your notes, "Family history said to be nil."—I understood Sir Maurice Craig, as far as I remember, to say that there was not any family history. I do not know whether he found any family history afterwards.

10,132. He certainly said so yesterday.—Yes, he did say so.

Chairman: We are much obliged to you, Dr. Smith.

(The Witness withdrew.)

27 January, 1925.]

Dr. JOHN GEORGE PORTER PHILLIPS.

[Continued.]

Dr. JOHN GEORGE PORTER PHILLIPS, sworn.

Examined by Mr. H. C. Dickens.

10,133. You are a Doctor of Medicine and a Fellow of the Royal College of Physicians, and at the moment you are Superintendent Physician of Bethlem Royal Hospital?—Yes.

10,134. Physician and Lecturer in psychological medicine at St. Bartholomew's; Lecturer in Mental Pathology at the London (Royal Free Hospital) School of Medicine for Women; Examiner in Mental Diseases to the Medico-Psychological Association of Great Britain and to the Royal Army Medical College?—Yes.

10,135. You were Gold Medallist and Gaskell Scholar in Psychological Medicine, 1911, and you have specialised in this branch of medicine for over 17 years?—I have.

10,136. Did you on the 10th December, 1916, receive a telephone communication from Dr. Maurice Craig, as he then was?—I did.

10,137. Asking you to go and see a patient?—Yes.

10,138. Mr. W. H., at Croydon?—Yes.

10,139. Did he tell you anything else?—I asked him the object of my visit, and he told me that he wished me to see this patient there, to examine him and to give an opinion, if necessary, and he informed me that the brother of the patient had been acting as petitioner and that already he had been seen by other practitioners, but he wished to have an independent opinion.

10,140. Did you go down to see him in your car, or in a car?—In a car.

10,141. That you had hired at the time?—Yes.

10,142. On the 10th December?—Yes.

10,143. Did you first see Dr. Dempster by himself?—Yes.

10,144. Did he tell you what sort of mental condition the patient was in?—Yes; he informed me that Mr. H. had been under his care for some time, but recently during the last week or two he had been giving him cause for anxiety, his personality had completely changed, and he had become very excitable and restless, and resented control and any treatment that he wished to carry out.

10,145. Did he tell you anything about the letter writing?—Yes; in addition he showed me a pile of letters which I examined; there were a great number of them, and they appeared to me to be very badly and carelessly written, and the contents seemed to be incoherent.

10,146. Abusive?—Yes; there were abusive letters to various comparative strangers in the neighbourhood, I understood.

10,147. Then did you see him alone?—I saw him alone.

10,148. Did you go into his room?—Yes, I went into his room.

10,149. What sort of condition did you find him in?—I found him in a very excited, restless and talkative condition. He had his coat off—I remember he was in his shirt sleeves—and seemed to be in such a restless condition, moving from one part of the room to another. After conversing for a little while he left the room and then came back again, and from that I gathered that he was in a very restless and abnormal condition.

10,150. Was his head shaved?—Yes.

10,151. Did you tell him what you had come for?—Yes, I told him I had been sent by Dr. Craig, who was a friend of his, to enquire into the state of his health, and I specially alluded to the fact that they were nervous about him, because his nervous condition seemed to be in an unstable condition. He rather laughed at that. I had a great difficulty in questioning him, because he was so garrulous, he was telling me about his affairs, and within a very short time told me about his financial status, that he was a wealthy man, and wished to make great use of his money. His attitude towards me was quite a

reasonable one as far as that was concerned. He seemed to be quite friendly, and he said, "You know I like you very much; I should like you to come and stay with me in the country." It struck me at the moment as being very unusual, because it was within five minutes of my first visit.

10,152. Did you ask him to go and stay with you?—Never.

10,153. Did you make a physical examination?—I did.

10,154. Did he tell you anything about his left eye?—Yes, he had received an injury to it some years previously. I examined it very carefully, but I saw no evidence of an injury, but on comparing the pupil of that eye with that of the right eye I noticed they were unequal and also that they were rather sluggish in reaction to light.

10,155. Was there any tremulousness?—Yes, I examined his tongue and lips, and he showed marked tremor of the tongue and lips; also his hands were in a very tremulous condition. I examined his tendon reflexes, they were certainly very exaggerated.

10,156. He was obviously in a very highly nervous condition?—Very highly.

10,157. He discussed his private quarrels and affairs with you, and so on?—Yes.

10,158. How long were you with him?—About half an hour I was in the house.

10,159. Now as to his mental condition, did you come to a definite conclusion there and then?—Yes. I did definitely.

10,160. What was it?—That he was of unsound mind.

10,161. There was no doubt about it?—There was no doubt about that.

10,162. Then had you been told about Moorcroft, that there was some suggestion of his going to Moorcroft?—Yes; Dr. Dempster told me that they had made an arrangement for him to go to Moorcroft.

10,163. Did you speak about Moorcroft to Mr. H.?—Not at that moment.

10,164. But at any time before you left the house?—Before I left the house I told him, "I understand you are going to a nursing home mutually arranged between you and Dr. Craig," and he said, "Yes," that, in fact, he had a number of his things packed.

10,165. He had them packed before you told him?—I remember seeing a trunk and various other articles being packed up in his room.

10,166. How did it come about that he went with you?—He seemed to be so agreeably disposed towards me. He asked me where I was going, and I told him I was going home. He said, "Now what about you driving me over to the place where I am going." I considered it very carefully, and I went back and talked it over with Dr. Dempster, and Dr. Dempster, who apparently was in a very anxious state of mind, said, "Now that he is so willing to go, and wishes to drive with you, do you mind taking him?" I again considered it, and I thought it a kindly act, and I said, "Yes, by all means. This is Sunday afternoon, and I can drive round that way." Mr. H. suggested that it would be very nice of me if I would take him, so he assented at once and we drove off, but he specially wished his two monkeys to go with him, and on looking at the monkeys I could see they would not give any trouble, so the two monkeys were put into the car and we drove off.

10,167. *Earl Russell*: Was he quite friendly all through the drive?—Perfectly.

10,168. *Mr. Dickens*: Is it true that you told him you were taking him to your own house?—Absolutely untrue.

10,169. Then did you drive together?—Yes.

10,170. And you left him at Moorcroft?—Yes.

10,171. Was that the last you saw of him?—Yes, until the other day.

10,172. The suggestion he made is, "I think it was a dreadfully wrong thing for him to spend his

27 January, 1925.]

Dr. JOHN GEORGE PORTER PHILLIPS.

[Continued.]

Sunday afternoon coming down and trapping a poor engineer in a workman's cottage."

Mr. Walter Stewart: Would you tell me the number of that question?

10,173. Mr. Dickens: 8687. (To the Witness): Is there any truth in the suggestion that you trapped him?—Absolutely no truth at all.

10,174. He was allowed to take what clothes he wanted?—Quite.

10,175. And his monkeys?—Yes.

10,176. Now with regard to your certificate; you had no doubt that it was your duty after your interview to sign that certificate, which you did sign dated on the 10th?—No.

10,177. The only other thing I want to ask you about is the sentence. "He exhibits the physical signs of general paralysis." First of all, is that true? Did he exhibit the physical signs of general paralysis?—Yes.

10,178. Now will you just explain to the Commission why you put that in your certificate?—Not to prove that he was insane—I thought it would be a guidance for those who would be looking after him;

Cross-examined by Mr. Walter Stewart.

10,184. Tell me, Dr. Phillips, who was it that put you in motion to visit Mr. H.?—Dr. Maurice Craig, as he was then.

10,185. You were in frequent touch with that gentleman at that time, were you not?—I cannot say frequent.

10,186. Seeing patients whom he was interested in?—No, not frequently.

10,187. You now hold a public appointment at Bethlem Royal Hospital?—I do.

10,188. I suppose you do not do this work any more—certifying in private cases?—I am often asked out to give an opinion.

10,189. Do you still certify?—Very seldom.

10,190. But occasionally?—Occasionally.

10,191. I need not ask you, you yourself appreciate the extreme gravity of such a step as certifying a person who had never previously been certified?—I do.

10,192. And that being the case, you would use every endeavour to make a really independent examination so as to arrive at an independent conclusion?—Yes.

10,193. How long were you occupied in your personal examination of Mr. H. on that 10th December?—I have stated about half an hour, as far as I can remember—and, of course, there was the journey in the car too.

10,194. I am not talking of that. You had already certified, had you not, when you got into the car?—No, I had not.

10,195. But you had decided to take the step?—Yes.

10,196. Were you told before ever you started off on that journey to Croydon that you were to try and get Mr. H. to enter a licensed house?—Not to my knowledge.

10,197. Not by Dr. Craig, as he then was?—No.

10,198. Then you had no idea when you went down that it was an object held in view by anybody to get Mr. H. into a licensed house—what is generally called a madhouse?—No. I remember Dr. Craig telling me on the 'phone that there was a question of his entering the place, but not instructing me to get him into it.

10,199. Did Dr. Craig ever say to you that he had disclosed to Mr. H. that he was going to have him put into a madhouse?—No, not to my knowledge.

10,200. And you never disclosed that to Mr. H.?—I told him he was going to a mental home.

10,201. Home you said. Mr. H. took a great fancy to you, did he not?—Apparently.

10,202. You would not regard that as evidence of any insanity on his part, would you?—It would

so that it would really be a note for observation and treatment, if necessary, should the physical signs develop and not disappear.

10,179. I take it that, in addition to certifying that a man is mentally unsound, it is advisable to give all the information about his case to those who are going to treat him that you can, within your observation?—In my opinion, yes.

10,180. In other words, to certify not only why he is unsound in mind, but the reason why he is unsound in mind in your opinion?—Yes. I did not suggest that he was suffering from general paralysis, and that therefore he was insane; he had certain signs which suggested that he might develop into that condition.

10,181. Those notes may have been very useful to the doctors who came after?—Essential, I think, in the interest of the patient.

10,182. Mr. Jowitt: Such as the reflexes and the tremor of the tongue?—Yes, and the condition of the pupils.

10,183. Sir Humphry Rolleston: It is a short description, I suppose, in other words?—Yes.

Mr. Geoffrey Moseley: No questions.

be very ungracious on my part to suggest that, but to the extent to which he showed his appreciation of my presence—

10,203. Did not you lead him to understand that you would be glad for him to come and stay, to be taken care of by you?—Never, I never mentioned it to him.

10,204. I have got the passage in his evidence?—It is absolutely untrue.

10,205. (It is at Question 8291. Did you hear him give his evidence?—I did.

10,206. "He came with the usual story, that he was a friend of Maurice Craig's." You did that, did you not?—No, I did not say I was a friend of Dr. Craig's.

10,207. But you were a friend?—I hope I am a friend of his in the ordinary professional sense.

10,208. "And that he" (that is, you) "was to take me to his country house"?—Absolutely untrue, I never mentioned it.

10,209. "He examined my eyes with a little flashlamp, and he tried the knee-jerks—the clipping on the back of the knee-cap." You did those things?—Yes, I did.

10,210. So that, in that answer, the only part that is untrue is the part in which you said you were to take him to your country house?—And also as to my being a friend of Sir Maurice Craig, I do not agree to that—not in the ordinary sense.

10,211. You were, in fact, but you say you did not say so. How did you introduce yourself to Mr. H.?—I told him who I was and Dr. Dempster was with me, and I think Dr. Dempster helped to introduce me.

10,212. Do you say that neither of you said you were there as a friend of Dr. Craig?—Not to my knowledge, no.

10,213. I must take your recollection. I suggest it is extremely likely that that might have been said to explain your presence. You knew that Mr. H. regarded Dr. Craig as his personal friend?—Yes, as a great friend.

10,214. Do not you see, if he did know that you were a friend of Dr. Craig, that that would have been likely to predispose him in your favour and make him friendly to you?—It might have done.

10,215. You were eight years younger then than you are now?—Yes.

10,216. Now, that being so, just try and take your mind back. You had made up your mind that it would be desirable that he should be got away from Croydon?—No, I had not formed the opinion then.

10,217. Had not Dr. Craig communicated anything to you?—Not an independent opinion. He

27 January, 1925.]

Dr. JOHN GEORGE PORTER PHILLIPS.

[Continued.]

had suggested the doubt as to whether he was fit to remain there.

10,218. With that in your mind, going there to examine him for the purpose of seeing whether he should be certified, do not you see it is highly probable that you would seek to induce him to come, by a representation that was not the whole truth—that is likely, is it not?—No, I do not agree.

10,219. You would not tell a patient straight out to his face that you were proposing to take him to a madhouse, would you?—Certainly not.

10,220. And yet if you were proposing to take him anywhere, and Dr. Craig had put that in your mind and you communicated that to him, would not you in that case try to put it to the patient in as nice a way as possible?—I try to put everything in a nice way.

10,221. Did you not in that case?—Perhaps I did.

10,222. And was not that the way in which the proposal for that little drive first originated?—No.

10,223. That is what I suggest to you, and that is what Mr. H. has sworn?—That I disagree with.

10,224. Very well, I do not want to labour it unduly. If you did say such a thing as that, that you would like to take him to your country place, would not that make it very reasonable for him to say, "Well, I hope some day you will come and stay with me"?—If I had said so, but I did not.

10,225. It is a question of recollection, his memory against yours. I know that my client has been certified, his testimony is destroyed. But where it is oath against oath, we must do the best we can. As far as any physical examination is concerned, you have told us all you did—knee-jerks and reflexes?—Yes.

10,226. I know you will be quite fair with me, are not those signs equivocal?—Abnormal knee-jerks and defective reaction to light on the part of the pupils may be referable to a number of different causes, may they not?—Taking the whole range.

10,227. I am taking all you said?—Associated with that clinical picture that one saw.

10,228. Was not that coloured by the statement made to you beforehand that he was suffering from general paralysis of the insane?—I had not been told.

10,229. Had you not been told that?—No.

10,230. Do you mean to say you had not been told that?

Chairman: The witness has said he was not told.

Mr. Dickens: Where was it ever suggested to anybody else that they told him?

10,231. *Mr. Walter Stewart:* I was only going to put a question about that Wassermann test which had been made and as to whether that had not been communicated to him. (*To the Witness:*) Surely you had been told that?—Not by Dr. Craig.

10,232. By anyone?—By Dr. Dempster.

10,233. Be it so. Did not that colour your mind against Mr. H.?—It did not colour my mind; it helped me to form an opinion.

10,234. Upon the mere physical symptoms, the reflexes and knee-jerks, you would never surely put such a thing against a man as that he is suffering from general paralysis of the insane?

Chairman: He has never said so, Mr. Stewart; really, do try and be accurate. He said that he showed symptoms which were indicative of the early stages.

10,235. *Mr. Walter Stewart:* I know. (*To the Witness:*) You would never put that against him on those mere symptoms alone?—No, I would not. As a matter of fact, I may say that I teach that particular point, that one should not diagnose conditions like general paralysis of the insane.

10,236. Because of the terrible consequences to the patient?—I will not say "terrible"—they are grave.

10,237. Supposing a man's wife were told that, do not you see what that would mean for the rest of his life, for him and for her?—I certainly think if one diagnosed a condition of general paralysis and told the wife—

10,238. Do not you agree it ought to be kept as secret as possible until there is no longer the possibility of doubt?—I agree.

10,239. Do you think anything suggestive of such a fact should be put on a certificate until it has been probed to the very heart?—Under the conditions I think one would be lacking in one's duty not to mention those facts, that there were certain signs suggesting general paralysis.

10,240. We have been told by doctors who have been called here, Sir Maurice Craig amongst others, that that factor was not necessary for the purpose of certifying, and you agree there, do you not?—Oh, yes.

10,241. *Sir David Drummond:* It would have to do with the treatment?—Yes.

10,242. *Mr. Walter Stewart:* Sir Maurice was his physician, and he knew the fact, and he was visiting Moorcroft, and he could have told them at Moorcroft without writing it on the certificate?—Of course, I did not know that Dr. Craig was in possession of those facts. I was sent down as an independent individual to give an independent opinion.

10,243. And it was only put there for the purpose of guiding the person. Looked at now, with your present knowledge, do not you think there would have been a better way of doing it than putting it on that certificate?—I think, taking everything into consideration, at the time that was the best method of conveying that opinion to those who were to look after him.

10,244. Without seeking to make any aspersion upon you personally, this was all done behind his back, was it not?—No, I cannot say all.

10,245. Did you communicate to him any of those things which you put in that certificate?—I remember distinctly informing him that the anxiety he had caused was due to the fact that he was not mentally well.

10,246. Did you communicate to him the object with which you were asking these questions?—Which questions?

10,247. About testing his reflexes, testing his knee-jerks?—I told him I was examining his nervous system.

10,248. But not for the purpose of certifying him as a lunatic?—No; I should not do that.

10,249. I know you would not, that is just the mischief. And do not you see there was nothing to put him on his guard, or to enable him to defend himself in such a dangerous emergency?—I think it would stultify the whole thing.

10,250. Supposing there were a neutral representative who was entitled to see the doctor's report before ever a man is certified insane, do not you think that it would be fairer?—In very few cases, I should think.

10,251. Fairer, I am saying?—Fairer in a very few cases.

10,252. Do you think it is fair, in any case, that a man should be certified without himself or any agent on his behalf having any knowledge of what is being done?—In some cases I think it might be advisable to inform the patient, but I think those patients are very few in number.

10,253. Not the patients, but the representative who could act on his behalf. Would that not be better for you, even as a doctor?—It might be.

10,254. It would protect you, would it not?—Yes.

10,255. And would give the patient a better chance to explain, if the facts were communicated to his agent?—Yes.

10,256. Now everybody admits, if I may be allowed to say this, that the conduct of affairs in Bethlem Hospital is better, perhaps, than any other institution of the kind in England. There they do not try and take advantage of patients by keeping them in the dark, do they—by deceiving them?—That is a thing we do not ever adopt—deception.

10,257. You try to avoid deception as far as the patient is concerned?—Certainly.

10,258. Is there anything more calculated to destroy a man's equilibrium than the suspicion that he is

27 January, 1925.]

Dr. JOHN GEORGE PORTER PHILLIPS.

[Continued.]

being deceived and kept in the dark?—I think it is a very dangerous thing to do.

10,259. Now, when once he is there in the institution, do not you think it would be desirable that there should be someone who should have the right to represent him on the occasion of his trying to get his discharge?—I presume he has.

10,260. On inquisition proceedings?—The relatives.

10,261. But sometimes, you will agree with me, there are interested petitioners whose interest is personal to themselves and not to the patient?—There may be occasional cases.

Re-examined by Mr. H. C. Dickens.

10,266. It is suggested that a neutral person should be invited in on these occasions when there is a question of certifying a patient. Do you consider yourself a partisan in the matter in any case—do you consider yourself in any other light than that of a neutral in these matters?—Perfectly neutral.

10,267. You have no interest in the matter one way or the other?—Not at all.

10,268. Do you see the necessity for any other neutral to come in? Are you acting in anybody else's interest than that of the patient?—Only in the patient's interests.

10,269. *Mr. Jowitt*: How far would the presence of a third person interfere with the intimacy you wish to establish?—I think it would interfere to an enormous extent. I think in order to gain the confidence of the patient you must, if possible, be alone with the patient. That is my experience.

Mr. Walter Stewart: May I say it is not suggested that the doctor should not see him alone. The doctors make a report, and then at the judicial enquiry the doctor should be a witness, and subject to cross-examination. I do not know whether you have the case which has been drafted on behalf of the Society before you. That is what I am reading here.

10,270. *Chairman*: That is a general question of much interest. The stage of certification is a very important and critical one in the patient's career?—Yes.

10,271. It is the stage at which the law intervenes for the first time?—Yes.

10,272. What we are all so interested in is the question of the legal safeguards, as you know. I am afraid we have dealt with it with much reiteration?—Yes.

10,273. Personally (I do not know how far I speak for my colleagues) I am very puzzled at that stage. One is so apt to look at things from the point of view of regulations on paper; but if one is able to use one's imagination and visualise cases as they must come before the medical practitioner from day to day, it is helpful to try and reconstruct the situation. Suppose we have an ordinary case of a patient who is living at home, has begun to give anxiety to the relatives and to the ordinary medical attendant: now in such a case is it the usual practice to invite a consultant to come in and consult with the general practitioner who is attending the case?—Not always.

10,274. *Earl Russell*: It is partly a question of means, I suppose?—Chiefly, I should think.

10,275. *Chairman*: We must assume that the case has given anxiety to somebody, and is, therefore, already in the pathological region, so to speak. Now do some cases suddenly develop acute symptoms in their home?—Undoubtedly.

10,276. And is it necessary in some cases, either for the welfare of the patient, or for the protection of the public, or for both, that some immediate steps should be taken?—Yes.

10,277. I mean that some immediate form of control is necessary?—Urgently, yes.

10,278. Can those forms of control be put in operation in a private house where a patient is living in his own home?—I presume so, yes.

10,279. Can you get in nurses and restrain the patient for the time being?—If funds are forthcoming?—Yes.

10,262. Is not that a terrible danger to the patient?—If it exists, yes.

10,263. Answer me, I know you will, fairly, has not your attention been called to cases in which husbands, from interested motives, have tried and succeeded in getting their wives certified, and *vice versa*?—It has been alleged, but I have not any experience of it.

10,264. Have you never known a case?—Not personally.

10,265. You have heard of such cases from other doctors?—Yes.

10,280. I suppose in many cases the absence of means would prevent it?—Absence of means and perhaps absence of adequate facilities for looking after the patient.

10,281. Suppose the patient happens to be the mother or father in a home where there are a number of children, with few rooms, and limited means, has some step to be taken to cover such a case?—Undoubtedly.

10,282. That, of course, I take to be the explanation of the urgency order which is provided for under the Act?—Yes.

10,283. Then that, I take it, is a step at which something has to be done at once, and at that stage it would be impossible, would it not, to have the kind of investigation that is suggested, namely, a magisterial investigation with yourself or the other consultant cross-examined, and so on?—Quite impossible under those conditions.

10,284. Therefore there must be some provision, somebody must be trusted for at least the temporary detention?—Yes.

10,285. Of course, as one knows, the urgency order expires in seven days?—Yes.

10,286. Then you come on to the next stage, where the more deliberate procedure is required for a reception order. Now there the magistrate, of course, intervenes?—Yes.

10,287. The patient may be seen by the magistrate or not, as we understand?—Yes.

10,288. If the patient were present with the magistrate, would it be injurious, do you think, to have the patient's condition discussed in the presence of the magistrate?—In many cases I think it would be very bad for the patient.

10,289. On the other hand, outside the presence of the patient, though I am afraid *Mr. Stewart* would call this behind his back, if the patient were not present—

Mr. Walter Stewart: If his agent were.

10,290. *Chairman*: Shall we say behind the back of the patient, but in the presence of his agent—if the investigation were so carried out, do you think that that would be likely to be protective? If we are to have the kind of cross-examination which we have had here for two or three days of medical experts, do you think that would be likely to lead to assisting the magistrate materially upon the problem before him?—I think in some cases it might eliminate a good deal of controversy.

10,291. Of course, the difficulty that one sees would be this, that you would have no doubt examination, and I suppose cross-examination, and possibly proceedings more resembling an inquisition, would you not?—Yes, I presume that would be so.

10,292. You would have possibly rival evidence, and so on?—Yes.

10,293. *Mr. Jowitt*: May I ask on that, what sort of agent have you in mind—is he going to receive instructions from the patient—the invalid?—I can see the difficulty at once: Who is going to be the agent, and who is to instruct him?

10,294. The question being: Is the man of unsound mind? To say he is to appoint an agent to resist or support his treatment, as the case may be, seems to me to beg the question.

27 January, 1925.]

Dr. JOHN GEORGE PORTER PHILLIPS.

[Continued.]

10,295. *Chairman*: One is anxious to investigate the question; one wants to explore the possibilities of it in reality rather than merely on paper.—It is a difficult point.

10,296. It is a difficult point, but take the point that Mr. Jowitt put. Who is to instruct the agent in the case figured? The agent might be equally open to the instructions of those designing relatives we have heard of, on the one hand, or to receive instructions from the subject of the investigation. It is difficult to see where else he would get instructions from.

Mr. Jowitt: Could you have somebody like the "Soldier's friend"?

Chairman: Yes.

Mr. Walter Stewart: That was the first suggestion. The justice is to do it, according to our suggestion.

Chairman: The difficulty about the justice is this. We have heard, and I have no doubt there is some truth in the criticism, that justices vary very much in the conception of their functions. Some will be much more perfunctory than others in the discharge of their duties.

Witness: Some justices insist on seeing the patient; they are very few.

10,297. That is a matter we shall have to consider. It is a question of the relation of procedure to the whole matter of certification, and it is hedged about with embarrassments.

10,298. *Earl Russell*: Have you ever known a justice insist on seeing either of the certifying doctors?—No, I have no knowledge of that.

Earl Russell: He has the power to, I take it, as the Act stands.

10,299. *Chairman*: He has. Now may I take it, Dr. Phillips, that in a large proportion of the cases there is really comparatively little difficulty?—Yes, I think, speaking generally, difficulties should not arise, and I do not think they do arise.

10,300. On the other hand, that is no reason why the exceptional case should not be protected, the rarer case which does arise?—Not at all.

10,301. And there are cases of difficulty, the borderland case, as we have always heard it described. What one is so anxious about is to see that there are adequate precautions for the full investigation of such a case, before the very serious step of depriving a person of his liberty results?—Yes.

10,302. A case, possibly, upon which even the most expert alienists might differ in opinion, a case in the balance. As one knows, opinions do differ sometimes. It might depend upon the action of the particular alienist who was called in whether the person was or was not deprived of his liberty?—Yes.

10,303. *Sir Humphry Rolleston*: With regard to the question of a neutral agent, that neutral agent would protect theoretically the alleged lunatic or suspected lunatic, against, on the one hand, any designing relatives, and, on the other hand, any liability on the part of our profession to certify unduly easily?—Yes.

10,304. With regard to the relatives, would it be fair to regard the judicial authority as representing their interests?—I do not think so.

10,305. You would not regard the judicial authority as taking the part of the alleged lunatic?—I think that the judicial authority in the exercise of his duties would be studying the case from the patient's point of view.

10,306. Exactly; that is what I mean. Then, from the point of view of the profession, is it not true that, at the present, the profession are very loth to certify unless they are driven to it?—Very loth. In fact, I know many doctors at the present time who refuse to have anything to do with mental patients.

10,307. I want to bring that out, because I believe it is the case that a very considerable number of people in Bethlem are not certified?—Nearly 50 per cent. of them,

10,308. *Chairman*: If we saw our way to recommend a provisional stage in the history of the patient's career, would not that eliminate a great deal of this difficulty? Suppose we had the type of case you are figuring, the borderland case, as to which you may be called upon to give an opinion at once: would not a very large measure of protection be enjoyed by the patient if, before the serious step of certification were taken, these borderland cases were retained under observation and time afforded for a fuller medical investigation of the case?—Undoubtedly, that is the procedure one would recommend.

10,309. It does occur to one that possibly the escape, on the one hand, from the over-elaboration of what one may call the legal element, and, on the other hand, from the risk which we have heard occurs in certain cases, might be secured by the interposition of this provisional period of observation?—Yes.

10,310. It seems to afford, possibly, the solution, I do not say necessarily that it does, but it may afford a solution, or at least a mitigation, of the risk which undoubtedly does exist?—Yes.

10,311. However, I do not think it is quite fair to go back again with you on these general questions, because you have been already good enough to give us evidence.

10,312. *Sir David Drummond*: Is it not a fact that, with regard to a considerable proportion of patients who are certified, it would be impossible to introduce this tribunal—in acute cases, I mean?—Yes.

10,313. Cases requiring an urgency order?—Yes.

10,314. It would be impossible to introduce this question of an agent?—Of course, the patient could not appoint an agent, in a very acute case, or an acute maniacal condition; it would be quite impossible for the patient to appoint the agent.

10,315. So that it could not be made universal, as it were?—No.

10,316. *Mr. Jowitt*: You and the medical profession would be only too pleased if you could shift what must be sometimes a very serious responsibility on to some other shoulders?—Undoubtedly; the feeling of the profession is very strong at the present moment.

10,317. *Mr. Snell*: I would be very glad if you would help me on a matter that has arisen in your evidence. Is the regulation of the patient's reflexes within his own volition?—Yes, he can exercise an influence over his reflexes—not the pupil reflex.

10,318. The argument has been that if the patient had known for what purpose he was being examined it might have made some difference to his condition. What I want to find out is whether, if a patient had known for what purpose the examination was taking place, he could have normalised his reflexes?—He might have controlled them to some extent. It depends upon whether he knows what "normal" means. The knee reflex he might control.

Mr. Walter Stewart: That never was asked him.

10,319. *Earl Russell*: On the question of a tribunal, do you happen to know anything about the proceedings with regard to pauper lunatics in Islington. I am told there is something rather resembling a tribunal there?—No.

10,320. I would be very glad if any medical man of your eminence could tell us what he thinks of that, from the point of view of effect on the patient?—I am sorry to say I have no knowledge of that.

10,321. *Mr. Micklem*: May I ask you about the patients in Bethlem—you say 50 per cent. are not certified?—Sometimes it is 50 sometimes below—over 40 at any rate.

10,322. Now in the ordinary course there is no reason why any of those should ever get certified. They may get treated and discharged, or they may get worse, but still, if they do not ask for their discharge you would not get them certified?—Did you mention treated at home?

10,323. No, in the hospital.—I did not gather what you said.

27 January, 1925.]

Dr. JOHN GEORGE PORTER PHILLIPS.

[Continued.]

10,324. I am afraid my question was not clear. There is no reason why these cases which are not now certified should ever be certified?—No; many of them are never certified.

10,325. Many of them would be cured and get a discharge ultimately?—Yes.

10,326. Many others would get worse, but there would be no reason to certify them unless they asked for their discharge, would there?—To conform with the law, of course, if a patient develops serious delusions, and yet does not ask for his discharge I think it is the idea of the authorities that the patient should be certified, because his volitional power is impaired at the time.

10,327. *Earl Russell*: You mean the Board of Control would make you do it?—They suggest it.

10,328. *Mr. Micklem*: Do you mean these are not voluntary boarders?—Becoming worse, as you suggest.

10,329. A voluntary boarder becoming worse is not necessarily certified, is he?—It depends to what extent his mental state has reached an abnormal condition. There are voluntary boarders whom I certainly consider should be detained on that status, and yet they have got very much worse; but if a patient becomes seriously ill mentally, then, of course, in order to conform with the law you have to certify.

10,330. But there is nothing in the law, is there, which says that a voluntary boarder, who becomes more insane than he was when he first became a boarder, should be certified?—No.

Mr. Dickens: Otherwise you could not keep him if he wanted to go.

10,331. *Mr. Micklem*: Then how about the voluntary boarder who is insane, but is not wildly insane, we will say?—I see your point, and I must say I am in harmony with your view that perhaps the patient who goes in voluntarily should remain on that status; but, of course, the Board of Control do not like to see a patient who is acutely ill mentally, perhaps in a state of confusion or maniacal excitement, who is not certified.

10,332. *Earl Russell*: The pressure really comes from the Board of Control, not from the doctor?—On their visits I have had suggestions made that certain patients are not on a proper footing as voluntary patients, and should be observed with a view to certification.

10,333. *Chairman*: Are the voluntary patients paying patients?—A voluntary boarder may be a fee-paying patient or a free patient.

10,334. The gravity of the position is this, if he is a paying patient and then is manifestly insane, you are at once in breach of the law, which says that no person should be detained for gain who is insane. I see your difficulty. A voluntary person comes in, anxious to have the shelter of your institution, and then, as *Mr. Micklem* puts it, while there develops the most maniacal symptoms; what is to be done?—You cannot take any money from him after that because you would be contravening the law. Then he might equally say—one form of his delusion might be, "I want to go away." In such a case in the interest of the patient himself you would require to take some step. You would have to proceed to certification?—Yes.

10,335. It is a question whether it should be done in the same institution or not—that is another question, as we have heard?—We now suggest that such patients should leave the hospital if they can—if the physical or mental condition will warrant it.

10,336. That is to avoid the unfortunate idea which might prevail that a voluntary patient going into one of those institutions, more or less inevitably becomes a certified patient. I mean that that idea

should get abroad would be most unfortunate?—Yes, the patient would feel you were taking advantage of him.

10,337. *Earl Russell*: When you did have to certify them at the end, I remember that the procedure was letting the relieving officer take them?—Not at Bethlem.

10,338. *Chairman*: It does seem in one sense a very cruel thing as regards a patient who has come voluntarily into your institution for treatment, and then unfortunately becomes acute; some step has to be taken, and you say, "Well, in order to keep up the reputation of my institution as a voluntary institution I cannot have you certified here," and the unhappy person is removed to some other place, to go through the necessary procedure, before he can come back to you as a certified patient. I can imagine that would inflict great hardship?—We try to avoid hardship. A doctor will come in and carry out the certification at Bethlem itself. A case occurred only the other day; a boy who came in, I think he was about 22 years of age—he came in as a voluntary patient, quite willingly, and the very next day he refused to remain; he wished to go, and yet he was in an acute melancholic condition, and perhaps suicidally inclined, and yet under his condition, when he definitely wished to leave the hospital he was allowed to go home; then his own practitioner certified, and he came back the same day.

10,339. That was comparatively an easy case?—He was handed over to responsible persons.

10,340. You kept him under a certain kind of charge?—Undoubtedly.

10,341. If he were of his own volition to say, "I want to go away now; I shall just be in time to be decapitated by the 6.50 express," of course you would not allow a man to go away under those circumstances, even if he were a voluntary patient?—Even if he were a voluntary patient.

10,342. *Sir David Drummond*: Cannot you detain them at all?—According to the agreement with a voluntary patient, 24 hours' notice has to be given.

10,343. *Mr. Jowitt*: It would not be a bad thing if that were given the force of law, and you had the right to detain them?—We do, really.

10,344. *Earl Russell*: What has been your general experience?—In some cases, of course, they show resentment. They think an unfair advantage has been taken of them: "I came to your hospital of my own free will; when I became worse you certified me," and it does always rankle in the mind of some patients.

10,345. *Mr. Micklem*: Take the case of a person coming in who is insane, but who is neither a danger to himself nor to other people; supposing after he has been with you six or ten months, and is getting rather worse and claims to be discharged, should you let him go?—It all depends. It is rather difficult unless you have a specific case, to consider the various symptoms. But, generally speaking, if one considers that he is a person of unsound mind in the ordinary meaning, then one has to take precautions if he leaves the hospital, and he has to be handed over to responsible individuals; or, if it is decided to retain him, owing to his marked mental symptoms, then the relatives are asked to take the step of certification, and the petitioner signs the petition, and the two visiting doctors will then sign their certificates, and he is retained; he may be retained for further treatment, or retained for the time being, to be transferred eventually to another institution.

Chairman: I am afraid we have strayed a good deal beyond the immediate topic of *Mr. H.'s* case, but we are much indebted to you for your contribution to our discussion.

(The Witness withdrew.)

Mr. Walter Stewart: On the point of urgency, may I direct your attention to this case. It is in the same case of *Whitfield*, at page 132. "*Mr. Hillman* is not alleged to have been a raving and

dangerous lunatic. The Common Law always allowed the restraint of the liberty of such persons." That would meet the urgency point. In our case there is no suggestion about urgency, as you have noticed.

27 January, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

Chairman: We are going to hear all that from Mr. Parker shortly.

Mr. Walter Stewart: If you please.

Chairman: May I make a suggestion to you, Mr. Dickens? As regards Dr. Cole's evidence, I understand that he is coming before us later on in another capacity. As to this particular case of Mr. H., I think, if we may suggest it, we have really had as much medical evidence as it is desirable to have upon it; and we may assure Dr. Cole that there is really nothing more he can contribute to the case that will assist us. We have heard both sides very fully. I quite understand some things were said against Dr. Cole.

Mr. Dickens: He is anxious to give a denial to the outrageous charges made against him, so long as the public understands—

Chairman: I think it is enough if you say that Dr. Cole is in attendance here to-day and is prepared to counter the allegations against his professional conduct. I think if that goes on the note that will be sufficient.

Mr. Dickens: If you please.

Chairman: On the general matter we will hear Dr. Cole later on.

Mr. Croom-Johnson: With regard to Moorcroft, there were one or two points on which, had Dr. Cole been called, I should have asked questions, but that also, it seems to me, has been explored.

Chairman: I think it has been fully explored.

Mr. Croom-Johnson: I think it has been explored somewhat fully; and, unless the Commission think I can be of any further assistance upon the Moor-

croft case, I propose to abstain from calling him as my witness.

Chairman: I think you have exercised a wise discretion. We have gone fully into the H. case, and we are obliged to the parties who have assisted us.

Mr. Dickens: I hope my clients have been of some assistance to the Commission in their investigation. It has been very distasteful and very unpleasant to have these charges made against them in public, and it has been a very expensive matter. If you think they have assisted you in your investigation, they have clearly done a public service, and it is very unfair that the Medical Defence Union should have to pay that. I do ask you to recommend the Government to make a grant towards the expenses to which my clients have been put in this matter as part of the expenses.

Chairman: We have no power to deal with costs in any shape or form; but as regards individual witnesses who have come, you know the very restricted scale upon which witnesses who attend are reimbursed. I doubt very much whether it would be within our province to make such a recommendation as you have indicated, although I fully recognise the hardship entailed upon your clients. However, we shall consider the matter.

Mr. Dickens: If you please.

Mr. Croom-Johnson: I make the same application on behalf of my clients, who have no Defence Union behind them, and who have come here on their own charges.

Chairman: We certainly are obliged to all the parties who have taken part in this investigation.

Mr. ROBERT MONTGOMERY BIRCH PARKER called and examined.

10,346. *Chairman:* Mr. Parker, are you Chairman of the National Society for Lunacy Reform?—I am.

10,347. When did you become Chairman?—I recently became Chairman, about three months ago, on the resignation of Mr. Bailey Weaver owing to ill-health.

10,348. I think you are also a member of the Bar?—I am, but I do not practise.

10,349. With regard to the Society which you represent to-day, I think it was founded in June of 1920?—That is correct.

10,350. And it has now a membership of just under 1,000?—Yes.

10,351. Will you tell us the objects of the Society?—The Society was originally formed to press for a reform in the Lunacy Laws—that was its primary object—and also to investigate the general position, to offer advice to ex-patients, or anybody else interested in lunacy matters; and in carrying out those objects it has sent a succession of deputations to the different Governments: one to Sir Alfred Mond in 1922, another to Mr. Neville Chamberlain in 1923, and to Mr. Wheatley in 1924. Then it also tried to stir up public interest by obtaining signatures to a petition to Mr. Wheatley that a Royal Commission might be appointed. I may say, Sir, that the Society has always taken a very strong view that this matter should never have been investigated except by tribunals who could hear evidence on oath; and perhaps it would not be out of place to mention here that for that reason no evidence was given before Sir Cyril Cobb's Committee.

10,352. I think the services which your Society render are voluntary except for the payment of your small permanent staff?—Yes, purely voluntary.

10,353. How do you manage to carry on?—We are supported by our members, and also, at times, by quite considerable contributions.

10,354. You get subscriptions from people who are interested?—Subscriptions from the public. They vary very much, and on more than one occasion, of course, those interested in the Society have had to maintain it temporarily.

10,355. Do you issue reports?—Yes, but I should say that in that respect, of course, the Society with

its growth is changing rapidly. We hold an annual public meeting.

10,356. It would be rather interesting if we might see the reports of the Society; you no doubt have printed reports of some sort?—Yes. I rather think the last one was typed, but it will be brought this afternoon.

10,357. I would rather like to read the reports of your work if you will be good enough to make them available to us?—Yes.

10,358. I understand that you find yourselves brought largely in contact with persons who have been patients in institutions?—We have a continuous stream of people calling. That is really one of the difficulties of our work, that we cannot deal adequately, both because of the limitation of our staff and the limitation of our finance, with the matters which are brought to our attention both in correspondence and personally.

10,359. That part of your work must obviously be difficult?—It is very difficult.

10,360. Do you, personally, interview ex-patients sometimes?—I do on occasions. Of course, I have seen a certain number since the Commission was appointed.

10,361. No doubt that has attracted a certain amount of public notice?—No; I think most of our patients we have had in hand from before then, but we are getting them every day.

10,362. I observe that you assist them to obtain the documents upon which they have been certified?—That is almost the invariable feature of all our proceedings; they come to us not knowing why they have been certified, not having the slightest idea; and in our first talk with them we try to ascertain what is in their mind. Then in giving them advice we give them a statutory form to fill up and ultimately they get copies of their certificates from the Board of Control.

10,363. *Earl Russell:* Is that a kindness to them?—I think it is a very great relief to their minds.

10,364. *Chairman:* There is, of course, just a point of view on this, and I am going to put all sorts of points of view because I am sure you will be most helpful to us. We have read this excellent and

27 January, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

instructive *précis* of yours with great interest; and if any of us are critical, I am sure you will appreciate that it is because we want to explore these matters from a practical point of view, and we want to put everything to you. Lord Russell's point strikes me, looking at the matter from the human aspect, as an observation worth examination. One would feel that when one had had an unhappy episode in one's life, assuming perfectly justifiable detention, and a case where everything had been all right, the last thing one would want to do would be to dwell upon the past, when one had emerged from that phase and returned to normal life. You want to make a fresh start instead of brooding on it again?—I quite see the point, and I can only answer it from those cases I have investigated myself. I cannot recall a single instance in which the patient was not relieved at hearing what was the matter with him, simply for the reason that, in many cases, for months and for years he had been trying to find out, and the moment he did find out he could direct his mind to that point; he might not agree with the finding on the certificate, but, undoubtedly, in all the cases I have seen, he was vastly relieved. Up to the time they have come to us they have practically been pawing the air to find out what is wrong with them.

10,365. Then the cases that come before you will all be cases where the patient has not recognised the propriety of his or her detention?—I should not like to say all. Of course, a great number of them are anxious to make complaints; that is the second aspect we get, people who think they have been wrongly detained, and I should like to add to that a very common feature, and that is, people who are so impressed with their own sufferings that they come to us and say they would like to join in our work and bring relief to others in a similar condition.

10,366. One quite appreciates that attitude of mind, but you tell us that a number of people wish to see the documents upon which they have been certified. Of course, I will assume that these must be people who are not satisfied as to the propriety of their treatment?—The great majority, I should not like to say all.

10,367. And these are people who think, rightly or wrongly, that they have cause to complain of the way in which they have been dealt with?—That is so.

10,368. Then a first step which they take, I understand, is to get the documents upon which they have been certified and which they then see for the first time?—We see them; they are generally sent to us, not always, and then we hand them over to the person concerned, and generally we keep copies of them for reference.

10,369. It is just at that point that this difficulty does occur to one. Let us assume for the moment the case has been a perfectly proper one for detention, and the certificate discloses for the first time to these persons what was wrong with them at the time, and the history of a series of acts which, fortunately, have entirely passed out of the recollection of this person, because one knows that, on recovery, a great many things mercifully disappear from the mind?—Quite.

10,370. You find that the wife or husband of the patient has had to recount and record many unhappy family incidents which were necessary to the case. I do feel there that you may be just renewing the whole distress again by giving this person for the first time the notion, "Oh, that was how I came to be in there, and that was what was said of me," and so on, causing just a renewal of the old unhappiness?—I can only speak from my experience; we have not come across a case of that sort. Inevitably there seems to be a relief; and when you say they see the whole details, of course, these certificates are very brief. We frequently get patients saying, "That is quite true,

but that only lasted a week or 10 days, and I have been there for months or years." We get nothing at present beyond the original certificate.

10,371. *Earl Russell*: It is also a record of acts which they may have done which they would very much regret being reminded of.—I can only say we do not find it.

10,372. *Chairman*: This very case which you have brought before us seems rather to exhibit that feature, because had it not been for the certificates being brought to Mr. H.'s knowledge he would never have known, nor would any member of the public have known, that there had even been a suggestion that he exhibited symptoms of general paralysis of the insane. Now Mr. H. has had that most distressing side brought to his knowledge and to the knowledge of other persons which would never have reached them at all, had it not been for these very proceedings.—I quite see the point, and it seems to me that the question of mentality comes in. I do not think until you fully grasp, as we try to grasp, the atmosphere in the asylum, that you can, if I may say so, give full sympathy to the state of mind in which the patient comes out. I am very much struck, as one gets further into the subject, with the state of mind in which they do come out. I am reminded that Mr. H. looked into the case book of Moorcroft, and that is how it came to his knowledge.

10,373. That may be more unfortunate still. You see the point is rather a general question in medical practice; it is not always desirable to tell a patient what he is suffering from. It may be a death sentence to do so.—I suppose it is one of the difficult points in medical practice, but may I suggest this, that a decision on that point presupposes a very detailed knowledge of your patient, as to whether you shall tell him or not.

10,374. That is a question of the adequacy of the investigation—we shall come to that.—Quite.

10,375. But it is just at the very outset of your evidence, when you told us that you had seen a number of these people, interested as you are in their welfare, that one finds on this whole topic as on so many questions that there are two sides; indeed you develop them yourself as you go through your own *précis*; and the balancing of those two counter considerations seems to be the most difficult task that could be set to anyone.—I quite agree.

10,376. Now we are asking you about the day-to-day work of your Association. A number of persons come to you from day to day and you interview them: Do you find that these people are all reliable people to talk to?—No, far from it; there is a sifting process which goes on, and, of course, it is only fair to tell you that there are a certain number of them who, when they find we cannot give them financial assistance, or cannot help them in contemplated litigation, drop us. Of course, that is another point that is frequently cropping up, the litigious ideas these people have, and possibly rightly.

10,377. I can see that the task of sifting, as you have described it, must be one of great difficulty?—Very great.

10,378. And you come to the conclusion that in a certain number of cases their grievances are imaginary and unfounded?—Yes, I think generally one could admit that.

10,379. On the other hand, some of the cases seem to you to present genuine features meriting investigation?—Unquestionably, and our only regret is that the cost of investigation, especially at a distance, is prohibitive really. Our investigations are really limited, except in rare cases, to London and round about. We cannot send people up to the North of England; there are the hotel and railway expenses. We cannot get access to any official information.

10,380. How many people come to you in the course of a year?—That is a question which I find it very difficult to answer; I should think the letter book would answer it the best. We do not keep any file of cases. I mean a case may involve a couple or

27 January, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

three letters, or it may run on to a very long file of correspondence stretching over months. I think our Secretary could answer you better than I could.

10,381. One only wants a rough idea of how many cases come under your cognisance, let us say, in a twelvemonth?—Personally?

10,382. Of your Society.—I should think it is quite a common case to have five or six people come in the morning, and ten or a dozen letters to go out, sometimes much more.

10,383. Of course, some of these are people coming back to see you?—Undoubtedly.

10,384. *Earl Russell*: There may be a thousand cases a year, or more?—Perhaps, I might just enquire.

10,385. *Chairman*: Yes, please enquire?—Our Secretary informs me that he thinks there are about 150 to 200 new cases a year.

10,386. That is quite sufficient for our purpose—and of those, how many do you think you have found to merit real consideration and investigation in each year?—Certainly, the bulk of them bring up points which we try and investigate. I mean our views are based, really, on investigating those cases.

10,387. Of those 150 to 200 cases that come before you in the course of the year, in how many cases have you found matters which, in your opinion, involve serious issues?—I think most of them raise questions that we should like to investigate, and then as we get complaints coming from various quarters we get a sort of cumulative weight of evidence; we get something up in the north and something in a couple of asylums just outside London, all speaking to the same thing. Then we begin to get evidence which we feel is of some value.

10,388. Then, I suppose, your investigations are entirely independent of medical advice?—Quite.

10,389. You do not have any professional man on your Council, do you, to assist you in investigating the cases?—Yes, we have both on our Council and on our Executive Committee, professional men and ladies, who are of very great assistance to us—experts. I should qualify that answer.

10,390. As regards your own personal experience, have you visited any asylums or licensed houses?—I have this year visited one licensed house and my home county asylum, the former many times, as it happens.

10,391. Which is your own county asylum?—Hertfordshire.

10,392. And in investigating cases, what means have you at your disposal. You told us, first of all, that the patient is entitled, as we know, to get copies of the certificates. Beyond that, what practical steps can you take?—Well, there are very few. We can get access to no official records. We get support and statements from the relatives. In many cases they are just as annoyed about the facts as the ex-patient, and occasionally, but not very often, we take up references to other patients in the same asylum who have got out. Of course, we send down sometimes a visitor to the asylum and check facts which have been put before us by conversation with inmates.

10,393. Do you have the authority of the ex-patients to make the investigation for them?—Yes, undoubtedly.

10,394. I can imagine it must be a task of very great difficulty?—It is a task which, to be properly carried out, would require a very big organisation, which we have not got, frankly.

10,395. But whatever the size of the organisation, it is a very difficult task?—Very difficult.

10,396. *Earl Russell*: Are these complaints which could not properly be made to the Board of Control?—Well, Sir, I think, speaking of all these patients, or most of the patients we see, they are tired of corresponding with the Board of Control; the most of them have in their time corresponded, and we certainly get a consensus of opinion that that correspondence leads to nothing; and there are patients who have corresponded with the Board of Control since they came out, and who have received very

courteous replies, but they do not advance the matter at all, so then they come to us.

10,397. *Chairman*: So far as the Board of Control is concerned, after the patient has left the institution, they have really no further concern with him, have they? Their function is to look after the patients while they are in the institution?—Yes. I think it is only fair to say that I understand they do go into complaints if they are lodged by patients after they come out.

Earl Russell: A case of ill-treatment?

10,398. *Chairman*: Of course, they would have to investigate a case of ill-treatment, but their actual duty relates to the patients in the institution?—Quite. I think it is only where their management or their control is impugned that they do, I understand, give quite an attentive ear, but nothing ever comes of it as regards the patient. I am reminded that in the Harnett case it was held that they were not acting. You will remember that Harnett went back to the Board of Control and they had no duty to act.

10,399. No, but you have pointed out quite rightly, and it must be the case, that if anything has arisen during the period of detention, then, of course, it is their business to investigate it?—Quite.

10,400. But you say nothing is done for the patient. What could be done?—You mean if he lodges a complaint?

10,401. Yes. We will assume that he is out, that he has come to you and that he says he should never have been detained; and then suppose you wrote, or he wrote, to the Board of Control stating that fact, complaining that he has been unlawfully detained: What would you suggest the Board of Control should do?—Personally, the view I am driven to over and over again is that nothing but an action will be the slightest good. We have only the patient's statements, which may be very convincing on the face of them; we cannot check them; and time and time again one feels that this thing ought to be investigated, but it means an action, and the patient has no money to carry it out.

10,402. And, of course, litigation has to be avoided always when one can avoid it; but the suggestion is that the Board of Control does nothing. But whatever body was established, supposing it were the local authority, there would be just the same difficulty?—I agree. I think complaints when patients come out may not be very profitable. One would rather have a system where complaints were dealt with when they arose.

10,403. Prevention is better than cure?—Quite.

10,404. *Earl Russell*: Of course, if a patient complains of detention after the patient is free there is not much the Board of Control can do?—No; it is a matter of opinion.

10,405. I mean supposing he is right, they cannot take up an action for damages against the certifying doctor?—No.

10,406. *Chairman*: But when one is told of the impotence of an institution, one wants to know in what respect they are failing to perform their duty; but you are more concerned, I take it, with the prevention of the occurrence of cases?—I think that is the real line of advance.

10,407. I think we should sympathise with that aspect, if I may say so. Now may we just pursue the general line of your *précis*, if you please. You next give us an historical *résumé* of the law on this subject. Now generally, of course, the law has been progressive, has it not?—Certainly, yes.

10,408. No one at the present day would seek to justify the methods by which insane people were treated in the past, which were both inhuman and unscientific?—Quite.

10,409. And do you recognise that the legislative history of this matter has been progressive?—Undoubtedly, yes.

10,410. May one take it also that the progress has at least been animated by a desire to produce adequate safeguards?—I think so, undoubtedly.

27 January, 1925.]

MR. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

10,411. The subject, as you point out in your *précis*, has been the topic of repeated investigations at the public instance from time to time?—Intermittent, yes.

10,412. The subject is one, is it not, which has more than once enlisted, not only the public interest, but the public suspicion?—Very much so.

10,413. As one knows, it has been a topic of literary discussion, as well as scientific discussion?—Yes.

10,414. And consequent upon those successive investigations may we take it that the last effort of the Legislature is what we have now before us in the code of 1890?—Yes.

10,415. Therefore probably the most profitable task to which we can address ourselves is considering with you whether the existing code with its safeguards really adequately achieves its purpose?—Quite. Since this was drafted you have had a lot of information. It is on your notes, I think, but I should like just to emphasise one point. If one takes a wholesale view of this legislation it does seem to me to point to this: a constant difference of opinion, quite a genuine difference of opinion, between the medical authority and the legal authority. I tried to make that clear from the earliest days. The medical people in the early days were the reformers. Then legislation came about which gradually limited their powers; and, of course, as you know, in 1890 the final limitation was made, that there might be no certification without the intervention of a magistrate. That, as it seems to us, is the important point of the legislation of 1890.

10,416. It does emerge from a consideration of this legislation that at first the doctor was in a very autocratic position, was he not?—Well, Sir, I think he was in an autocratic position, but he was a great reformer. I do not think anybody would wish to belittle the work which medicine did for the lunatics, especially under Lord Shaftesbury's guidance all through the early part of last century or the middle of last century.

10,417. But their position was certainly a trusted one, and it was a position which they used to reform the law?—To reform the law?

10,418. If you will select any other phrase?—?—I think they started in a position of absolute autocracy; that is, in the old days, when the physician or even the apothecary was allowed to certify.

10,419. I have seen some of the old certificates, and they are very interesting.—Yes. Then there was a gradual limitation brought about by public agitation, in which the law seems to have re-asserted that side of the question, namely, the liberty of the subject.

10,420. Now, of course, if we had an ideal medical profession (my medical colleagues will pardon me), you would not require any legal control—if you had a profession which was all-wise in the matter?—Yes.

10,421. And you point to this, that there has been in the legislation an increasing introduction of the legal element?—A re-assertion, I should like to put it.

10,422. Would you add, by way of control by the legal element?—A qualifying control, I think one might say.

10,423. Of course, the difficulty of the whole subject is just this, that this particular ailment, unlike other ailments, does require the intervention of the law to justify detention of the patient?—Quite so.

10,424. An ordinary patient is a voluntary co-operator in his treatment; mental patients may not be?—That is so. I have taken that up to 1890. I do not know whether you want any other evidence on that topic.

10,425. Unless you have any particular point you wish to be brought out on the earlier legislation, I do not know that it is necessary to get it on the note?—If you please.

10,426. We have followed you down, then, to the 1890 Act. I think there has been a little misapprehension—I do not know—on this subject of the 1890 Act. It did, did it not, considerably alter the existing law?—I have not quite been able to check it, but I think it was the Lunacy (Amendment) Act of 1889 which altered the law, and the 1890 Act was purely consolidation.

10,427. I think what so often happens in the case of these reforms is that you, first of all, have a reforming measure introduced, and then you have a codifying measure, and the codifying measure codifies the recent reforms. That is what really happened in this case, I think?—Yes. This reform took many years to bring about. In 1877 there was a Select Committee to deal with it, and at that period they did not decide to introduce the magistrate. It may be of interest to the Commission to know (I happened to look it up the other day) that in the report Lord Shaftesbury said: "If a magistrate is introduced you must insist by Act of Parliament that he must act judicially." That is of interest, because that led on, no doubt, ultimately to the legislation which followed, and I think it may interest you to know that even in those days the question of the capacity of the magistrate was very carefully considered. Lord Shaftesbury refers to him as a man of comparative inferiority, and he also makes use of the phrase about a magistrate who runs down in a hurry and looks into a cab; so that the gentleman referred to the other day as having looked into a cab was in existence 50 years ago.

10,428. That is extremely interesting. The point about the Act of 1890 is cleared up by the Fifth Schedule, which is the Schedule of repeal. The Lunacy Act of 1889 was repealed *in toto*, and re-enacted, and that was the Act which embodied the recommendations of the Committee?—Yes.

10,429. Now, as you say, in 1890 there came into existence the present code, and, as you also point out, the code contains a multiplicity of safeguards. I think you are not satisfied that even this multiplicity of safeguards has really achieved its purpose?—No. We feel that most of the authorities do not function as they ought to. That again is not particularly a new feature in the history of this matter. I am thinking for the moment, perhaps, of visiting committees, which we shall come to later. Even a century ago, when they were first appointed, they did not function, and Commissioners had to be sent down specially from London. That really led to the legislation of 1845—that one point.

10,430. However, we shall come to that. Of course, we shall always have this difficulty, that to whatever body powers are entrusted, the question of the exercise of those powers is a matter for that body. You can only introduce exhortations to them and penalties upon them for not performing their duties?—But in endeavouring to find a suggestion which will persuade them to function, we think that public opinion is the one thing that is always available, and always has, as far as one knows, succeeded in other directions. It is the great goad behind a man which persuades him to do his work.

10,431. It is an excellent stimulus, no doubt?—I think we are all agreed upon that.

10,432. Is your general criticism upon the Act of 1890 that, although it contains many safeguards designed to secure the very object you have at heart, the instruments through which the Act operates are not satisfactory?—The instruments; and I do not feel satisfied that the intention of that legislation is carried out, as we shall try to show.

10,433. It has failed to achieve the object it set out to accomplish?—That is so.

(After a short adjournment.)

27 January, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

10,434. *Chairman*: Mr. Parker, continuing our examination of the progress of legislation, I think you wish to draw our attention to a paragraph in the Report of the Royal Commission of 1908, which, I gather, in your view represents the proper aim in this matter. It is paragraph 815, page 280 of the 8th volume, if you will just read it out?—"Our aim has been to broaden the whole position and outlook of the Lunacy Commission, and to reorganise it as a Board of Control, so that it may be an active and efficient centre, both for the general protection and supervision of the mentally defective, and, also, for the promotion of measures of scientific administration and investigation, which will prevent, as far as may be, the increase of mental disease and defectiveness." That is not, of course, the only reference. That is the conclusion they came to. We thought it might be of interest to stress the point that they wanted a directing supervision. The views of that Commission were that there should be a directing supervision in the central authority.

10,435. Then you draw attention next to the recommendation of that Royal Commission which follows, at page 323: "That there be one central authority for the general protection and supervision of mentally defective persons and for the regulation of the provision made for their accommodation and maintenance, care, treatment, education, training and control"?—That is so, and then they go on in recommendation IV to define what they mean by the mentally defective persons.

10,436. Is it a long definition?—No, it is quite short.

10,437. Then you might give it us?—The first heading in recommendation IV is "'Persons of unsound mind,' i.e., persons who require care and control owing to disorder of the mind and are consequently incapable of managing themselves or their affairs, and are not included in classes (2), (3), (4), (5), (6), (7), (8), and (9), below." Then they pass on to the mentally infirm, idiots, and so on. Then there is a footnote: "The term 'unsound mind' under this recommendation might be said to stand as generally equivalent to the word lunatic."

10,438. Then, as we know, the Board of Control in its present form was reconstituted under the Mental Deficiency Act of 1913?—That is so. But then a very curious position seems to have arisen: while this report of the Commission of 1904—they reported in 1908—had made voluminous recommendations, legislation, when it followed, ignored the whole of those recommendations, I think, practically, and I have not been able to trace out how that came about; but the Mental Deficiency Act, of course, dealt with mental defectives, and left out lunatics. I think I am correct in saying that practically the only recommendation that Act adopted was the term "Board of Control," so that you got a Board of Control established which was, in fact, the old Lunacy Commission under a fresh name, with no more control than they had before. That is our reading of the position which we want to put before you.

10,439. And in that connection, as showing the limited powers of the Board of Control, do you also refer to a passage in what we know as the Cobb Report, at page 12?—Yes; we suggest that that is the most recent, authoritative definition of their powers, and it is as follows: "We are unable to find anything in the Acts, the Commissioners' Rules, or the General Rules made by visiting committees which prescribe or standardise what treatment individual patients shall receive in the matter of classification, clothing, medicine, occupation, exercise, recreation, parole."

10,440. Now the position which you are describing to us just now is a position in which your criticism is that there is not truly a controlling central body?—That is so; that the powers remain what they were, purely advisory, and we give you some further quotations.

10,441. First of all, on that, do you consider it desirable that there should be some central body charged with the appropriate duties?—We think that, with the great growth that has taken place in the number of people under control, you must have a central administration—not necessarily the present one. We should suggest, as we do later on, some supplement in that way.

10,442. But you think some central body, armed with appropriate powers, is essential?—We think so. We feel that if the law deprives a man of his liberty it should, at any rate, lay down some sort of general standard of the treatment he is to get, and we are going to show you that at the present there is none.

10,443. That might be done by directory legislation, but this is on the administrative side. Do you consider that it is essential that there should be some central body charged with the duty of seeing that whatever directions there are shall be fully observed?—We think so. We think the position is developing so much to-day that no legislation could deal with it very far ahead. You must have a central body.

10,444. *Earl Russell*: You said a central administrative body. Do you mean taking the place of the present local authorities?—Yes. We think they should act in liaison with them; "directly" is the term we use.

10,445. *Chairman*: I do not know whether the idea has occurred to you of a certain measure of decentralisation, in the sense of having district boards as well as the central body? We are familiar with that in Scotland.—I refer to that later on. This is a recommendation of this very Commission in 1908. They suggest that there should be a sub-division of England and Wales into eight divisions, and that there should be a district commissioner in each, with the full powers of a commissioner.

10,446. There are two points. There is, first of all, what you may call organisation, and then there is definition of duties. The two things are really distinct, although they are related, no doubt, because when you prescribe the duties, it is important to have an organisation to see that the duties are fulfilled.—Quite.

10,447. But is the machinery which commends itself to you the central body coupled with some form of localisation?—That is so, to begin to carry out the administrative duties.

10,448. As to the particular body to be selected, or the particular constitution of the controlling bodies, we shall consider that later.—Quite; we think that that must be done. We do not see, considering the large numbers to be dealt with, how you could carry on a business of this sort in any other way, by pure decentralisation, that is to say.

10,449. The Board of Control themselves have been the first to recognise that with the very large area under their control and the limited numbers they possess, it is not possible to carry out a detailed investigation of every case; and they complain also of the shortness of their staff?—Quite. Yet in spite of that—I do not know whether it is with their consent or not—the proposed legislation suggests a reduction of their staff.

10,450. *Earl Russell*: Which is that?—That is Lord Onslow's Bill.

10,451. *Chairman*: I do not think they will share that view.—It is in the draft, is it not?

Chairman: Does it contemplate the reduction of the membership of the Board of Control?

10,452. *Earl Russell*: What clause is it?—Section 3, sub-section (1). They say there: "Sub-section (1) of Section 22 of the Mental Deficiency Act, 1913 (which provides for the constitution of the Board of Control), shall have effect as though it required that not more than eight of the Commissioners should be paid Commissioners, and that of the paid Commissioners two should be legal Commissioners, and two at least should be Medical Commissioners." I believe the present position is that there are actually 12 authorised, though not all are appointed.

27 January, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

10,453. Not 12 paid, you know.—Are they not authorised to be paid? I am not quite certain of that.

10,454. *Chairman*: But is not this limitation coupled with proposals for inspection by inspectors?—That is so, and that is a point we want particularly to draw attention to, because it is a point which the Royal Commission of 1908 reviewed very closely.

10,455. Favourably or unfavourably?—Unfavourably, to this extent, that they thought inspectors would not carry the same weight as Commissioners.

10,456. They would not have so much authority?—And what we feel in dealing with this Bill is that this is really an indirect attempt to meet the position we have tried to show, and to augment the medical representation on the Board of Control, because we trace that out. We find that these inspectors are in fact being appointed. For instance, in the Board of Control Report for 1922 we find there are two inspectors, both doctors; and then when we turn to the Report for 1923 we find that that number has already grown to four, of whom three are doctors and one is a lady.

10,457. *Earl Russell*: Which do you think more useful in inspecting an asylum with a view to finding out abuses and dealing with treatment—medical men, or lawyers?—I think our view is this, that it has always been maintained by the Legislature that there should be both. We look upon the lawyer, not quite from his legal capacity necessarily, but as representing the public—the views of the man in the street; to some extent he takes the place of the old jury in an inquisition. We look upon the doctor, on the other hand, as holding a quite defined medical view, which may, and often does, differ from that of the man in the street. We carry it through a little further when we consider the judicial authority. We say that should take the place of the old jury in the inquisition. It is a summary way of dealing with the same problem.

10,458. *Chairman*: Let us follow out the question of the central body a little further. In your view it should have, I gather, not merely supervisory powers over whatever be the local bodies, but it should have, in addition, directory powers?—That is so.

10,459. Then, as to its composition, is your view that it should be composed partly of legal and partly of medical persons?—Partly, and I think we should like to suggest for your consideration that there might be even what one might term a business man on it. They are dealing with very vast sums of money, with the application of upwards of £6,000,000 a year, and we think it is in conformity with the growth of modern boards that there should be that business man, and also a lady, on it, as there is already in the form of an inspector.

10,460. There is a lady commissioner, of course, at present?—Yes, there is.

10,461. There is no doubt about the propriety of that?—Quite.

10,462. One difficulty does arise, that in connection with the question of visitation, of course the Commissioners do not visit in a body; they must go individually, to different institutions. Therefore you might have one institution visited only by a lawyer and another only by a doctor, if you have different qualifications?—I rather think that is provided for in Clause 2 of Lord Onslow's Bill, is it not?

10,463. *Earl Russell*: The present rule is that it ought to be one of each, is it not?—That is under Section 65 of the Act of 1913, I think. There is this, if I may read Section 65, Sub-section 1, of the Act of 1913, or the first paragraph of the Section, which says: "All the powers and duties of the Commissioners in Lunacy under the Lunacy Acts, 1890 to 1911, shall, as from the commencement of this Act, be transferred to the Board, and His Majesty may, by Order in Council, direct that anything which under those Acts is required or authorised to be done by, to, or in respect of,

any one or more Commissioners in Lunacy or any officer of those Commissioners shall be done by, to, or in respect of, one or more Commissioners under this Act, or the corresponding officer of the Board: Provided that nothing in such Order in Council shall authorise anything by those Acts required to be done by two Commissioners, one a medical practitioner and the other a barrister, to be done otherwise than by two Commissioners, one a medical and the other a legal Commissioner."

10,464. Yes, I am aware that certain steps require the intervention of both a legal and a medical man?—That is so; of which visiting, I think, is one.

10,465. Now suppose you introduce the business man; what are we to do with him? Is he to visit?—I think he might be allowed to visit independently, even. I do not think he need make a third, necessarily. I am not suggesting that.

10,466. However, I do not suppose that that is so vital to your present contention as that you should have a body composed of an adequate number of properly qualified persons?—Yes, and representative. We feel that there are very big problems. One that has been often discussed is the question of architecture. I think the old Commission of 1908 suggested that there should be an architect on the then Lunacy Commission. We feel that that is not the work of a doctor or a lawyer.

10,467. You can always employ an architect, you know?—I daresay they do.

10,468. *Chairman*: They have an architect on the staff?—I am only instancing that as one of the points which ought not to occupy the time of a medical man.

10,469. On the other hand, you might restrict the number of Commissioners at headquarters and not send them all over the country, but rather have the visitation and inspection carried out by district commissioners on the spot, and use the central board more as a central consultative and directing board. I can imagine that, at present, if the members of the Board of Control are being constantly dispersed over the country, as they must be, in the performance of their duty, you may not have what is desirable in a central authority, a permanent board in session dealing with questions which may come up from the country?—I think, generally, we should agree with that, and we think probably this proposed district commissioner would be a connecting link.

10,470. *Earl Russell*: Yes, but I would like to put this to you on that point. Supposing you have a district commissioner; is there not a danger of his visiting the same asylums all the time and getting, rather, into a rut? Is it not better to have a different man coming in, with a different point of view?—I quite agree, but that would be easily dealt with by changing the Commissioners from time to time.

10,471. Putting him on a "Wesleyan circuit"?—Yes, a "Wesleyan circuit" is just what I had in mind.

10,472. *Chairman*: We have heard of the multifarious duties of the Board of Control, and they are so frequently *en voyage* throughout the country that it must be an embarrassment to the conduct of the daily business of the office?—I think they complain of it very seriously themselves.

10,473. I know; but do you think it would afford adequate protection if one had a central authority in London, armed with appropriate powers, which, so to speak, would be in continuous session, receiving and acting upon information and where necessary, of course, going down to visit in particular cases, but not paying what we may call the routine visits which are at present required, those being delegated to district commissioners?—I think it is very difficult to say what your qualification, "going down where necessary," might amount to. If they did not visit occasionally, of course, they would obviously get out of touch with their work. What the middle course

27 January, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

would be I do not think it is for us to say; we do not profess to deal with the matter in that detail. We are trying to put some main principles before you.

10,474. If I may say so, it is uncommonly easy to express ideals, but, as you and I know as lawyers, when you come to draft clauses it is so often very, very difficult to give practical effect to your ideals; and what we are welcoming from you is assistance in not merely laying down canons—I think you and I could enunciate half-a-dozen propositions that everybody would applaud?—Quite.

10,475. But when one comes to work these things out—and here one must be practical—it is just there that one wants practical assistance most of all. You will do your best as we go along?—Perhaps when we come to deal with the practical benefits which arise, at any rate to the patients, from these visits, we shall be able to dispose of that side of it.

10,476. Yes. Like every other Government Department, the Board of Control has attracted to itself a very considerable amount of criticism and, I do not hesitate to say, abuse; and they have expressed the disabilities of their position more than once. We are, therefore, concerned at the very apex of the whole system to consider whether we can improve that position in any way?—Quite; that is why we tried to be fair and point out the position in which they are—having no directing power. From that fact we think the position which we criticise has directly arisen.

10,477. There has been a good deal of criticism of this sort: That the Board of Control should be abolished and its functions transferred to some other Department, and so on. I have very much this feeling, if I may be so indiscreet as to express it, that you might be exchanging King Stork for King Log. It is not the body so much as what are the functions of the body?—We quite agree with that. We should not suggest for a moment that they should be entirely abolished. I do not know, if you were setting up a fresh authority, how you would get on without their knowledge. We suggest a half-way house

10,478. If we set up a new body it would become the target for criticism for the next Commission. Therefore, it does not help matters to level abuse upon the central body, but rather to suggest in what way their difficulties may be met?—Quite.

10,479. However, we have your general view on that position. Now let us pass on to the question which is so important, namely, the case of the person who is suffering to some extent from a mental disorder, but has not yet been certified. You have, I think, strong views upon the expediency of introducing some method, some provisional system, whereby cases may be dealt with without certification?—Yes, that is so.

10,480. You have that view, I understand?—Yes, and it has been expressed in the evidence which has been given since the suggestions were made; in some respects I think the memorandum put in by the British Medical Association is on similar lines, as regards the period, at any rate.

10,481. And we have had evidence from a number of medical superintendents to exactly the same effect, that they think some such system would be very desirable?—Quite, and I think you had it from expert doctors yesterday, and to-day also—Sir Maurice Craig especially.

10,482. Yes; there has been remarkable unanimity on that point?—Yes.

10,483. I do not think we need labour it very much, except to ask you what form you think that provisional treatment should take. All being agreed upon the principle, what is the method you would recommend for carrying out that proposal?—The first principle which we advance is that there should be a provisional order for a period of 28 days; that is the same period, I think, as is put forward by the British Medical Association. Within that period it is obvious that there would be two types of cases to

consider; the urgency case and the ordinary case. Perhaps it would be convenient to deal with the ordinary case first.

10,484. *Earl Russell*: You have got your 28 days under Section 6 now, have you not?—Section 6 of the principal Act?

Earl Russell: I think so; I am not quite sure.

Chairman: That is, by the accumulation of periods you can get it.

Earl Russell: You only have 14, I see.

10,485. *Chairman*: It is in Section 6, subsection (4). (*To the Witness*): But that, I think, if I may say so, is looking at it from rather a different point of view from that which you are advocating just now, is it not? That is, after the case has been brought before the justice, it may be adjourned?—You want to deal with treatment without certification first?

10,486. Yes; that is, the first time, so to speak, at which the patient is brought into contact with any form of treatment?—Yes. We make the point that there is practically no provision for such treatment, with the exception of the Maudsley Hospital and Bethlem Hospital, and the provision for voluntary boarders in licensed houses.

10,487. We might take the voluntary boarder system first of all, because that seems to come first in logical order. That deals with the person who suffers the least possible interference with his liberty, the patient who subjects himself of his own motion to treatment. Now on this subject of the voluntary patient, again I think we may say there is a consensus of opinion that the system should be extended?—Quite so, extended to established institutions.

10,488. Yes, and extended in particular to county and borough asylums?—That is so, we agree with that.

10,489. *Earl Russell*: The pauper class is quite unprovided for now under the voluntary system?—Yes, quite uncovered.

10,490. *Chairman*: There again one is happy to find that your views are in conformity with those of the last Report of the Board of Control which I have in front of me: "We find a general consensus of opinion in favour of allowing early cases of mental disorder to be received for treatment for a period without certification, under proper safeguards, and of extending to public mental hospitals the power to receive voluntary boarders." So that upon that topic we may assume universal agreement?—Yes.

10,491. I do not know whether I am quite following the order of your *précis*, but I would like to follow out this idea of the voluntary boarder. Let us take the case of a person who, feeling unbalanced and apprehensive of what may supervene, presents himself at a public asylum and asks for admission as a voluntary boarder. Now we shall assume that the county asylum or the mental hospital will have been authorised by legislation to receive such a person. That person would become chargeable to the rates at once, would he not?—Not necessarily. I suppose he could be classed as a private voluntary boarder if he had the means.

10,492. If he had sufficient means he could become a private voluntary boarder?—Yes.

10,493. If he had not sufficient means, what safeguard would you suggest against an imposition upon the rates of unsuitable or unnecessary cases?—I suppose up to a point some of those cases would be in receipt of the "dole" already. One hopes that that would not continue necessarily.

10,494. What one feels is this: notwithstanding the drawbacks of asylums which you are going to tell us about, I can imagine that to quite a number of people, who had no comfortable home at all, it might be rather attractive to represent themselves as voluntary boarders?—I can assure you from the ex-patients we have interviewed that very few would share that opinion at present.

10,495. But you must remember your experience has been of the people who have complained?—As it happens I have had an experience of rather a curious case in the last six months. It was a voluntary case

27 January, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

in a licensed house—no question of mentality at all. There are a certain number of cases dealt with in the police courts in that way—ex-officers and so on, and I can assure you from his experience that it is not a thing he would very willingly repeat. He was a voluntary boarder under an order of a Chairman of Quarter Sessions conditionally.

10,496. *Earl Russell*: A condition of a recognisance?—Practically, yes. Mr. Stewart reminds me that our proposal is that it should be voluntary on both sides, that is to say, there should be no right of entry. The superintendent may refuse on due cause if he suspects.

10,497. Surely, apart from malingering, there ought to be a right of entry to a rate-aided institution?—I quite agree.

10,498. *Chairman*: I should not like to feel we were left in this position, that an unhappy person who felt the coming on of this affliction, should present himself at an asylum and say, "I want to come in for the shelter I shall get here," but be refused, at the mere discretion of the superintendent of the institution?—I quite agree: we could not leave it in that stage, but our proposals go a great deal further of course, that there should be other places open to that voluntary patient.

Chairman: Yes, if you start a new series of institutions of a different type altogether, then, of course, the conditions of entry into those institutions would have to be laid down.

10,499. *Earl Russell*: I limited my observations to rate-aided institutions, of course?—Quite.

10,500. *Chairman*: Now take this voluntary patient. You desire that he should be admissible, at any rate, to the public mental hospital. Do you think it is desirable that those voluntary cases should find their way into existing institutions at all, or would you rather that a new class of institution were brought into being?—We would rather a new class of institution should be instituted, as we hope it will be, but we recognise that it must take some time.

10,501. Meantime your view is that the doors of the public institutions should be thrown open to the voluntary boarder?—That is a measure we should support, and we understand a good many superintendents support it too.

10,502. That I think you may take as being a matter of general assent. The next question would be this: Under what conditions would you contemplate the voluntary boarder being received? Would you contemplate that he should be absolutely at liberty to leave as and when he pleases, or that he should be called upon to submit himself to some conditions?—Well, I think we recognise that the ideal condition of absolute freedom probably would not work, any more than it would in workhouses or anywhere else; but we do take strong exception to the idea that it should be extended to 72 hours. We think 24 hours for general convenience, and to prevent a man acting on the spur of the moment, is reasonable. Anything beyond that we consider is dangerous to the individual.

10,503. *Earl Russell*: Have you considered this, Mr. Parker, that if you had in the country to communicate with the relatives, say, on a Saturday, 24 hours may not give you time to get them there, particularly if they are away from home. If, therefore, you only allow 24 hours, it may be necessary that without the relatives hearing of it an urgency order may be signed; whereas if you have the 72 hours you may get the relatives there within the time and communicate with them as to the disposal of the patient?—That might be a difficulty in some cases, of course.

10,504. You understand that if you have a statutory provision, it must be fixed?—Quite. We are continually, of course, coming across these sort of points, and one can only make recommendations on a sort of balance of advantages. We think that that case would obviously be an exceptional case and must be risked, in the general interests of people who take other views.

10,505. *Chairman*: That will not quite do. You cannot lay down legislation and then say some people will fall out of it and they must take the consequences. Take the case Lord Russell puts: the case is that of a voluntary patient who says to his superintendent, "I propose to leave at the end of 24 hours." The superintendent says, "Oh, but why are you going away?" He says, "I propose to go and drown myself in the canal; I do not like this institution." The superintendent's duty would be at once to communicate with some responsible person and say that if the patient is going to leave, he must leave in somebody else's hands. Suppose he did not succeed in getting into touch in 24 hours with any of the relatives, what would happen? He could not keep him a moment more than 24 hours?—That case, I thought, had been dealt with already. Am I wrong in saying that Dr. Edwards, of Camberwell House, dealt with it? He said he found the 24 hours ample in practice, if I am right in quoting him, and that in a case, such as you suggest, he would of course communicate with the police and the policeman would take up the trail as the fellow walked out of the door.

Earl Russell: What may be found ample time in practice in London may not be ample in practice in Carmarthenshire.

Chairman: We had some evidence from a rural doctor saying that that would not give him time enough.

10,506. *Earl Russell*: What can the superintendent do in that case except summon the relieving officer and turn the person into a pauper patient under an urgency order, so as to protect him?—Then he would be no worse off than he is now.

10,507. We want him to be better off, and so do you?—I quite agree there might be that exceptional case.

10,508. It is not exceptional?—It is not Metropolitan, clearly. It is a country case on a Saturday night.

10,509. *Mr. Jowitt*: Would you be prepared to accept the differentiation between London and the country?—We should if that is considered wise. We look with very grave suspicion on the 72 hours, particularly in view of the evidence which has been given, that it is proposed for the purpose of certification if necessary. We consider that that destroys the whole basis of the voluntary treatment.

10,510. *Earl Russell*: True, but what else could you have it for, except for the purpose of restraint of some kind or other?—I thought it was also for the purpose of the administration of the place.

10,511. *Chairman*: No, I do not think so. I really think that the reason for the delay is this: that the patient may want to exercise his right as a voluntary patient to go out when the exercise of that right might be most detrimental to the patient and to the public. Suppose the case goes from bad to worse instead of from bad to better. Now what should be done for such a case? You manifestly cannot say that the person who has come in voluntarily with a comparatively mild attack is to be allowed out when the attack has become severe. It is a real problem?—It is a very real problem, but I think you have to look on the other side of it, and if a patient knows that that may happen, and that he might be certified, I am afraid that will deter a vast number of patients from going in.

10,512. *Earl Russell*: Of course, you must remember that it may happen to a man walking in the street now?—Quite so. I must say that we agree with what has been laid down in the case of the Maudsley Hospital, a rule that was not lightly arrived at.

10,513. *Chairman*: That is quite a different point. You wish to avoid the association of certification with voluntary treatment altogether?—Quite.

10,514. For the moment we are assuming that the voluntary patient is admitted to the public mental hospital. We are all agreed as to the advantages of that. He is in there, and then the question arises, what is to be the system or code under which he is

27 January, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

to be there? He cannot just walk out as and when he pleases; he must submit to some limitation, and 24 hours is advanced by you as being an adequate time. Personally, I am not so very much impressed with the question of whether it is 24, or 48, or 72 hours, because contrasted with the idea of detention for years, such as we have heard of in other cases, the difference between the deprivation of liberty for one or two days is not really a very serious thing, for we must assume that the case will be at least one of some anxiety before a person gets there at all. I do not attach so much importance to the difference between one day and even a week?—On the question of time, no, but on the question of the result—

10,515. If I may say so, we must be logical. That is a different question. The question of the time is, how long ought the man to be detained; or ought there to be any power to detain him against his will although he came in as a voluntary patient?—May I put this suggestion? In our view the 24 hours is not only to deal with those cases. We look upon it as a provision to prevent a man acting hastily and to allow people in authority to talk to him and speak for him. I believe in practice these cases do arise. A man says, "I am going to-morrow," and the doctor sends for him and has a talk to him. That is what the 24 hours is partly for.

10,516. *Earl Russell*: True. There are a variety of cases. There may be cases at Maudsley or Bethlem where a patient says, "I am going out," and the doctor says, "It will be very bad for your health, but I do not feel bound to stop you." There are other cases which he cannot let out; and if you were to give him such short notice and there was a patient who was growing worse, might it not lead to him certifying the patient a month earlier than he otherwise would do, for fear of that very risk?—That is so, and that is the difficulty in considering these voluntary cases. We have considered it, and we think that it has a preventive effect.

10,517. *Sir David Drummond*: Does the Witness not recognise that in practice a very large proportion of these cases will not take advantage of the system, and therefore we cannot be very much further on?—I think I do recognise that, and I ventured to say just now that our proposals were much wider than extending the proposal to public institutions.

10,518. *Chairman*: It is only one of the mitigating proposals, but at the same time you understand that if we make recommendations as the recommendations of a Royal Commission, it does not do merely to state general aspirations. One has to think the thing out in its detail. Here we have a gentleman who has thought the thing out, and it is our duty as well as our pleasure to explore these questions with you. We are putting to you the different aspects of the questions as they seem to strike us as men of the world.—Quite. I must repeat that our view is this: that the interests of the small minority may be prejudiced by that of bigger interests; the interest of the number of people who are likely to avail themselves of this voluntary treatment is the one which should prevail, and the others must take their chance. We are continually cropping up against that difficulty. You cannot legislate for the lot.

10,519. *Mr. Jowitt*: Do you think if a man says before he goes in as a voluntary boarder, "I may be kept 72 hours," it may have a considerable influence upon his willingness to go into that institution?—We think so.

10,520. On the balance of convenience you think it is better to have 24 hours?—The balance of convenience is making voluntary treatment merely voluntary. 24 hours, I am afraid, we must accept. It is current in the workhouses, I believe. It will not alarm the public quite so much, perhaps.

10,521. You do not think we could meet the difficulty by having 24 hours for London and 72 hours for the country?—I am bound to say as an opinion I think not.

10,522. *Chairman*: There is a very practical case that one might put on that. A patient unfortunately,

on a Sunday morning, develops very acute symptoms, maniacal symptoms, if you please. Up to that time he has been a well-behaved and exemplary voluntary patient; something has occurred to upset him. On the Sunday morning the medical superintendent is informed that the patient has become exceedingly ill, and he finds the case almost in *extremis*. It is Sunday morning; he cannot get into communication with anybody until the next day. Twenty-four hours afterwards, the next morning at breakfast, this patient is an absolutely free man, although he may be in a state of mind in which we all recognise he ought to be restrained. If that doctor kept him a minute longer than the 24 hours on his premises, he would of course have committed a serious offence.—Would he have given notice if he were in that condition? I think the case you mean is perhaps after a man has given notice.

10,523. I think your criticism is sound. If he is in a state of mania, he will not give notice at all. But suppose, on the other hand, he is in a suicidal condition, which is often accompanied by considerable intelligence; he might say, "I know my rights, and I give you notice that to-morrow morning I am leaving this institution, and I am going to drown myself in the canal," what does he do in that case?—I am bound to say my personal opinion is this: he is no worse off than if that attack had taken him outside, and I do not think you can make him better off except at the expense of a great number of other individuals who would be prejudiced.

10,524. One quite understands that. I agree he would be no better off either?—No, and there is always this: surely evidence has been given that, under those circumstances, whether it is legal or not, just as in a hospital, a good deal of restraint would in fact be exercised, or if it came to a point, the police could be communicated with.

10,525. You must not ask us to wink at such a thing?—No, but evidence has been given that it is done.

10,526. In fact, one of the things we have heard is that often in the interests of a patient it has been necessary to stretch the law a bit. One would far rather make the law cover the case than make the practice exceed the law?—Quite.

10,527. The point on voluntary treatment which seems to me to arise is this. You want to do everything to encourage people to take advantage of voluntary treatment?—Certainly.

10,528. Therefore, the first thing you say is: "You will still be a free agent while you are there, subject only to this, that you will have to give a day's notice"?—That is so.

10,529. Then you want next, as I understand, to dissociate the voluntary treatment as far as possible, from the consequence or risk of certification?—Yes, to avoid what has been described here as the stigma, and the risk.

10,530. Let us follow that out. Is your view this: that if it is seen that a voluntary patient in a mental hospital is unhappily deteriorating and has become certifiable, the certification should not take place in the institution which he has entered as a voluntary patient?—That is our view, yes.

10,531. And is the object of that that persons may not be deterred from going in as voluntary patients by the apprehension that they may find themselves becoming, whether they like it or not, involuntary patients?—Exactly.

10,532. It does seem to me, however, a little in the nature of a mere subterfuge to suggest that the patient in the case I have figured should be taken out of the mental hospital, and, if I may put it quite colloquially, put through the mill of certification in some other institution. It seems to me rather a cruel idea?—I think it is, and I wish we could suggest some way of dealing with that very difficult case; but again we feel, though we quite see the difficulty of that case, that the feelings of the individual must give way to the interests of the majority.

27 January, 1925.]

MR. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

10,533. *Earl Russell*: Exactly the same objection?—Yes, Mr. Stewart points out to me that, in the event of that sort of case arising, they could proceed, as we propose elsewhere, by the usual sworn information, and so forth.

10,534. *Chairman*: In the asylum?—And would keep him there, I take it.

10,535. The whole question we are on just now is the association of the place. One does not want to have inscribed over the portal, "Come in as a voluntary patient, and remain in as an involuntary one"?—No, that is what we wish to avoid.

10,536. The suggestion is this, as I understand, that if the patient enters as a voluntary patient, he should never be certified inside the portals of that institution, lest it should attract to itself an unhappy association?—We think that is the only safe rule to make, and we quite recognise that it will work hardship in a few individual cases.

10,537. Perhaps it is a matter of personal temperament, but the case that always appeals to my imagination is the case of the individual sufferer. One wants to figure out the real thing as it happens in human life, and one knows that people in this unhappy condition are often upset, distressed, frightened, and miserable, and one has the feeling that one wants, as far as possible, to avoid elaborate machinery, and so on, which even to people of complete sanity is often found, as you and I know, to be exceedingly distressing and worrying?—Quite.

10,538. It seems to me that it would be an extraordinarily harsh thing to take a patient out of a place where he is receiving care, a patient who has suddenly become very bad, and say to him, "We cannot keep you here any longer and you must be taken away," under the present system, as far as I can see, "to a workhouse"?—Does not this point arise—What type of institution are you considering? Are you considering an institution where you shall have nothing but voluntary and free people, or are you considering an institution with mixed patients—voluntary and certified?

10,539. True. If we got this ideal intermediate institution, which was not a mental hospital in the sense of being an asylum at all, but was a place of observation and care, and you had your voluntary patients there, that might be the solution; and yet, even there, you might have to have some of the cases certified?—We have discussed those types at very great length, and we are quite unanimous in feeling this, that once you get certified patients kept in voluntary institutions, that is to say, institutions which are purely voluntary, you will be half way to associating those institutions with the present asylums and getting the stigma attached to them. Therefore, we say, that the voluntary institutions must be purely voluntary, and once a person is certifiable he must go out, and if he goes out it does not matter very much where he goes.

10,540. *Earl Russell*: Then you would not approve of our existing county asylums establishing cottage hospitals, and so on?—That is a different point. I think we should welcome that.

10,541. *Chairman*: We are on existing institutions for the moment, because we have got to take things as we find them?—Quite.

10,542. We are fully alive to the point that you do not want the voluntary patient to be deterred from resorting to an institution by any apprehensions of the sort you indicate. Now, it is just a question whether the fact that some other friends of his had gone there as voluntary patients, and had been certified, would be a real deterrent to him in going in turn. That is the real point?—Yes.

10,543. You think it would be a deterrent?—We think it would, undoubtedly.

10,544. Would it be any more deterrent that his friend should have gone there, had stayed for a while, had been sent away to some other place, had there been certified and brought back and put into the certified ward?—You are speaking of the existing institution?

10,545. Yes.—I think in the existing institution, which has already fully certified people, it does not matter very much.

10,546. That is an important distinction?—It is.

10,547. Because I can quite see that if you are contemplating a new sort of institution, you wish to keep it as free as possible from the idea of compulsory detention?—Quite.

10,548. And so you instance the Maudsley experiment?—Even if to-morrow you got legislation admitting voluntary patients to existing institutions, we only look upon that as a step.

10,549. *Earl Russell*: They do, in fact, go to Claybury and these private licensed houses as voluntary patients, though there are certified cases there?—Quite, and I think they will, until they can get something better.

10,550. But you think there are a larger number deterred who do not go?—We thought so, and I thought that was the medical evidence you have had.

10,551. *Chairman*: Then I understand that, so far as the existing public mental hospitals are concerned, they should be open to voluntary patients, but in their case you do not insist, as one of the terms of your reform, that there should be no certification of a voluntary patient in that hospital?—I do not think we can press that in view of what you have said. It will no doubt be very carefully considered.

10,552. You must not take it that these are considered views at all. They are just the kind of views that occur to anyone who is exploring this, I hope, carefully; and one is so anxious in advancing any ideas for reform to see that they are practicable?—I quite agree, if I may say so, that if the institution is already tainted by the stigma, it would be foolish to take the patient out and bring him back again.

10,553. You also suggest, however, that the ideal would be to have a new class of institution for those cases?—That is so.

10,554. While we are on the existing régime, that is to say, before we get institutions such as you desire, what is your objection to the Board of Control, with its existing or such additional powers as it may receive in consequence of recommendations from us, having control of those voluntary patients?—Of course I am putting before you now the views of different members of our Society; and from their experience, which is much greater than mine, they do think that the connection of a Board in daily touch with lunacy matters, also administering these places, will cause what we have decided to call the stigma to attach to them in time; and they also believe that those sort of places will be much better run by local authorities—that is on the question of decentralisation which we were discussing—and they really do not concern a central body. I think they do not like to feel that even the names will go on the records of the central body.

10,555. That would be so, if you were able to obtain your ideal of having institutions dissociated from the present administration of lunacy altogether; but taking it on the makeshift of allowing voluntary patients to enter public mental hospitals, of course, there you could not dissociate them from the Board of Control?—No.

10,556. *Earl Russell*: But do you think that even in your new places the patient would require no protection in that sense?—I do not see why, if he is free to walk out.

10,557. The reason why the Board of Control is notified is to make sure that a person, whose judgment and will are not quite sound, is not having anything done to him that he should not have done.

10,558. *Chairman*: I see possibilities of abuse in the voluntary system which might be very grave. The trouble is that whenever you introduce into our law a new system, you at once bring with it a train of new abuses?—Quite.

10,559. Is not the trouble just this, that if you have not some kind of authoritative control, you might have a case, which was, on the pretext of being voluntary, in point of fact not voluntary at all, a

27 January, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

weak-minded case, let us say, simply controlled and unfairly treated?—And he would be lost sight of.

Earl Russell: He would be remaining there and with no public authority to protect him.

10,560. *Chairman:* Yes, and possibly paying for himself as well?—I am bound to say that my view is that that case would not be in a very different position from that which cases find themselves in to-day, that is to say, we do not feel that the central authority is such a protection as is suggested.

10,561. No, but one of your reforms which we certainly are going to consider is the improvement of this control, possibly, by some decentralisation also. But I cannot figure with comfort to myself the idea of voluntary establishments in which persons in this state of mind are to be housed, and who are so peculiarly exposed to possible ill-treatment or abuse, unless there is some real and effective control over them?—Do not you think the local health authority would be an effective control in that case?

10,562. You do not, perhaps rightly, attach a great deal of importance to the way in which justices of the peace or visiting committees perform their duties. It is just the same people over again who compose the authorities in these places?—Quite. I am afraid there we should come down ultimately to the interest which the public take in these places. The public at present do take an interest in hospitals. Many of our Committee feel sure, and I must say I agree, that there will be members of the public who will take an interest in these places. Of course, that is not an absolute safeguard, but it is a very great help.

10,563. *Earl Russell:* If you take the case of some feeble-minded person who is bullied into a sort of consent to remaining there, no visiting member of the public would get anything out of that place by going there, whereas if you had a central authority to whom the patient had to be reported, at least it would be known and some official would see him?—Could it not be dealt with in this way, that, after a fixed time of residence, notification to a central authority was insisted on? Would not that cover the point?

Chairman: That is rather the question of the way in which the central authority is to be invoked. Your present proposal is the dissociation altogether of such places from the central authority. Once it is assumed that some measure of control is appropriate, the question of extent is a mere matter of machinery.

10,564. *Sir David Drummond:* Is it your idea that these voluntary hospitals should be run on the lines of general hospitals?—That is what we hope to see.

10,565. In those cases, we know, the patients are safeguarded by the Committees?—Quite. I do not think we contemplate long periods of residence in these voluntary hostels. The whole object of them is to deal with the temporary cases. Therefore I do not think there would be any objection at all to legislating that a case which had been in fact in residence over two or three months must be notified. I think that would be quite a reasonable thing.

10,566. *Chairman:* I think you must not assume that voluntary patients are only short-term patients. Personally I have been visiting a few institutions myself, and I hope to visit a great many more. I have seen patients who have been there for years as voluntary patients.—That is so. I am reminded that Dr. Lewis gave a lot of evidence on this point, and he said that even control by the county councils would be better.

10,567. Whatever be the controlling body it will inevitably attract abuse one way or another. I am not so much impressed with that. I do not quite see why the county council is a better body than any other central body may be. It is local, of course?—Of course, we have proposed that the Ministry of Health might be an ultimate sort of Court.

10,568. After all the Ministry of Health would be just another Board of Control?—That is just the difficulty.

10,569. Anybody who knows how a Government Department is run knows that there would simply

be a Department in the Ministry of Health, by whatever name you call it. That is rather playing with it, if I may say so?—I agree.

10,570. The other proposal, though, is substantial, namely, that it should be in the charge of the local authority—the borough council, or the county council?—Yes.

10,571. Then, again, I suppose you have had some knowledge of local administration?—Not very much.

10,572. Some of us have. Again, if you take the case of a county council or a town council, at the present moment these bodies are simply overburdened with work. No one who knows the course of modern legislation—I am sure my friend, the late Lord Provost of Edinburgh, would bear me out in this—is not aware that the burdens that have been put upon local authorities in recent years are almost inconceivable. Do you think you could ask these bodies in turn to give the measure of real supervision which we want, or would we not again get the same kind of thing as having a committee which just goes and lunches there once a month? Would we be getting any nearer the heart of the problem?—The way we visualise it is that it must develop gradually, that is to say, the large centres will start the hostels of this sort, and we do feel that outside the actual authority appointed there will be honorary members interested in the work.

10,573. I am more attracted by the view of a reorganisation of the Board of Control. I am not concerned with the name; I am concerned with the substance. A reorganisation of the Board of Control, coupled with a system of district commissioners throughout the country who would be persons whose business it would be to do this; rather than confide it to persons who are already immersed in a great deal of public business, and who, with the best will in the world, would be liable to regard it as part of their routine work instead of being their professional duty?—Subject to that reorganisation, I think that course would have a great deal to recommend it.

10,574. I am merely throwing out ideas as they occur to me. Let us picture a central body in continual session to which all difficulties could be referred by really responsible district commissioners, who would have under their charge, not the whole country but reasonable areas, in which they would be constantly moving about and supervising and reporting difficulties and suggesting inquiries, and so on; so far as you can get an effective machine (all machines are imperfect) that would go a very long way?—I think we should quite agree with that, subject to the reorganisation of the central body.

10,574A. Just link that up with what Lord Russell put to you. If the central body were so reorganised, and you had a system of distribution of work amongst district commissioners, would you still think it desirable that these voluntary hostels should be entirely dissociated from such a body?—No, for this reason, that they would really be associated with something fresh, that is to say, the district commissioners.

10,575. Very good; that meets one's point there. Then you say what is very important, that you would wish to see more public interest taken in these places, and that you regard an increased interest on the part of the public as a very valuable safeguard?—We do, yes.

10,576. I think you will remember that one medical superintendent who gave evidence before us said that he wished he could get the public to come more to his place, and treat it more as a general hospital is treated. Now is there not just a difficulty about that? The atmosphere, after all, however much one may try to improve it, of any place where a large number of persons mentally afflicted are gathered together, can never be the same as that of a general hospital?—Never.

10,577. One feels oneself in visiting an institution of that sort that a brave show may be made by the best people, but at the same time you can never get the same atmosphere as you will get in a general hospital?—I do not think you can, subject to this,

27 January, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

that as you put your permanent cases aside you probably will not get such a bad atmosphere as you get at present.

10,578. Improved classification would largely assist in that, I agree.—I thought we were talking still of the voluntary patients.

10,579. I am talking for the moment of the general point. Publicity means that the public will go to them as they go to a general hospital just now. You go to a general hospital, and no doubt see a great many people who are suffering there, but there is a different atmosphere about it, is there not?—I do not think we expect that you will get the public to visit these big asylums very much.

10,580. I do not think a great many members of the general public could stand it, putting it quite frankly?—No, as one witness said, you require very robust mentality.

10,581. *Earl Russell*: If it were known that it were encouraged, do you think that you would get more visitors of the kind mentioned at Claybury—the voluntary visitor?—I do not think I can express an individual opinion upon that.

10,582. I think probably the public imagine now that they are not wanted in asylums, and that their presence would be resented?—I think that is the feeling very distinctly.

10,583. *Chairman*: You see, what one may call the normal suffering of the human body is a thing which everybody knows about, and which, after all, most people can stand; but this particular form of suffering has got concomitants of a peculiarly distressing type?—It has.

10,584. And I do not mind saying that when you have seen even a very few cases you may find yourself haunted for days afterwards, even though the cases are getting every possible advantage?—Yes.

10,585. You are not haunted with a case of a sick person who is suffering from any of the ordinary diseases. You may be very sorry for, and very distressed about him, but it does not haunt you in the same way as the case of a person who is distraught mentally.—Quite.

10,586. Now the difficulty that I feel about encouraging the public to go to these places is just that: the sights and sounds which are inevitable in such a place, even in the best conducted place, may be very distressing, and are not really a fit subject for people to see or hear. What do you say with regard to that?—For people generally, perhaps not, just as you might say, people will not go into the slums, but there have been people who, in the past, have met all sorts of conditions there, and I think would do so in this case.

10,587. No doubt many people of a philanthropic turn of mind would go on that errand of mercy, but it is a little different from the coming and going that you have in a general hospital.—You have fewer people, certainly.

10,588. *Sir David Drummond*: Is it your view that that class of patient would be with the others?—Not at all.

10,589. *Chairman*: The voluntary patient would not be in that class?—No.

10,590. *Earl Russell*: You could find a certain number of voluntary workers from people who had been on asylum committees, but who were no longer on them?—I think so. I think the Report of 1908 somewhere suggests that the visiting committees should be enlarged by honorary appointments.

10,591. I was not thinking of that, because that at once makes them official. I am thinking of the sort of person we were told of at Claybury—an outside worker entirely.

10,592. *Chairman*: I think that is a delightful idea, if you can get people of the right sort, to go about the place and be friendly with the patients and make the patients feel they are still members of society and not outcasts from society. In a general hospital, as one knows, there are people who go and conduct services, sing hymns, take flowers and do all sorts of things.—We touch upon that point a little

later in the proof by suggesting that something analogous to the prison visitors might be considered.

10,593. I again agree with Lord Russell on this point, that this is a great sphere for voluntary effort, rather than to get it into the atmosphere of officialism.—Possible criticism, you mean.

Chairman: Yes.

10,594. *Earl Russell*: I think possibly the prison visitors you have referred to are the permitted persons who are not paid.—It is voluntary work, and they go in when they like. If we deal with that now, it will cover two points—visiting and inspection from outside—to which we attach great importance.

10,595. *Chairman*: Contact with the outer world?—Yes.

10,596. Now the only other point on this branch of your case is whether the existing general hospitals throughout the country could not be made to play a role in this matter of treatment without certification. Of course, if you could get the general hospitals to deal with the mental cases, incipient mental cases, in wards, you would have practically solved your problem, because there you would of course have no association of insanity?—Quite.

10,597. You would only have the association of treatment and care?—Quite.

10,598. Suffering, no doubt; but a different outlook?—Yes.

10,599. And there also opportunities would be afforded for observation of cases, and, if unhappily it proved to be necessary, their ultimate removal; just as a patient may be removed from a general hospital now to a place for epileptics, they possibly would have to go to an asylum. But is not the difficulty this, that the general hospitals at the present moment are overtaxed—the accommodation is overtaxed?—Yes. It has occurred to us that that might be met; I do not know about the accommodation, but the expense might be met in part by a subsidy from the State. We are all anxious that that should be brought about, but what inducement you can give to the hospitals to do it, I do not know.

10,600. There is a Committee sitting at this moment in Scotland which is considering this very question, and I have no doubt similar inquiries are being pursued in England; but I do not know that the idea of converting the existing voluntary hospitals into rate-aided institutions or grant-aided institutions finds universal approval?—I was not quite meaning that. I was suggesting paying patients. A person going in in that way as a mildly mental case might possibly carry rate aid, or be a part-paying patient in some form.

10,601. This is a very large subject, and I did not want it to be missed, namely, that you might get those cases dealt with in the special wards of general hospitals, if that could be brought about?—We should favour that very strongly, but we could not suggest details with regard to it.

Sir Thomas Hutchison: Many general hospitals at present are grant-aided. All the hospitals which are carrying out the treatment of venereal disease receive 75 per cent. of the cost from the State through the local authorities.

10,602. *Earl Russell*: And you might perfectly well make these patients rate-aided if they were patients who would have been rate-aided in an asylum?—Yes, quite.

Sir Ernest Hiley: Is there not a danger of the particular ward in the hospital which deals with these mental cases being stigmatised in the same way?

10,603. *Chairman*: I suppose that is so, Sir Ernest. I suppose Mr. Parker would not disguise the fact. If a ward be a ward in which mental cases are dealt with, it will be called the mental ward?—I suppose it will.

Earl Russell: It will be called, as Mr. Stewart called it in his cross-examination this morning, “the mad-house” by the other patients.

10,604. *Chairman*: After all, that is just the trouble. We cannot disguise the facts of human nature by giving them different names. That effort

27 January, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

is being made a good deal in legislation nowadays by periphrases.—I do not think it matters much what it is called.

Chairman: It is a question of what is going on there.

Earl Russell: And what the public thinks of it.
10,605. *Chairman:* Yes. That the public should feel that their relatives are liable to ill-treatment is, of course, intolerable?—Yes.

10,606. We are happy to find that there is a very large measure of agreement, the only possible points of divergence being on the detail of carrying it out?—That is so.

10,607. Now comes the next matter, which is the first thing to which our attention is directed in our remit, namely, “the law and administrative machinery in connection with the certification, detention, and care of persons who are, or are alleged to be, of unsound mind.” I gather from the cross-examination of the last two days that there is evidently in the mind of your Society considerable dissatisfaction with the existing methods of certification. Now you may take it that we know the existing methods pretty well, because we have been well indoctrinated by the evidence we have heard upon the subject?—Quite.

10,608. A number of suggestions have already been made to us. With one of them, I gather, you are in complete agreement, and that is that there should be no difference in the methods of certification, whatever they are, as between the private patient on the one hand and what has hitherto been called the pauper patient on the other?—That is so.

10,609. Now, if I may say so, it is superfluous for you to dwell upon that point, because every person who has sat in that chair has told us the same thing. Therefore, whatever be your recommendations with regard to the improvement of the safeguards of certification, I take it you would wish the same safeguards applied to all classes of patients?—That is so. We look upon that distinction as almost an historical survival.

10,610. I ventured myself to put it that there should be no difference in matters of this sort, because in this connection class and mass are quite irrelevant considerations?—Quite.

10,611. Having got that length, that we should have a uniformity of system if it is possible, let us see what the system should be. There is a great variety of procedure set out in the Act of 1890. I have no doubt you have studied it?—Yes, I have.

10,612. Have you felt, as I confess I have felt, some little difficulty in understanding the different circumstances under which different sections of the Act should be brought into play?—I have felt great difficulty. If one had had more time, I think it might have been possible to trace out where they came from, but I think in substance it is the result of the amalgamation of the various Acts, starting with the Vagrancy Acts and coming right up to modern times.

10,613. You think some of them are vestiges of earlier codes of law?—Certainly, the last century, and, I think, the century before.

Chairman: We have had officials who have said to us that they do not find the existing code in this matter comfortable to administer, that is to say, they have not found the programme laid out for them to be sufficiently clear.

Earl Russell: Or elastic.

10,614. *Chairman:* Or elastic. Again, I suppose, we may have your concurrence in that view?—I think it is extremely complex.

10,614A. Now let us think for a moment what are the cases in real life which have to be met. There is the patient, a well-to-do person with ample means and ample accommodation, who can call for the services of nurses and first-class medical attendance, and so on; and from that stage at one end, through varying gradations, we pass through the stage of

the small, but quite comfortable, home of a respectable working man and his family, down to the class of person who is to be seen occasionally in the streets of our cities, ragged and insane, with no one to look after him at all, and no home. You have that gradation of persons and all these different types. I wonder if it would be possible to devise one system of certification for all those classes, or must we still recognise some differentiation?—I think our view is, that the system should be one, but the differentiation would come about from the way in which it was put into force, that is to say, that the man with money and means must, obviously, and would always be in a different position from the man without.

10,615. Of course, one has to remember that possibly, even, the susceptibilities of the parties would differ to some extent, because if you take a person from surroundings with which he is familiar and put him into other surroundings of a totally different type it may produce unhappy results in an unstable mind?—We quite agree with that, and, if we may say so, that is one of the arguments we shall advance presently as an objection to these urgency orders, that the upset to the patient's mentality, of course, is much greater in some cases than it is in others.

10,616. For instance, if you take the different classes I was figuring a moment ago, you must have some place of immediate disposal for the person who is in the street, possibly in rags, shouting and gesticulating, surrounded by a crowd. Now that person, in my humble opinion, is entitled to just the same consideration as any other person?—I quite agree.

10,617. He is there, one of the unhappy waifs of civilisation, if you please, but how are you to deal with his case? What would naturally happen? Let us think of facts again. A policeman comes upon the scene, of course, and he says, “What's this?”; then somebody says, “There is a looney there, making a row,” or something of that sort. The policeman goes up—and one is glad to know that our police are very humane people, as a rule—and would say, “Come along, now,” and he would possibly send for an ambulance or, if the person is not very bad, just ask him to walk along, and the man may have the good sense to do so. Where is that person to be taken?—We think he must go to the infirmary ward of a workhouse, but we hope it will be a very different infirmary ward from what it is at present.

10,618. Do you think the workhouse is the only place we can relegate him to?—I think yes, for that particular type. It may be that in years to come we shall have voluntary institutions willing to deal with that type of case.

10,619. *Earl Russell:* He has got to be disinfected and clothed, among other things?—Yes, he is the true genus pauper.

10,620. *Chairman:* But suppose the case is not that which we have figured—which, as you have said, is the true genus pauper, and it is no more degradation for him to be taken to the workhouse, because he has probably come from a workhouse: suppose the case of a person who is obviously a most respectable working man or a professional man, apparently well-to-do, but who had just become afflicted in the same way. Is he to be taken off to the workhouse also?—No. We say he is to be taken to his home, be it an artisan's cottage or a bigger establishment.

Earl Russell: While still violent?

10,621. *Chairman:* Is not that an appalling idea? Supposing the unhappy wife was at home, and the policeman had taken this person, do you suggest he should be brought in an ambulance to his own private home, and the door opened by the maid or the wife, and the first thing that happens is that the lunatic is thrust into the house?—If you are dealing with an ambulance case, he must unquestionably go to the infirmary.

10,622. I think it would be better, would it not, to get him taken to an observation ward of an asylum at once—one of those provisional wards we are contemplating?

27 January, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

Earl Russell: We can do that equally with the pauper, because the asylum is a rate-aided place, and it could supply the necessary clothes and so on.

10,623. *Chairman:* Yes.—Mr. Stewart points out to me that under the common law right of arrest he may be taken to any place suitable to his means, not necessarily to the asylum; there are other places; and then the process we shall come to presently would be set in motion by the sworn information of the man who arrests him.

10,624. *Earl Russell:* Do you mean a licensed house?—No, I did not contemplate a licensed house. It is a question of keeping him somewhere until the process of the law can be set in operation. I think the practical difficulties of a case of that sort are rather disposed of by the facility of communication nowadays. You can get in touch with his people pretty quickly. You might keep him at the police station.

10,625. He might go to the infirmary ward of a workhouse for twenty-four hours, if it were properly run?—Yes, that was my suggestion.

10,626. *Chairman:* Incidental to any system, your most perfect system involves interference, and an unauthorised interference, with the liberty of the subject, at least for some time. Is not that so?—I agree; for some time.

Mr. Walter Stewart: Not unauthorised, Sir. Common law right, if disorderly. The common law of England provides for that.

Chairman: I doubt if it does, because the only remedy there is the *Habeas corpus*.

Earl Russell: Anyhow, the two things are quite different. In the one case you take him to a police cell.

10,627. *Chairman:* What I am thinking of is this: before you can get any protective machinery in operation, the very nature of the disease involves that you may have to exercise a kind of control over one of your fellow beings, that you would have no right whatever to exercise in the case of a person not so afflicted?—I agree—a temporary control.

10,628. Of course, that is an infringement of the liberty of the subject?—It is an infringement which takes place every day in the case of an accident or anything else.

10,629. Exactly; with this difference, probably, that the person whose leg is broken in the street says, "Take me to a hospital," whereas the person who is insane says, "I am not going to one of your asylums"?—Then there is the case of the person who is drunk.

10,630. But he is a criminal, and he is taken up as being drunk and disorderly. It does seem as if, whatever be the scheme devised, there must be, in some cases at least, no time available for those deliberate protective measures which one would seek to devise?—No; we recognise that from the nature of the disease it must be so.

10,631. But one wants that as little of what one may call unauthorised detention should be permitted as possible?—That emergency action of that sort should be limited as closely as possible.

10,632. Yes. Of course, on the other hand, that does bring one back to this, that you may have to

have some form of emergency order?—I think so, unquestionably.

10,633. To secure time for more deliberate consideration?—Unquestionably, but if I may say so, we hope in a much less number of cases than at present. I was rather surprised to see 60 per cent., I think it was, mentioned in the evidence of the British Medical Association.

10,634. *Earl Russell:* Might I take you back to the very case we have been listening to for the last two days? Assuming it to be a fact that if Mr. H. had been left alone at Croydon he would have run into the street with a shaved head and created a disturbance, would it not have been kinder to the patient to certify him under an urgency order then, than to give him that chance?—I must say that with a man of his means the kinder thing would have been to have sent him to his flat with a couple of male attendants.

Earl Russell: But you have no right to do that.

10,635. *Chairman:* You could not do it unless he is willing?—The evidence as I have followed it —

10,636. *Earl Russell:* The evidence was that he was not willing to submit to any restraint, and that he might run out into the street and be taken up by the police. If that were the true case, was it not kinder to have an urgency order than to have let that happen?—I think I should have let him run out. I do not think that an urgency order was fully justified on that hypothesis.

10,637. I think if he were my brother, I should not?—I would rather not express an opinion. Putting this particular patient out of the question, I am not at all sure I could assent to that—namely, that because you think a man is going to do something, you are justified in signing an urgency order. We are raising a big question here. It is a matter of opinion, I think.

Chairman: Of course, we find many of the things under discussion here are matters of opinion. There is, in every system a point at which the discretion of some individual must operate. The whole question is within what limits that discretion is to be allowed to operate.

10,638. *Earl Russell:* Supposing a workman has taken a chopper and has said to his wife on two occasions that he is going to chop the children's heads off: Is she to wait until he has done it, before she signs the urgency order?—Is certification a proper remedy there?

10,639. Ought he not to be dealt with at once? I am assuming he is of unsound mind, and is not the kind thing to do, to take him to a police cell?—Threats are made by lots of people who are not of unsound mind. If he is of unsound mind, I agree that is a case for an urgency order.

10,640. *Chairman:* I do not think Mr. Parker suggests there should be no urgency orders. The question he is concerned with is that the urgency order should not be resorted to except in cases which justify it?—That is the point I was trying to make.

10,641. The urgency order is one which is designed to meet an emergency?—Yes, that is the point I was trying to make.

Chairman: I think we have reached a stage at which we might conveniently adjourn.

(The Witness withdrew.)

(Adjourned to To-morrow morning at 10.30 o'clock.)

5, OLD PALACE YARD,
WESTMINSTER, S.W.1.

EIGHTEENTH DAY.

Wednesday, 28th January, 1925.

MEMBERS PRESENT :

THE RIGHT HON. H. P. MACMILLAN, K.C. (*Chairman*).

THE EARL RUSSELL.

SIR THOMAS HUTCHISON, BART.

SIR HUMPHRY ROLLESTON, BART., K.C.B., M.D.

SIR ERNEST HILEY, K.B.E.

SIR DAVID DRUMMOND, C.B.E., M.D.

MR. N. MICKLEM, K.C.

MR. H. SNELL, M.P.

MRS. C. J. MATHEW.

MISS MADELEINE SYMONS.

MR. P. BARTER (*Secretary*).

MR. W. FAIRLEY (*Assistant Secretary*).

Mr. ROBERT MONTGOMERY BIRCH PARKER, recalled.

10,642. (*Chairman*): Mr. Parker, yesterday afternoon we had discussed with you the suggestions of your Society with regard to the treatment of voluntary patients, and you had favoured us with various suggestions as to how that might be worked out?—Yes.

10,643. I think we all recognise that the provision of some such system of treatment may well have an effect on the whole administration of the Lunacy Law, because it seems at various points to meet the difficulties which are experienced in the administration of the existing code, by providing periods of observation, and in that way possibly obviating formal certification in many cases that are at present certified. That is an important aspect of it?—Yes, subject to this, that in the case of existing mental institutions it would only be a transitory step.

10,644. We all recognise at the moment that while the ideal would be the provision of quite separate establishments, either in association with general hospitals, or possibly quite independent, taking matters as they stand at present, some improvement could be achieved by permitting voluntary patients to be received on a carefully adjusted basis in existing public institutions?—Yes; and there are, as you know, existing private philanthropic institutions; there is one for ex-service men, recently opened at Beckenham.

10,645. I think we have the general view of your Society on that aspect of the case, and I propose this morning that we should pass to the topic which you deal with next, namely, the actual process of certification as at present carried on, and the amendments which you advocate upon that system. Might we take that up now?—Yes. Might I just make this suggestion? Later on in my proof there is an attempt to get at the legal definition of "sanity." I do not know whether it would help you if you took that now, and then trace its application.

10,646. Whichever way you think is more convenient?—It is in its wrong place there.

10,647. Let us take it now if you think right. Where do you deal with it?—Page 41.

10,648. Let us just take up that before we go into the procedure of certification. Now I gather that

you have views upon the question of the definition of insanity which you wish to put before us?—Yes. I have endeavoured to extract from the Act, as we read it, three standards, as I call them, of insanity which seem to be set up under the Act. There is, first of all, the standard under inquisition, or its survival from inquisition, where a person is of unsound mind, and is incapable of managing himself and his affairs.

10,649. We will just take the references; it will be useful to have a note?—Section 90, sub-section (1); Section 94, sub-section (1); Section 95; and Section 98, sub-section (1); with the reservation in Section 98 (2), which perhaps I had better read.

10,650. Yes?—"If upon such inquisition it appears that the alleged lunatic is of unsound mind, so as to be incapable of managing his affairs, but that he is capable of managing himself, and is not dangerous to himself or to others, it may be so specially found and certified."

10,651. Now that is one of the statutory standards. There are others, are there not?—There are others which seem to be set up under the proceedings by petition, and other proceedings which are called summary proceedings which do not require the intervention of urgency orders.

10,652. I think it will be quite useful if we collect together the various phrases which have been used?—The general standard (I have not attempted to quote it with all its limitations) is that a person is "a lunatic," which is defined as "of unsound mind"—that is Section 4, sub-section (1). Then the next reference is Section 13—that is the summary reception order—sub-section (1). The next reference is Section 14, sub-section (1)—that is the notice to be given of a pauper lunatic who ought to be sent to an asylum by a relieving officer. The next is Section 15, sub-section (1), a lunatic wandering at large. Then for the purposes of the reception order you seem to get an additional standard introduced, viz.:—that he is not only a lunatic but that he is a proper person to be detained.

10,653. Yes. The words "a proper person to be detained" are contained in certain of the sections also?—Section 13, sub-section (3), Section 16 and

28 January, 1925.]

MR. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

Section 23 (2). That is the reception order by two Commissioners. What I would like to emphasise there is this, that apparently the judicial authority finds something a little different to what the doctor finds, he finds he is a proper person to be detained. Those sections I have quoted are all sections in which the judicial authority is operating.

Earl Russell: Do the words "a proper person to be detained" not come in the form of the medical certificate?

10,654. *Chairman*: They do, I think. The phrase there is, "proper person to be taken charge of and detained under care and treatment." That is the phrase used in Form 8?—Yes, I see that. So that it comes to this, that the form does take us a little further than the terms of the Statute.

10,655. And again a slightly varying phraseology; it is not "a proper person to be detained," but "a proper person to be taken charge of and detained under care and treatment." We might add that to your collection of phrases used in the Statute?—Yes. Then we pass to the third standard, which is, broadly speaking, "the welfare of the person, or the public safety," and that is primarily set up to justify summary detention. You will find that in Section 11 (1), which is the ordinary form of urgency order, and you find it again in Section 20, and again in Section 21, sub-section (1). Now, Sir, those sections provide periods respectively of seven, three and 14 days. It is perhaps convenient to note that, and then when those periods have been in operation, the other process comes into operation. In fact, this welfare of the person and public safety is operated to justify the urgency detention, and seems to stop, having served its purpose. The magistrate then comes in if he is invoked, and applies the other standards, presumably. Then that limitation (though it is not very clear, it is, perhaps, worth mentioning) seems to be set up again by the Statute when it is considering the discharge of patients.

10,656. The other end of the history?—Yes. It is not quite so clear there, but I think, perhaps, it is worth referring to Section 49—that is, the two medical men, "Any person may apply to have the patient examined."

10,657. The standard there is, "without risk of injury to himself or the public"?—Yes. It is slightly different in phraseology, but I suggest it is rather the same in substance. Then Section 74 is the next. That is the medical superintendent's veto on discharge, and he may exercise that veto if he certifies in writing that the patient "is dangerous and unfit to be at large." Then the last one that I have noted is Section 79, the discharge of a patient on the application of his relatives or friends. There the necessary conditions are much wider, but it is in this form that he shall be properly taken care of and "prevented from doing injury to himself or others." It is the same in substance, but rather different in phraseology.

10,658. Have you any observation on that diversity of terminology?—We cannot help suggesting that it is a most confusing terminology, and, as far as one can see, unnecessary; and that the standard required for reception should also be that required for discharge. It is a logical conclusion. I might say that where the magistrate interferes and sets up a standard of unsound mind which justifies him in committing, we are not at all satisfied that the medical superintendent exercises anything like the same standard in discharging. We think that the medical view of what constitutes sanity is infinitely stricter than that of a magistrate, or what I might call the jury, and we think that that is hardly logical.

10,659. There is a difficulty there which some of the medical witnesses have emphasised. Let us assume the case is one proper for detention: everything is in order, and everyone would agree that the patient is a proper subject for a detention order. He is an inmate of an institution for some time, and fortunately his case is improving. Now there is a

practical difficulty there, which seems rather to differentiate, from one point of view at least, the discharge process from the admission process, because the exact moment of convalescence is a very difficult thing to define. The man is for the moment *ex hypothesi* in the hands of a doctor, and the doctor may think: "Well, this patient is on the high road to recovery; I really could not say at this moment, if I were asked *de novo* to consider the case, whether it was a case proper for detention. On the other hand, I could say, looking at the case medically, that to send the patient away at this stage of his convalescence might be very detrimental to him." It is a very difficult question?—It is; and we think that that is a question which a medical man ought not to be asked to decide. The risk of deciding it is so great that one has to recognise that he must defer his decision until he is certain; just as it is difficult to decide, it is equally difficult to be certain. Somebody has got to take the risk.

10,660. It seems to me that the process of recovery is not a process in which you can say that at one moment the man has completely recovered and the previous moment he was detainable. Then one feels there is this: that the only person who can really pronounce that the convalescence has reached a stage when the patient can go back to the world and face it again is the doctor; it is so eminently a medical question. I cannot quite imagine a magistrate deciding the moment when one is convalescent from any ailment?—There is the alternative which the statute provides under Section 55. When we come to deal with that, we shall have to make some comments upon it. The statute did contemplate that very practical test: let him out and see.

10,661. That is a very useful point. I am only putting this criticism to you: whether one can say that the convalescent stage, which is really what you have in mind here, is precisely the same and should be judged in precisely the same way as the admission stage. I see the logical point. You may say: If for his admission he requires a magistrate's intervention, equally you may say that the person discharging should be the magistrate. I see the logical force of that, but I am thinking of it a little more practically for the moment, and I do see a medical difficulty there.

10,662. *Earl Russell*: He is, in practice, in rate-aided institutions; there is a public authority there—namely, the visiting committee, they are the discharging authority. You do have the public intervening, or somebody representing them?—Yes, and I am reminded that Dr. Lewis dealt with this point. It is in Mr. Stewart's note. "I do not think that the onus of detention should be put upon the medical superintendent. I welcome the intervention of the legal or judicial element. My view is that the cases should be passed in review by the judicial authority which originally certified."

Sir David Drummond: Would the medical superintendent not be bound to take notice of what he would conceive as the prognosis of the case; that would enter into it very forcibly? That is to say, he would not discharge the patient, though he might think him at the time practically recovered, if he thought there was the liability of a relapse at an early period.

10,663. *Chairman*: Yes, I have always felt this to be a very difficult part of our investigation, because again thinking of the patient's welfare, which is what one ought to think of, the doctor and indeed the visiting committee, are both faced with this dilemma: they have no legal right to detain a man a moment beyond the time at which he is mentally sane. That is the technical position?—Quite.

10,664. And if these matters were susceptible of precise definition and ascertainment there would be no difficulty. The real difficulty in this chapter of the law is that that moment at which (in the interest of the patient) his discharge can be effected is a very difficult moment to define. I mean even if you are to try it out with all the apparatus of a Judge and a jury. I can imagine Judges or any tribunals

28 January, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

taking very different views as to the propriety of discharging a particular case. One wants a safeguard there, but I commend to your consideration the practical difficulty of the case, having regard to this: suppose we all agreed that he was sane; we saw the gentleman as a jury and said, "Now this person is in our opinion sane; he has recovered, but we are equally satisfied that although recovered, and therefore no longer detainable, the worst possible thing for him at this stage of his recovery would be to send him out." In every other illness there is a period in which people say: "He has quite recovered, but he requires another month's rest before he can get back to his ordinary life." There is that difficulty there. If you were to restore the person at once to ordinary life you might defeat the whole purpose of his treatment?—I quite realise that, but if I may say so, that seems to me a very dangerous theory to admit, that though a patient is sane, because it is to his general advantage that he should have another month's restriction, therefore he should be kept there.

10,665. I should agree with you at once; in fact it would be illegal at the present moment?—It would, and that is what in fact is continually happening.

10,666. I say that would be illegal, and is illegal at the present moment; but I am envisaging the practical difficulties that arise, and wondering what the solution is. One solution put forward was, that the patient at that stage should become a voluntary boarder, that is to say, a patient who may leave if he wishes, and should pass out of the category of a legally detainable patient into that of a voluntary patient. That would be one way?—Quite.

10,667. The other one you were suggesting just now, the utilisation of Section 55, the parole system, is excellent; but then again remember, would not even that involve an infringement of the law, because the patient when on parole is still legally detained and subject to a legal *nexus* which, in your view, and I rather think in my view also, would be illegal. If he were sent out on parole really recovered, the *nexus* should disappear there?—Yes.

10,668. The parole system does not quite meet this difficulty. How are we to deal with the case of a patient in process of recovery, who has not reached the state of health in which it would be fair to restore him to the strain of ordinary life? He must have an intervening period of complete convalescence. What are we to do with that case, in your view?—We submit this that, first of all, we quite recognise that the logical test is not the only one; there must be a practical test behind it, and we say the first practical test is that you should reintroduce the civil element to confer with the doctor and reach a conclusion. Though I quite appreciate the difficulty of what you are going to do. One possibility would be an extension of these After Care Associations—that seems a distinct line of advance.

10,669. *Earl Russell*: You have all the difficulty there, of course, of losing the rate-aided contribution, unless you change the system?—Would you, under Section 55?

10,670. Not while he is on trial?—I did touch on this in my proof. If it ever comes about that people who serve long periods in asylums and work there, are allowed to be paid for it, which is one of the suggestions we are going to make, I think you might get an accumulating fund there in an individual case, which would be applicable to the cost of some after-care treatment.

10,671. *Chairman*: That would only deal with some cases, of course?—I quite appreciate that.

10,672. *Earl Russell*: I want to ask you what would you do about it yourself if you were the honest and well-meaning superintendent of an asylum who, after a great deal of difficulty, had a rather bad case practically recovered, but you knew perfectly well as a doctor if you sent him home it would do him great harm and possibly cause a relapse. What would you feel about it yourself?—I should feel this that, first of

all, I should certainly give the patient freedom, as the Chairman suggested, make him a voluntary boarder. That would be a mental tonic to him, I should think. Secondly, I recognise that before you could send him out on trial you have to ascertain what his home conditions are, and they may be quite unsuitable.

10,673. And if they were, of course, it would be bad for the patient?—And if they were, the only proper step there is to send him back to the infirmary, if he is a pauper or dependent upon the rates.

10,674. Where he would be probably less well treated than in the asylum?—We hope that state of things will not continue.

10,675. Less well fed?—I am not even sure about that.

10,676. *Chairman*: Another great drawback would arise there—we are taking Lord Russell's case: imagine transferring the patient from the care of the very medical attendant who has achieved the cure to the care of a workhouse doctor who has not known the case at all, and placing him in surroundings which were, we shall assume, less suitable, with possibly the cessation of the treatment, whatever it was he was receiving, and the change into a new environment just at the critical stage of recovery—would not that be rather a menace to your patient? Supposing one were recovering and feeling restored, feeling a new outlook on life and feeling that one is getting better, then to be told: "Now we cannot keep you any longer." Let us assume you have confidence in the doctor, that you have been getting on very well, you liked your surroundings, and all the rest of it, and you were at the moment in a condition when you could no longer be a certifiable patient, and yet, undoubtedly, for your own welfare, a fortnight, or a month, or two months, might be necessary to complete your convalescence so as to enable you to return to ordinary life; I do not look with pleasure at the idea of this patient being sent to a workhouse infirmary?—In that case, if he has confidence in his doctor, it is completely covered if you provide that he may become a voluntary boarder.

10,677. *Earl Russell*: We know perfectly well that many working men, after illness, have to go back to work much sooner than a doctor would like them to. It is not impossible that they should go back to work, it does not kill them, but, in fact, it is a bad thing for them to do. In the patient's interests you do not want to send him out into an unfriendly world?—When the patient has reached that stage of cure, I think the patient will recognise that, and, as far as one reads the proofs, they do recognise it in certain cases. The medical superintendents have said so; and they do not seem to raise any objection to staying another month.

10,678. *Chairman*: In the case we are putting, the patient is sane?—Quite; he is able to judge, and a sympathetic medical superintendent will point all that out to him.

10,679. *Earl Russell*: You mean you would like the medical superintendent to say to him: "You are free, but if you take my advice you will stop here another month"?—Yes.

Chairman: Yes, that seems very much to the purpose.

Sir David Drummond: Are we to understand that Mr. Parker wishes the process of discharge to be set in motion from the time the medical superintendent regards him as no longer certifiable?

Chairman: I think not. He does not wish the medical superintendent to be the person who says he has now recovered—and we are assuming that, whether by the medical superintendent or some other machinery, it has been decided that he has recovered; then this other point arises.

Witness: Yes.

10,680. *Sir David Drummond*: A long time before the patient has recovered he may be in the position that he is not any longer certifiable—if he were starting *de novo*?—I recognise there is that period, and we say the responsibility or the difficulty in

28 January, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

arriving at a decision is so great that we think that the outside authority, the judicial authority or visiting committee, should come in and collaborate with the doctor in that decision, to relieve him of the onus of reaching such an important decision.

10,681. From the moment that he is regarded as no longer certifiable?—That seems to us to be a very difficult question of fact. We suggest that the statute does, in fact, lay down that that decision shall be arrived at partly by the visiting committee, undoubtedly.

10,682. *Chairman*: You are not content, I take it, for the visiting committee as a body to adjudicate upon this matter, partly because, in experience, you find that the visiting committee take their cue from the medical superintendent?—Quite. I think the great bulk of our patients are very definite on that point—that the details of their case are never gone into with the visiting committee. Sometimes they are called before the visiting committee, but only for the purpose of discharge.

10,683. And also a point arises in this way: I gather you say, and, indeed, there must be some foundation for it, that the cases appropriate for discharge are brought to the cognisance of the visiting committee by the medical superintendent, and therefore the burden is upon the medical superintendent to initiate the proceedings?—Yes. We are not at all sure really that, in a great many cases, the visiting committee does function in that respect. In fact, I could show you returns taken from the Board of Control Report where they have not met.

10,684. That is the trouble I mentioned yesterday, that when you delegate things to an authority, you may not have an efficient authority?—We say there is only one proper controlling authority to introduce, and that is public opinion.

Earl Russell: Even if efficient, a visiting committee could hardly know enough to initiate discharges in going round the asylums.

Chairman: Yes. I think we might defer this a little, because Mr. Parker deals with this on the question of detention. It only applies at this point because Mr. Parker assimilated the stage of discharge to the stage of admission, and suggested that what was appropriate at the stage of admission would be equally appropriate at the stage of discharge; and I was only putting to Mr. Parker some considerations which seemed to make the stage of discharge different in character from the stage of admission.

Witness: Yes. Mr. Stewart points out to me that, in the case of a private patient, Section 72 says this: "A private patient detained in an institution for lunatics or under care as a single patient, shall be discharged if the person on whose petition the reception order was made by writing under his hand so directs."

10,685. Unless there is a barring certificate?—Yes. That is in very general terms. That is a different class of case.

10,686. But again the whole matter is open to us including Section 72, whether that is appropriate?—Quite.

10,687. *Earl Russell*: It looks rather there as if the private patient was regarded as the prisoner of the petitioner rather than as the prisoner of the institution. Surely, the visiting committee stands in the same position as the petitioner. They can also discharge them?—Yes, in the next section, Section 73.

Chairman: Just take another class of case which is difficult. We know there are cases of what is called "recurrent mania," that is to say, you have a person who is very bad, and then has intervals in which you and I will agree the man is perfectly sane—not a certifiable person at all. Then you have a recurrence of it again. I have no doubt that there are cases in our institutions of persons who are the unhappy victims of that most distressing malady, recurrent mania, of whom on a particular day

you and I would say, "That man is perfectly sane—what is he doing here?" The answer is, "Three days ago he was in a complete frenzy," and probably in three weeks to come he would be in the same condition. How are we to deal with that? Because at the moment, in my opinion, he really would not be a certifiable person, but, of course, to let him out would be a most dangerous thing, because he is a person of unsound mind. He is suffering from a disease, namely, recurrent mania.

10,688. *Earl Russell*: Of course a doctor would not say he was a sane person?—No. I have another case in mind. It is the case of a gentleman now who has been in seven asylums off and on, sometimes at intervals of two or three years, sometimes at intervals of six months, but he is doing perfectly useful work in between. We could call him, but perhaps you would take the evidence from me. He is at present in employment. In that case it is rather curious. One of the asylums he was in recently he could not get out of; but quite deliberately he arranged for a transfer to another institution, where he was told the conditions would be much easier, so he got himself transferred with the object of being discharged, and in due course he was discharged. His view is, if he had stopped in the first institution, I will not say he would never have got out, but it would have been much more difficult, and that is not an isolated case. The patients know that the standard of discharge varies very much in different institutions; so in practice it must depend upon the medical superintendent.

10,689. *Sir Humphry Rolleston*: I just want to make the point which perhaps Mr. Parker rather anticipated, that the real desire is to protect the individual against any lapse of efficiency on the part of the medical superintendent. Is it not better to have an outside person who will consult with the medical superintendent, and, so to speak, be the friend of the individual?—We consider it is a point that requires two or even more brains on it.

10,690. Where is he going to get his information from?—From the patient primarily; from the patient's friends, who, we are told, and it is so, I think, have numerous chances of observation; from the case book; from the doctor, and I think very often from other patients, though you might not look upon that as reliable evidence. Still there is plenty of it available—people who have really had this man under much more close observation from hour to hour than the doctor certainly.

10,691. Then with regard to the case of recurrent mania, where would he get his information as to the recurrence of these attacks?—From the case book and the Board of Control files.

10,692. It would be from the medical superintendent?—And the Board of Control, if the recurrence was over a period of years.

10,693. So that he really has to depend very largely for his evidence upon what the medical superintendent can provide?—Up to a point; we quite recognise that.

10,694. *Chairman*: I do not think Mr. Parker would suggest that the medical superintendent, if he is doing his duty, and has the case under observation, would not be the proper person to state the history of the case to this independent authority?—Not at all.

10,695. Let us follow that a little further. You have spoken on a point which I have not the least doubt is perfectly sound, namely, that the discharge process may vary in different institutions. What you are concerned with is this, that you may have a case in which the medical superintendent is over cautious, having regard to the consequences, which of course are very serious to him, if a patient is discharged and then goes and commits suicide. There might be very serious reflections on the medical superintendent for having advised the visiting committee that this case was proper for discharge. The newspapers would comment very adversely on that medical superintendent for having allowed this

28 January, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

person out. Your suggestion is that the medical superintendent should not have the sole responsibility in such a case, but that some independent judgment should be brought to bear upon it?—We think in cases of extreme difficulty that the intervention of a judicial authority would help. It would disarm just that type of criticism which you suggest.

10,696. I am not so much impressed, at least under the present system, with the value of the justice's intervention as perhaps I should be?—As we go through perhaps we shall have other points at which the justice may be of use.

10,697. *Earl Russell*: Might I ask you if you know much about the actual practice in rate-aided asylums now?—No, not individually.

10,698. Does this in fact happen: the visiting committee frequently go through the wards and quite often patients say they are wrongfully detained and ask to get out, and it does happen that, if they produce any impression of apparent sanity, the member of the visiting committee who has been spoken to does look up the case book and talk to the medical superintendent about it, and he serves to some extent the watch-dog purpose you are suggesting?—We know that that happens, but we should like to know how often it happens.

Earl Russell: That is, I think, a sound comment.

10,699. *Chairman*: One of the real difficulties that surrounds this is that the worst cases are the cases which are most insistent on their release?—Quite.

10,700. And I think any of us who have visited these institutions and have spoken to patients ourselves have found that the most insistent case is generally a case in which you can have no possible doubt—which even we could certify and could appreciate was a case proper for detention. Do not think one is the least critical of your points. It is just of the essence of the points that your Society is so interested in?—Quite. Of course we feel we are trying to put the patient's point of view.

10,701. I confess that that is in my mind the whole time, as you can see from the trend of my examination.

Earl Russell: That is the very point we are looking at.

10,702. *Chairman*: Yes. In that we are entirely at one, I hope?—I hope so.

10,703. Just to complete your citation, you have given us the various formulæ that are used in the statutes to describe the insane person, but I think you also have another criterion to bring before us which is mentioned in the Report of 1908?—Yes, paragraph 557. Terminology was discussed at some length. "Of these words, we have chosen 'of unsound mind' as the most suitable to supersede the word 'lunatic'; and our definition of it is a 'person who requires care and control owing to disorder of the mind and is consequently incapable of managing himself or his affairs.'"

10,704. Now that definition you have a comment upon, have you not?—Yes. The comment is on page 42.

10,705. I think your comment is that it is too vague?—Yes, our comment is that it is too vague a term by itself, and in the hands of a newly qualified practitioner of course it leaves room for all sorts of interpretations. We submit in that connection that conduct really is the test, and that it is the test applied in this definition, or one of the tests. Perhaps I might just draw your attention in this connection to the definition proposed by the British Medical Association.

10,706. Please do?—That, I think, is in paragraph 16, and reads as follows: "Persons of unsound mind means persons who by reason of mental disorder may properly be taken charge of and detained for care and treatment." We do suggest that that word "properly" is rather begging the question; it seems to us it might cover almost anything.

10,707. *Mr. Micklem*: What would you insert?—The other definition is "consequently incapable of managing himself and his affairs." It does set up

a definite standard. That is the one recommended by the Report of 1908.

10,708. *Earl Russell*: Does it not occur to you that a man who commits a murder may be described as quite capable of managing himself?—And his affairs.

Earl Russell: Certainly.

10,709. *Chairman*: The British Medical Association's suggested definition is "'Persons of unsound mind' means persons who by reason of mental disorder may properly be taken charge of and detained for care and treatment." One notices as a feature of all these attempted definitions, that they define the person by the steps which are necessary to deal with him, they define him by the consequences of his condition rather than by the attributes of his condition which entail those consequences. I think all are agreed that for the purposes of legislation a pathological definition would be impossible and undesirable, therefore the criterion must be some criterion which is based upon his suitability for treatment. It must be a criterion based, if you please, upon his conduct or his ability, which requires that he should be subjected to this particular form of treatment involving detention?—Quite.

10,710. It must be, I am afraid, defined by its consequences, rather than by its attributes. I do not see how we can do it otherwise?—We only want to submit generally that the second definition I have read is really very vague.

10,711. *Earl Russell*: But then the courts would have to interpret the word "properly" or some similar word?—Yes, I know.

10,712. What a jury would think proper?—We should like to lay down some guide to juries as to what was the standard to be applied.

10,713. *Chairman*: Of course implicit in any of these phrases there is a standard, because when you say "capable of managing his own affairs" that must mean capable of managing his affairs as a reasonable man manages his affairs. A reasonable man is a familiar figure in the Law Courts, but he is not always recognisable as the same person. There is that implication obviously in all these attempts to define a standard?—We are suggesting they should be explicit up to a point, if possible, but how far you can carry that, of course, it is not for us to say, but the Commission of 1908 tried to make it more explicit, I submit, and that is the general view we put before you.

10,714. Certainly the avoidance of varying terms to describe the condition of the patient seems desirable. A uniform terminology would be more appropriate. One knows that as a principle of legislation it is undesirable to pass from one formula to another formula in the course of the same Act, because that leads to a suggestion that something different is meant at the different stages, whereas you point to the desirability that whatever be the formula adopted it should be uniform and consistently applied throughout the statute?—Uniform; and we say there that the statute made very useful standards—the "capacity to manage himself" and "safety to the public."

10,715. Would you add "patient's welfare"?—Yes, if it is adjudicated on. The difficulty we feel is that the medical view of the patient's welfare is often and must be quite different from that of the man in the street, and also, I think, of the Law Courts.

10,716. *Earl Russell*: Not always, I hope?—I say it not in a sense of criticism. I think they are going for an ideal of perfection or of cure which is not attainable. We think it is a very serious thing to interfere with the liberty of the subject just because you think you can turn him out to a standard.

10,717. *Chairman*: The doctor might think it well for the patient to be detained, but the law might say it is well for him, but it is not legal for him to be detained?—Quite. In physical illnesses doctors often give one advice which is absolutely sound, but it does not follow one takes it. You take a risk with your eyes open.

28 January, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

10,718. Of course the risks here are rather of a graver character than the risk one takes when one goes out with a bad cold?—Quite.

10,719. Mr. Micklem: Is not your definition practically the description which the 1890 Act takes?—It is. We say that that gives you two very useful descriptions, but we are not satisfied that they are at present applied. They are scattered about through all the sections, and we think it would be valuable to extract them and put them together as a definite definition of "unsound mind."

10,720. Chairman: I take Mr. Parker's point perfectly. He examines a statute and finds in different sections different criteria are set up, and his suggestion is that it would be desirable to have a uniform criterion by which cases shall be judged, not only on admission, but also for the purposes of discharge.—That covers the whole point.

10,721. Now, Mr. Parker, we will turn from that matter to the question of the methods of certification. I think you had already told us yesterday that your Society advocate the unification of the methods, that is to say, that all cases should be dealt with by one and the same form of procedure?—Yes, that is so.

10,722. And that a recommendation should be made that the existing diversity of procedure should be abolished?—As far as possible.

10,723. And in particular you advocate that the existing distinction of procedure in the case of the private patient, on the one hand, and the pauper patient, on the other hand, should be done away with?—We think they are out of date.

10,724. There was a proposal, was there not, to that effect in the Report of 1908?—There was. It is section 720—shall I read that section?

10,725. If you please, yes.—"Generally in the procedure of certification we adopt the lines of the Lunacy Act of 1890, but in the case of reception orders on petition, we recommend the following changes: The principle of these alterations is to adopt the system in force under the Lunacy Act and extend it to all classes of mentally defective persons as defined in Recommendation IV without regard to the question whether they are 'paupers' or not." That is the point.

10,726. That recommendation has, of course, not been given effect to in the legislation since; we are still under the Act of 1890, which is the subject of comment in that paragraph.—That is so.

10,727. Now you set out the existing methods of procedure which you have classified under six heads?—Yes. I think they have been very fully dealt with in evidence.

10,728. You very conveniently group them all, but I think we have had evidence upon them all from the persons who administer the Act. I hardly think we need put that in, but your comment is that at present putting aside reception after inquisition, there appear to be no less than eight methods by which a lunatic may be certified?—Quite, and apart from the obvious comment we feel that most patients really do not know, and never will know quite, how they have been certified. It is so complicated that it requires rather a highly trained mind to follow it.

10,729. And I think historically you point to this, that this diversity of method is probably an inheritance from the various attempts that were made in the earlier Acts to deal with different cases?—As I say, "probably." I have not had time to trace it out, but I think it is so.

10,730. It is very likely so?—Yes.

10,731. Then, coming to a large matter of principle, I understand the view of your Society is that the certifying authority—I do not mean the medical certifying authority, but the legal certifying authority—should exercise a judicial function in contradistinction to an administrative function?—That is so. We think it was clearly intended in the case of petition, and that it is not so clear (I believe it is a matter of great discussion in the Law Courts), as to

what was intended in the other cases, and what the law is at the moment.

10,732. The distinction which exists at present between the ordinary justice who is invoked in the pauper case, and the justice who is clothed with the name of a judicial authority strikes one as rather remarkable. In the one case a selection is made among the justices, and certain of them, it may be all of them, are described as the "judicial authority," which is a much more impressive phrase than the ordinary "justice of the peace." The justice of the peace, pure and simple, if I may so describe him, is regarded as adequate to certify the pauper or rate-aided patient, but for the purpose of certifying the private patient you must have a justice of the peace who has the more grandiloquent designation of a "judicial authority."—Quite.

10,733. After all he is just a justice of the peace, whatever you call him.—That is all in many cases.

10,734. Of course, he may be a selected justice of the peace, and there may be a point there that a certain gentleman who may be interested in this work, or desirous of engaging in it, or has special attributes for it, might be selected. At least there is an opening to the justices of the peace to select persons suitable to the task?—Yes. There is the converse to that which I might put. We have a very distinct feeling that in some institutions there is a justice, often of considerable age, who comes in quite regularly and gets very used to certifying. Obviously that may be an advantage, or it may be a disadvantage.

10,735. It would certainly only be a great disadvantage if the justice came to regard the matter as a mere piece of routine?—That is the danger, we think.

10,736. On the other hand, if he were a person more alive to his duty, his experience might be an asset. Those are the two considerations?—Yes, but we do comment on the very old justices coming in. Evidence will be given before you in one particular case, and they are not isolated comments. It is a line of inquiry we cannot follow up, but I think we ought to bring it before you.

10,737. It hardly requires evidence; we can see that at once.—Quite.

10,738. Now this part of the case is one which we must obviously discuss at some considerable length, because it is very critical. I think you refer, first of all, to our predecessors' recommendations in the Report of 1908, section 726. We may just take the effect of it. Their recommendation was that the magistrate should act judicially and should see the patient?—That is so, "accords best with English feeling," is the way they phrase it. They considered it very carefully.

10,739. They evidently did. Now, in the next place, you point to the provisions of the Act of 1890, in which under Section 9 (2), the judicial authority in the exercise of the jurisdiction conferred on him, is to have the same jurisdiction and power as regards the summoning and examination of witnesses, the administration of oaths and otherwise, as if he were acting in the exercise of his ordinary jurisdiction. I take it your inference from that is that he should act judicially?—That is so. Not only was full provision made in that section, but I also came across another allusion to it which may be of interest. Section 338, sub-section (4). There is a provision there in the case of pressure of work on any one court that "the Lord Chancellor and a Secretary of State respectively may make rules to provide for preventing interference or delay in the exercise of the ordinary jurisdiction of the judges of county courts, and magistrates respectively by the transfer of petitions and notices, or otherwise as such rules may direct."

10,740. Now here we come into an interesting contact between your Society and the British Medical Association. The British Medical Association, in their evidence before us in Appendix A, have collected (but for a different purpose) the various sections of the Act in which the justice of the peace or judicial

28 January, 1925.]

MR. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

authority is referred to as being clothed with judicial powers. You remember the passage?—Quite.

10,741. Their purpose, of course, was a different one from what you have in view. Their purpose was to emphasise the judicial character of it in order that all persons taking part in the proceedings should enjoy the protection which everyone enjoys in judicial proceedings. You are looking at it from the patient's point of view?—Quite. They wish, as I understand, to pass on the responsibility, and to cover themselves against any liability for signing a certificate.

10,742. They wish to have the status of witnesses in a law court?—Quite, and we have very strong views on that, of course, antagonistic.

Chairman: You must be consistent, you know, Mr. Parker.

10,743. *Earl Russell*: Even if it is a judicial enquiry on oath, in public?—We feel this, that the signing of a certificate is such a serious thing, owing to the purpose for which it is going to be used, that it is a condition precedent, quite a separate action; and we think it would be deplorable if the liability to take reasonable care was removed from the medical man, particularly so when, I understand, that is to be coupled with the provision that any medical man may exercise that power fresh from his Varsity; having gone through his 24 lectures, he is to be allowed to go and exercise this power without any limitation on his liability, as we understand the proposal.

10,744. *Chairman*: That is another topic, but for the moment I was pointing to this, that if we are to go the whole length, and if the proceedings are to be judicial and the doctor is to be relegated to the position of a witness rather than a certifier, then of course, he would have to have the same immunity as any other witness has?—We do not quite suggest that; we suggest that he shall make a report, which is the important document, and so set the law in motion.

10,745. We have already had a collection of the sections of the statute pointing to the judicial character of the procedure as contemplated in the Act, though for a different purpose. Now your comment, I take it, generally upon the existing procedure, is that the intervention of the judicial authority or justice, as the case may be, is not as at present administered an adequate safeguard?—That is so.

10,746. And that for the reason, I take it, that the justices' duties are at least liable to be interpreted as purely administrative and tend to become perfunctory or routine?—In practice; and we further submit that in law there is some want of knowledge as to what the position is. I do not know whether you would like me to refer to the Everett case, just to have it on the note?

10,747. Certainly.—The Everett case is reported in 1920, 3 King's Bench Division, at page 203.

10,748. Then it went also to the House of Lords?—(*Mr. Walter Stewart*): Yes. This is the dissentient judgment of Lord Justice Atkin we are referring to. He was in a minority in the Court of Appeal.

10,749. What happened in the House of Lords?—(*Mr. Parker*): I have not looked it up, but I understand in the House of Lords the points raised in the Court of Appeal were not dealt with. Lords Justices Bankes, Scrutton and Atkin were sitting in that case, and I can refer you to the passages if you like, but the first two would not decide the point at all whether the magistrate in that particular case acted in a judicial or administrative capacity. Then Lord Justice Atkin gave a considered judgment of very great interest in which he gave it as his view that the magistrate was acting in an administrative capacity.

10,750. *Mr. Micklem*: Do you mean in that particular case, or under the Act?—That was the particular case in which these questions cropped up.

10,751. *Chairman*: On this matter is the decision of Lord Justice Atkin this, that the law prescribed that the justice shall act in an administrative capacity, on his reading of the law, or did he merely say that this particular justice who functioned in this

particular case chose to act in an administrative capacity, whatever be his duty?—Perhaps I had better read you the passage, because it was a very involved judgment.

10,752. Just read the passage from Lord Justice Atkin?—The passage is: "I come to the conclusion that the justice of the peace, acting under Section 16 of the Lunacy Act, 1890, is acting as an administrator and not as a judge."

10,753. That is a general pronouncement?—Yes. (*Mr. Walter Stewart*): The other judges took the other view. (*Mr. Parker*): He was in a minority, and that is the position of the law to-day, I believe. (*Mr. Walter Stewart*): That page 203 is his criticism in which he argues that the justice must be acting in an administrative capacity.

10,754. *Mr. Micklem*: Did the other Lords Justices agree?—(*Mr. Walter Stewart*): No, they did not; they held that he was acting judicially.

10,755. *Earl Russell*: As far as I understand they did not deal with the point?—(*Mr. Parker*): They would not deal with it. Lord Justice Bankes dealt with it in this way: "It becomes unnecessary therefore to express any opinion whether the respondent Griffiths when acting under Section 16 was acting in a judicial or in an administrative capacity."

10,756. *Earl Russell*: Do I understand that this point was not raised in the House of Lords?—I understand not—not decided.

Mr. Micklem: They do not seem to differ; they simply said they would not express an opinion.

Chairman: That is quite a different point from saying that Lords Justices Bankes and Scrutton differed from Lord Justice Atkin.

Witness: I do not think I said they differed.

10,757. *Chairman*: Now that is a comment upon the existing machinery. The justice of the peace, or the judicial authority at any rate, according to the view of one eminent Judge is acting in an administrative capacity and not in a judicial capacity. Whether that is sound or not, of course one cannot say, but the view expressed there is entitled of course to great weight. It is at that point, I understand, that you join issue with the existing legislation, because if Lord Justice Atkin's view is correct, your opinion is that the functionary should not act in an administrative capacity, but should act in a judicial capacity and that should be made plain to him on the face of the Act?—Yes.

10,758. That it should be expressly so enacted?—So enacted.

10,759. Now follow that a little further. At the moment the justice of the peace or judicial authority has, in the ordinary case, two means of forming an opinion, whether he forms it administratively or judicially. He has the means of examining two medical certificates or one?—Yes.

10,760. And he has the duty in the one case, and the right in the other, of seeing the actual person?—Or not seeing him.

10,761. I put it in that way: the option in the one case, and the duty in the other, of actually seeing the patient?—Yes.

10,762. He is furnished by the statute with further powers of investigation if he chooses to utilise them; but may we take it that the great majority of cases (this is the tenor of the evidence we have had) are disposed of on the medical certificate or certificates presented to the justice, with the personal presence of the patient in the one case, and with the option of the patient's presence in the other case?—Quite.

10,763. And that represents the extent of the material that in the ordinary case is before the justice, unless he chooses to avail himself of the further powers that are open to him?—Quite.

10,764. That leaves it to the discretion of the justice as to whether or not he will resort to those further powers of enquiry?—Absolutely, at present.

10,765. Surely he must or ought to exercise some judicial mind on the matter, if he is even to consider the question whether he ought or ought not to resort to those further powers of investigation. That involves a certain judicial appraisalment of the

28 January, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

situation?—Quite. I must say we think it is almost amazing to hear the evidence which has been given as to the way in which many justices do function; and further than that we are continually getting cases in which *prima facie* one would have thought a justice would have investigated, but he has elected not to see the patient.

10,766. Now what are the main recommendations which you have to make to us on this very important branch of the law?—On the basis that there is to be a judicial procedure, we suggest that it must follow the procedure in other similar cases. We suggest that it should start at any rate with a sworn information.

10,767. *Earl Russell*: By the petitioner, or by some person representing the petitioner?—By whoever is seeking to set the law in motion, as a necessary step precedent to setting the law in motion.

10,768. *Chairman*: It is curious again that in certain cases there must be sworn information by the relieving officer?—That is so. I tried to emphasise that.

10,769. You point to this that there already exists provision in a certain class of cases for the initiation of the proceedings to be upon a sworn statement?—That is so, in Section 13. But in Section 14 no oath is necessary.

10,770. Now on that do you attach great importance to an oath. I am not asking you that question in any personal sense, and you are not on oath at this moment, as you know; but I am asking you rather from the point of view of a sanction: do you think that a person would realise more fully the solemnity of the occasion if the information setting this procedure in motion were required to be on oath?—I think undoubtedly so; it is the most serious form of allegation you could make almost that anybody is insane, and if one is entitled to go and make that statement lightly and set the law in motion, I think it would be a deplorable state of things.

10,771. Of course, we are taking just now the documents at the very inception of the case which emanate from a relative or a relieving officer; these are not sworn statements that the person is of unsound mind, because the relative, of course, is not capable of forming a judgment upon that, nor is the relieving officer a competent person to do that. You rather mean that the facts upon which they think the case is proper to be dealt with should be stated on oath?—That is so.

10,772. The relative can only say that upon the facts he desires the case to be dealt with, and he puts forward certain facts. It is these facts you wish attested on oath?—That is so.

10,773. It really comes to this—take a concrete case, a case of a husband or wife, you would desiderate that the statement should be: "I swear that the condition of my wife is such that it ought to be considered with a view to possible detention of the case," or something of that sort?—Yes, as enabling the magistrate to judge whether it was justifiable to call in a doctor.

10,774. Of course, in all forms of procedure, whether administrative or judicial, there must be some one to initiate the proceedings?—That is so.

Earl Russell: Before you have any medical certificate at all, I understand?

10,775. *Chairman*: We are at the stage just now before the doctor has officially intervened?—That is so, and Mr. Stewart asks me to point out that it may be a constable, a relieving officer, or a health officer, but the health officer is a new suggestion, I think.

10,776. Yes, the health officer has not been suggested before, I think. But this is the stage of initiating the proceedings; and whether the proceedings be administrative or judicial, someone must set the proceedings in motion. You suggest that the person who sets the proceedings in motion, be he a relative, or be he an official, ought to do so on some form of affidavit?—That is so.

10,777. Because, in your view, that would impress upon such a person the importance of the step which he was taking?—Render it less likely to abuse.

10,778. *Earl Russell*: You mean it should go a little beyond just having a paper put before him and being told to sign at the bottom?—As Mr. Macmillan says, it would invest it with a certain solemnity.

10,779. And, of course, he has to go before some proper person to swear?—Exactly.

10,780. *Chairman*: We appreciate that, but that is only on the threshold of the proceedings?—Quite.

10,781. Suppose there is an affidavit by a person, a relative or an official who desires to initiate the proceedings: to whom, in your view, should that application be presented?—To any justice.

10,782. Any justice?—In the first instance. One is trying to cover emergency cases as well.

10,783. Let us pause there and examine it, because we must watch each step very closely. Do you favour the discontinuance of the distinction between justices who are judicial authorities, and ordinary justices?—We hope that they will all be judicial authorities.

10,784. Yes, but in the technical sense of the Act, a selected justice or any justice?—I think for this purpose of initiating proceedings it would have to be any justice.

10,785. Have you any comment, if I may ask at this stage, to make upon the suitability of the ordinary justice to discharge this function?—At this moment you are assuming that the justice who receives this information will become the adjudicating justice. That does not follow, does it?

10,786. In your view, do you think that the justice is the proper person to be the judicial authority in these matters at all? I am raising a very large point there, you see?—You are, but I am not quite clear whether you mean for the initial setting of the law in motion, or for adjudicating upon the facts later. For the first purpose I think any justice would do.

10,787. You are contemplating now the urgency order?—I am trying to cover that as well.

10,788. Of course, there is a larger question as to whether the justice of the peace, who, no doubt, ever since this form of procedure has been brought into being, has been the selected person to do it, is the most appropriate person. Perhaps I am for the moment thinking of another part of the British Isles where we do not do it by a justice of the peace at all?—The sheriff?

10,789. Yes. We have heard, and we have been rather struck by some evidence we have had, of the way in which some justices of the peace do discharge this duty at present?—Quite.

10,790. And, without in the least seeking to detract from the great services of what are commonly called the great unpaid, one must recognise that in a very large body of men you will inevitably have some less suited to the responsibilities of the duties than others?—Of course, it is a very difficult question. There is this point of view, later, when we come to consider appeals to Quarter Sessions, which we shall have to deal with—you get a check there.

10,791. Your view is, that the justice of the peace should be still the central figure in this matter, but you suggest certain safeguards which might restrict his jurisdiction?—We think any justice of the peace might function, but when we go on to the hearing, we take an opposite view.

10,792. *Earl Russell*: You do not regard this first justice as doing more than seeing that the proceedings are in order?—Seeing that there is a *prima facie* case. Purely administrative action.

10,793. *Chairman*: Now, having got that length, there has been presented to this justice of the peace an affidavit or sworn application setting the law in motion. What do you contemplate would be the next step?—That he should at once communicate with a medical practitioner to make an investigation and report.

28 January, 1925.]

MR. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

10,794. *Sir David Drummond*: Any medical practitioner or one he selects himself?—We suggest that there should be a panel. If you get a full judicial proceeding afterwards in open court, I think any medical practitioner.

10,795. In all probability the doctor who is attending the patient?—Quite.

10,796. And to that doctor the magistrate would refer the matter?—I think, on the whole, we should say any medical practitioner. We have put here a qualified practitioner, but on further information we have got we have no reason to limit it in that way at this stage.

10,797. *Earl Russell*: Anyway, you would be satisfied to leave it to the justice to do the choosing?—Certainly.

10,798. *Chairman*: The justice would, in effect, be remitting to a doctor to give him a report upon the case?—Quite.

10,799. And, presumably, he would in the ordinary case preferably select the patient's medical attendant, if he had one?—Obviously.

10,800. Now such a report having been received, if such a report was negative as to the necessity for the pronouncement of any order, in that case the proceedings will come to an end, I take it?—Yes.

10,801. *Mr. Micklem*: Would they come to an end if you are going to have a judicial enquiry into all these cases?—The only action the justice has taken up to this point is to get a medical report, and if he finds that the medical report discloses no serious facts, I take it the proceedings do not go any further.

10,802. Is that so? Where you have a sworn information that there is a case of insanity, and the first report is negative, the parties who have made the sworn information, if you are going to have a trial in each case, might like to go on?—Yes. I suppose in those circumstances they might, and you would have to proceed to a hearing.

10,803. Is not that a grave difficulty if you are going to have these proceedings in every case?—No graver than in the present case.

Earl Russell: Except that you have definitely initiated a litigation.

10,804. *Chairman*: I do not know that the case will be likely to arise frequently, because friends, who would be the applicants in the ordinary case no doubt, would have been advised by their medical attendant to take action, and the medical attendant would then give a report, and would say that the case was one in his opinion of unsound mind which should be dealt with under the Act?—Quite.

10,805. There is just that point of view that Mr. Micklem puts as one of the many difficulties. The relatives are satisfied that the case is one proper for detention—I mean they feel they cannot have the person at home any longer, family life has become impossible, and so on, and one knows how trying these cases may be. They make their perfectly *bona fide* application; the justice selects, shall we say, a very inexperienced doctor who happens to be a friend of his own—such things are not unknown?—Quite.

10,806. This young doctor says, "I think there is nothing wrong with this case; the person is not of unsound mind, at any rate." The justice receives that and dismisses the application, and the relatives are left with this patient on their hands entirely in consequence of what may be a quite inadequate medical report. What about that case?

10,807. *Mr. Micklem*: I put it a little higher than that. If you are to have a trial, in each case it must be open to both sides?—I think we are bound to agree with that, that it must proceed a step further to a hearing, and the only way I see of providing for that is to provide for a second doctor where desired; but that might be a negative one.

10,808. *Chairman*: Just pause there a moment. In the meantime while these steps are being taken, all of which take time, what is to be done with the patient? Are you contemplating that at once some form of restraint shall be available if a case requires it?—Not necessarily any more than at present under

petition. Of course there may be circumstances which justify urgency.

10,809. At present you get your restraint at once under an urgency order?—If you have an urgency order, and of course one knows the tendency is to work under that more and more. Of private patients I think the British Medical Association gave you evidence that 60 per cent. were dealt with under urgency orders.

10,810. I am not sure we are satisfied that resort to the urgency order was intended in so many cases?—We mean, of course, later on to raise that point.

10,811. Yes, I am thinking now of the patient. All this procedure is going on outside his knowledge?—Up to this point.

10,812. Naturally and necessarily so. The last thing you can do is to go to persons who are distraught and ask them what proceedings they would like taken. In this case the unhappy patient may require to be under some form of authorised restraint. With regard to the presentation of the affidavit to the justice, would that, in your opinion, justify a magistrate in at once pronouncing an order for the interim detention of the patient, before he receives a medical certificate at all?—No, surely not, except in emergency cases. We are contemplating procedure analogous to the procedure laid down in the Act by petition.

10,813. *Earl Russell*: A three-day petition?—That is urgency again.

10,814. *Chairman*: In other cases the thing can take its time?—Yes.

10,815. When I speak of the case of a person who requires restraint I am thinking of an emergency case. In an emergency case the preparation of an affidavit, the swearing of it, the presentation of it to a justice, the pronouncement of a justice's order, obtaining a remit to a medical man, obtaining the medical man's report, all that takes time, and meantime what is to happen to the patient?—Does that take more time than at present? Where is the order got from now?

10,816. The order is got now by the relatives filling up a form and a medical man giving a certificate, and you go to a justice and get your order at once?—Is not that the same procedure in rather a different way? It does not seem that the procedure in our suggestion is any more cumbersome than the present one.

Earl Russell: You do not have to do that in the case of an urgency order.

Chairman: Yes, I am wrong about that.

10,817. *Mr. Micklem*: You are going to suggest an urgency order in necessary cases to take the place of the present emergency order?—Yes, quite; we are really dealing here with the general procedure in ordinary cases.

Chairman: Let me correct myself. All that you require for an urgency order is a statement by a relative and one medical certificate. Upon that the patient may be detained.

Earl Russell: Yes, and much less than that in pauper cases: only the relieving officer's or constable's signature.

Chairman: Strictly speaking, there is not an urgency order for paupers, is there—it is another sort of order.

Earl Russell: There is an urgency detention.

Chairman: Yes, Section 20, I think. Under Section 20 the relieving officer, as Lord Russell has pointed out, can remove the patient to a workhouse, and he is kept for three days, so that at present there is some machinery whereby a person can on very short notice be put under restraint. That is where I was wrong: the magistrate need not be brought in.

Earl Russell: The constable, relieving officer, or overseer.

Chairman: Yes.

Witness: I see on Form 8, which is the usual form, there is this note, "If an urgency certificate is required, it must be added here." The urgency certificate is in Form 9.

28 January, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

10,818. *Mr. Mickleth*: I doubt whether we need trouble very much about the emergency order, because you assent to the view that in necessary cases an emergency order must be made?—Absolutely.

10,819. And the matter you are concerned with is the ultimate decision after the urgency order is made in urgency cases, and the ordinary decision in ordinary cases?—That is so. We are really contemplating the majority of cases which we say are ordinary. There will have to be an emergency procedure, as now, that procedure will at a point drop into the ordinary procedure.

Earl Russell: But I wanted to know whether your urgency order is to be upon the petition alone, or is it not to require the intervention of the justice, because that would be a change.

10,820. *Chairman*: It does not now; I misled you?—I feel great diffidence in suggesting it must require the intervention of the justice, because urgency is urgency however you deal with it. I think one must leave for real cases of emergency a very free procedure.

10,821. You do, however, suggest an alteration in the law to this extent, that the person who is using an urgency order should have attested what he states in it on oath?—Exactly, that is the alteration. He should take a definite step which will bring home to him the responsibility of his act.

10,822. Even at present the urgency order expires unless the formal order is pronounced?—Quite.

10,823. Your suggestion on the temporary expedient, that is to say, on the urgency order is, that it should proceed in solemn form supported by a sworn statement?—In that form; by introducing the justice, whatever his capacity, you do get a fresh view on the question of urgency.

10,824. *Earl Russell*: Necessarily, that sworn statement would be either before or after the arrest of the patient?—Of course one can conceive cases. You instance the man with a hatchet where the local police step in.

10,825. *Chairman*: There seems to be a kind of fringe, a margin in these cases of emergency where people must just act as they think right; use common sense, and then use law, if there is any difference between the two. Now come to where you become more critical, if I may say so. Whether an urgency order has been pronounced or not the ultimate matter, of course, is the pronouncement of the formal order?—Quite.

10,826. The urgency order may lapse because it may be recognised on all hands that nothing more need be done, and then the patient is free; but if, on the other hand, the case is one for further procedure, let us examine that further procedure now. What do you contemplate should be the next step?—We contemplate that at this point the alleged lunatic as he is, shall, either through himself, if capable, or through a representative if not capable, begin to be acquainted with the danger he is in, that is to say, the loss of his liberty and so forth.

10,827. *Earl Russell*: That is at the bottom of page 11. No. 9?—No. No. 3. "An authorised representative be available to assist the alleged lunatic, and that he be selected from a panel."

10,828. *Chairman*: Now here we are approaching the heart of the question where we wish you to help us. This authorised representative whom you contemplate is manifestly, I take it, somebody other than the relative or official who has presented the application?—Certainly—the same independent person, as we think is contemplated under petition under the present Act.

10,829. The next friend, if you please?—The next friend, yes.

10,830. Now just see there what we come against. This person, if he is one of the relatives but not the applying relative, may be just in the same interest as the applying relative, may he not?—Quite. I do not think that we necessarily contemplate a relative. We contemplate, when we talk of a panel,

people who are acquainted with the law, which is so intricate, who would be able to advise the alleged lunatic. May I deal with the panel? The suggestion is that "it shall be the duty of the Registrar of each County Court in England and Wales to keep a panel of such members of the bar and solicitors admitted to practise in their respective districts as may be willing to act as 'authorised representatives' of any alleged lunatic requiring legal aid when appearing before the judicial authority, either on the occasion of the inquiry as to whether the alleged lunatic is a proper person to be certified, or, on the inquiry hereinafter provided for, to determine whether a certified lunatic is a person fit to receive his discharge."

10,831. Now, first of all, the word "authorised" attracts my attention. Who is to authorise this representative?—The justice—the magistrate. Of course these proposals are based upon the accumulated evidence we have had, which we shall be putting before you later, that the alleged lunatic so often does not know in the very least what is happening, and never knows.

10,832. I think we know that, but the question is whether he should know?—That is the point we want to put before you, that in many cases he should know, and in other cases an independent person should act for him, because the relations are not always dependable.

10,833. *Earl Russell*: It will be the justice to whom the sworn affidavit is made, in the first instance?—Yes.

10,834. *Sir David Drummond*: Who is to determine whether the patient is to be told about this or not?—I should think this accredited representative would use his judgment.

10,835. But it is a medical question, purely a medical question, whether it would be advisable to tell the patient what these proceedings meant?—I quite realise that in certain cases it may be, but is it so in any great number of cases?

Sir David Drummond: It would be so in a very large number.

10,836. *Chairman*: I will tell you a difficulty which I have felt throughout the whole of this chapter of your case. It proceeds not unnaturally on the hypothesis that all these persons are sane persons, and that therefore they must have all the facilities for protecting their liberty that an ordinary sane person would have. The real difficulty at the root of the matter is this, that we are dealing with a person who at least may not be sane, and therefore who is not like an ordinary person, and is not in the position of giving instructions, and so on, and taking his own course. The hypothesis seems to underlie a great number of your suggestions; that one is dealing with sane persons whose rights are to be protected as ordinary sane persons' rights are protected. For such a case the code you suggest would be excellent, one sees that; but to my mind it rather loses sight of the circumstance that we are dealing here with a pathological case, with a patient, and that therefore these ordinary considerations are out of place. The point that Sir David put just now is a very striking one. Of course, if you or I were going to have a sane person put away, that person would be entitled to take all possible steps, and would do so; but when the person is not in a condition to give instructions, and is really a patient, the situation seems to me to alter completely?—Of course, we are putting forward these suggestions to try and cover the cases coming before us, and in which, whatever the mentality of the person may be, they are perfectly capable at the time of following the facts and arguing very closely. That class of case we say we must provide for. We realise there is the other class of case. In that case we try and cover the difficulty by suggesting that there should be an authorised representative, because there are many cases which are purely temporary, cases of high fever, and that sort of thing, where it may suit the relatives to get rid of the incumbrance; but where at the stage

28 January, 1925.]

MR. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

of certification we feel that other influences should be set to work.

10,837. We are on the question of whether the party most intimately concerned, the party to be confined, should in all cases himself be apprised of what may happen to him. It was put very emphatically several times in the last few days, and it is quite worth consideration. What should you say upon that, because I have great difficulty there. Of course, if a sane person were going to be detained, he must be apprised of what is to happen to him in order that he may have every opportunity of resisting possible detention?—May I perhaps suggest an analogy? It is the law still to read the Riot Act, not that it has in many cases any influence, and not that there would be any attention paid to it. Would there be an insuperable objection to taking the same formality in these cases?

10,838. I will suggest one to you for your consideration. We have been exhorted to bear the patient always in mind, and that is our desire. I could imagine nothing more distressing to a patient who is suffering acutely, with a distraught mind, unhappy, and suffering every form of mental discomfort, that some person, possibly a stranger, this authorised representative, should approach that person and say, "I have to inform you that your liberty is at stake, and that certain proceedings are about to take place in which the issue will be whether you are of unsound mind or not." Honestly that strikes me as a most inhuman proposal, if I may say so?—But what is the present procedure in so many cases? That same person is approached. They are asked whether they would not like to go for a drive. They are taken for a drive; they are shown in by a door; they hear the doors closing behind them. At one stroke you have torn up and destroyed the whole of the home connection of that person; and it seems to me quite idle, if that is the alternative, to suggest you would be exposing this person to a shock if you tell him beforehand you are going to do it.

10,839. One knows quite well that you are not always apprised, even as a sane patient, by your doctor of the issues attending the particular malady you have, and that it would be from a clinical point of view one of the most dangerous things to do it. You often try to persuade a person to come away by agreeable fictions, because those are part of the palliatives of the condition; people who are in a pathological condition are unable to bear the harshness of the facts of life. I am not so appalled at the idea that a person should say to a lunatic, "You come along with us and it will be all right for you." That might be the kindest thing to do instead of saying, "Now you are going to be taken to an asylum under section so-and-so of the Act"?—I should be content to agree, if you were going to take that patient to a place where he would go into really good surroundings.

10,840. This is the stage of procedure, and the suggestion is that there is to be some authorised third party who is now to intervene. The person is to be appointed by a justice, or some other authority, from a panel. Now is he to be brought into any personal contact with the patient?—That must depend, I agree, upon circumstances, and in a great many cases emphatically yes.

10,841. *Earl Russell*: At any rate, he must once see the patient in order to satisfy himself that a sane person is not put away?—Yes.

10,842. *Mr. Snell*: Would he advise the relatives as well as the patient that he was watching the interests of the patient?—I suppose the relatives would know.

10,843. Suppose you have a family of very poor people not very well educated; they may be as much in need of a representative as the patient himself as to the best thing to do with their stricken relative. I gather that the representative is to be appointed by the magistrate in much the same way as a Court

appoints a counsel to defend an undefended person?—Exactly.

10,844. Would his intervention be limited to the patient himself, or would it include the interests of the family?—We have not contemplated that it would include the interests of the family, because we look upon them as articulate people whose sanity is not in question, and who could advance their point of view before the magistrate.

10,845. *Chairman*: Then really only one side is to have the advantage of defence in this matter. As Mr. Snell points out, the family who are interested in the other side of the case must just do the best they can for themselves without assistance?—That seems to me unquestionable. On the one side you have the person whose intellectual capacity is impugned; he requires assistance.

10,846. However, at this stage some official is brought in. It is just there that I have considerable doubt, and I think you may remove it?—Quite.

10,847. *Earl Russell*: Do not you think the patients would be at least as much upset if there is a proceeding going on, in which they are present and take part, and they hear this thing discussed; and they have hanging over them for a week or a fortnight the prospect of an asylum?—We feel they need not be present; that is the point of the authorised representative.

10,848. *Chairman*: The whole point is this, that your criticism of the existing system is that so much is done behind the back of the patient?—That is so.

10,849. What I suggest to you is this, that in dealing with all kinds of illness a very great deal is done and must necessarily be done, as you put it, behind the back of the patient?—Quite.

10,850. Personally, I should not like to be present at a consultation on my case which took place between a consultant and my own private doctor. It might be interesting from a curiosity point of view, but if I were ill it would be extremely bad for me, I am sure?—We do not propose that that need be so.

10,851. We see the value of such a person, but I want to see what he is to do. The authorised representative is to see the patient. He must, of course, if he is to discharge his duties to any effect. I am rather anxious about this side of it. Surely it is difficult to bring in a person who *ex hypothesi* is a complete stranger, and introduce him to a person who again, on our hypothesis, whether sane or insane, is at least very ill (because the proceedings will not start unless there is some justification for them)—to introduce a complete stranger to a person who is in this state of mind, and to accompany his introduction, as you would need to do, with an explanation of why he is there. Suppose a patient is in bed and says, "I cannot see anybody just now," and you say he must see him; this person must thrust himself into the presence of this suffering human being and say, "Will you kindly listen to me; I am appointed to see that your liberty is not going to be infringed, and I want your instructions," while the only interest of the unhappy patient is to say, "Please go away, please leave me." I see a very difficult situation there?—But how does the medical practitioner act under those identical circumstances?

10,852. The doctor comes in, but then he comes in as a professional man. A doctor, after all, notwithstanding some of the criticisms we have heard of him, is a person who is invoked by the relatives to see the case, and who is accustomed to handle these cases; but a barrister or a solicitor does not necessarily have a good bedside manner?—Very bad, I should think.

10,853. We are talking of real life just now, as you know?—Quite. My answer is this, that in that case, if the authorised representative got to the door and heard that "Please go away," he would be satisfied that it was not a case of the person being fit to deal with the matter.

Earl Russell: That is a very small observation on which to decide that the patient is not fit to understand his liberty is in danger.

28 January, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

Chairman: It seems to me, on a limited experience of life, that that is the sort of thing that must happen pretty often.

Witness: We are, of course, advancing these views naturally on the type of evidence we have had before us.

10,854. But we have to consider all cases. We are on a very large issue at the moment, and again I am sure you pay us the tribute of recognising that we are most anxious to sound this thing really to the bottom; and the danger in all these matters is that one is apt to take a theoretical view which is rather remote from real life?—Quite; I quite realise that.

10,855. Often it has been a painful experience of reformers that the very effort to reform sometimes results in worse consequences than even the evils that you have. I do not say in this case we shall not be able to assist in reforming the procedure, because I hope we shall; but when one is putting forward reform one must be careful to see that one is not doing harm in one's very effort to reform?—Quite. This is a question of degree. On which side of the balance does the majority lie, and I think I am right in saying that evidence has been given here that these violent and extreme cases amount to about 3 per cent.

10,856. Violent and extreme cases are quite few, fortunately; but, on the other hand, we have had evidence that a great number of the cases are cases which are sunk in stupor, depressed and melancholic.

Sir David Drummond: And suicidal.

10,857. *Chairman:* Yes, suicidal. You know the exciting effect upon a person who is suffering even from an ordinary illness of a stranger being introduced?—Well, we can only repeat that in our humble view it is nothing like the exciting effect that occurs when the same individual is plunged into a ward of an infirmary or the receiving ward of a mental hospital.

10,858. *Earl Russell:* The moment he is put there he is calmed with a sedative, while all this time he is subject to litigation?—Not necessarily so. We do not suggest he should not have sedatives in his home.

10,859. *Chairman:* All these subjects are correlated. Mr. Parker says quite truly that if you are to plunge a person into the asylum, of course, that may be a great shock, but it may be mitigated, may it not, if one of your other suggestions, namely, observational treatment in a ward attached to a general hospital or a special institution, were carried out at the intermediate stage?—Once you get that, this procedure would not arise, because that would be voluntary treatment.

10,860. Not necessarily, I think?—That is our suggestion, that that type of treatment should be voluntary.

10,861. I was hoping that we should be able to deal with cases which, although they manifestly required restraint and, therefore, some legal sanction for their detention, might nevertheless be transitory cases, which would never reach the stage of certification. I hope you are not going to rule out that very important case in your suggestions. We want to avoid certification, with its stigma, in as many cases as possible; and if you are going to rule out the class of case which is a transitory case and would pass off under a short term of provisional detention and say that all these people must be voluntary patients, I am afraid you are rather going to spoil the reform?—Do I understand there is to be an intermediate stage really certified, for a provisional period?

10,862. Yes, that has been suggested, for the reason that we would in that way avoid the final certification, and would in the meantime be in the position to exercise the necessary control over a case during the short period of the duration of the disease?—You are on the 28 days' period?

10,863. Under observation, but also under control, though not certified?—I think we certainly support that.

10,864. For the moment you were suggesting that you must only have two classes, voluntary and

certified. We think there is another class, persons who require a measure of control for a time.

10,865. *Earl Russell:* In the hope that they never may be certified?—Yes, we agree with that.

10,866. You are trying to persuade us to do something which we do not like very much. Assuming we have this provisional period, and assuming we have the voluntary boarder system, will you tell me in the view of your Committee in what percentage of cases this elaborate procedure will do any good at all?—I quite see that on your assumptions this procedure might become unnecessary. I am afraid it is going to be some years before these assumptions come about.

Earl Russell: Royal Commissions have no control over their report after they have reported.

10,867. *Chairman:* We can only recommend, you know, and we want to recommend what will be best, if we can. For the moment I do not think any of us round this table are convinced that the intervention of this defender of the liberty of the patient in the way that you contemplate here would necessarily be an advantage. I mean we are impressed with the difficulties which I am putting to you in the most human way I can?—Quite.

10,868. *Earl Russell:* And we should, I think, be prepared to consider whether anything of the sort could be done, if there was a large percentage of cases in which this would lead to the prevention of injustice?—Quite.

Chairman: Exactly. Mr. Parker might make this point and say, "Well, at whatever cost of suffering if an injustice is liable to be perpetrated you must take the responsibility for it."

10,869. *Sir David Drummond:* Has Mr. Parker any idea as to who would pay for this?—I think we look upon these duties like the poor prisoner's friend, as largely voluntary. There would be professional men quite willing to act, as there are in the Courts. There is great difficulty in one's ascertaining what sort of percentage of cases we are dealing with. All we can say is that in the cases brought before us there is a heavy percentage where this procedure would be of an inestimable advantage.

Earl Russell: Could you tell us exactly what it would have done? Take four or five typical cases that you have in mind and tell us what this procedure would have done in those cases.

10,870. *Chairman:* Yes. I am going to assume that you have established to our satisfaction that you have received a number of cases in which you are satisfied the patient ought never to have been detained; and that if that patient had had some such protection as you contemplate here, he would never have been certified at all. You tell us you are satisfied yourself that such cases have existed. That is enough for the purposes of our discussion. Let us assume that. In the cases that you have in your mind what would have been the result of the patient being told by such a third party that his liberty was at stake, what would he have done?—Take the case of a petitioner—I have a special case in mind here.

10,871. Please just take one?—The petitioner was the father, and there was undoubtedly want of sympathy between him and his daughter of a certain age. She became mentally ill in hot weather, and lack of sleep and so on. The story is this. He came to the conclusion that she could very suitably be treated in the local mental asylum. He got two doctors in to certify, on what seem to us very slender grounds.

10,872. *Earl Russell:* Can you tell us what overt acts she committed?—She is supposed to have gone to church once without having been dressed properly, and in a state of collapse was brought home by a friend; and I think on one occasion she tried to get out of her room at night into the corridor, though the certificates are conflicting on that point.

10,873. That was all?—Perhaps I had better read the certificates.

10,874. No, we will take your version of it.

10,875. *Sir David Drummond:* Have you got the certificates?—Yes. However, she admits that for

28 January, 1925.]

MR. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

three or four days she wanted attention of some sort. She went to the asylum, where she speaks very highly of her treatment, but she was kept there for six months, and one cannot but feel in reading her comments, firstly, that she need never have gone, of course, if her parents had been more sympathetic, and if there had been somebody to interfere they would have deferred the thing for a day or two.

10,876. *Earl Russell*: Was this a private case?—Yes.

10,877. *Chairman*: Now let us see what would have happened there if your procedure had been in operation. She would have been seen by a legal person, a barrister or solicitor appointed for the purpose, and he would have conferred with her, and this was a case of a person who still had certainly a considerable degree of intelligence, obviously. Do you think it would have been right that she should have been told that proceedings were being taken by her father which might result in the deprivation of her liberty, and that she should have appeared before the justices and criticised the adequacy of the certificates upon which she was about to be detained?—No, I am not satisfied in that case that she herself was in a fit condition at the moment, but I do feel that some pressure might have been brought upon the parents not to expose her to it.

10,878. This is putting a very different duty upon the member of the panel?—Our view is that he would have examined the conditions on behalf of this person, and the knowledge that an outsider was interested in the case would have carried some weight; it might not have prevented this taking place.

10,879. I rather gather that this is a case in which you are satisfied that the person was a certifiable patient?—Strictly speaking, yes.

10,880. But can you give us an illustration rather of a case where there has been really a miscarriage of justice, that is to say, where a person really sane has, through the absence of such protection as you contemplate, been improperly detained. That is really the case that we are concerned with at the moment?—Of course, we have cases of that sort. We cannot test them, as I have pointed out to you.

10,881. It is not a question of testing them really. Whether they are true or not, they are criticisms upon the Act, and they illustrate what people are feeling about it?—We are calling one case before you of a person who certainly holds the view, and I think we hold it, that he was not certifiable.

10,882. Frankly, I attach much more importance to the views that you express to us as the result of your experience and the stories people have told you and of the result of those many cases, than to what an individual person may tell us here and now?—If I may say so, that puts me in a very difficult position, because we realise fully that we are here only hearing one side of the story. We say that we do get certain cumulative ideas.

10,883. The weak spots in the existing legislation are brought to your knowledge in that way by complaints, whether ill or well founded?—We do say we have a lot of cases in which the criticism is this:—"If we had had any friend to turn to, we feel that our case would have received quite different consideration." Obviously, those are cases in which the family were completely ignorant of this Act—and I do not suppose one family in a thousand knows anything about it.

10,884. Take the case of the unhappy lady you spoke of. Of course, if she had had a friend in this sense, an intimate friend who had influence in the household, your suggestion there would be that he might have gone to the father and said, "Your daughter may recover shortly, there is nothing illegal in having your daughter in your house for the time being." But then that person's function is quite a different function from that contemplated in this procedure. That is the kind friend of the family, and there are many things one would escape in life if one had a good friend at hand. What is contemplated here is that the person is a person

in the interests of the patient, but a stranger to the patient, and certainly not a person who could go and reason with the father in such a case?—Unless he had got a legal position, appointed by a magistrate.

Earl Russell: He would have no legal position to give the father good advice.

Chairman: I think his only legal position would be to see the patient; tell the patient what was at stake, and ask her to give him what we may call instructions for the defence.

10,885. *Earl Russell*: Have you got cases in which you think if you had had this tribunal set up the verdict would have been one of acquittal, so to speak?—Of course, that is rather a difficult question to answer. Yes, I think we have, but it turns on the question of fact whether the case was certifiable or not. We are not going to say that we are necessarily better judges of that than the people who dealt with it.

10,886. There are comparatively few, I take it, of such cases?—Yes, I suppose so.

10,887. *Sir David Drummond*: Are you going to put forward any case in which the person was not certifiable?—Yes, we are.

10,888. *Chairman*: And never was certifiable?—In our judgment, apparently not.

10,889. And in the patient's own judgment?—And in the patient's own judgment.

10,890. *Miss Madeleine Symons*: I am still not quite clear about the function you would assign to this representative. Are you thinking of him really as an advocate, as somebody whose duty it would be to resist certification in all cases, as you would try to get a man off if he had been accused of murder, or are you thinking of something more advisory?—We think it would be an advantage if he could exercise both functions. Perhaps I may point out this: we do say at present that in many cases a person gets no sort of notice of the proceedings contemplated; they get no notice of the allegations made against them, they do not know what is going to be said because they are not there when it is said, and they are very often tempted to make statements which they certainly would not have made, if they knew they were going to be used as they are used. I am raising a very big point there, of course, whether it is legitimate to misrepresent the position to a patient to get him to make statements.

10,891. *Chairman*: I am a little appalled at the idea of a doctor who makes the examination saying to the patient: "Now it is my duty to tell you that anything you say to me may be used as evidence against you." I cannot imagine that that is likely to induce confidence at the onset of the trouble?—We have to contemplate the opposite, where a man or woman does not know he or she is talking to a doctor.

10,892. Why should a person be less likely to tell a doctor the truth than anybody else? If the whole object is self-revelation, why is it necessary it should be a doctor? The warning seems to me to deprive the interview of a large part of its value. You want to see how the person behaves at the time, and the less you get the idea that they must brace themselves up and pretend to be better than they are, the more satisfactory it will be?—That, I am afraid, in our view, might raise a very serious issue, whether you are entitled to go to a person and persuade him to unburden himself. I quite see you may get a greater insight into their characteristics, but it does not seem to me as fair or desirable.

10,893. You are always importing the idea, if I may say so, of a quasi-trial of some sort into this thing—that is the fundamental difference of view. It would be most unfair to go and see a prisoner on trial for crime and try and worm your way into his confidence and get him to tell you things. On the other hand, exactly the opposite considerations may obtain in the case of a patient. One thing desirable may be to put the patient at his ease so that the patient may just disburden himself of the

28 January, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

very things which, if it were a criminal trial, would be shocking things to obtain from him. The object is the benefit of the patient?—I am trying to put before you cases where people say they have been trapped into making statements which they would not have made; and without being a doctor, it seems to me that this is a sound proposition,—that a patient, if he is trying to cure himself, should be able to direct his mind to what I call the weak spot in his mentality. We think that that issue should be raised with him early on, and we think all the more that it should be raised with him while he is under examination. I cannot conceive how I should set about to cure a weak spot in my mentality if I had no conception what it was. That is the sort of case we have month after month—they do not know. When we come to consider the sort of treatment which we say they get, we do not know how they can begin to help themselves. The point goes a great deal further. We may be proposing a procedure which is unnecessarily cumbersome, to cover the number of cases we have in mind; but there are all these border-line cases, and they go a good long way, who are perfectly capable of discussing reasonably.

10,894. Yes, but again we have reached the discretion stage. It would be manifestly improper in many cases for a stranger to be introduced at all. It would be manifestly improper for a stranger to intervene in the sense of talking to the unhappy subject, and then you reach this: Who is to be the judge of whether the patient is one who can be seen and talked to, whether he is a borderland case or not a borderland case—whether it would injure the prospect of his recovery? Again the medical profession must be the arbiters of that. Supposing the doctor said to this defender at the door: "Really, you must not go in and see that patient just now. To bring in anybody, a stranger, at the present moment will bring on an access; the patient will jump out of bed and fly at you." "Oh," says the defender, "This is one of the cases where the medical profession are trying to hush up the proceedings. I hold a warrant to see the patient, and I insist upon my right." He goes in, and the immediate result is an access of frenzy on the part of the patient. He has the satisfaction that he has performed his duty, but the patient dies. That is not a satisfactory outcome?—I quite agree, but is the strange doctor who goes in under similar circumstances any less likely to cause an access?

10,895. Very much less, because he is thoroughly accustomed to that class of case. He knows how to handle it. He probably would be able to use different means altogether from a man who goes in equipped merely with legal knowledge. If you are to select the person, I have no doubt the person accustomed to seeing such cases would be the better person?—Of course, we realise in that type of case that this procedure would not be suitable.

10,896. Somebody is to judge which are to be the cases and which are not, and you may have the same grievance about them. The patient may say, "The doctor kept away this person whom I

ought to have seen"?—That person would still be operating under the appointment of the justice. He would only satisfy himself that it was not wise for him to intrude any further, and that is the case we contemplate, and there must be a great number of them, of course.

10,897. *Earl Russell*: But he would only be doing the duty of the judicial authority anyhow, enquiring into the validity and competence of the certificates?—I quite agree. This does hang on the method in which the justice is going to carry out his work.

10,898. Yes. I think if you make the justice's duty much more solemn than it is now, and have that understood, that would help a great deal?—Yes.

10,899. *Chairman*: I really feel, Mr. Parker, that a solution which might be more effective, consistently with the patient's welfare, would be the bracing up of the justice of the peace in the performance of his duty. He has a discretion at the present moment, but it is quite within our competence to recommend that there should be certain directions as to the procedure he is to pursue, which might achieve your purpose, and ensure that more adequate safeguards were interposed between the patient and detention. What is rather repugnant to one's mind is the idea of the introduction of the instructed advocate into the proceedings, because I can see that that personage in the drama might be anything but an advantage. There is no one who has had to do with advocacy but knows that, while it is an excellent instrument for certain purposes, it is not an excellent instrument for others?—I quite agree, if I may say so.

10,900. The controversial element which arises in the conflicts of advocacy is of great public value for the elucidation of certain topics, and notably, of course, in the administration of the civil law and criminal law, but it seems to be entirely dissociated from the realm in which we are moving at the moment, where we are not dealing with rights at all, but with something which is more subtle than rights?—Of course, the object is the same, that the judicial authority shall address his mind to the real points, and shall have the evidence before him.

10,901. And shall have sufficient authority to enable him to get the material he ought to have before passing judgment?—Quite, and we are not quite satisfied that if left to himself he will in fact get that material. Who is to produce it? That is our difficulty, and that is why we suggest the other thing. I quite see the criticism.

10,902. I think these criticisms are rather difficult to get over, but it may be we can achieve the same object through the medium of remedies at other stages rather than at this. We have been told that the intervention of the third party in the present procedure has turned out quite nugatory. I asked a number of question about that, and as far as I can gather it really had not been of much use. Whether the persons always knew they had a right to bring in a third party or not is a different matter, but apparently that safeguard, devised in 1890, has turned out to be rather a dead letter, as far as I can see. Of course, it had not the sanctions which you propose to attach in this case?—That is so.

(After a short adjournment.)

10,903. *Chairman*: Mr. Parker, we were at page 11 of your *précis*, and discussing the provisions which your Society has suggested in connection with certification, and we had reviewed at considerable length the question of the suggested authorised representative. Would you pass on to the fourth head, now, in your summary, in which you recommend that the medical opinion and the evidence of other informants should be disclosed to the alleged lunatic or his representative? You have to some extent anticipated that question in what we have been discussing previously?—Quite.

10,904. Very much the same considerations seem to arise there. Again you recognise, I am sure, that there may at least be some cases in which it would be inexpedient to disclose the medical opinion to the

patient?—Quite, and that proposal is subject to the decision we arrived at before lunch, that if the judicial authority is functioning more freely, naturally our proposals would be modified to that extent; that covers this point, too.

10,905. Yes. Then the suggestion is, if not disclosed to the alleged lunatic it might be disclosed to this authorised representative. Now on that there is one point which occurs to us. This particular affliction, of course, is one which people do not like published about themselves more than is necessary, as one knows, and indeed the Statute contemplates secrecy, at any rate in the case of the private patient, as an essential requisite. Do you not think another drawback that might arise might be this, that either the patient himself or the relatives might rather object

28 January, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

to a third party, a solicitor or barrister outside, being told of what had befallen the family?—I may say frankly that our view is this, that a question of lunacy is no more serious than any other family secrets, such as divorce or other matters which have to be disclosed, and in the case of lunacy the facts have to be disclosed later, because it is known that the patient has been to an asylum in the great majority of cases; and we find great difficulty in taking the view that the relatives should be protected, at the expense of the man who is unfortunately in this position.

10,906. But it is the man himself, for the moment. We are assuming a lunatic who is quite intelligent up to a point and able to take an interest in the proceedings. Might he not say, "I do not want this barrister or solicitor butting into my affairs. I have got my doctor, and I do not want this fellow to come along"?—Absolutely. If you have a case of that sort, capable of defending himself, all we say is that the issue should be brought to his notice. May I remind you that in Mr. H.'s case there was just that point on the disputed property. One cannot help feeling, if he had known that that was one of the grounds, he could have satisfied an independent person that at least he had a claim.

10,907. *Earl Russell*: You mean that things are put down as delusions which are not delusions, but which at any rate have some foundation in fact?—I tried to follow the evidence, and I think it came to this, that they are put down in the certificate, and the damage is done.

10,908. *Chairman*: And besides, on questions of that sort, where the allegation may not be a delusion at all, and yet may be assumed to be a delusion, one can quite see how fallacious that information may be. It depends upon the quality of the delusion?—Quite.

10,909. Of course, if the patient says that he sees St. Paul sitting on the top of the tower there, well, of course, the doctor is entitled to assume that St. Paul is not sitting there, and therefore he need not proceed to get an opinion as to whether St. Paul is sitting on the top of the tower or not. He may decide that case there and then?—Quite.

10,910. But take the typical case of a man saying that his wife has been unfaithful to him—unhappily that may be the case?—And often is.

10,911. *Earl Russell*: I have seen that put down as a delusion.—There are cases on it, and they have been before the Courts afterwards.

10,912. *Chairman*: It may be a delusion, and, on the other hand, it may be a perfectly well-founded fact.—You may have in mind the case that went through all the Courts and ultimately the man was able to bring proceedings for divorce and he established all his delusions.

10,913. You can assume that we have been furnished with a considerable amount of literature for our instruction, and that was one of the cases brought to our notice. It is important, therefore, that if a particular statement of fact is made by a patient which is susceptible of a perfectly rational explanation, that should not be put down as a delusion, until it is ascertained whether it is or is not a delusion, by some inquiry?—And also the converse—if a particular fact is communicated by third parties or communicated to them by other parties, the least that should be done is that it should be brought to the attention of the alleged lunatic, and the issue should be looked into. I think we go so far as to say this, that this is about the only procedure which is said to be legal where double hearsay evidence of that sort carries weight. I do not know of any other.

10,914. Just for the reason that it is quite outside ordinary procedure. Facts communicated by others are not facts at all in a Law Court; but they may be very material facts in connection with the certification of a patient, and it is all the more important that they should be well-vouched facts.—Tested.

10,915. Tested in some shape or form. On the other hand, you cannot test them in the sense of having them proved. You can only make such inquiries as

are available to you.—It seems to me reasonable that the person against whom they are alleged should have an opportunity of denying them.

10,916. *Earl Russell*: But unfortunately you cannot necessarily accept his denial if he is of unsound mind?—That is so; but if there is an issue it does seem reasonable that there should be some delay before that issue is acted upon.

10,917. *Chairman*: Take the very simple case of a person who alleges that his wife has been unfaithful to him. Now, as you know, it may often take, through proceedings in a Court of Law, a couple of years before that issue of fact is decided. He would have alleged that his wife was unfaithful. Therefore, for the moment, that would be taken as his assertion. Then the question is: Was that a delusion or was it justified? Whom could the doctor ask? He could ask the wife, but that would not be much use, because the wife would very probably deny it at once. Is he to proceed to investigate whether the wife's conduct justifies it?—If he likes to take the risk of acting upon that opinion he can, but we submit that is just the class of case that ought to be dealt with judicially.

10,918. *Earl Russell*: That may involve a jury and two days before a Judge?—Quite. Recognising that, surely it ought not to be accepted as a delusion. I quite recognise that the justice cannot try it, but it is much more unfair that it should be accepted as a delusion simply because somebody says it is.

Chairman: I agree. I think it is ridiculous to say it is evidence of a delusion on a man's part to say that he asserted his wife had been unfaithful to him. These are assertions made by perfectly sane people, constantly.

Earl Russell: And they are sometimes made by sane people without their being true.

10,919. *Chairman*: Certainly. That of itself, I think, you would recognise was a quite inadequate ground for holding that the person was suffering from delusions. It could only be an element taken into account with something else; it might be of importance, even although not proved, in association with other facts?—Certainly.

10,920. Supposing the man was making allegations all round, and among other things accused his wife of unfaithfulness, it would not be necessary to thresh out each of those controversies, if the conclusion was that this was a man who made random accusations all round.

10,921. *Earl Russell*: If he said, "My father tried to drown me and my sister tried to poison me."—That is so, of course.

10,922. *Chairman*: Taken by itself it is no ground for saying that a person is unsound?—No, but it is, I am afraid, not a frequent cause of certification, but a contributory cause.

10,923. *Earl Russell*: I have quoted a case in which it was the only fact on the certificate?—Quite. I have a certificate here before me of interest in this connection. Here is a certificate on a lady who lost her husband. Then I think she had nursed her father-in-law, and had been through a very trying time indeed. This is the certificate: "She is melancholic and has delusions of moral unworthiness and of extreme poverty for which there is no ground." Then there is another matter I need not refer to. She writes a very sensible letter to say that as regards "extreme poverty for which there is no ground." "My income at that time was less than £250. In 1920, when the £1 was not worth 10s., this represented an income of £125, and may fairly be considered poverty." The other thing she makes a very sensible comment upon: "What I really wanted was the attention of a really good clergyman, who would have discussed the religious aspects of the case." She was probably depressed after these experiences, and one knows that at that time those sort of questions do crop up.

Earl Russell: After all, a feeling of moral unworthiness is considered to be a necessary religious experience.

28 January, 1925.]

MR. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

10,924. *Chairman*: I always thought it was a virtue.—Exactly; and there you are touching a very difficult point.

10,925. Of course one must recognise in dealing with these certificates that the power of expression and description of what one has observed varies very greatly in different persons. You may have a most accomplished doctor, on whose judgment we should all place implicit reliance, who might in point of fact be the worst possible witness, or incapable of describing exactly what had carried conviction to his mind in the appropriate language that would carry conviction to another person's mind. For example, in other cases, engineering and so on, you get a man who is the best possible craftsman, and you ask him to build a bridge for you, but you may have to say of him, to put it colloquially, "He can't make a report for nuts." One cannot say he is incapable in his art, but he has not the added art of being able to describe in convincing language the things which have influenced him?—Still, on that case I want to suggest that the issue of poverty was a misrepresentation, because that amount of money is comparative poverty.

10,926. I would say that the data there were very imperfect?—That part of it should not be in the certificate, obviously.

10,927. And of course it would much depend upon what the doctor had actually meant by his words. For example, "a sense of moral unworthiness" is one thing, and, indeed, may be a virtue. On the other hand, she may have meant this "I have committed the unpardonable sin," which would show at once a pathological state of mind.

Earl Russell: A very common case in asylums.

10,928. *Chairman*: Yes; it is very difficult to get a standard of descriptive power?—Quite. I think I ought to read the other medical certificate, which is: "She is melancholic, and divulged to me delusions of spiritual and physical unworthiness. She considers herself a moral degenerate, and that she should be destroyed."

10,929. *Earl Russell*: That is a great deal stronger, is it not?—That is stronger, but now listen to the explanation. She says: "I was in a most depressed condition, feeling there was little left to live for, and that my ill-health, inability to sleep, and financial position made it impossible for me to take up any work. When I tried, I could do nothing. I had also lived for years a life of religious apathy, and this came home to me very deeply. I was overcome by a knowledge of my sins of omission. I remember saying that I felt myself a moral degenerate, only fit to be destroyed. I needed a priest accustomed to hear confession. Had I seen one, I should have been immeasurably helped."

10,930. *Chairman*: That is a letter written, of course, after recovery?—That is written afterwards.

10,931. *Earl Russell*: About how long afterwards?—Well, Sir, it is not dated.

10,932. Is it a month or a year?—It is longer than that ago, I think. The date of this was after the war, 15th July, 1920. Then her general comment, which I think is worth reading, is this: "I consider, therefore, that while the statements are made in good faith, wrong inferences were drawn. I was certainly not normal, and think that I was a typical case of neurasthenia, requiring early treatment, and especially needing spiritual help and comfort. I think the medical practitioners cannot have had much experience in such cases, and they were certainly unnecessarily nervous." That is her opinion, of course.

10,933. *Sir David Drummond*: You told us that you had one case in which the patient should not have been certified. Is this the one case?—No, this is not the case I had in mind. She goes on: "I was not a case that should have been certified; I made no objection to entering a mental hospital, and I consider that the magistrate should have seen me before signing the reception order." It is a very reasonable criticism.

10,934. *Earl Russell*: An admission as a voluntary boarder, I suppose, with spiritual assistance, would probably have met her case?—Quite; it was a reaction to the loss of her husband.

10,935. *Chairman*: I do not think that the complaint is so much that under the existing law her case had not been dealt with as the existing law provides, but she is one of those people who would wish some reform of the existing law so as to meet her case. Do not you think that is her attitude?—Of course, she has some very strong comments to make on her experiences. She does not object to being certified. She objects very, very strongly to what happened when she was. I think the statement has been put before you.

10,936. That is a different topic altogether. What we are concerned with now is the entrance into these asylums, and to see that the portals of the institutions are sufficiently safeguarded. Now may we go on. How, in your view, is a more satisfactory form of judicial procedure to be ensured than is at present in operation? What are the measures to be taken?—My first comment is that the judicial authority must see the patient, except in those emergency cases.

10,937. May I say that you need not labour that to us, because we have heard so much upon it, and I think I am right in saying there has been a complete consensus of testimony before us on that point, so that we have been much impressed with that suggested reform. That, of course, is an important element of evidence, provided that the seeing of the patient is a reality, and not merely a perfunctory step?—Quite.

10,938. Seeing a person may cover a great many things. It may cover a mere glance at a person in a motor cab, which does not seem to me to be of any very great value. Seeing a person may mean interviewing him, examining him, and really attending to his case?—Quite. Then the next point we feel is that publicity, if desired by the patient (I quite recognise there are many cases in which it could not take place) would ensure that the case was fully considered.

10,939. Before we come to the publicity of the proceedings, I think you might just take up the question of whether the evidence which the justice is to have before him, in addition to his own seeing of the patient should in all cases include two medical certificates. I want to get the material, so to speak, before we get the case stated. What is to be the material put before the tribunal whatever it is to be? Have you any view as to whether the medical certification should in all cases be doubled?—Frankly, it seems to us to depend upon the efficiency of the judicial authority's investigation. If that is efficient—of course, we submit it is not at present—then I do not know that two medical certificates are necessary, and certainly not if they are made in consultation.

10,940. *Earl Russell*: Before we deal with consultation, do I understand that you would be satisfied with the power on the part of the judicial authority to call in a second doctor, if he really exercised his functions properly?—Quite. We recognise that the calling in of two medical men at that stage is probably cumbersome.

Earl Russell: I am glad to hear that.

10,941. *Chairman*: Yes. We have put that to quite a number of witnesses and, curiously enough, you, who are so zealous a student of reform, put that view before us; whereas all the medical superintendents have said that there should be two certificates. It is rather curious, if one may say so?—I couple it, of course, with the question of the efficiency of the judicial authority.

10,942. The things all hang together?—They interlock.

10,943. I am not sure, if one looks at the matter from the public point of view, that a recommendation from us would be welcomed which would involve the diminution of this particular form of safeguard; because if we are to have a uniform system, then as

28 January, 1925.]

MR. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

you think one certificate would be sufficient in the ordinary case with the proper judicial procedure, so one would have to be sufficient for the private patient, and we should actually be recommending then a diminution of one of the existing statutory safeguards. I do not know what would be said of us if we recommended that?—One does feel that there should be provision to call in additional medical assistance if wanted, and I take it that that would be in the discretion of the judicial authority.

10,944. *Earl Russell*: He is the proper person clearly?—He is the proper person to do it.

10,945. *Chairman*: Take one of those certificates you have just read to us—the first one of the two. The properly constituted judicial authority would say to the doctor—he would probably send for him—"I have read the certificate; I am not satisfied upon it; I have seen the patient, and I am not clear about the case; I want to have another opinion," and then might have followed the second certificate you have there. He might then say, "The first and second together coupled with my inspection of the case are sufficient for me." On the other hand, an out-and-out first certificate, I gather, would be in your view sufficient evidence coupled with a seeing of the patient?—We think so.

10,946. Of course, you are placing upon the single medical practitioner, who might be inexperienced, very considerable responsibility in that case?—One realises that, and one hopes that it might be a deterrent to the inexperienced man from acting. There again in that connection one does feel that the medical practitioner should appear before the judicial authority. As you rightly pointed out, Sir, it is very difficult to reduce to writing the impressions that he gathers, as we have seen from these certificates, and if that be so, it seems doubly important that he should appear.

10,947. He certainly at present is available in the sense that he may be summoned by the judicial authority.

Earl Russell: But never is.

10,948. *Chairman*: He apparently never is. Also there is this odd feature, that while the justice of the peace in the pauper case is told he is to call in a medical man, as far as I can gather the medical man has generally been called in before the medical certificate is put before the justice, and the medical man is not of the justice's own selection?—That is so, and then of course there is that present provision in the statute that his certificate shall have value as if made on oath.

10,949. *Earl Russell*: In the pauper case it would mean that the doctor would have to attend on a different day from that on which he had seen the patient. From his point of view it means two visits?—I suppose he would be paid for that, and considering the issue, I do not think the extra guinea is prohibitive.

10,950. I agree he would be paid for it, but then the guardians come in.—But still when one thinks what is paid for out of public funds in the case of criminals—

Earl Russell: I am not differing from you at all.

10,951. *Chairman*: It would be, I think, very much more satisfactory for the justice to see the doctor, not only in order that he might discuss with him the terms of the report, but also that he might be able to form an opinion of his competency?—Quite.

Earl Russell: And if that were so, it is much better that the doctor should be directed to attend by statute instead of its being discretionary, because a justice may hesitate to put the guardians to an expense, whereas if the doctor has to attend anyhow, he has nothing to do with it.

Chairman: And, moreover, if the doctor were present with his certificate, it would have a tendency to make the justice attend to the case, because the doctor was present. If a justice had the least interest in his work, he would naturally want to ask the medical man who had seen the patient all about him. Even human curiosity would lead him to ask

about the case, and he would have the advantage of getting a much fuller explanation of the case.

10,952. *Earl Russell*: And also of course it would make the doctor more careful, because he would know that if he had put down any ambiguous sentences in his report, he would have to explain what he had meant?—Quite. We think that is really a very important provision.

10,953. *Chairman*: I do not think you have gone the whole length of this provision in your case?—No. Of course one would like to deal here with the doctor's liability. As we said earlier, we think that that certificate or report which is made early, whatever it be, should be a condition precedent to all that is happening; and that there should undoubtedly rest on anyone making that report the duty of taking reasonable care. As to the evidence he gives on oath, of course he would have on that the natural protection of a witness.

10,954. You contemplate, then, that if we have the patient brought to the justice or the justice going to the patient and interviewing him, the justice should not only have the doctor's certificate, but also see the doctor?—Have the doctor before him.

10,955. *Sir David Drummond*: Is this the first justice you are dealing with now?—No, this is the judicial authority.

Chairman: This is the real inquiry which is to issue in a certificate.

10,956. *Earl Russell*: You do not suggest that the doctor should be bound by the rules of evidence at this inquiry? You would allow him to give testimony of hearsay, would you not?—Yes, I suppose so. I think you would have to do that probably, because one recognises that you cannot have a technically strict procedure which might entail bringing witnesses from all over England.

10,957. And, more than that, you cannot form a medical opinion without having the history, to some extent, for what it is worth?—Quite.

Chairman: The ordinary medical certificate produced in a Court of Law includes the phrase, "on soul and conscience," which is supposed to be a formula of much solemnity. The Court will not accept a certificate unless it has those words in it.

Earl Russell: Is it not really the pledge of his professional honour?

10,958. *Chairman*: Yes, a Court will disregard a certificate which has not those words on it. You want the same kind of solemnity to be attached in this Act?—We do not see how these alleged facts can be tested in any other way. We simply say that they should be put through a sieve, as we believe the statute intended originally.

10,959. Then you contemplate that the doctor when he attends should bring with him a certificate which would be a certificate "on soul and conscience" or sworn, as you please, and you would then expect him to be put on oath before a justice?—Unquestionably. We suppose all the evidence will be taken on oath. Is not that one of the essentials of a judicial inquiry?

Chairman: It is.

10,960. *Earl Russell*: It depends what importance you attach to it. You may have arbitrations which are in the nature of a judicial inquiry but the evidence is not on oath?—Quite.

10,961. *Chairman*: But if the doctor were then put on oath, the justice would examine him on any points that arose. Of course, he probably would not examine him if the case were too clear for argument?—It would be quite a formal inquiry then.

10,962. If, on the other hand, it were a case in which he had some doubt, he would examine the doctor on oath, you suggest, and elicit from him additional information. Would you contemplate that deposition being taken down?—I suppose it would be. I am not as familiar with the procedure in the Law Courts as perhaps you are, Sir.

Chairman: We are getting on in the way of procedure and records, if this has to be taken down by a shorthand writer.

28 January, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

10,963. *Earl Russell*: He would be attended by his clerk, I suppose?—One feels that one is dealing with a decision which may involve many years of detention, and that it is at least as important as many minor criminal decisions in which an immense amount of money is spent.

10,964. *Earl Russell*: It is at least as important as a prosecution for trespass?—Exactly.

10,965. *Chairman*: I do not mind saying that I think it is probably one of the most important duties that can be performed, in my view?—Quite.

10,966. *Earl Russell*: Of course, I suppose the doctor being there might also be of some use in advising what institution the patient should be sent to, if he is going to be certified and if you are going to have some choice of institution to which he could be sent?—I should think undoubtedly they would confer on that.

10,967. The justice is the person who directs where a patient shall be confined?—Quite, and we contemplate on that point that the justice might wish to hear relatives and would hear them.

Earl Russell: Naturally, he would, I hope.

10,968. *Chairman*: The medical man, if in attendance, might say to the justice, "Sir, there is no doubt about this case whatever. I have been the medical attendant of this case for some time. I am sorry to say it is a very bad breakdown, and in amplification of what I say in my certificate I will tell you some other things which you ought to know. You have seen the patient for yourself," and the case then concludes, and that would be a case where the patient would be sent at once to an appropriate place—certified and sent to an asylum. There would be no doubt about that case, I take it?—Then there is that other provision as to not making a final certificate if it is likely to be a temporary case.

10,969. But I am putting the kind of case where that intermediate stage would really be superfluous. I am thinking whether the doctor's intervention at that stage in his interview with the justice might not be of value as indicating what type of case we are dealing with. He might say, "This is a case which is a border-line case or is a recoverable case. It is one of those cases where the state is transitory. If I might suggest it, this case might be appropriately dealt with by being sent to an observation ward and the prognosis of the case is that in a fortnight this state may pass away, and it may not be necessary to certify at all." He would therefore be useful in advising the judicial authority in the immediate destination of the patient?—I quite agree with that.

10,970. I do not know that we would contemplate that every case would pass through these observation wards which we have in view?—No, there must be a large number of cases in which a final decision could be taken at this point.

10,971. In every region it is always the borderland cases which are the difficult cases, and it is those cases which need protection?—Quite.

10,972. I am impressed, and my colleagues are too, with the suggestion that in addition to seeing the patient, which we all as at present advised are agreed upon, it might be well worth considering whether the justice should not also see the medical man; and if we were to recommend a single medical certificate as adequate, that that should be accompanied by the attendance of the medical certifier before the justice?—Yes, and then there is this additional point: we feel that the medical man is not in a position to compel the attendance of relatives. He may, and in certain cases no doubt has, interested relatives who will tell him a lot of stories which may not be strictly true, but the magistrate is in a position to compel the attendance of a relative. If the lunatic says, "My sister-in-law can explain that to you," the magistrate would say, "I am not going to come to a decision until I get that explanation."

10,973. Do you contemplate that the patient himself is to be a participant in this inquiry?—We think there must be a certain run of cases—what their number is I do not know—in which the patients

are quite competent to be present. We think the statute itself contemplates that in proceedings under petition they should be present themselves. We know it is not observed, but the sections are quite clear on the point, that they may not only be present at the discretion of the magistrate but they may have a representative present.

10,974. *Earl Russell*: The statute, as I read it, was thinking nearly all the time of the personal liberty, and this is 35 years ago. Now we are thinking rather more of treatment?—Some of us are. We are putting our case on personal liberty.

Earl Russell: This provision did proceed on the assumption that this was a person who could carry on a litigation.

10,975. *Chairman*: But the point is this, that while the procedure at which the patient was to be present under the existing code has been described by Mr. Parker and others as more or less a perfunctory thing, Mr. Parker is now contemplating that we should have something much more formal and something in every case, or in practically every case of any difficulty, which would be of the nature of a judicial investigation of the patient's mind in his presence?—We are rather urging that, in the case of a petition proper, the petitions are now or should be of a judicial character, and when you approximate the pauper to the private patient, as it is suggested you shall do, then that the whole proceedings should be of a judicial character; and just as the statute contemplates in that case the presence of the alleged lunatic, in the new procedure the person is just as capable of being present.

10,976. *Earl Russell*: Or as incapable?—Or as incapable, in the case of serious illness.

10,977. *Chairman*: If we are overhauling the whole system in this respect, and, in particular, if we are introducing some new safeguards in the way of insisting upon more investigation, that will make the inquiry of a fuller type, and may possibly render it a type of inquiry at which the presence of the person involved may be undesirable. Altogether apart from what the present code is, if we were going to establish a system under which the justice should see the doctor and examine him on the details, I should think there would be very few cases in which it could be said to be beneficial to the patient to hear his case discussed between a doctor and a justice of the peace?—Of course, it has always been the practice in cases under inquiry, and it would perhaps seem wrong to expose a person day after day to those proceedings.

10,978. The exposure would be shocking, I think. Suppose a case in which the doctor in giving his evidence to the justice has to say, "This is an undoubted case of general paralysis with very little hope," that is a dreadful thing to say in the presence of the patient?—Of course, I agree, and that points to somebody having a discretion as to what shall be done.

10,979. But the justice cannot have a discretion when he does not know what is going to be said, can he?—I think the medical man, as he is there, would say, "Now there is something I do not want to say in public."

10,980. That would just involve again the suggestion that things were being done behind the patient's back. He would say, "I was never told what passed between the justice and the doctor. If I had been told, I could have explained it completely, and have shown that it was all wrong."

10,981. *Earl Russell*: And do you realise that suspicion is very often an incident of unsound mind—rather a common incident?—That is another reason why we are urging our general proposition that it should be at the option of the patient, if he is capable of exercising an option, to hear this. If he exposes himself in certain cases to hearing something which will be upsetting, we think that has to be faced. The only alternative is, as you suggest, to leave the decision to the magistrate.

10,982. But do not you see that to ride off in that easy way by saying, "if he exposes himself,"

28 January, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

is precisely as if you were to say, "If a patient with a temperature of 104 chooses to run about on a frosty lawn, he exposes himself to dying," but you do not let him do it?—That brings us back to our original position—that he should have a representative.

10,983. *Chairman*: But think it out, Mr. Parker. Take the case of the unhappy person being present, what happens then is that this person who is the protector of his destiny will, no doubt, examine the doctor upon the certificate he has given, and I think we can imagine what would happen in that case. He would feel himself to be an advocate of the liberty of the person and therefore bound to take every point that an advocate would take. Advocates do not always take wise points. You might therefore have a long contest with the doctor, who may well warm up to his task under the stimulus of Counsel's cross-examination, while the unhappy patient is sitting there all the time until the doctor at last comes out with: "Well, if you will have the facts plainly, I will tell you: the man will die in three months' time," whereupon the patient faints. That is not a very happy thing to see?—I quite agree.

10,984. One must think of these things as they will happen, not as they will be on paper?—You must think of extreme cases on both sides.

10,985. These are test cases, I suppose?—Yes.

10,986. *Sir David Drummond*: You have attended. I think, throughout most of the Commission's meetings, Mr. Parker?—A good deal.

10,987. And you have heard superintendent after superintendent say that the safeguards, in their opinion, are adequate, that is to say, they suggest that two medical certificates might be given, but, taking things generally, the safeguards are adequate?—The safeguards covering admission?

10,988. Yes, to prevent wrongful certification the safeguards are adequate; we have heard that again and again. You are suggesting a change of a judicial character, but you have not brought before us a single case in which you could show that a person has been wrongfully certified?—May I qualify that expression of opinion by this, that while under the present law there may have been a period of time when the certificate was properly given, it was of such a short duration that we suggest that case should not have been dealt with in that way.

10,989. *Chairman*: That is quite a legitimate point, but a different point. You are dealing there with illegal detention—not illegal certification?—It seems to me that we come back inevitably to the question of what constitutes insanity and all the definitions we have been discussing earlier in the day.

10,990. Could you say with your large experience of cases good, bad, and indifferent, have you had any case in which you have been satisfied that there has been illegal certification as distinguished from illegal detention after certification?—I think we have got cases where the abnormality of mind seems to us on our evidence to have been so very slight as not to justify certification, but then that is a question of opinion obviously.

10,991. *Earl Russell*: You do not put it higher than saying that you think it was unnecessary?—Unnecessary.

10,992. *Chairman*: These are cases which under a more enlightened system would never have required certification?—That is another point.

10,993. What I would like to know is this, because you have had an exceptional experience of the people who think the present system is wrong, whether any of them have satisfied you that they have been illegally certified as distinguished from retained unduly long?—Of course, it is a difficult question to answer, for this reason, that we never have access to all the facts; we are listening to *ex parte* statements.

10,994. *Sir David Drummond*: But you have the certificates?—We have the certificates, and they are not always very informative.

10,995. Might we see a certificate of one case in which you contend a person was wrongfully certified?—Certainly, we will get those out for you.

10,996. *Chairman*: That would be helpful?—It would. I am afraid I have not many certificates.

10,997. We will get any certificate you like. We will preserve secrecy about this absolutely, but if there are any cases which have come under your cognisance in which, with such imperfect means of investigation as you have got, you have thought an illegal certification had arisen, we would be rather glad to have that, and we can of course call for the certificates and see them. We will assist you in every way in that respect, because one must bear in mind that they are two different things. Illegal certification is one thing; unduly prolonged detention is another thing altogether?—Quite. Do you consider that these pneumonia cases we have heard of are properly certified legally?

10,998. I do not know.—That is our difficulty.

Earl Russell: I should be prepared to say they might be properly certified legally, but it was a ridiculous thing to do.

Sir David Drummond: They were within their rights to certify them according to the present law, but it was a foolish thing to do.

10,999. *Chairman*: That is an important suggestion of Sir David's, showing that you do not want the law to compel you to do inexpedient things. Therefore I should hold personally that a mere incident of delirium occurring in an illness is an improper ground for certification?—I mentioned that because there are all that class of case of temporary toxic poisoning, with a temperature.

11,000. *Earl Russell*: I regard some of the cases we were told about as ludicrous?—Quite. We cannot say what the law is upon that. We do not profess to do that.

11,001. *Chairman*: As Sir David puts it, it may be that a person at that moment could legally be certified who presents two qualifications: first of all, that he is of unsound mind at that moment; secondly, that he is a person who requires to be detained; but whether such cases should be certified, is a very different question?—Yes.

11,002. Now we have got the procedure this length, a single certificate would in your opinion be sufficient, especially if the doctor were in attendance also. The patient has been seen, and the justice is in a position. I suppose, then to make his order, is he?—To make an order of some sort.

11,003. Now there is one other matter on the proceedings—a general question. You rather recommend, I take it, that the proceedings should be public at the option of the patient?—To cover that class of case. We feel that the patient really is capable of, I was going to say, pleading, but of making rational statements to the Court.

11,004. *Earl Russell*: You have got his relatives and the doctor; do you want the reporter of the local newspaper?—We think that is a matter for the individual. We are dealing with the case where the relatives are interested against the patient, as I am afraid will happen.

11,005. But any future employer will look at the fact that he was charged with insanity?—The alternative is that he goes to an asylum without that chance.

11,006. No. You can have your inquiry. I want to know whom else you want there besides the people we have mentioned.

11,007. *Chairman*: That is contrary to the protection given to private patients. The private patients' procedure is that everybody is sworn to secrecy?—Quite. Of course, one point on that is trying to make the judicial authority function, and we felt that if the public were admitted he would carry out his duties, perhaps, much more fully than he does at present.

11,008. *Earl Russell*: The only public that will go there will be the local reporter. Do you want a report in the "Local Herald" that John Jones, after

28 January, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

having a great deal of family trouble, was accused of being insane, and the doctor showed he was insane? Do you want all that in the public Press?—I can see there are strong objections to it. It is a question of degree. Of course there is this aspect, that so many people, apparently, who suffer in this way think they have not had a chance of clearing their own characters. Is that necessarily insane? That is the point.

11,009. *Chairman*: We are fully sensible of that point, but we are not satisfied that publicity is the remedy, because another thing about publicity is that it is to be at the option of the patient in this case?—That is our suggestion.

11,010. A fallacy is the hypothesis that the patient is capable of exercising an option which will be in his own interests. Just remember this: there is a class of patient whose very delusion, delusion of exaltation, courts publicity; he wants to have a scene, and wants to talk about himself in public?—Quite.

11,011. That patient, in whose case publicity would probably be most unfortunate, is the very man who would say, "Certainly I want to go before the justice, and if I could get the Lord Chief Justice I would get him," and with a reporter taking down the sensational parts of his evidence, if I may so put it, you would just be putting him in the environment which would tend to exacerbate his complaint.

11,012. *Earl Russell*: It would be almost going back to the barbarity of the Middle Ages?—Of course, it is his last public performance, but I do not think it would damage him very seriously. There have been cases of that sort. There was a case where a man stood on the steps of the Royal Exchange and got into trouble with the police. He did it a second time; when he did it a third time it was considered a condition of mental instability.

11,013. How do you know what the medical evidence would have been at the trial, what history of disease it might have shown, that he would not care to have had published?

11,014. *Miss Madeleine Symons*: Is it not conceivable that that kind of patient might regret it very much on recovery?—In this particular case I do not think he would have regretted it. We must take general cases, of course.

11,015. *Sir David Drummond*: What about his reputation after he had recovered and went back to his office, and lived in terror of cuttings from the newspapers?—You think he is less prejudiced if it is merely known that he has been away, without knowing the cause of it?

11,016. *Chairman*: Surely, I think so. Let me put this case: the man has delusions of exaltation, but they are not very pronounced, and he says: "I want to be examined in public, and I am going to put up my case there and establish my case for my liberty"; the doctor appears; and the patient himself, or this person who has been appointed to be his representative, cross-examines the doctor in his presence, and the doctor says, "Well, it is a very unpleasant matter I have got to go into. I ought to say that this is a case where, although I cannot be certain of my diagnosis of the case, I am afraid that this patient is suffering from the initial stages of general paralysis of the insane, but as it is not possible at this stage to pronounce definitely on the subject I would not like to say so, but I must tell you conscientiously what I think. I hope I am wrong, but I think it is so." Think what damage would be done to that man if in point of fact the reading of the symptoms was wrong, and he never had general paralysis. His wife and family would read this in the newspapers, and the man suffers. I should consider it would be a very grievous injury to the man. Now in the ordinary case of a doctor consulting in a case outside the room, he might quite well say to his consultant, "What do you think of this case? I do not like the symptoms he shows; they look like G.P.I." The other doctor says, "I have seen a lot of these cases. I am not at all convinced, but it does look like it," and they would say,

"We must not say anything to the people involved until the thing is clear." And one must remember how the scientific mind looks at these things. Now if all that had to come out, I can conceive irreparable injury done to a patient in public?—Need it necessarily come out, if the doctor's opinion is that? I do not think we contemplated a long cross-examination as to the reasons for his opinion. I may say that, of course, one does see at both ends of the extreme a great number of cases in which it would do damage, and we suggest that there shall be a discretion, which might reside in the magistrate, that if the patient demands publicity he shall consider it.

11,017. *Earl Russell*: What are you going to gain by publicity? I could understand if you said you wanted other justices to be there to see fair play, but otherwise what are you going to gain by publicity?—I think we have nothing much to gain by publicity, once we can be satisfied that the judicial authority is really functioning; that is what we expect to gain by publicity—that he will be forced to function.

11,018. *Mr. H. Snell*: Do you not want the patient to know anything that is charged against him? And, if so how can it be in the discretion of someone to withhold information from him?—I was conceding that, in the interests of those patients who might be damaged.

11,019. Yes, but he would still have the grievance that he was condemned to be detained without having the fact of what was wrong with him disclosed?—I do not think you can settle the point at one end.

11,020. No; it is a difficulty?—There is the patient who will be damaged and the patient who will be prejudiced, and our experience does not extend to so large a number of cases that we can attempt to say what those proportions work out at.

11,021. Would you admit that there may possibly be cases in which it would be inadvisable that the full medical trouble should be disclosed?—That is obvious; we must admit that.

11,022. *Chairman*: Then the result of these proceedings would be either that the justice decided that the case for detention was not made out, whereupon the subject of the application would be discharged; or (and this would be a new procedure) that the justice should direct that the patient be sent to some intermediate institution, some observation ward or some such place, in order that the case might be further studied and observed and a judgment come to after fuller information; or he might take the last step of saying, "Well, it is perfectly clear in this case. There is no need to carry the matter further, unfortunately, and I shall here and now pronounce the order."—Quite. And is not there a fourth case, where he might permit voluntary treatment without any order, if he were satisfied?

11,023. It would be then for the patient to be advised to volunteer?—Yes, but we had contemplated that would be open to the patients.

11,024. *Earl Russell*: True, but in form it would mean that the justice made no order?—We are suggesting that, except in the case which is really settled and beyond discussion, the order shall not be made for twenty-eight days.

11,025. If he is going into voluntary treatment, that does mean that the justice, as far as he is concerned, makes no order. What he notes in his book is, "No order"?—Yes.

11,026. *Sir David Drummond*: What length of time do you suppose all these proceedings would take, from first to last?—I suppose they would be almost as quick as the present proceedings, would they not? There might be cases in which evidence is more fully gone into than it is now. Our suggestion rather is that the evidence which we presume now is taken by somebody should be given before the judicial authority.

Chairman: I think what Mr. Parker contemplates could be embraced within the same time.

Earl Russell: I should think it could be done in three days, in normal cases.

28 January, 1925.]

MR. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

11,027. *Chairman*: Now you pass in your *précis* to detention, but we have not finished with certification. What further suggestions have you to make on the safeguards relating to certification?—We do suggest that there should be an appeal to Quarter Sessions, as I think there is.

Mr. Walter Stewart: It is Section 327—"Appeals."

Witness: There is that provision, and we compare that with the proceeding under the Mental Deficiency Act of 1913, where these rights are given. The section there is Section 8, sub-section (5).

11,028. *Earl Russell*: I am very much interested in this: it is quite new to me. Can you tell me what Act this is taken from and put into this Consolidation Act?—I am afraid I cannot.

11,029. *Chairman*: I am afraid this is a mare's nest, if I may say so. Section 327 refers to "an order of the justices under this Act"; that is a special thing; it is not a reception order?—It did cross my mind whether that might be so.

11,030. I think there is no right of appeal at present?—Is there not in the Mental Deficiency Act? I think the relative section is Section 8, sub-section (5).

11,031. *Earl Russell*: That is notice of intention to charge a defective with an offence?—That is notice given, yes. It is Section 61 of the Act.

11,032. *Chairman*: "Any person aggrieved by the conviction or sentence of a court of summary jurisdiction under this Act may appeal to quarter sessions." That is a person who has been found guilty of a misdemeanour under the Act? In that case he receives warning that he is going to be treated as a mental deficient.

Chairman: No. This is a person who has committed an offence against the Act.

Earl Russell: This is an ordinary appeal.

11,033. *Chairman*: Yes, it is exactly the same thing as in Section 327 of the 1890 Act. However, the point is not important, whether it is there or not. What is important is whether it should be there.—I think our view again is that if you get the judicial authority really to function it is not so important. We were anxious to preserve in the procedure anything that was there already.

11,034. *Earl Russell*: You were under the impression that it was there already?—Yes.

11,035. *Chairman*: I am afraid upon that, though it is no part of my duty to express opinions, it does not apply?—I am not familiar with that part of the law.

11,036. Then the centre of your whole contention is that you want a strengthening of the judicial element in the initial stages of certification; you wish the safeguards strengthened?—Yes, for two reasons: firstly, because it is the procedure which we think legislation has adopted from time to time and, secondly, because one cannot help feeling that the public point of view, the point of view of a jury, or even of the Courts, is quite different from the medical point of view, and we feel very strongly that both those elements should act together in reaching a decision.

11,037. Now I think we have explored that topic very fully with you. May we pass next to the question of detention. This is on page 12 of your *précis*. Here you draw attention at the outset to the multiplicity of provisions intended for the protection of the certified lunatic, after certification, in contrast with what you describe as the paucity of statutory safeguards prior to certification?—That is so.

11,038. There is no doubt, of course, that the Act appears to be full of precautionary measures of one sort or another designed to protect the inmate of the institution?—Quite.

11,039. Now, first of all, you submit as a criticism of those safeguards that they are for the most part illusory?—That they do not function as they were intended to.

11,040. The effort in the statute is plain, of course?—Quite.

11,041. How are we to ensure that people will do their duty, Mr. Parker?—I think that is impossible, Sir.

11,042. We can, of course, visit them with punishments if they do not, and we can address admonitions to them to do their duty, but it is more difficult to secure that it will be done in the fashion in which we wish it done? We feel that there are really only two ways of doing it: one is to put in a supervisory organisation, which seems to be effective, and to depend upon public opinion to make that organisation effective. We cannot suggest any other way. Of course, we realise there are difficulties in introducing public opinion into this particular question, but at the same time there are very big risks on the other side.

11,043. Now let us just look at one or two of the points to which you draw attention here—the various forms of existing safeguards. You have dealt with them in series. I am rather struck with this: you do not draw attention to the present system under which a private patient who has not been seen by the judicial authority is to have the right to be told that he may be seen by the judicial authority. That, of course, would disappear if the judicial authority had in every case to see him?—Yes.

11,044. That is why you do not deal with it?—Yes.

11,045. Then you advert first of all, I think, to Section 22?—Yes.

11,046. Which relates to a power to allow a relative or friend to take charge of a lunatic?—The comment we want to make on that is that, of course, so often in these cases it is a question of emergency, and people do not know of these rights; indeed, we have one case in mind where the authorities themselves did not know of the Act, and said there was no such right; and that observation applies to a good many of these sections. People do not travel with the Lunacy Act in their bag, and one does not know where one can get it in an emergency. I am speaking from my personal knowledge. Prior to this inquiry, I had not the slightest idea where to go, and the general public do not know. It would take them a long time to get a copy of the Lunacy Act, and meanwhile all sorts of things have happened. The public ignorance on this question is perfectly amazing.

11,047. *Mr. Micklem*: What is your proposed remedy there?—Generally, we think the big remedy is to simplify the procedure, but having done that, we think that some synopsis of the Act might be available in pamphlet form. The Government issue all sorts of instructions in the case of pensions and other matters. I do not think there is any great difficulty in having something of the sort available in these cases.

11,048. *Chairman*: I thought something of that sort might well be done?—Setting out, not in legal form, quite clearly what could be done.

11,049. *Mr. Micklem*: Do you mean setting out Section 22?—No; I am dealing with the whole of the rights which are open to the public. You see, we get such a number of complaints, not only from patients, but also from the patients' friends. They may be months before they ascertain what their remedy is. They are people who cannot go to a solicitor; they have not got the means. They hear in the asylums of the existence of our Society, and they come to us and say, "What are we to do?" and we advise them.

Earl Russell: You mean a short placard setting out their rights in plain language.

Chairman: Where a member of a family is certified and taken away, I see no difficulty in handing the relative a short statement. I mean, if the Government wants us to deposit moneys in savings banks they have no difficulty in telling us how to do it, and I do not see why, equally where a family has had this misfortune, you should not be able, at the time the patient is certified, to say to the relatives, "Here is a useful summary for you." It would

28 January, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

show them that they had a duty to come and see the patient, and they should be told that in definite language; and should also be told of their rights to visit, and half a dozen things like that. It seems to me it would be a most useful thing that the household, of which there is an inmate in an institution, should know the simple things and the main things that they ought to know. Of course, for complicated matters they may have to consult a lawyer. That is not what you want. What you want is something that tells people about it.

Mr. Snell: Could they not be referred to the office of the local medical officer of health, or some appropriate place, for further information?

Chairman: For further information, certainly; but I think they should have something, so to speak, that they could look at.

Earl Russell: A card printed on both sides, which would have everything on it.

Sir David Drummond: The magistrate who deals with the case might hand them the information in written form.

11,050. *Chairman:* It is very proper, when you are dealing with an obscure branch of law like this, that you should not have to go and buy King's printers' copies of the Act, which the public cannot understand. One might well have a summary of the general rights and provisions about getting letters, and things of that sort?—Yes; we shall come across them as we go through.

11,051. On the immediate question of Section 22, that is rather a direction to the justice, if the friends or relatives can really look after the case, to say that it is not necessary to pronounce an order or, rather, to leave the case in the hands of the friends or relatives?—We believe that that section, as far as our information goes, is very seldom availed of; I do not know why.

11,052. I suppose it will be for this reason, that it is very difficult for the relatives to take proper care of a lunatic?—Quite.

11,053. That must be the real reason. One knows how extremely destructive of the home life a person of that type may be. Take a small house, where you cannot get a nurse: manifestly, proper care could not be taken of anything but a slight case. On the other hand, wealthy people might be able to look after them in their own homes?—My attention was drawn to a case where an old lady was taken ill and the son came down from Scotland and asked if he could not take her to his own house; and in that case they said, "No." Under this section apparently, he had the right to do so. We are not complaining of that, but that is the sort of case where this section might operate.

11,054. Are you sure that this section applies to the case where a summary reception order has actually been made, or is it applicable only to a case where an order might be made?

Mr. Micklem: I think it applies to both, because it says, "retaining or taking."

Chairman: Probably it does; it does not say "alleged lunatic," as it does in other places; it says "the lunatic."

Earl Russell: I think what Mr. Micklem points out in the second line makes it quite clear.

11,055. *Chairman:* Yes. It is rather curious, because it is really tantamount to a method of discharge to the care of relatives?—Practically it is a recognition that relatives may be in a position to give the best possible treatment, where institutional treatment is not required.

11,056. You think that more advantage should be taken of that?—It is one of the things one would like to see on the printed notice.

11,057. Then the visit to private patients under Section 39?—Of course, we just make that comment that so many patients become technically paupers under Section 18, and that that does not operate quite as freely as it was intended to.

11,058. Are we to assimilate the pauper case to the private case and to require a month-end report

in the case of the pauper, or are we to abolish the month-end report in the case of the private patient? That seems to be the choice before us?—I think the former. It seems to me the so-called pauper is as worthy of a month-end report as anybody else. That seems to accord with modern feeling, I think.

11,059. Do you attach importance to this month-end report as causing the medical officer to address himself to the case and to communicate with the central authority?—I think so, obviously, because it does show that the case is then reconsidered.

11,060. Now, on the question of correspondence, which you deal with next, correspondence is of importance, because it is one of the matters which maintains the contact between the patient and the outer world?—That is so.

11,061. I think we may take this point fairly shortly. We have been at a loss to understand why there should be a difference in the matter of apprising patients of their right to have letters sent in the case of the pauper patients as distinguished from the private patients. Do you remember the section which says that in the places where private patients are detained a notice regarding these things should be put up?—Quite.

11,062. There seems to be no reason for that distinction. On the other hand, all letters written and addressed to public persons should, of course, be compulsorily sent unopened, as at present. Notices should be put up, indicating to patients their right to address those persons, and then you have to make physical provision for the posting of their letters?—Yes, and of course, as I point out, there appears to be a great grievance amongst patients that they never know what happens to their letters. They post them, and wait and wait, perhaps for weeks—and one knows the inconvenience in one's own home if one does not get an answer, and wonders whether the letter was posted; and we certainly think that, whatever decision is taken, they might be told that the letters would be returned to them, as I think is done in the Army where letters are censored.

11,063. Yes, but there is this difficulty. There must be a certain discretion in dealing with the correspondence of these people as distinguished from ordinary persons. It may be that letters addressed to public functionaries must go at all hazards, but I can well see that ordinary correspondence not addressed to public officials would have to be supervised?—Quite; but then two points arise: firstly, do the letters in fact ever reach the responsible person who is to exercise that discretion?

11,064. Who is to judge?—Yes; and to meet it, I understand, in asylums recently there is a more marked development in putting in an equipment of locked letter boxes.

Chairman: That is undoubtedly improving.

11,065. *Earl Russell:* I can tell you this, that 35 years ago, in the London county asylums, every patient's letter was seen by a member of the visiting committee. They, and they alone, decided whether the letter should go forward or not?—Yes, and in the 1877 Committee this very question of letter boxes and supervising of correspondence was very closely considered, and the proposal was made then that vetoing should not be by anyone in the asylum, but that locked letter boxes should be sent, as in America, to an outside authority.

Earl Russell: We decided, in the case I am referring to, whether they should go on or not. We used to have baskets full of them.

11,066. *Sir David Drummond:* What is your suggestion?—Our suggestion is that letters should be returned or that patients should be notified whether they have gone. Secondly, we should very much prefer that the visiting committee should be the censor, if that is practicable.

Earl Russell: Of course, I do not mean that all letters were necessarily delayed for a fortnight. It was only those which were not sent on which came to us. No letter was detained which we did not see.

28 January, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

Chairman: I think this is rather a difficult matter, because there manifestly must be letters of a type which cannot possibly be sent on.

Earl Russell: The majority are.

Mr. Snell: We receive them ourselves.

Chairman: I am thinking of things even worse than that—not merely offensive things.

Earl Russell: Incoherent.

11,067. *Chairman:* There are cases in which patients have included their faces inside an envelope, and posted it?—Yes; I am not suggesting that there should not be supervision.

11,068. Reams of correspondence are often produced by a disordered mind. One of the difficulties, I have learned, with regard to the supply of toilet paper is that it is used for writing to the Board of Control. These may seem small things, but they are really in administration very often difficult things to deal with. They are not trivial really?—They are very difficult.

11,069. And one wants to ensure that no letter that is of moment to a patient fails to reach its destination, and yet, on the other hand, you want to prevent causing unnecessary pain outside. Take the rambling letter which is full of obscenities and dreadful things; of course, for that to reach a relative would be most painful. It would be as bad, almost, as asking the relative to come and watch the frenzies of the patient. You must safeguard that. How are we to discriminate? There must be some person to judge. We agree that the letter-box should be there, and that the patient should have the satisfaction of depositing the letter in a letter-box, and that somebody would take charge of it.—That disposes of our main contention, but then there is the further point, and that is the question of complaint. We do attach considerable importance to that fact, that a complaint as to treatment can get through, and one cannot help saying—I hope it is not a reflection on the medical superintendents at all—that people lower down in the administration might be and would be tempted to put a letter of that sort aside, and if you can cover that point you have covered the whole of it.

11,070. *Earl Russell:* The suggestion is that these boxes in the wards should be locked, that they should be cleared, not by an attendant, but by a superior person like a charge nurse, and taken straight away to the central administrative block and taken out unopened—not come into the hands of the inferior staff at all?—I gather that, but it does seem to me a very difficult position, where justified complaints against any institution can be held up. That is what is suggested to us. If they are not held up, there is this further suggestion made, that people are penalised if they make complaints in their letters. That is a much more serious thing to suggest.

11,071. That, of course, is a thing you have to be prepared for in every institution, from the Army downwards.—Certainly, and one does not like to put any limit upon the correspondence, excepting the necessity of sorting out the type of letters you have referred to.

11,072. Which is the chief output in the correspondence from asylums. I am bound to tell you that of the letters we looked at there were not more than 1 per cent. that were fit to be sent outside.—I think the case really would be met, as I have suggested, if the letter which was vetoed, for whatever reason, was returned to the writer. He would then have the opportunity of bringing it before another authority, the visiting committee.

11,073. Consider that. Two large washing baskets full of letters: Are those to be sorted out and returned to their writers?—If the committee have read them, we should be quite satisfied. Our present view is—I do not know whether you can correct it—that it is beyond the capacity of the committee to go into them.

11,074. No. In the case I am speaking of, every letter was looked at by the committee.—That was 20 years ago.

11,075. Yes.—Is it done now?

Earl Russell: Yes, I think so

11,076. *Sir David Drummond:* Would you not trust the medical superintendent?—I think we could trust him, but I do not think he would have the time to deal with the matter.

Chairman: And we are concerned to see that his time for medical duties is as little trenched upon as possible, and I should not like to think of a skilled alienist spending his time reading reams of letters.

11,077. *Earl Russell:* I would very much like you to have 1,000 letters taken at random from the output of an asylum.—I have tested the position by one's experience in the Army, where the number of letters that one had to censor was so large that after a time many were passed without being read.

11,078. *Mr. Snell:* Have you any information as to mechanical difficulties, such as the getting of stationery and postage stamps or anything of that sort inside asylums?—There are constant complaints as to the limitation of stationery.

11,079. *Earl Russell:* We have heard nothing about the cost of postage from any superintendent, but we know that with the number of letters sent out it must be something substantial in the big asylums?—I quite see the difficulties, but I am wondering whether there is any way of dealing with them. Could you make special provisions for patients who have reached the stage of parole?

11,080. A class of uncensored letter writers would be quite a good idea?—We quite recognise that you must cut away the person who writes those impossible letters.

11,081. And they are the most prolific?—They are the most prolific, but there is the other class.

Earl Russell: It would be quite an assistance in your discipline to make a class of uncensored letter writers.

11,082. *Chairman:* I rather think I have had a hint that that has been done in some cases. For instance, I was told a very interesting thing about one place, with regard to parcels coming in. The ordinary parcel has to be opened, because it may contain anything—razors, and all sorts of things. One or two of the patients whom I saw received all their parcels without having them opened at all, and I asked the very question; I said, "Is there not some danger about that?" The answer was, "No; we know that patient quite well, and we know the relatives, and the parcels for that patient are handed to him direct, unopened by us. Those patients are trusted by us." It seems to be one of those things which could be usefully dealt with in rules rather than by legislation, if the general principle is assured, that all letters are dealt with by some responsible person, and not by subordinate attendants?—That is the great thing we want to provide against.

11,083. The risks of victimisation are possibly more likely in the lower ranks than in the upper ranks?—Yes; one does not like to be criticised, and the criticism passed outside.

11,084. *Mr. Snell:* You do not urge that all the letters written, whatever may be their nature, be sent out uncensored?—Oh, no.

11,085. You make no claim that the next-of-kin should see everything that is written?—I think that is going too far.

11,086. *Chairman:* Yes, it looks to me to be a matter concerning which, if we had assured the principle, the detail would be appropriate for regulation in the institution—if we had a sound principle. Now let us pass on to the next thing, about the visits of friends. I am a little appalled at the suggestion that the obligation is to be placed upon friends to visit. How are you going to enforce that?—Are you dealing with Section 47?

11,087. Yes; it is the middle of page 14 of your *précis*: "Visits of Friends, Section 47. This right, we submit, should be obligatory and not permissive, at any rate for a monthly visit." I do not quite understand the obligatory right?—I was referring to the word in the section, that one of the Commissioners "may" give —. I was rather suggesting that he "shall" give, that right of visitation is permissive at present.

28 January, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

11,088. What is the safeguard you are going to impose there? As one knows, at present it is generally recommended that a patient during the first period of detention should not be visited by relatives, until he has had a little time to quieten down and get accustomed to the place; or again there are many cases whom the presence of a relative may excite unduly. If you made it an absolute right that the friend in every case should be entitled to insist on access to the patient you might be infringing upon the medical interests of the patient, might you not?

Sir David Drummond: Very clearly that would be so.

Witness: We have in mind a case there where permission was refused, not by the Commissioners, but by a superintendent to visit a certain patient who was said to be violent, and it was pressed, and I think on the third occasion the visit was allowed for three minutes. The person who paid the visit found that the individual was not in the least violent.

11,089. *Earl Russell:* That was probably why the visit was allowed, was it not?—In this particular case it had gone on for several days, and within two or three days afterwards the man was dead; but still, business of a very urgent nature was transacted. Still, that objection was made, and one does not know whether it was properly made or not.

11,090. But there you did not apply this section. Do not you think the Commissioners are fit to exercise this discretion, without the word "shall"?—Yes, I suppose so. We should not press that.

Chairman: Just look how far it would go. No other authority can go to a patient's room and force his way in.

11,091. *Earl Russell:* And even a prisoner, you know, cannot be visited against his will?—I did not know that.

11,092. *Chairman:* Visits are not always welcome, you know?—Quite.

11,093. But the important thing to safeguard is that the person who has a proper interest to see a patient and whose visit will be calculated to help the patient ought to be admitted, of course?—Quite.

Chairman: I do think this is largely a medical question.

11,094. *Sir David Drummond:* I do not think your medical *confrères* will agree if the Commission recommend interfering with the medical superintendents in such a matter?—I think the only instance in which this arises is cases in which an ex-patient may want to go back and visit his friends, and that may not be considered suitable. However, that is only an exceptional case.

11,095. *Chairman:* I can well imagine that the visits of some ex-patients may be of an agitating character. Of course, we know so often that the ex-patient, particularly the ex-patient who disliked his treatment, if he went back might produce very undesirable results in the institution, might he not? He might be the very source of the agitation, which would be most undesirable, especially if he were not just entirely well balanced, as is the case even with some quite sane people?—Quite.

Chairman: It is now four o'clock. I was going to suggest that we might take your further examination possibly in a fortnight. We are very anxious not to break its continuity. I think we have already arranged to hear the evidence of the Asylum Workers' Union at our next sitting, but they have been good enough, through Mr. Gibson, to tell us that they will meet our convenience in the matter; and in that case we propose to meet on Monday, the 9th February, to continue your examination. Will that be convenient for you?

Witness: Yes.

Chairman: As you can see, we are not anxious to hurry your evidence in any way.

Witness: I am at your disposal entirely.

Chairman: Then we will adjourn to the 9th February.

(The Witness withdrew.)

(Adjourned to Monday, 9th February, at 10.30 o'clock.)

5, OLD PALACE YARD,
WESTMINSTER, S W.1.

NINETEENTH DAY.

Monday, 9th February, 1925.

MEMBERS PRESENT :

THE RIGHT HON. H. P. MACMILLAN, K.C. (*Chairman*).
THE EARL RUSSELL.
SIR THOMAS HUTCHISON, BART.
SIR HUMPHRY ROLLESTON, BART., K.C.B., M.D.
SIR ERNEST HILEY, K.B.E.
SIR DAVID DRUMMOND, C.B.E., M.D.
MR. W. A. JOWITT, K.C.
MR. N. MICKLEM, K.C.
MR. H. SNELL, M.P.
MRS. C. J. MATHEW.
MISS MADELEINE SYMONS.

MR. P. BARTER (*Secretary*).

MR. W. FAIRLEY (*Assistant Secretary*).

MR. ROBERT MONTGOMERY BIRCH PARKER, recalled and further examined.

11,096. *Chairman*: Mr. Parker, on previous days we have examined with you a number of suggested reforms, and when we parted last time we had been discussing the question of visitation.—Section 47.

11,097. Yes; and the general topics we had been considering with you, I think, were all related to the safeguards for inmates of institutions. We had passed from certification and admission, and we were discussing the various safeguards which exist with regard to persons who are actually under detention. You were concerned to show us that in several respects those safeguards in practice did not work satisfactorily, and you had some improvements to suggest to us. We have dealt with correspondence and the exhibition of notices giving patients an indication of their rights, and we have discussed visitation by relatives and others. I think we might now pass on to page 14 of your *précis*.—There is just one point on notices. I have not had the opportunity of reading my evidence, but in my recollection I do not think I have made it quite clear that we strongly urge that all notices affecting a patient while under detention should be exhibited. At present of course only one is exhibited, the right to correspond with the Lord Chancellor and others, but it does seem to us rather absurd that where the law provides all sorts of provisions for a lunatic's protection, which he may use once he is getting better, he should not have access to them; as far as we know he never has under any circumstances access to the Lunacy Act.

11,098. You may recall that in the course of your evidence we discussed a suggestion which I personally thought was a very useful one, namely, that when a person is admitted to an institution, that person, if fit to receive it, should be handed a short pamphlet, or a notice, written in simple language describing the general rights, and that a similar document might appropriately be handed to the relatives or persons interested in the welfare of the patient.—I am rather dealing with a case where the patient would not be in a fit condition to receive it, and am suggesting that he should have access to that kind of document in the asylum when he is well enough to consider it.

11,099. I think there is a great deal to be said for giving information in some form to patients?—Yes.

11,100. You could have notices put up, such as the notices about correspondence, which we have already discussed. Of course, on the other hand, one does not want to convey too much the impression of an institution regulated by all kinds of Acts—you know what I have in my mind?—I quite agree.

11,101. We are all concerned to emphasise the idea of the general hospital as much as possible, and the legal detention aspect as little as possible; but at the same time I appreciate the difficulty which patients who have a genuine desire to know about their rights must experience in ascertaining them?—We have quite a number of cases where this occurs. A patient after months or even years at last has access to the Lunacy Act in particular, and then for the first time he begins to find out how it is possible for him to get out. We shall come to Section 49, the right of calling in two medical men. We have more than one case of that kind where the minute the patient found out there was the right, he called in a medical man and got out. That is the point.

11,102. I follow. Of course I have no doubt that the Board of Control and others would receive many amateur exercises in the law from patients—that would be inevitable—if they were supplied with the material, but that is probably unavoidable. However, I think we are with you in the view that some form of simple information should be provided whereby the general rights, without setting them out in detail, should be ascertainable?—Yes.

11,103. Then let us just pass on to some of the other questions which you deal with. On Section 49, which is obviously a valuable provision of the Act, I think your view is that some provision should be made for meeting the expense of the examination contemplated by that section, where patients are unable to pay?—That is so. If the distinction between pauper and private patient is done away with, of course it seems to us that that point will inevitably come up. It is a very valuable right to get a fresh medical opinion on the condition of the patient, and we want to throw out that suggestion for your consideration, whether anything can be done on those lines.

11,104. Manifestly there also we would require to put some limitation on it, because you could not

9 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

have constant enquiries, and possibly useless enquiries, into the same patient's state of mind repeatedly?—We quite realise that. It is a question of detail. It is the question of the principle we want to put before you, and in that connection on that same section I would like to make this further suggestion: we think it would be very valuable if outside medical men could be induced to visit the asylums more freely, and, particularly, the patient's own doctor. As far as our evidence goes that hardly ever takes place. In fact, I do not know that the patient's personal doctor has any right of entry once a patient passes into an asylum, except under this section.

11,105. Yes, one can see the value of that. Then we pass to an important question, the provisions of the statute for dealing with temporary absences on trial, or for health, Section 55?—Yes.

11,106. What have you to say upon that topic? We all recognise, of course, the value of the provision?—It seems to us probably the most valuable provision in the Act from the patient's point of view, that in the course of convalescence he should be subjected to the only conditions which can really test his condition of mind, and in that connection we want to point out a very wide divergence in the application of this section. Perhaps I might refer you, first, to the Cobb Report. At the bottom of page 62 they deal with it rather conveniently. They say: "The evidence before us does not support Dr. Lomax's suggestions that this practice is neglected. Out of 95 public mental hospitals there are only 12 which do not at present use the procedure; and there are 37 in which all patients are sent out on trial before discharge." We submit that even 12 is a very, very serious figure: this valuable provision is not used at all in 12 hospitals; and if I may refer to the Board of Control's Report of 1923 at page 184—this is a case in which it is extensively used: "Fourteen patients were out on trial. We are glad to notice that considerable use is made of trial by way of testing a patient's fitness for discharge. During the period under review 176 patients were allowed out on trial, and money allowances were granted in just half of the cases so dealt with." That is a London asylum, I think, Bexley. That shows you what can be done. Then on the other side we get very numerous quotations, if I may just give you perhaps one or two. At page 204, Napsbury, they say: "We would strongly urge that trial as a means of testing a patient's capacity to face the world is a most useful thing, and might, as is now largely the case, be made use of extensively, not only to ascertain if a patient has recovered, but also to see if, though not recovered, a patient's condition is such that he might with safety be handed over to the care of his friends. We would recommend this suggestion to the committee's and Dr. Rolleston's consideration." Now, there are very numerous instances which I can give you which show two things, that in many cases it is hardly used at all—perhaps I ought to give you a stronger one—and even where it is used the provision of money varies enormously. Birmingham, I think, is a case where they give money very freely; in other cases they give no money allowance at all, and we do submit that if you want to ease a patient's mind when he goes out to try and face the world, the money grant is probably the most important thing to consider.

11,107. Now, at present the right to give permission for absence on trial is vested in any two visitors of an asylum who have the advice in writing of the medical officer?—That is so.

11,108. So that it is two representatives of the local authority who have the power just now, and the visitors are also the persons empowered to make the allowance, I notice?—Yes.

11,109. On this topic there seems to be again complete unanimity that the provision should be more largely taken advantage of. It is manifestly an admirable thing?—Yes. May I give you just two more instances where no money grant has been made?

One is on page 224 of the Report, Staffordshire, Burntwood. In that case seven patients had been allowed out on trial, but in no case was a money allowance during trial granted. I think that was an asylum with 685 patients, so apparently the percentage is very low and no money is given. On page 246 there is the Worcestershire Asylum, Barnsley Hall. The Commissioner says: "I must again note that in no case was an allowance of money granted to trial cases by the Committee."

11,110. Yes, in that case, however, the right to go out is freely used?—Yes.

11,111. "I was glad to see that 58 patients have been allowed to go out on trial, and to learn that trial is used with a view to finding out if patients are fit to live in the care of their friends, though not recovered, as well as a test for recovery; but I must again note that in no case was an allowance of money granted to trial cases by the Committee." I think you have made your point quite clearly that there is a very large divergence of practice in the matter, and that those institutions where resort is not had to Section 55 suffer in consequence—at least the patients suffer. If it is found advantageous in some asylums, it is natural to infer it would be advantageous elsewhere also?—Yes, and perhaps I might add this, that reading this last Report of the Board of Control, it is quite obvious that they are pressing for this reform very hard.

11,112. I drew the same inference myself from reading it.—Again, the pressing does not seem to have any effect.

11,113. That raises, of course, the difficult question which I have put to you several times. You may enact Rules and Acts of Parliament until you are black in the face, but the question is how you are to get them carried out if you give discretionary powers. It seems to me that the method which would be the most hopeful to pursue would be to give much stronger powers in framing regulations for institutions. At present that power is not a very strong implement?—It is really another reason why we suggest that the Board should have a directing power.

11,114. That is a hopeful line of progress, that you should be able to frame regulations on this and other topics which would have the effect, not only of bringing those powers to the notice of the bodies administering, but also insuring that they exercise them. That is what we want?—Yes.

11,115. So that this is not so much a complaint by you against existing legislation, as that the existing legislation is not being taken advantage of?—That is so.

11,116. Therefore the point is rather an administrative one, to ensure that the existing legislation, though apparently excellent if used, should in point of fact be put into operation?—That is the point.

11,117. No doubt the divergence of practice must be to some extent due to the idiosyncrasies of the medical superintendent—some men would be more cautious or, if you please, frightened to let patients out, while others are more prepared to take risks. It is the advice of the medical officer which goes before the visitors in dealing with this matter.

Mr. Mickle: Under sub-section (6), I think, that is unnecessary, is it not? The advice of the medical officer does not seem to apply to the case of a pauper patient where he is in a hospital or licensed house.

11,118. Chairman: "A Commissioner as regards any hospital or licensed house and two members of the managing committee of a hospital, and two of the visitors may, of their own authority, permit a pauper patient to be absent upon trial." But as it happens there are no paupers, as we know, in licensed houses or registered hospitals. If they were there they would have the advantage of this. (To the Witness): But I think that is the case, is it not?—I suppose they are not technically classed as paupers. Of course, there are people in registered hospitals who pay very little.

9 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

11,119. But they are not, I think, classified as pauper patients?—I was going to suggest that the visiting committee probably have a very great voice in the exercise of this section besides the medical superintendent.

11,120. Yes, but the fact remains that while this subsection (6) deals with patients in hospitals or licensed houses, and gives power to a Commissioner and certain other persons to permit a pauper patient to be absent, I am afraid the answer is, in fact, that there are no pauper patients in those institutions; and, at any rate, the great bulk of the pauper patients are in public asylums?—That is so.

11,121. And what you are concerned with is to see that this right is more freely taken advantage of?—That is our proposal.

11,122. It does apply, of course, to other institutions as well; the probation system is very useful for all classes of patients, I should imagine?—Very.

11,123. You do not confine your recommendation to paupers?—No, by no means, but that it should be general to licensed houses and registered hospitals.

11,124. We have your view upon that. Then may we pass to the boarding out provisions which are to be found in Section 57?—The suggestion we want to make there is that where a justice of a locality to which it is proposed a patient should go is satisfied, that that should equally apply, and if the justice is satisfied the right should be made obligatory instead of permissive. That is rather carrying out our suggestion that the lay authority shall not only have something to say to discharge, but also in the preliminary step of boarding out.

11,125. Yes. This section raises, of course, a question of general policy of some interest. We have been told that the boarding out experiment has been tried in England and has not been very successful. On the other hand, I am aware that in Scotland the boarding out system was very largely taken advantage of. I learn, however, that latterly there has been some falling off in that respect. We will hear evidence later on, of course, of how it is worked in Scotland, but I think in Scotland it has been largely used for the purpose of sending patients who were really harmless, and indeed to some extent useful, out to country cottages where they were more or less incorporated into the household and did some work, did their share of work on the farm or small holding, and lived with the people there?—Yes, that I gather is so. It is largely dealt with in the report of the last Commission.

11,126. Yes. That is a method which has been largely taken advantage of in Scotland. In many of the Highland parishes you will find in a number of cottages a person staying there who is quite harmless, but who is obviously mentally deficient, but is well looked after and does some work, and lives a more or less happy life. The difficulty, I gather, in England has been the difficulty of supervision. That in Scotland, I know, is met by sending round visitors who under the Scottish Board of Control go round and visit these people in the houses and find out that they are being properly treated. It is manifest, of course, that it would be liable to abuse if there were not some supervision?—Quite. It occurs to me in that connection that if the system of district commissioners which we have discussed were adopted, it would facilitate all that kind of supervision.

11,127. It has an attractive side, because it means that the unfortunate patient is not segregated from his fellows, but is allowed to carry on as well as he can still as a member of society, subject to his disability and with the necessary protections?—There is no question, I should think, that he leads a much happier life, and a partially useful life, because I understand some of these cases earn money.

11,128. Those of us who come from Scotland know that they are quite useful about the house, if one may put it colloquially, and also on the holding?—Yes.

11,129. Now, I think we may pass to the question of discharge. We have discussed the terms on which the patient enters the institution; we have discussed the rights which he possesses while an inmate of the institution, and then comes the important question of his discharge, and I should rather imagine from your experience that that is a point upon which attention is concentrated by your Society?—That is so, yes.

11,130. And I suppose that most of the complaints you have had are by people who say that they have been detained after recovery longer than they should have been?—Unduly detained.

11,131. We discussed earlier with you the difficulties which do surround that question—I mean the difficulties of convalescence, and we need not recur to that. Let us attend now rather to the statutory code of discharge, and hear any observations which you have to make upon that topic?—The first point I would like to put before you is Section 72: the case of the private patient who apparently can only be discharged if the person, on whose petition the reception order was made, by writing under his hand so directs. Now that brings up quite a biggish class of cases where we find that the petitioner is interested adversely to the patient. Take the simplest case of all: it is not always that a wife wants to get her husband out. One very strong case of that kind came under my personal observation last year, which I should like to mention, if I may?

11,132. Certainly.—That was a case where a very busy man in the north of England got run down, and he attempted to take his life. He was then under treatment for six weeks in the local infirmary. He was very well known and was visited by a lot of friends. He had the assurance that nothing more would be done, and that he was free to go out. He was then persuaded to go for a fortnight's change, as it was put to him, to a very big registered hospital in the Midlands; of course, he knew nothing about it. His wife knew nothing about it, his two sisters knew nothing about it, and these three ladies took him down to this place. He was admitted and the usual thing happened. When I say "usual," I think it is almost invariable; they are given sedatives when they arrive. His sisters came to visit him the next day and were advised not to disturb him; he himself told me he was under the influence of the sedative well into the next afternoon. When it gradually transpired to the two sisters that he was not in a home of rest at all, but in a big lunatic asylum, they then went up to live in his neighbourhood, and for eleven weeks they lived there, having him out every day. The medical superintendent said, "This man has no business to be here, get him away," and they were absolutely, and entirely powerless until the petitioner, the wife, was at last persuaded to act. There were other features about that case which I should like to mention. That happened to be a case where a very violent assault took place while he was there; his arm was so badly wrenched that the whole of the muscles under the left shoulder blade were destroyed. That was represented at the time to these ladies as complaints on his part of rheumatism, and then ultimately the authorities found out it was something far more serious. Of course, when he came out he had massage, but he will never use that arm again. I could give you the name, but I cannot give it publicly.

11,133. *Sir David Drummond*: Was he certified?—He was certified on the petition of his wife ultimately. That is a typical case, where the man has gone back to his work, and it is very responsible work, and for obvious reasons he does not want to raise the question. He takes no action and it stops there. I only want to point out that it took these ladies 11 weeks to get that man out.

Sir Ernest Hiley: Has the Witness overlooked Section 83?

11,134. *Chairman*: I was just coming to that. (*To the Witness*): You rather suggested that the only

9 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

person who could extricate such a patient was the petitioner; but is there not provision in the Act for the discharge of patients on recovery, apart from the petitioner.—There is that provision, but the point is, how often is it used?

11,135. That is another question; we are looking at the Act itself just now?—I thought I qualified it when I said that, as far as our information goes, this section is very seldom availed of. Of course, one cannot say that positively; I can only say that in the cases that come before us this section is never used.

11,136. That is not quite the point; I understand that in this case it was a hospital that the patient was in?—A registered hospital.

11,137. In that case the medical superintendent who said that the man should never have been there could have given an intimation to the wife to that effect, and then if the patient were not moved in seven days he could have discharged him right away?—He could.

11,138. And should, I take it, in such a case?—Well, Sir, of course one never quite knows. A medical superintendent may say to one person, "You are a person who ought not to be here," and yet he may not care to take the onus of exercising his powers under this section where the petitioner will not act. No doubt ultimately he would, but meanwhile this interval has elapsed.

Mr. Walter Stewart: I did put a question on that point as to how many times Section 83 had been put in operation by a medical superintendent of one of the largest institutions. Perhaps at a later stage you will put that to a witness.

11,139. *Chairman*: Yes. Of course what one is concerned really here with is two things: first of all, is the code adequate, and, secondly, if the code be adequate, is it properly put into operation? These are the two questions which one has always to deal with in legislation. Section 83, I can well believe, is not availed of to the extent it might be. All I was putting to you for the moment was that there is at least in the law, whether it is used or not, provision whereby that gentleman could have been got out in seven days, or should have been, if he was in point of fact a recovered patient?—There is in this 1908 Report the conclusion that the Royal Commission came to, viz., that the real effect of the statutory provisions is that the person is returnable at the instance of the person who lodged him; but really the working of the Act is that the petitioner should be the person to free the patient, and that, no doubt, is subject to Section 83, if it is ever used.

11,140. But your general criticism just now is that the fate of the patient is left too exclusively in the hands of the person who has obtained his or her incarceration, shall we call it, in the asylum?—That is so, and it works excellently if there is no ulterior object.

11,141. But there is the risk, of course, of the petitioner having an interest adverse to the patient?—There is that risk; I do not know; I think it exists perhaps more than one would suspect.

11,142. Of course there is this element to consider, apart altogether from what one might call the more sinister motive, of having a pecuniary or financial interest, which is something of course quite apart; there is the other, which one might call the social element. Take the case of a wife who has had a very painful experience with her husband; she has perhaps quite properly brought about his detention in an asylum; she is told by the other relatives that he has now recovered and ought to be out. She may be not unnaturally reluctant to resume life again just because of her past experiences, and that apprehension may be the cause of the reluctance to put in operation the powers of the Act?—That is probably the explanation.

11,143. It is not a financial matter at all, necessarily, it may be a social matter?—Quite. We submit

that that is a terribly unjust thing. I think that probably operates much oftener than the financial element.

11,144. The financial element is the more dramatic element and lends itself to treatment in novels; but I can well understand the case of a family which has had an alarming experience feeling reluctant to take back the person round whom all the trouble has centred. I can appreciate that that may arise?—I am afraid it is very frequent, and the only thing is that in urging the interests of a patient one has to take that into view; but it is the last thing a family very often wants, whether their experience has been alarming or not, to have anybody who has been the subject of discussion coming back into local family life.

11,145. I will agree with you that that affords no reason whatever for the detention of a person against his will after his recovery, but it may explain the reluctance to resort to the power of release, which is conferred on the petitioner?—I think it does. Then there is another question which is always arising, and that is the fear of legal proceedings. They are frequently threatened, but in practice they are not taken because the money is not available.

11,146. *Mr. Jowitt*: Legal proceedings by whom, against whom?—By the patient when he comes out if he thinks he was wrongfully certified, against the petitioner in the case of a private patient.

11,147. *Chairman*: What would be your practical suggestion upon this, Mr. Parker?—The suggestion we make is that there should be an additional power of discharge vested in the judicial authority—that is to say, that you should have a quick application to the local judicial authority to investigate and to discharge.

11,148. At whose instance do you contemplate that application should be made?—At the instance of the patient or his friends.

11,149. The patient involves difficulties, of course, does it not?—Of course it may. Mr. Stewart points out to me that if the patient had an authorised representative he would be available for this particular purpose, but at any rate for the patient's friends we consider that would be a very valuable provision.

11,150. *Mr. Jowitt*: Logically, you would leave it that the person on whose petition the reception order was made had the right at any rate to procure the discharge of the lunatic at any time?—Certainly, because that operates, no doubt, quite well in the large majority of cases. We are dealing with the opposite class of case where the petitioner is not anxious to exercise the right, and we say there should be some definite alternative.

11,151. *Chairman*: You do not want the patient's fate to be entirely in the hands of the petitioner?—That is so.

11,152. There is, of course, in sub-section (3) of Section 72 a provision which is of some little importance: "If there is no person qualified to direct the discharge of a patient under this section, or no person able or willing to act, the Commissioners may order his discharge." If you had a petitioner who was recalcitrant altogether, and would take no action, that would be "no person willing to act." I do not know whether that means willing to act as petitioner; probably it does. It does not necessarily mean a petitioner unwilling to do his duty?—That follows on sub-section (2), the right of substitution of a person, if the petitioner is dead.

11,153. *Mr. Jowitt*: Of course, the combined effect of Sections 72 and 83 is this, that if you get an unwilling petitioner, a man who *ex hypothesi* has perfectly recovered is detained against his will for at least seven days?—Yes, and much longer.

11,154. But at least seven days?—At least seven days, I agree.

11,155. *Mr. Micklem*: Section 72 does not throw any onus on the petitioner to demand discharge, does it? It only gives him a right whether the patient has recovered, or has not recovered?—It gives him the right.

9 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

11,156. But it does not throw any onus upon him?—No. I wish I could give you this reference here. I will look it up. I think the conclusion came to by the 1908 Commission was that in practice the procedure was that the petitioner was the moving spirit, and that these other clauses are not exercised. They are there, I agree.

11,157. But, *prima facie*, the petitioner would not be inclined to move unless he was so instructed by the medical superintendent. He would have no information before him?—I rather understood that the basis of the Act was that the petitioner should visit at intervals and use his own discretion as to the point at which he should remove the patient.

11,158. *Chairman*: Of course, this Section 72 covers, not only cases where the patient has recovered, but cases where the patient has not recovered?—Exactly. I thought the petitioner was to be in a position to exercise his own discretion as to the point at which he would remove a patient, whether he was recovered or not.

Mr. Walter Stewart: Unless Section 74 comes in.

Chairman: That is the barring certificate.

Witness: Yes, that is the veto.

11,159. But one is considering for the moment what duties are involved in regard to a patient of that sort. As Mr. Micklem points out quite properly Section 72 is really an empowering section. It empowers the petitioner to procure the release of a private patient; but, looking at it from the point of view of the patient, who has the duty to discharge that patient when recovered? As far as that is concerned, I think Section 83 seems to be the section that is applicable. Section 72 does not impose a duty upon anybody; it confers a right?—That is so.

11,160. Therefore the real safeguard for the private patient under the existing code seems to reside in Section 83, and in Section 83 alone, does it not?—I agree; under the statute that is the position and that is why we are so anxious to find out to what extent in practice this Section 83 is availed of. We can only give you the information as far as we go, that it is seldom availed of, if at all.

11,161. But that again assumes recovery on the part of the patient. Section 72 deals with the case where the patient may not have recovered but may still be released by the petitioner. Now the cases are different. A patient may not have recovered, but may nevertheless be quite a fit and proper case for discharge, in the sense of discharge to the care of relatives; that we have in another context. Do you contemplate that there should be this application to the justice, not only in cases of recovery, but in cases where the patient, although not recovered, might be discharged to the care of friends?—We do, because in many of these cases you are dealing with moneyed people, and it does seem to me if they reach a point in their recovery where they can be treated privately, and a judicial authority reviews those facts, and there is no danger to the public or anything of that sort, that would be the proper course to pursue in the interests of the patient. You would hasten his recovery by putting him in more congenial surroundings.

11,162. There are difficulties there, you see. Because, if not recovered, then he could not be kept in a nursing home for gain at present, because he would be a person of unsound mind; and if the relatives said "We really cannot undertake his care" (they might say so quite legitimately, they might not have the means at their disposal, or they might say so from a reluctance to have the anxiety of his care)—what would one do in that case, assuming a man has enough means to receive private treatment outside an institution?—I suppose factors such as that would be eminently ones for the judicial authority to consider. I do not think you can legislate for them; they would turn on the facts of each case.

11,163. I mean the unrecovered patient must be taken to some place of care, obviously. You cannot let loose the unrecovered patient on society plainly;

therefore there must be some method for providing for the continued treatment of that patient, and that seems to be obtainable only in two places, either in a nursing home, or in the private home of the patient himself or his relatives?—If one contemplates that these After Care Associations will grow there will be an outlet there possibly. When you talk of the unrecovered patient, I was rather considering the man who may not be technically recovered, but has very much improved; perhaps you mean by the man who has recovered that the man is in the same condition as when he went in.

11,164. He might be a case, although properly certifiable, who might nevertheless be harmless, and if there was a proper environment for him he might be kept at home?—Quite.

11,165. But you cannot compel relatives, of course, to undertake the duty of care?—No, we are not suggesting that they should. We are suggesting rather the case of a patient who has the means himself, and that, if proper provision can be made for his particular state of health at that moment, the judicial authority obviously is the person to make it.

11,166. At any rate your main criticism upon this part of the statute is that it leaves the private patient too exclusively in the hands of the petitioner?—I think we go further, and say entirely in the hands of the petitioner.

11,167. *Mr. Jowitt*: In practice?—In practice.

Sir David Drummond: Is it not reasonable to assume that in practice nearly always the petitioner, the relative, would be guided by the medical superintendent, as in any case of illness?

Chairman: I should think, Sir David, he would be guided by the medical superintendent on the medical question of recovery or non-recovery, but not as to whether he wanted the person home or not.

Sir David Drummond: But the question would be put to the medical superintendent, "Are you quite sure there is no danger?" and the medical superintendent might be cautious and say "I am not quite sure but I think so." That will happen in the great majority of cases; therefore it is conceivable that the relatives would decline to take the responsibility.

11,168. *Chairman*: Of course, Mr. Parker says he has in view at the moment not the general case, because in the general case fortunately the petitioner is very anxious to get the patient home again if recovery has taken place; but he is contemplating now a case where there may be motives operating the other way. I have put it rightly, have I not, Mr. Parker?—I think so. One has to bear this in mind in the case Sir David raises, that of course in these licensed houses there may be motives operating which will prevent the medical superintendent from pressing a point of that sort.

11,169. That is the financial interest?—The financial interest.

11,170. That, of course, one can imagine, but I think we have been rather impressed with the circumstance that the accommodation in licensed houses just now is so limited that, so far from there being a desire on the part of the medical superintendents of those institutions to get more patients, the difficulty rather is to accommodate the patients there are. They are rather like hotel keepers who have too many applications for their rooms. That may be due to the fact that, although the population has increased, the licensed houses have diminished, as you know?—Perhaps later on we may give you our views on licensed houses.

Mr. Jowitt: May I just ask this with regard to Section 83? Miss Symons points out that it applies to every manager of a hospital and licensed house. Does it not apply to asylums?

Chairman: No.

Mr. Jowitt: Why is that?

Chairman: "Hospital" is defined under the statute. I think that the code dealing with the discharge of pauper patients is different.

Mr. Jowitt: I do not see why it should be. It does remain a remarkable thing I think. Under

9 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

Section 83 in the case of a petitioner who will not help, the doctor makes up his mind that the time has come when the patient has recovered, and yet he has got to keep him shut there for at least a further seven days.

Chairman: That is so in the case of patients in hospitals and licensed houses. In the case of patients in asylums Section 77 provides for their discharge by the visitors.

Mr. Jowitt: That, I suppose, is forthwith.

Chairman: Forthwith. Then you have Section 73, which puts the Poor Law authority practically in the position of the petitioner with reference to a private patient.

Witness: As Mr. Jowitt says Section 83 rather points out that the petitioner is in the possession of extraordinary power. He has to be notified, and the patient may not be let out until the petitioner is notified.

11,171. *Chairman:* There is no doubt that the scheme of the Act is to confine to the petitioner practically the control of the destinies of the patient?—Absolutely.

11,172. Subject to this (again one must carry as many of the provisions in one's mind as one can), that of course, in a licensed house the patients are kept for gain, and if a patient has recovered and the owner of the licensed house continues to keep the patient there for gain, he is contravening one of the cardinal provisions of the Act?—Yes.

11,173. And he has to look after himself there and take his risks of that?—Yes.

11,174. Then you refer to Section 73, which we have already mentioned. It is enough to say there probably that the Poor Law authority is in the position of the petitioner in relation to the pauper patient, and may order the discharge.—That is the position, and both sections are subject to Section 74, which is the right of veto of the medical superintendent, and you will notice that it is confined to: "if the patient is dangerous and unfit to be at large."

11,175. You draw attention to a point of some importance, the money question. The patient on discharge, of course, will find himself in the ordinary case without means if a receiver has been appointed. He is discharged, and until he is reinvested in his estate he is practically penniless?—That is so. We were not sure whether it was in your Terms of Reference, but we wanted to put it before you, that in practice the procedure of obtaining possession again at this stage is a very slow one, and as far as our evidence goes the allowances given are extremely meagre. Of course you have the case of Mr. H. in mind; he had money from his club. In another case which occurred very recently, I think, the Master offered £1 or something; it was a small estate of £200 or £300, and under pressure, and a lot of arguing, it was ultimately raised to £3. Of course that is quite inadequate.

11,176. At present, where the estate is taken charge of by a receiver the patient's money is applied by the receiver for the benefit of the patient. If he is in a licensed house the charges are paid by the receiver?—That is so.

11,177. What you contemplate, I take it, is that upon his being discharged recovered, he should be entitled to call for payments from the receiver out of his own estate until the formal re-investing takes place?—Yes. Even if those payments were to come out of capital, he is in urgent need of money, obviously, and the procedure is rather cumbersome at present, and the decision is very strict apparently.

11,178. But suppose he was a patient in a licensed house where the receiver was paying five guineas a week for him. I should have thought there would have been very little difficulty in his getting the five guineas a week when he recovered, by intimating to the receiver that the payment, instead of being made to the keeper of the licensed house should be made to himself?—I am afraid we have not enough evidence upon that point to be of assistance.

11,179. It is a practical point, of course?—It is.

11,180. Because it is concerned with the rehabilitation of the patient as a member of society. We are assuming he has recovered; he is going out into the world again, and he is naturally in rather a difficult position, because his estates are in the hands of a receiver. Some provision should plainly be made for his maintenance during that time until he gets control of his property once more. However, I think we need not explore that with you, because we propose later on to call some evidence from the Master's Department. It has only this bearing, I think, upon the Terms of Reference, that we are concerned with the discharge of patients, and I think we are concerned incidentally to see that the patient is discharged under circumstances that are for the benefit of the patient; it is only in that rather remote way that we are concerned with it, and we shall have some evidence upon it.—Perhaps if you are going into that, we might put in a memorandum giving you some instances on that point.

11,181. If you would; there is no difficulty in doing that, I take it. Then, on the barring certificate, Section 74, I suppose you really cannot criticise that; there must be in somebody a discretion to say whether the person can or cannot be discharged under Sections 72 and 73.—We think that would be quite well met if you had the judicial authority functioning as well, because then his opinion would become purely a matter of evidence.

11,182. It is a little alarming to contemplate that the justice might be permitted to overrule the decision of the doctor in charge of the case. Suppose the doctor certified, as he has got to do in writing, that in his opinion his patient was unfit to be at large, does your confidence in the justice go so far that you think he might quite well say to the medical superintendent, "I do not agree with you"?—What we feel all through is this, that the opinion of the judicial authority will, and always must, vary from the opinion of the medical authority. The medical authority is trying to establish an ideal, the legal authority in our opinion is taking a practical view, and is prepared to take a practical risk; and that is the difficulty that we see all through, that the two standards will always be dissimilar. We think in the interests of the patient, and the liberty of the subject, on all these questions that the practical standard is the one that should prevail, that a slight risk should be taken.

11,183. If we read on, in Section 74 you will see that the barring certificate is not absolutely autocratic?—It is qualified.

11,184. And observe there is just what you desire, though possibly not in the form you desire it; but there is a provision for the intervention of what one may call the lay mind, because it is qualified by this, "unless two of the visitors of the asylum" (these are the men of the world that you want) "or the Commissioners visiting the hospital or house, or the visitors of the house, or in the case of a single patient, one of the Commissioners, after the certificate has been produced, consent in writing to the patient's discharge." So the medical superintendent may say, "I certify this patient as dangerous and unfit to be at large," and nevertheless two laymen, visitors of the asylum, may consent in writing to his discharge?—Again we come to the practical point: Is this ever exercised? We say in practice it is not.

11,185. We must keep our minds clear of the distinction between the existing code and its exercise?—That is the reason we want the outside authority. We believe that the relation of the visitors to their superintendent must be such that they are entirely guided by his opinion. They do not exercise an independent authority, and it is for that reason we say if you get a fresh mind coming in you get a different state of things.

11,186. *Mr. Jowitt:* But surely on a point of time this is the right machinery. Under Section 72 the petitioners would have the right to demand the dis-

9 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

charge of a lunatic, and you must have the medical superintendent who is on the spot able to put a stop order on the discharge until you call in somebody whose visit may take some time to arrange?—Yes.

11,187. But really you accept the machinery in Section 74, but you want to substitute for the visitors to the asylum the judicial authority?—I prefer to say add a judicial authority, because if there was a judicial authority in the background we think it would be a spur, a certain incentive to the visiting committee to function freely.

11,188. *Earl Russell*: Adding by way of appeal to the persons named at the end of the section?—We have not contemplated an appeal. Mr. Stewart asks me to read this section from his case: "Subject to modifications in detail the following is in rough outline the procedure suggested as appropriate for insuring fair play to alleged lunatics at the hearing before the judicial authority. The patient or his authorised adviser, together with any person seeking to show cause for or against the granting of an order absolute, shall be entitled to be heard, subject to the right of the patient or his authorised representative to inspection of all entries in the case book relating to the patient and to cross-examine adverse witnesses, and to call medical or other witnesses (if available) to depose to facts relevant to the question of his mental state, and to make such comments as may properly be made concerning documents produced in evidence. The judicial authority shall be entitled to address such questions to witnesses as he may think proper, and after hearing all the available evidence, may either make a 'rule absolute' or dismiss the application for the same as to him seems proper." That is a summary of the judicial authority functioning as such, if the case ever reaches that point.

11,189. *Chairman*: I have a little difficulty in seeing why the justice of the peace would be more effective here than two of the visitors. No doubt he would be a different person. But the justices of the peace are chosen from just the same class of people as the visitors come from. The visitors are members of the local authority, county councillors, or borough councillors?—Yes.

11,190. The justice of the peace is, after all, generally chosen from very much the same class of people. Why do you think he would be a more efficient person to have this power than the visitor would be?—We think so, because at present we do not think the visitors function under this section at all.

11,191. That I can understand.—As an ideal, if you could insure the visitors functioning, we should say at once that they are just as competent as a justice of the peace, but if you get with a justice of the peace an open judicial proceeding in the background, a sort of court of appeal, we believe that that would be very valuable in making the visitors function.

11,192. *Mr. Micklem*: May I put this to you: In this particular case of Section 74 the petitioner requires the person of unsound mind to be handed over to him?—Yes, in the case of a private patient.

11,193. Yes. The medical officer says, "No, he is not in a fit and proper condition; he is dangerous and unfit to be at large." The petitioner thereupon would immediately apply to two of the visitors, or to a Commissioner, and he would say, "This man should be handed over to me; I am prepared to make these arrangements for him and take care of him. I want you to consider whether I am not to have him." Do you say, in that case, the visitors or the Commissioner would not properly function?—We have no cases before us in our limited number of cases in which discharge arises in that way. It seems to be entirely in the hands of the medical superintendent; and if he is adverse we do suggest that the members of the visiting committee very seldom take an opposite view, and we should like that tested.

11,194. This is the case where the petitioner and the medical officer are at variance, and the petitioner

calls in the visitors or a Commissioner to assist him.—And they go straight to the medical superintendent, and all you get is his view repeated—he has not thought that patient fit for discharge himself.

11,195. Would you get any more if you had a justice of the peace?—Yes, we should get that outside view to which we attach so great importance.

11,196. *Chairman*: If the whole machinery which you contemplate of a judicial investigation were initiated, I could understand some different results might follow; but if it is merely exchanging the visitor for the justice of the peace as the person who is to decide, it does not seem to me you would get very much further.—We do not say exchange; we say add.

11,197. You add a great deal there about the cross-examination of witnesses, and so on, all of which suggests the paraphernalia of a court of appeal.—That is really what we suggest: the judicial authority should be here, and if these people do not function, there should be an outside court of appeal, quite apart from the permanent officials of the asylum. It is a question of principle.

11,198. *Sir Ernest Hiley*: Does Mr. Parker suggest that the justice of the peace would be more efficient in this case than he is with regard to certification, because it is complained he is not efficient with regard to certification; is it likely he would be more efficient when it comes to discharge?—We say he is not efficient under the present procedure; that the procedure should be more properly judicial; that at present it is administrative.

11,199. *Earl Russell*: Before we leave these sections I would like to put to you another view of it. It has always seemed to me that the principle in Section 72 and Section 73 is wrong, by which the patient is regarded as the private prisoner of the petitioner, and the petitioner has power to take him away without any reason assigned and put him somewhere else. It may be that the petitioner is either hostile or careless or a brutal person and wants worse treatment, or wants to have the patient himself in his own house when it is not right that the patient should be there. What do you say with regard to that?—I think before you came in we had been discussing that point at some length.

Earl Russell: I am sorry if I am putting something to you which has already been discussed.

Chairman: The view taken by Lord Russell was that to confide the entire control of the destiny of the patient to the petitioner is unfortunate unless you have adequate safeguards.

Earl Russell: It had rather occurred to me that instead of the barring certificate it should be done the other way about.

11,200. *Chairman*: You know there is the other point, Mr. Parker, there is the other class of relative who wants to get his weak-minded relation out of the asylum and into his own charge, into his own power. You know these things do occur?—We realise that, if I may say so, very fully. There are such a number of cases that we have been driven back to the same argument, that you must have an authority which will go into each case on its merits and weigh up the evidence. I think that is an additional argument for a judicial authority to come in.

11,201. *Sir Humphry Rolleston*: There is a point, I think, which lies at the bottom of that, and that is that Mr. Parker is extremely anxious to avoid any abuse on the part of the medical superintendent, and he says that in order to attain that object it is desirable to have an enquiry quite apart from the superintendent. The medical superintendent will know the case, either directly or from information received from the medical officers under him, who are constantly looking after the patient; is it conceivable that an enquiry without any reference to the medical superintendent would really be in any way adequate—because a patient may be perfectly sound in mind for a certain time, but it is known to those who are watching that at times he becomes

9 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

violently homicidal?—In that connection I was rather struck with Dr. Barham's evidence, because he told the Commission quite frankly that he was largely guided by the views of his doctors. He did not pretend that he could deal with all the patients himself. It occurred to me then that if he is simply weighing evidence, he might quite well weigh that evidence in collaboration with a judicial authority. It becomes purely a question of evidence. The medical view is put forward in one case; in the case we put before you, we say just as the lay authority is involved in certification so he should also be called in in the question of the discharge, and that they should collaborate together and reach a decision.

11,202. I think I misunderstood you in using the words, "quite apart from the medical superintendent"?—I quite recognise that the medical view would have to go fully before the judicial authority.

11,203. *Chairman*: I think Mr. Parker's view involved this, that the medical superintendent, or the particular subordinate medical officer in charge of the case, should certainly contribute to the investigation. I do not think you excluded that at all?—Not for one moment.

11,204. You rather meant that instead of their having, what one would call the control of the situation, they should be rather contributors to the decision of an independent body?—That is so.

11,205. With direct evidence?—Is the decision to be purely medical, or is there to be a lay element in it; that is the issue.

11,206. *Mr. Jowitt*: I think, in practice, unless you get as the judicial authority a man with experience or expert knowledge, you would always find him completely bound down inevitably by the opinion of the medical expert. You will not get the ordinary justice of the peace to take the responsibility of differing from what the doctor says?—I am afraid, up to a point, that is a very strong probability.

11,207. And the only way you would get over that would be by getting somebody who has sufficient experience or expert knowledge, to act off his own bat?—Subject to this qualification, that if you get publicity, that is a very great spur, and of course we should suggest there should be a representative in charge of this man all through who would draw out the necessary evidence.

11,208. *Earl Russell*: But take the case that was put to you: supposing it is said by the medical superintendent "Although this man looks very sane now, he is homicidal, and he will be homicidal again," no judicial authority (however strong a man he was) is going to take the responsibility of saying "I will let him go"?—I quite agree, but what percentage of cases would that cover? As far as my information goes with regard to homicidal cases the percentage is very very small.

11,209. But what percentage of cases do you think a medical superintendent keeps now that would otherwise be discharged? Put it the other way?—I am not going to give a percentage, but from the class of case we get I think it is considerable.

Sir Ernest Hiley: Is it suggested that there should be a public enquiry?

11,210. *Chairman*: We are just back again to the topic which we discussed at such great length with regard to certification. You advocated the optional publicity of the proceedings, and I am bound to say that that part of your evidence did not carry with me personally so much conviction as many of the other things you have told us, because it seems to me that publicity is the very thing people want to avoid in this matter. We have heard a great deal about the stigma of insanity, but surely the publication of the stigma to all and sundry, which would be involved in public proceedings either at certification or discharge, would be exceedingly unfortunate?—May I just make this comment, that if insanity is to pass, as we are led to

suppose, into a much less terrible thing, and we are to do away with the stigma by various means, I think I can conceive its becoming not of very great public interest to the Press. I do think that the feelings of the relatives ought not to be allowed to weigh with the freedom of the individual. That is the point we are on.

11,211. *Sir Ernest Hiley*: Is it not rather the well-being of the individual?—Of course there again we are supposing that a man is reasonably sane, and wants to get out. Of course the case you are putting is of a person who is insane and wants to get out.

11,212. *Chairman*: A very common inhabitant of the asylum, as we know?—The great majority, I agree. I am afraid we have to face that comment, that we are dealing all the time with the percentage who are wrongfully detained.

11,213. It may be actually a feature of the patient's disorder that he courts publicity; there is a certain attraction to unbalanced minds in seeing their names in the newspapers; even to well balanced minds I have heard it is not entirely unattractive; and to a person who is egocentric (and one knows the egocentric idea is a very common feature of mental disorder) to have headlines in the newspaper might be quite attractive. But the disastrous results might be obvious, because the patient would become excited, stimulated by all the surroundings which you have described, and the excitement of cross-examination, and so on; and the result is that you would have a considerable amount of sensationalism imported into the case, and the patient, at the end of it, might possibly, to put it colloquially, just go off the deep end. That is quite possible in human frailty?—I am afraid it is quite possible in a large number of cases.

11,214. You could have a gentleman very anxious to have publicity, and it might occupy a good deal of public time among other things, and he would very far from benefit from such procedure—the class of person whose case you are figuring. A man who is really sane, and who can take a balanced view of the situation would probably very much prefer that his case should be taken in private, I imagine?—That is why we say it should be at his option. We say the difficulty is that publicity might be used by the wrong type of man.

11,215. Exactly. In that case you would be bound to say it is by discretion?—Mr. Stewart says the authorised representatives, or perhaps the judicial authority.

11,216. *Earl Russell*: I do not think you need be afraid of the small number. If you can satisfy us that people are wrongfully detained, I am sure we are all anxious to do everything possible to avoid it. It is not the small number that will stop it?—You will see that from the evidence we are going to submit.

11,217. *Chairman*: Now this judicial authority who is to be invoked is, I gather, to be a person who has an additional power of discharge over and above the existing power of discharge?—That is the proposal we make.

11,218. When you talk of him being additional, is he to be by way of appeal from the existing persons, or is he to be independent of them?—By way of appeal only.

11,219. I want to know how you contemplate it. You say there should be an additional power of discharge vested in the judicial authority. Now is he simply to be added to the persons operating under Section 72, or is it to be an appeal from the persons who are contemplated by Section 72?—I think it would be quite sufficient if it were made an alternative.

11,220. *Earl Russell*: But then you would not bring him in if the visitors had functioned or failed to function?—If they failed to function, then the patient or his friends would have access, and in the summary of points in the last section of my *précis* we add this point. "That any person having reasonable cause to suppose that any person is wrongfully detained and swearing an affidavit to that effect

9 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

may be entitled to a hearing before the judicial authority."

Mr. Jowitt: If it is alternative, and the visiting committee have affirmed the decision of the medical superintendent, then there is no room for the judicial authority.

11,221. *Earl Russell:* That is your trouble; he will not come in at all?—Then it must be additional, by way of appeal.

Mr. Walter Stewart: In our case it is put as additional, but subject to a time limit; it would not be reasonable to have these proceedings, perhaps, once every three months. Perhaps once a year is suggested.

11,222. *Chairman:* That is not quite the point. Under Section 74 the relative, let us say, has applied to have the patient restored to him. The doctor says: "This patient is dangerous and unfit to be at large." At the present moment he can approach two visitors of the asylum, and ask them to consent, notwithstanding what the medical superintendent has said, to the discharge of the patient. Do you contemplate that the option should be given to that person to go instead to a justice of the peace rather than to two visitors of the asylum and say: "Now will you order the discharge of this patient," or do you contemplate he should go, in the first instance, to the two visitors, and on the two visitors having turned down the application, resort then to the justice to obtain a reversal of the decision of the two visitors?—Undoubtedly the latter. It would be an appeal, would it not?

11,223. Yes?—That is really an appeal.

11,224. *Sir David Drummond:* Do I understand you to say that you have never known the visitors function independently of the medical superintendent?—I meant to say this: within the limited number of cases we have dealt with, I do not recall one in which we know the visiting committee has functioned. Of course, obviously they must function frequently.

11,225. *Earl Russell:* Sir David and I can give you half a dozen cases from our own knowledge where they have gone flat against the advice of the medical superintendent?—That is very interesting.

11,226. *Chairman:* For the moment this is only on the question of the barring certificate, whether the visitors overrule the barring certificate, and of that you have not had experience?—No, but quite frankly I want to say that our cases are so limited that we cannot suggest a general principle on that limited number of cases. We ask you to address your questions to it, to find out from other witnesses. We do not know, and we have no means of finding out.

11,227. Besides, quite apart from individual cases, I think, if I may say so, the value of your evidence is the criticism of the code. If you can show that there are possibilities of abuse, apart altogether from whether you can prove that those abuses are real, it is relevant?—Yes.

11,228. But I think we may pass from that now to the utilisation of Section 79, which is the discharge of pauper patients to the care of relatives. That is a very useful provision, as we know, and in this case I think it is taken advantage of to a considerable extent, is it not?—Yes.

11,229. We have heard that in evidence?—You see there again this section is permissive, and if you compare it with Section 22, which is the same sort of procedure, as an alternative to certification, the language there is rather different. It says: "nothing in this Act shall prevent a relation or friend from retaining or taking the lunatic under his own care." Here it is much more permissive, and we think it might with advantage be strengthened.

11,230. Surely there must be an element of discretion in the exercise of the powers of Section 79 also?—Of course, there again it is a question of principle. Prior to certification, in Section 22 there is no such limitation.

Earl Russell: But it might be an undesirable friend in every way.

11,231. *Mr. Micklem:* There is a limitation, Mr. Parker, in Section 22: It is "nothing in this Act shall prevent a relation or friend from retaining or taking the lunatic under his own care if a justice having jurisdiction to make the order, or the visitors of the asylum in which the lunatic is, or is intended to be placed, shall be satisfied that proper care will be taken of the lunatic"?—Yes, that of course, is in both sections, and we say that in the second section which we are considering, Section 79, if the judicial authority is satisfied, then nothing shall prevent it.

11,232. *Chairman:* I see you merely mean this, that if the visitors are satisfied that the lunatic shall be no longer chargeable to any union, county or borough, and are also satisfied that he will be properly taken care of and prevented from doing injury to himself, then on their being satisfied on both those matters, they ought to discharge?—They ought to. Use the phraseology of the other section.

11,233. That does assume that they have applied their judgment to the question of whether he will be properly taken care of?—We wanted just to call attention to the dissimilarity of the two provisions.

11,234. *Earl Russell:* You want to put "shall" instead of "may if they think fit"?—Yes, or the wording of the other section.

Chairman: You may put it that the two visitors, upon being satisfied of certain things, shall discharge?

Earl Russell: Yes.

11,235. *Chairman:* I do not know that there is much probably in that. Then Section 75 relates to the discharge by Commissioners?—Yes, and the only comment we make on that is that the same power of discharge should be vested in the judicial authority. If the proposals are acceptable that would follow, possibly.

11,236. Then we have already referred, I think, to Section 77; but that section, and Section 78, both relate to the general methods of discharge, in the one instance from asylums, and in the other from licensed houses by visitors?—That is the general method, and I do not think I need repeat there what I said just now, that we do not think that the visitors do function as fully as they are intended to under the statute; but that is a question of fact, of course.

11,237. Something could be done, could it not, by regulations, making the visitation more effective, and enabling a patient as of right to have access to the two visitors, or three visitors, as the case may be, at reasonable intervals, and to state his case to them?—Yes. That comes in again, of course, under Section 188, the next section.

11,238. We might just pass to that, if you please?—Sections 188 and 193.

11,239. This is the large question of visitation, and may I take it at the outset that the general criticism you make is that the visitation, which is intended to keep the patient in contact with the outside world, is liable in practice to prove ineffective, because the visitation is liable to become perfunctory?—That is so, both the visitation by the visitors, and, of course, the annual visitation, the other form, by the visiting Commissioners; and we do attach very great importance to this. If I may refer, first of all, to what the last Royal Commission said, I think it perhaps would be of assistance.

11,240. If you please?—First of all, section 654, page 217 of the Report of 1908, I should like, if I may, to give you the Commission's view of the visit, and then to read you an attendant's view of the visit, and then a patient's view, and that will put before you, what in fact does happen on these occasions.

11,241. First of all, we accept the principle that visitation is a most important safeguard?—Intended by the statute to be the most important safeguard.

11,242. The question is whether it is accomplishing that object?—Yes.

11,243. And you are now going to give us some criticisms upon the way in which visitations are

9 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

carried out in practice, and how the system may be improved?—Yes. In Section 654, at the bottom of page 217, there is Dr. Needham's description of a visit: "It is always a surprise visit. We go into the asylum and we see the superintendent and we hand in a schedule of particulars which we ask to have filled up with reference to the admission of patients and changes that have taken place amongst the patients since the last visit, the number of deaths, causes of death, and matters of that kind, mechanical restraint, seclusion, and a number of particulars. That has to be done by the clerk, and by the medical officers while we are inspecting; we also inquire as to the number of attendants who have left, and a number of matters of that kind. Then we go round the wards. We go into each ward, and as we go in we see the charge nurse. We are accompanied by the medical superintendent and the assistant medical officers, and by the matron or by the head attendant. We take down in each ward the number of patients, the number of attendants, the number of patients who are epileptic, and the number of patients who are suicidal, and the number of patients who are in bed. Then we proceed to count all the patients in the ward, so as to make the numbers tally with the number given to us. Then we go round each ward, walking slowly from patient to patient, and giving every patient the opportunity of speaking to us, many of the patients availing themselves of that opportunity. If a complaint is made to us we investigate the complaint." And then he says they go into the committee room, and write their report. We believe the suggestion is that the Commissioners investigate anything up to 600 cases each a day, and if you turn to the opposite page, there is a very important bit of evidence that was given by Sir George Savage before this Commission. Towards halfway down Section 654 he says: "I may say the visitation by Commissioners, when they talk of being able to see 800 patients in a day, although a large proportion are weakminded, must mean very imperfect visitation; periodically I go to a lot of these private asylums and hospitals, and if one sees 30 or 40 in a day and really takes any interest or notice of their progress, it is as much as one can do. As for seeing 600 or 800 patients no one can do that in justice to them, it seems to me." And then he goes on to make a very valuable suggestion that with a view to preparing a case to come before the Commissioners on that visit they should send down a clerk—he says "a clerk from the Commission should verify the cases of the patients and should ask them if they wish to make any complaint." That is beforehand, so that the case may be ready for the Commissioners when they come, and the Commission itself rather adopted that view. They say this in section 661: "The inspection of the insane is unlike much other inspection, as it is necessarily liable at any moment to involve a minute and expert investigation of the cases of individuals. It must, therefore, be very laborious and exacting. Partly for that reason alone, it is inevitable that there should be a large delegation of detailed work to others than the Commissioners themselves, perhaps on the lines suggested by Dr. Savage; and certainly the terms of the Lunacy Act in regard to visitation should be reconsidered." That is their finding.

11,244. *Earl Russell*: The object of this visit which Sir George Savage comments on there is not to find out whether the patients are sane, is it? It is to give them an opportunity to make complaints and of speaking to the Commissioners?—I agree.

11,245. I mean you can give 300 people an opportunity of making complaints much more quickly than you can find out what their mental condition is?—Yes, but any serious complaint that is made would require investigation, and would receive it up to a point. If I may, I am now going to put before you an ex-attendant's view of visitation. This is a man who had been twenty years in a very big registered hospital in the Midlands, and, as far as one can judge, his views are entitled to be heard, at any rate.

11,246. *Chairman*: I have read a good many accounts. I have read Dr. Lomax's book and his account of visitation, and I have also read other accounts.—I hope I am not wasting your time.

11,247. Not at all. Let us have it if it is comparatively short.—It is one page, Sir. He said this: "Whenever the Commissioners called at the County Asylum, we would be advised by telephone and make our arrangements for their reception. If they called upon us first, we would advise the County Asylum. We would generally have sufficient warning as the word would quickly be passed round the wards. As head attendant" (he was head attendant for 14 years at this place) "I would see that all the lavatories were cleaned up and paper put in, that tooth brushes, brushes and combs, were put out (seldom seen at other times). The patients dressed up in their best clothes and tidied up, sometimes a special attendant put to look after a troublesome patient and keep him tidy for inspection. The side rooms would all be emptied (wherever possible) then cleaned out and disinfected, all the doors left open. The Commissioners would usually stay a little time in the medical superintendent's office, partaking of a little light refreshment after their journey. This would give more time for everything to be put in order. Moreover, the Commissioners would always visit the convalescent or best wards first, thus giving every opportunity to put the worst wards in order. The medical superintendent would always accompany the Commissioners, with whom he always appeared to be on the most friendly terms, laughing and cracking jokes together. To prevent any shortage of staff being discovered and to create a good impression, attendants would sometimes be quickly transferred from a ward which the Commissioners had inspected to another to be inspected by them. They never seemed to observe that this had been done. Several of the Lunacy Commissioners had been medical superintendents themselves and were able to turn the Nelsonic blind eye. Owing to the medical superintendent not knowing many of the patients personally, he took care to always have the charge attendant of the ward or myself at his elbow. If the Commissioners asked any question concerning any patient we would at once whisper the desired information to the medical superintendent. The Lunacy Commissioners would walk through the wards, stopping to converse briefly with any patient that desired to speak to them. If a patient expressly asked for a private interview it would be granted to him" (this is a private patient, not a pauper patient) "but very few patients would ask for this, and they would generally be the old more or less hopeless cases."

11,248. *Earl Russell*: I thought you said this was a county asylum?—A registered hospital. He referred to a county asylum as 'phoning them to say when the Commissioners were coming: "Most of the patients seemed to be afraid to speak to the Commissioners in the presence of the medical superintendent. I consider the visits of the Commissioners a farce, because they appear to depend on the medical superintendent. I have never known anything to result from patients' complaints to the Commissioner except with reference to the heating of the rooms, which on one occasion was almost below zero when the Commissioners came. This was immediately remedied. The reports, with very slight exceptions, were always very favourable to the institution, and the superintendent would laughingly express his satisfaction concerning same to me. I do not consider that the visits of the Lunacy Commissioners afford any real protection to the patients. There is in fact no really independent tribunal to whom they can appeal. Whichever way they turn, they meet supporters of the system. I consider it essential that some such independent legal tribunal should be appointed, to which both the patients (and the attendants) can appeal."

11,249. *Chairman*: Of course that amounts to this, that there is a system of deception practised upon

9 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER

[Continued.]

the Commissioners?—I am afraid it is common to all inspections in all walks of life which are supposed to be surprise inspections. Somehow or other information generally gets out beforehand.

11,250. *Earl Russell*: Is your evidence that that is general, that asylums almost always know when the Commissioners are coming?—Almost invariably. That is why I am stressing it before you, because we attach very great importance to this.

11,251. *Chairman*: Of course an inspection which is an inspection of something which is dressed up for the occasion is not an inspection at all. You want an inspection of the normal state of matters, not of the show state of matters?—Exactly, and that is the alarming thing about it; that our evidence, collected from so many sources, all seems to point to these sort of conditions, and it is the cumulative weight of it which at last does begin to sway one's mind.

11,252. I do not subscribe to the view that the Commissioners who visit are quite such innocent persons as the attendant suggests?—They have a very full day's work.

11,253. But the suggestion is that they are so innocent that they do not see they are being hoodwinked.

11,254. *Mr. Snell*: Is this man known to your organisation?—He is prepared to come here and give evidence upon oath.

11,255. And he is thought to be reliable?—I think so, from the fact that he served for 20 years in his position. I have not seen him personally.

11,256. *Chairman*: However, it is quite a good point to make. One thing strikes me as showing that that must be exaggerated. If you take these large institutions with anything up to 3,000 patients, as we know it is positively a community by itself. I have great difficulty in seeing how, even if the word is sent round as rapidly as possible, you can in the course of an hour or so remodel the whole administration of the place, and have everything in order for the inspection?—I do not think we should suggest that in the case of a big community.

11,257. *Earl Russell*: I thought your suggestion was that they had notice the day before?—In this case, yes. The Commissioners being in the neighbourhood would obviously visit one or two places.

11,258. Do you think the element of surprise would be easier if you had your local inspection? That is to say, somebody living near who would jump into a motor car and drive straight to the institution?—I think you would never know then when your Commissioner was coming. There again this question of notification is not isolated to this. You had the evidence of one medical superintendent before you as to a private asylum in Kent, and we have exactly the same evidence from there. And it is human nature; I do not doubt that it is there for one moment, and I do not think you will ever stop it.

Mr. Walter Stewart: You remember Dr. Yellowlees said that it was tried on with him, but that he would not have anything to do with it.

Witness: May I complete it with a short statement from a patient?

11,259. *Chairman*: Just one moment. I am just thinking over what you have been saying. It is difficult to see how you are to secure surprise visits if there is some system of espionage in operation. I do not see how you can get the surprise visit that you want?—I agree; I think it is almost impossible with the telephone nowadays; I do not see how you are going to do it at all.

Mr. Jowitt: Unless you get, as Lord Russell says, somebody who lives in the district and just walks up.

Earl Russell: If a man gets in a car in the morning they would not know he was coming.

11,260. *Chairman*: You know we are paying some visits ourselves. Probably you will tell us they are not surprise visits, but I think they are?—I think in your case probably they are.

11,261. We must not give evidence ourselves, of course, but I personally have paid a visit to more

than one institution, and I can assure you they had not the faintest idea we were coming because the medical superintendent was not even there to receive the Chairman of the Royal Commission. I was in the reception ward within five minutes of my entering the building and I do not think I was hoodwinked in that respect?—I do not want for one moment to suggest that these big institutions are overhauled in a few hours, but I do think that the weak spots in many of them are overhauled.

11,262. *Earl Russell*: Patients who are dirty are cleaned up, and that sort of thing?—Yes, especially in connection with side rooms, and so on. Of course behind this there is a mass of evidence of patients being specially got up for their visiting friends and taken to other wards. I am not going to trouble you with that, I want to go to the principle. No doubt it occurs, but I do not see how you are going to stop it.

11,263. *Chairman*: May the reform which might at least mitigate this trouble be found in having district commissioners who would have a very much smaller area to handle, and who would be able to drop in and out of the institution much more frequently?—That is one of the bases of our suggestion, that the thing is getting too big to work from one centre.

11,264. Now give us the third party to the transaction, namely, the patient?—The patient I hope you will hear, but what he says is as follows: "The patients are seated on chairs or forms with their backs to the wall. Two gentlemen not known to any of the patients enter the ward accompanied by the medical superintendent (possibly by another medical officer) and also by the head and charge attendants." As you know of course the Commissioners rotate; these successive visits are by different Commissioners to any one institution. "The two gentlemen (Commissioners) part company, one taking one side of the room and the other the other. Without any introduction or information as to who they are, the Commissioners pass by patient after patient, either in silence or wishing them good day. Previous to their visit however there has been a general smartening up of the wards and the patients. The detached attitude usually adopted by the Commissioners and the fact that they are accompanied by the medical superintendent is calculated to create a feeling of timidity and nervousness on the part of the majority of the patients, who therefore refrained from approaching unknown officials, especially is this the case when it is recognised that by writing letters, making complaints and approaching officials a patient prejudices his prospects of discharge. If a patient rises from his seat and approaches the Commissioners they will stop, but the situation of one man standing up in the presence of 60 or 70 other patients, and all the head officials, and detailing his private affairs is very invidious and unfair. Moreover it frequently happens that more than one patient wants to speak to the Commissioner at the same time, some of whom are very excited, and noisy patients will then be told to sit down and the Commissioner will pass on. When the Commissioners are about to leave the ward some of the patients will then pluck up courage to make an appeal, the consequence being that several patients will congregate together, all trying to make their requests known at the same time, causing great confusion, in the midst of which the Commissioners walk out. All these defects might be remedied if in the first place the Commissioners were introduced upon their arrival, and an announcement made that every patient would be given an opportunity to speak to them in private. Although I was always a private patient in the first place, my maintenance being paid by my family, and on the second occasion by the Minister of Pensions" (this was an ex-soldier) "I was not given any private interview until I had made repeated requests. A private interview appeared to be an unheard of thing. Previous to my requests I do not remember any patient having a private inter-

9 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

view. I cannot recollect any pauper patient being given a private interview."

11,265. Yes, our attention has already been drawn to that. The pauper patient has not of right the privilege of a private interview.—Of course that seems to me a very graphic description, and putting the three together, you do see that through them there is running the same type of comment, and I doubt whether the Commissioners themselves would come here and deny it if they were asked.

11,266. You have certainly told us they are over-worked, and they tell us so in their report.—Exactly.

11,267. *Earl Russell*: Would it frighten the patients less if the Commissioners sat like a person examining passports, and the patients are brought before them one at a time and sit opposite them at the table?—The suggestion, of course, is that a private room should be available.

11,268. Even apart from that, you might have a side room, and the Commissioners might sit in a side room. What do you think the effect upon the patient would be?—All our pleas are that there should be something less formal than many patients filing by. Of course the real substance of the complaint is that it is an appeal in the presence of the medical superintendent and the other attendants, and they do not care to make it, because unfortunately there is that impression that it reacts on them if they lodge complaints, and the only way of getting round that is that they should be entitled to make those complaints in private.

11,269. Therefore if every patient passed through a private interview with the Commissioners there would be no invidious distinction between them—a purely private interview?—That would help very considerably, undoubtedly.

11,270. *Chairman*: Of course, the Commissioners would need to make enquiries of the medical superintendent, would they not, after they had seen the patient, if there was any point calling for their attention?—Obviously. Of course we are not stressing these Commissioners' visits; it depends upon other matters, of course, but you want something that operates much more frequently than once in 18 months, and as bearing on that perhaps I may give you the final conclusion of this report of 1908. They come to the conclusion at the top of page 222 that "The policy of the sections referred to is to throw on the local managers—the visitors of asylums and of houses licensed by justices the duty of discharge, and . . . not upon the Commissioners." We suggest that that is really a very sound view to take, that the question of discharge is not one in which the Commissioners visiting once in 18 months can very usefully function.

11,271. On the other hand, they might function very usefully if they were persons on the spot familiar with the asylum, and who had seen the patients frequently?—I agree.

11,272. Many of your suggestions, Mr. Parker, are inter-related, are they not?—That is the difficulty.

11,273. You put forward a suggestion at one point as to the judicial authority operating more. On the other hand, the judicial authority might operate less if you had really reliable persons taking an interest in the cases and looking at them from an independent point of view. The whole question is what are the best points at which to strengthen the procedure—where will you get the most reliable safeguards?—Yes.

11,274. That is your account of visitation, and we have your criticism of it, the visitation by committees and by the Commissioners.—There is just one more point on this question of the visiting committee functioning. I want to give you just an extreme case, on page 161 of the Board of Control report, to show you that these things have substance in fact: "Some male patients informed us that they seldom saw members of the visiting committee in the wards. This matter was mentioned by our colleague in his entry two years ago, and we would draw the attention of the Committee to the provisions of Section 188 of

the Lunacy Act, 1890, which requires visits by at least two members once in every two months. From the entries in the visitors' book only one member appears generally to visit at a time. Some patients also stated that they seldom saw any of the guardians of their unions, and this particularly applied to the Unions of the Isle of Sheppey and Milton." So that you see there is the Commissioners' own report on the failure of an individual committee to pay any attention to the statute. It is a continuing failure for two years.

11,275. But in justice to the Board of Control and the efficacy of their visits I am bound to say there is a lot of very useful material contained in their report. The detail with which they criticise the different institutions is very remarkable?—We want to give them full credit for that, with this comment, that of course this was the first year since the war when these details have been published, and I have not been able to find out whether such detail was ever published before. You have had three Departmental Committees in the last two years, and a great mass of detail which of course is most useful.

11,276. I am told they were published before the war, and were dropped during the war. But I have been very much impressed, upon looking at the report of 1923, with the extraordinary detail with which they have gone into these institutions, and have picked out all sorts of things which were matters for criticism; and they have assisted you very much in your case before us?—Quite. We want you to see that a great deal of our criticism is an admitted case, but when is anything going to happen?

11,277. But it rather takes off the edge of the criticism that the Board of Control is lacking in vigilance. I am surprised really how a comparatively small number of ladies and gentlemen have been able to get through this amount of work and detect so much?—But I do want to make this point, to ascertain whether that vigilance is a new found vigilance, because of the appointment of this Commission.

11,278. *Earl Russell*: It could not have been in 1923?—The new Commission was being pressed for then, and there was this publication of Dr. Lomax's book. I am bound to put before you that we think that did stir up life which did not exist before. Many of these things, when you come to deal with detail, you will find are recent developments; take dentistry, for instance, there has been a tremendous move to introduce dentistry in the last two years.

11,279. From whatever cause, or with whatever motive, I do not care, the point is conspicuous, I think, that the Board of Control have already, if you prefer recently, applied themselves very minutely to the very questions which you are so interested in. One cannot read this report without being impressed with that?—I quite agree, and there one wants to urge that that activity shall continue.

11,280. And do not you carry it further, that they shall not only have power to draw attention to those things, but have some power to see that redress is given?—That is the important thing.

11,281. Now will you just pass from the visits of the Commissioners and the visiting committee to the visit by the guardians. We have had the guardians' visits criticised as being of no particular importance. What do you say upon that topic—Section 201?—Shortly, the evidence we have got is just the same, that in the case of the guardians the proceedings are even more formal. They simply, as a rule, tick off the names of their patients, and it is suggested that the visit really is to see that the money they supply has been properly applied.

11,282. You notice in Section 201 there may be a medical practitioner who has the right to visit; that is rather interesting?—Yes; I noticed that recently, but some months ago I saw a guardian from Hampshire (I did not know the Act then), and he raised this very point. He said he was continually being pressed by the friends of people who had gone into these asylums to report on the case, and he said he very much wished

9 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER

[Continued.]

to take one of the guardians' medical practitioners there; but he had been unable to get his way on that.

11,283. "A medical practitioner appointed by the guardians of a union and also the guardians of any union shall be permitted, whenever they see fit, between 8 in the morning and 6 in the evening to visit and examine any pauper lunatic." That is an important thing if it is taken advantage of?—A very important provision.

11,284. *Mr. Snell*: Is it your suggestion that the guardians do not know of this provision?—I only suggest that in that particular case they obviously did not. I do not know what the general knowledge of guardians is on this.

Earl Russell: The words in the second line of this section are "and also the guardians of any union." I rather take it that means the boards of guardians. It is not quite the same as if it were any guardian of that union. If a single guardian desired to go when the others did not, he might not be admitted.

Chairman: I do not know that that means they must go *en masse*, does it?

Earl Russell: Supposing there were two guardians who wanted to go and the rest of the board did not go, would the two be admitted?

Chairman: I think what we heard was that in practice some of them went; they appointed some of their members to go.

Earl Russell: Yes.

Chairman: It does not indicate whether the medical practitioner could go by himself without the guardians, or whether they must go together.

Earl Russell: I think he could go by himself, because it says "also."

11,285. *Chairman*: Yes, I think he could go alone, if he were appointed by the guardians. Of course, one knows that the departments are in the habit of sending out circulars from time to time to local authorities where any laxity is taking place, reminding them of their powers, and exhorting them to use them. That is all that can be done by a central authority where there is a discretion given to a local authority, unless there is a complete dereliction of duty where you can proceed by a mandamus against them?—Yes.

11,286. Then leaving visitation, you refer next I see to the question of the patient's knowledge of the grounds on which he has been certified?—Would it be convenient just to interpose here before we pass to that, our views on licensed houses, which we wanted to put before you?

11,287. If you please?—They are really these, that first of all we hope this Commission will take the opportunity of ascertaining what the profits of these licensed house are; that is knowledge which is denied to the public, because they are nearly all registered as private companies, and we submit it is a very large question whether in the present state of public feeling any institute of that sort should be allowed to function for exorbitant profits; there are rumours, and these rumours are very widespread; and we want to suggest to you that it is against public policy that extravagant profits should be made out of the misfortune of individuals, and that if it is a question of compensation to vested interests that might well be considered by the State.

11,288. What is your view on the subject of licensed houses generally; do you consider they play a useful part?—Our view is that the legislature is quite right in limiting their number as they did in 1890, and we are strongly opposed to the proposals that have been put before you by the British Medical Association that they should be increased. It is very lightly touched on in their evidence, but I think Sections 47 and 77 are the references in their memorandum.

11,289. But there is this point: the legislature evidently thought in 1890 that they did perform some useful part, because they were continued, although no doubt restricted in number. Is there not room for some such institution; take the ordinary private patient of the middle upper classes who is able to

pay; the surroundings and circumstances of the private house, which are reproduced to some extent in the best licensed houses, surely afford a very desirable environment for treatment?—We agree, on philanthropic lines, yes, such as Bethlem. On the lines of registered hospitals of which there are several, yes, because there are people who can pay, and if they do pay a little more money than is usual it goes to pay for poorer people; but when you come to private profit we then say it is entirely opposed to public feeling to-day.

11,290. Nobody need go to these places unless they like. You might say it is contrary to public policy that an eminent lawyer or medical practitioner should have extravagant remuneration?—That is optional, is it not?

11,291. But is it not optional to go to a licensed house?—I am afraid it is not altogether. The petitioner lodges his patient there.

11,292. *Earl Russell*: But you would not say, assuming you get safety, it was more morally wrong to get money out of a lunatic patient than out of a nervous patient in a nursing home?—Not more morally wrong, but the conditions are very different. If you do not like your nursing home you go out; if you do not like your private asylum you unfortunately have to stop in.

11,293. Is not the real difficulty the doubt about safety where the fees are higher?—Yes; I am afraid personally I have a very strong aversion to the idea that exorbitant profits are made out of that class of business.

11,294. People do make exorbitant profits out of other things?—You have the State interfering in other directions. Perhaps broadcasting is the most recent one, in which they say an individual shall not make enormous profits out of a monopoly of that sort; we think the same thing should apply to a business of this sort.

11,295. It is not quite the same thing, of course. There the State is letting out something that belonged to it?—I am only instancing that the State does interfere in these matters.

11,296. Because it was the State's property that was being dealt with?—True.

11,297. *Mr. Snell*: Is the question of excessive profit the main thing here? Is not the real difficulty that the medical proprietor has to choose whether he will forego the fee that his patient pays him, or whether he will keep him? Is not the position one of conflicting interest, which constitutes the real danger?—Yes, very frequently. That is rather a different point.

11,298. *Mr. Jowitt*: The larger the profit the more the interest conflicts?—Yes; the larger the profits that are permissible the less likely any institution of this sort is to afford the real benefits which the patient is entitled to receive.

11,299. *Earl Russell*: The greater temptation?—The greater temptation.

11,300. *Sir David Drummond*: What is your view as regards the sufficiency of the accommodation for private patients throughout the country?—I can only say I am surprised to hear that there is pressure on the existing places. Within my own knowledge, which is very small, there is no such pressure. I hope it will be removed by these voluntary institutes, and the other matters we have discussed. I do not think that pressure will serve any reason for extending the present places.

11,301. *Earl Russell*: Take a philanthropic place like "The Retreat" at York, which is not run for profit, but suppose you do not find a community of people willing to establish such places, what are you to do with those who want treatment?—We hope that need will be met by all the things we have discussed, by hospitals being made available and all the treatment prior to certification. We hope that that will relieve the pressure.

11,302. But all those things might not meet the case of a man who wants an exclusive high-class place

9 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

for which a large sum is paid?—I think the existing places are ample for it, because they will always make room for the high-class patients, I should think.

11,303. *Chairman*: That is not a very nice way of looking at it?—I am afraid we have evidence behind it; I am not making these statements lightly. You have had evidence of one sort given, and if you force me to it I am going to ask you to send to Somerset House and get the files in the case of the particular institute about which you have had evidence given.

11,304. The question is rather this: Suppose one has a relative and one wants to secure for that relative the best possible treatment. You want to get privacy, and you want to get quiet; you are able to afford it; it may be your own money you are spending, not the unfortunate patient's money at all. The father may be a wealthy man, and the daughter has no money; he is anxious to secure for her the best possible circumstances, is able to afford it, and is willing to afford it. Why should he not be entitled to go to some suitable institution and pay, if he pleases, extravagantly to secure for his daughter the surroundings he desires?—I do not think he should be prevented. But I will give you an exact case, which came within my own personal knowledge within the last few months, of a rich father who wanted those conditions for his daughter, who sent her to one of the licensed houses in London which appears to be one of the best; and I happened to be visiting somebody else down there and came across this girl shortly after she had been there. She told me herself that she was in the refractory ward, that before she had been there (I think it was) a couple of days she had been seized by the hair; she was a very strong girl and high spirited, and she said she turned round and bit the nurse. "Would not I have done the same under like circumstances?"

11,305. I do not see that is quite relevant; in that case the payment was being made and the treatment was not being got.—That is the suggestion we made—that what is being paid for is not being got, and that therefore that class of institution should not be extended, unless you have very strong evidence before you that the need exists for its extension.

11,306. *Earl Russell*: But does not a place get a reputation in the end which depends on its general conduct?—I do not know. My own experience is this—that the inside details of these places are only known to those who have become inmates there.

11,307. The incident you gave us looks to me like one which would cause a man to lose his good will.—It depends how widely that incident is spread.

11,308. *Mr. Jowitt*: That really is a safeguard, is it not? One may say there is a temptation to a barrister *prima facie* always to advise people to bring lawsuits or a temptation to a doctor always to advise operations. The real safeguard is that if a doctor or barrister goes on in that way for long he will lose his reputation?—Subject to this, that these statements are always discounted, because they are made by certified people. There is the difficulty.

Chairman: There is this also. One knows that a great many people have come out from institutions and they have been thoroughly satisfied with their treatment. These people say pleasant things about the care they have received, and so on, and are the best advertisers for the institution where they have been treated. Every person who comes out from treatment is not in a state of indignation, as you know; many of them fully recognise the benefits they have received, and fortunately many of the institutions are well conducted.

11,309. *Mr. Snell*: Is it not true to say that the West Riding County Council runs a private asylum. Have you the same sort of objections to the private asylum run under auspices of that kind?—That is not run for profit, is it?

11,310. Well, no, I suppose it pays its way?—Yes; that is quite legitimate.

11,311. *Chairman*: Mr. Parker says that the possibility of making large profits out of a patient exposes the management to a temptation.—That is the point. I am not suggesting for one moment that all these licensed houses have these abuses. I have several statements of patients who said they considered that the treatment was very good; but it is exactly in those institutions where the temptation proves too great that these abuses arise.

11,312. *Sir David Drummond*: Might we hear Mr. Parker's views upon institutions where the charges are not so great, where they are very moderate, where small fees are taken, and people are able to send their patients there?—Take an institution like Bethlem—I have not been over it; one listened to the evidence, and one could not help being very favourably impressed in that case.

11,313. *Chairman*: That is a registered hospital, of course?—Yes.

11,314. *Sir David Drummond*: What objection have you to places where moderate fees are charged? I am afraid I cannot say that I have any objection; I have no knowledge of such places.

11,315. *Earl Russell*: Would you object, in the case of the rich man who was willing to pay handsomely, to single care—under proper supervision, of course, of the Board of Control?—I think in many cases that would obviously be the most suitable treatment, and it is largely done to-day.

11,316. Of course, there would be the same temptation there, you know, to the doctor in charge of him?—I am afraid in all these cases one can see it is a two-edged sword.

11,317. *Chairman*: All that one really is concerned to see is this, that if this class of institution when well conducted supplies a public want it is desirable that there should be enough of them to meet the demand; and we have an indication that in some parts of the country when the doctor is anxious to have his patient sent to a suitable private institution, not a public institution, he has a difficulty in obtaining an admission to that institution because the numbers are now restricted; and, of course, they are gradually falling in; the tendency is to diminish that class of accommodation. I gather you do not object to that class of accommodation, but your criticism is rather this, that there is a danger that in this kind of institution the patient may be unduly detained because there is a financial motive to do so; and you are out to see that the financial motive should not be allowed to prevail, that safeguards should exist against it. If there were adequate safeguards against abuse, I take it you do not object to the extension of this kind of accommodation if it is wanted?—Not if it is wanted, and subject to what I believe is a strong public view that that class of business should not be run for excessive profits; and that is easily dealt with by making these type of places disclose their accounts, or having them reviewed by some central authority.

Sir Thomas Hutchison: Apparently what Mr. Parker advocates is what is known in the case of other houses as disinterested management.

11,318. *Mr. Jowitt*: Do you have a larger proportion of complaints from these places than from others?—No, I think not.

11,319. So far as you know in practice, there is no evidence that this conflict of interests has any adverse effect?—We could give you cases.

11,320. But you see in other cases, too, with regard to asylums, the motive is obviously an interest to get rid of the patient, to prevent him being a charge upon the rates?—I do not quite follow the point.

11,321. I want to see if you could give us any statistical help to show that the proportion of complaints is greater in the case of these institutions?—No, I am afraid I cannot. In all these things we are limited to the number of cases that come before us. I hope you will get the supplementary evidence

9 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

from elsewhere. We can only give our limited views on a limited number of cases.

11,322. *Earl Russell*: It is a thing we should find it very difficult to get evidence on?—I understand you have had a great mass of evidence tendered to deal with these sort of points.

Chairman: We have.

Sir Humphry Rolleston: I am not quite sure what is the object gained by extracting from the licensees the amount of profit they make.

11,323. *Chairman*: Suppose we find that A.B. who conducts one of the best houses in the country has recently died leaving an estate of a quarter of a million, which is described as having been made from the nefarious profits out of lunatics of this country,—supposing the lunatics have been well treated under his care, why should he not leave a quarter of a million?—If they have?

11,324. That is the whole point?—That is the whole point; but supposing the same A.B. is getting 35 per cent. profit a year, and that you get at the same time statements from the patients that the food is beastly, and so on?

11,325. That means that the man who is paying for all these things is not getting them.

Dr. Sara White: Perhaps the Chairman would allow me to say that in the York Retreat large sums are paid sometimes, but there is no profit, because it has to go to reduce the fees for others.

11,326. *Chairman*: We understand that system; but really Mr. Parker just now is on the general question as to whether licensed houses should be allowed to make large profits.—If you are going to extend them. Admitting the need, we say that the principle of the York Retreat or elsewhere is a very sound principle, that if some pay big fees, and if there is a surplus, it should go in relief of those who cannot pay big fees, and give them treatment which they would not otherwise get.

11,327. Is not your case really this—that persons who pay large sums to these institutions do not receive value for their money?—Unquestionably they do not.

11,328. Why do they go to them?—Because there is nowhere else to go.

11,329. Does not that suggest that if there were more of them they would reduce their tariffs and provide better accommodation?—If you introduced un-

limited competition you might get that result, but I am afraid you might get other results as well. I do not think I can take it any further than that.

11,330. Now we will pass on to another topic. You have a paragraph dealing with what you describe as the patient's knowledge, that is to say, his right of access to information about his own certification. I think we have really discussed that incidentally already, have we not?—I think we have dealt with it.

11,331. We have seen the pros and cons of that subject?—Yes, but the additional point we make is this—that records such as the case book, and so on, we do feel should be available at any rate to relatives; and, of course, as you know at present they are guarded with the utmost secrecy. We ourselves in the case of patients whom we are going to call before this Commission applied to many asylums, asking for leave to inspect the case book of the special patients we were going to call, with a view of saving your time and checking their evidence.

11,332. Of course, there again you are dealing with a difficult question. I do not suppose I have any right to see the case book of my own doctor who has got my own record and many things said about me, and if I asked him for the case book he would say, "I am certainly not going to show you that; these are my own private notes about you?"—I quite agree, but is that case quite on all fours with a public institution?

11,333. But why does not he show them to me? It is just because he says, "I have made a number of notes; it is not always desirable that you should hear everything I have noted about you. It may make you imagine all sorts of things about yourself."—I quite see that, but the difficulty is this—that the relatives never know what is alleged against the patient—I am assuming the case of a petitioner who wants to get a patient discharged—and the patient never has any opportunity of contradicting what is stated there, which is much more important. Later, when we come to a case book, I think you will see that that crops up.

11,334. *Earl Russell*: The actual case book is rather different from telling him what is alleged to be his condition. I can imagine there are very few people, sane or insane, who would, without harm, learn the full medical details about their condition?—No, quite.

(After a short adjournment.)

11,335. *Chairman*: Now, Mr. Parker, with regard to the medical superintendent and his position, I believe you have some comments to make?—Yes. I should like, first of all, if I may, to call your attention again to the Report of 1908, paragraph 655, where Dr. Needham again says this on the question of the interference by Commissioners with the treatment of the patient: "I think we have always held that interference with the medical treatment would be an encroachment upon the duties of the medical superintendent, would limit his responsibility and be rather undesirable. In the medical profession it is not customary for one man to criticise very closely the dealings of another, even if he is in a consultant capacity, unless he has reason to think that the treatment is unsatisfactory." In that connection we feel that that is really the underlying factor which militates against these different authorities acting, that they do not in fact, and they do not care to, criticise each other's duties very much.

Sir Ernest Hiley: Subject to that proviso; you have not completed the sentence here in your *précis*. The sentence you have is, "In the medical profession it is not customary for one man to criticise very closely the dealings of another": but there is something else you read.

11,336. *Chairman*: "Even if he is in a consultant capacity, unless he has reason to think that the treatment is unsatisfactory." Why should he criticise unless he thinks the treatment is unsatisfactory?—The point we want to make is that the Commissioners in fact on their visits do not interfere with the medical treatment, and that is one of the reasons given by a Commissioner himself, and we suggest that probably what held good in the Commissioners in those days still holds good now.

11,337. *Earl Russell*: How could they?—If they are going to discharge, obviously the medical view of the medical treatment is one of the first things they must look at.

11,338. *Chairman*: I do not quite follow this because it is an odd thing to observe that the medical treatment should be removed from the sphere of the medical practitioner. One might as well say that the legal treatment of a case should be removed from the legal expert—some people perhaps think it should?—I am not suggesting that. The point I want to make is that it is left exclusively to the medical superintendent, that he in fact gets no interference from above on treatment or on discharge, and that when we come to deal with his functions he does not in fact himself exercise an independent view below. You have had that in evidence from Dr. Barham.

9 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

11,339. *Earl Russell*: But surely they do interfere with treatment to the extent of calling attention to the people that are employed, the advantages of giving them work, and they call attention sometimes to the use of drugs, and also to mechanical restraint; all those are part of the treatment?—I suppose they certainly are in that sense.

11,340. How much further could they interfere with the medical treatment?—I am not suggesting they should. I only want to clear the ground, and say the Commissioners do not in fact interfere with that side of it.

11,341. Supposing a man is to be treated for some physical ailment as well, how on earth can a Commissioner deal with hundreds of cases of that kind when he comes round?—I am not suggesting that he should, I only wanted to clear the point in considering what the medical superintendent's own position is, that he is in fact in an unchecked position, in an autocratic position, and I think that is fully recognised.

11,342. Just like any other doctor treating any other case?—The comment I am going to make is that he has so many duties that that is a dangerous position to leave him in.

11,343. *Chairman*: You know one of the ideals, if I may so call it, of reform in the matter of the treatment of the insane is to assimilate their case as much as possible to that of people suffering from other ailments. Now people who suffer from other ailments are necessarily to a large extent in the hands of their doctors, because these are the very people who are skilled to treat them. In a sense there is rather an inconsistency in saying on the one hand we want the insane person to be treated just as an ordinary patient, and, on the other hand, we do not want the insane person to be treated just as an ordinary patient, because we do not want the doctor to be the person in supreme control; you cannot at the same time assimilate mental disease to ordinary disease from the point of view of treatment, and subordinate the doctor, because the doctor of course is predominant in the treatment of ordinary disease?—I hope you do not think we are seeking to eliminate the doctor. We are trying to suggest that the medical superintendent as such should have his duties far more closely confined to medical duties.

11,344. That is a large and important topic of course. But the question that arose for the moment was that you seemed to cite Dr. Needham as if you rather challenged his view that interference with medical treatment was inappropriate?—No Sir, I do not challenge his view. I accept his view and I think that reluctance to interfere runs all through the treatment to which patients are subjected. There is no interference from above, and I do not think there is much interference except on rare occasions from below; that is to say, the medical superintendent I do not think does interfere very much with the treatment given by his subordinates, and when we come to consider cases I think I shall be able to show you that.

11,345. *Earl Russell*: Unless he disagreed with it, or thought them incompetent, why should he?—Because there seems to be the idea prevalent that the medical superintendent has his patients in close touch, and under his thumb. (I think Dr. Barham suggested the opposite view.) That was the suggestion made to you, and it is a suggestion which we want to combat.

11,346. *Chairman*: That arises on the question also of whether the institutions at present are not too large to enable the medical superintendent to be in personal contact with the cases; but I am in a difficulty in seeing why, if you have an institution of the proper size and a medical superintendent in proper relationship to his patients under his care, you should interfere with his method of treatment of the cases?—We do not want to interfere with that.

11,347. *Sir Thomas Hutchison*: Is there not some confusion of thought? Medical treatment there does not mean the general management of the patient but the therapeutic treatment?—Yes.

11,348. *Chairman*: Yes. Of course it would be ridiculous if you were being treated for influenza to have a friend coming in and saying "I do not think the doctor is treating you in a proper way; I propose that you take somebody's cough cure." I do not know that that would be a desirable state of matters; you have got to rely upon the medical man in therapeutic treatment. Whether he should have so large a control of the destiny of the patient in his hands when he has so many other things to attend to is a very different topic, and a very serious topic. However, I do not think we are very much at variance on that?—As it is a finding, might I just refer you again to the Cobb Report, page 21, at the bottom. They say this "The Committee are however impressed by the consideration that the fate of an institution and its inmates is determined perhaps for many years by the personality of the medical superintendent placed in charge of it. And we have considered very seriously whether the present methods of appointment are calculated to ensure that the best available men are selected for these great responsibilities." Now that, of course, I suppose is admitted on all hands.

11,349. Yes, I have read that passage, and was very much struck with it too. Of course every institution, even a Royal Commission, depends upon the efficiency of the persons in whom the duties are confided, and in a human world you will always have people of varying degrees of capacity. I can quite imagine you will have some medical superintendents who will not be satisfactory?—That of course is what we submit, in the past and in the present there is again an enormous divergence in the capacity of the people administering these things, and it is very wrong that the law should not lay down stricter provisions for their selection.

11,350. What do you think of the suggestion made in the Cobb Report on this subject just over the page, that there should be an advisory board?—I think that is quite excellent as far as it goes. Of course the question one would like to see raised is what their capacity is really to be.

11,351. Dr. Lomax's suggestion is that the appointment should be vested in the Minister of Health, but you know the Minister of Health may appoint an incompetent person, too?—One hopes, if you have got a central board with wider representation, that they might have, shall we say, a veto on the appointment.

11,352. One cannot always get the class of person for these responsible duties; the supply is limited, obviously, because it is a post that undoubtedly requires a remarkable combination of qualifications, does it not?—Of course, that is what one feels; it requires very high technique, I should think.

11,353. Not only technique, but, if I may say so, one ought to have very high qualities of human sympathy?—I quite agree with you.

11,354. Then they go on to say this in the Cobb Report: "We consider that at no distant date it should be made compulsory that no one should be appointed medical superintendent unless he has obtained a diploma in psychological medicine." There is another suggestion which in process of time may be given effect to, that they should be specialists by trade?—One hopes that will come about, but as you say, it will take a long time.

11,355. *Earl Russell*: Have you got any view about the possibility of the superintendent becoming stale? Suppose he is appointed superintendent and settles down for life, do you think at the end of 20 years, or something like that, he ought to be removed in case he is getting too much of a routine superintendent?—I think we have two views that bear on that. It is recommended somewhere, and we thoroughly approve of it, that there should be frequent visits by the medical superintendent to other more advanced institutions, or even if you got it, to a central body which is doing research work; and then, of course, there is the other alternative, whether it should be a fixed appointment, or whether it should rotate like the Wesleyan Circuit, whether it should be a life appointment or not.

9 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

11,356. Then you see, of course, there are advantages in a man getting to know his own asylum. As against that, after 15 or 20 years it might become too much a routine matter?—I think the view we take is that the move should be long before 15 years, or not at all, because I think there is the personal interest that a man takes in his institution. I was very much struck in one institution I went to in Hertfordshire by the superintendent telling me that he had seen the thing grow up round him; he felt it was his life work. That was a very valuable outlook.

11,357. You do not want to uproot him if he is really planted?—As far as one has an opinion, I think it would be much more valuable if he visited other places.

11,358. *Chairman*: Of course, one has to recognise that a man who must have the diploma of the Medico Psychological Association might be on paper a "100 per cent. man," who might equally have commended himself for various reasons to an advisory committee, and yet might be an extraordinarily bad medical superintendent; not because he had not the technical qualifications, but just because he might be a hard type of man and not the sympathetic type. He might be a failure, whereas, on the other hand, you might have the kind of man who cannot pass a single examination and yet who is a perfectly ideal administrator, because he has the other human qualities. It is very difficult to get a standard which must be satisfied?—Yes, but I feel in that connection that a central body who are frequently dealing with that type of appointment would exercise a better judgment than a local body.

11,359. Then may I take it generally that you agree with the recommendations of the Cobb Report?—Yes.

11,360. *Earl Russell*: Do you think it would be a good thing if a medical superintendent were not finally appointed until he had been two years on trial?—I think that would be a useful provision. The appointment should be provisional.

Sir David Drummond: I do not think you would get the best man under those conditions.

Earl Russell: If it were universal they would have to come under it.

Sir David Drummond: Yes, but I do not think it would be acceptable to the profession.

Chairman: I think possibly Mr. Parker's suggestion, which is the Cobb Committee's suggestion, of an advisory committee, might meet the point; because, after all, medical superintendents are selected to a large extent from the medical officers of asylums who have had training, and who would have come under the cognisance of a board such as you suggest, and would therefore be persons whose qualifications were known. The Advisory Committee would be able to select them as men who by disposition as much as by technical qualification would be appropriate, and this body would be able to make very useful suggestions. There is something in what Sir David said. A man does not like being appointed to a job, and their saying "We will see how you get on; we will put you on probation."

Earl Russell: You would not get him to give up anything good to take it?

11,361. *Chairman*: No. Now so much for his appointment. What else have you to say about this?—We say at present of course he is in a very powerful position, and there is really nobody who can interfere with his decision; and we suggest that there again there is an argument for introducing a judicial authority.

11,362. At this stage do you desire to take up the question so much discussed as to whether he should be relieved entirely of administrative work?—Yes, we do; we feel strongly on that point, that what is demanded of a medical superintendent at present is really quite impossible. On the other hand, of course, one is very much impressed with the difficulty of splitting that work from an administrative point of view.

11,363. You probably have read the discussion, because it is argued on both sides in Dr. Lomax's book—you may remember the pages devoted to the subject?—Quite.

11,364. If I remember rightly, he sums up against the present system.—I think he thinks they should be divided.

11,365. Yes, but I am impressed with this view, that in the case of mentally afflicted persons treatment is so largely a matter of the regulation of conduct and regimen, which in turn depends upon a whole lot of administrative considerations. The position would be very awkward if you had the medical superintendent entirely divorced from what one might call the general conduct of the establishment, though it is the very conduct of the establishment which is itself one of the curative agencies?—They interlock, of course, very, very closely.

11,366. Do you not then rather look with sympathy upon this view that the true solution is not to be found so much in dividing the functions between two heads, one administrative and the other medical, as in reducing the size of the institutions, so that the medical superintendents will not be overburdened with administrative work?—Unquestionably we should support that, and I think it is generally urged everywhere, and has been throughout, that the institution shall be limited. I think 1,000 is the highest figure given.

11,367. Some, I think, have put it higher, but 1,000 is a figure which has commanded general assent. You must have it a certain size in order to be efficient and economic?—Yes.

11,368. But if you have institutions on a more moderate scale than many of the present public asylums, would not this difficulty to a large extent disappear?—Even 1,000 people, with the administration of all these details, is still a very big matter.

11,369. *Earl Russell*: Of course, you could give him a steward and competent clerks, and all that sort of thing?—I think he has that at present.

11,370. If you take away from him the final say you make it very awkward, as the Chairman says.

11,371. *Chairman*: I think the difficulty is largely a question of temperament. Some men, of course, try to avoid matters of detail as much as possible, while other men are positively attracted by the detail of routine, and enjoy more perhaps than their medical duties the filling up of forms and all the neat and tidy arrangement of their books. It is a matter of temperament, I should think, largely?—Yes.

11,372. *Sir David Drummond*: But even reducing the asylum to say 500 it would not relieve the situation?—I am rather inclined to agree with that; I do not think reducing the numbers will dispose of the difficulty.

11,373. *Chairman*: It would not dispose of it altogether, but it would mitigate it?—In the particular asylum I went over one could not help being struck with the fact that the medical superintendent was an expert on the farming question. He could answer questions about pigs and so on. It does seem to me deplorable that he should be wasting his time on matters of that sort, but that is one of the profit-earning departments of the asylum, and one which is very closely watched by the visiting committee, and I gathered that he had to be in a position to satisfy them, and one wondered how much time was wasted on that. It seems a deplorable position, if you consider it.

11,374. I am not sure that the solution is to be found in having a co-ordinate authority in two persons under the same roof?—No, I agree with that. The only suggestion that has crossed one's mind is this: Would it be possible to concentrate the purely medical duties in a senior medical officer? Let the superintendent be an overriding authority, but let the routine be definitely that, and the medical duties given over to a senior medical officer, and then you

9 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

would have to give him under the Act certain of the powers at present given to the medical superintendent.

11,375. I imagine in practice that obtains to a considerable extent just now, that the second in command is the person who is most conversant with the medical side of the institution?—I should think it does in practice, but ought not that to be regulated? There is somewhere in the Act, I think, a reference to the senior medical officer. I only throw that out as a possible suggestion.

11,376. *Earl Russell*: That again must depend upon the conditions of each institution to some extent?—Undoubtedly, but I think you would want some statutory change to make that scheme work.

Earl Russell: I do not think so—would you?

Chairman: It could be done, I think, through rules and regulations.

11,377. *Sir David Drummond*: What is the advantage of having a special authority upon mental disease, if you are not going to give the medical superintendent the medical charge of the patients?—Then it would be your senior medical officer who would be that authority; you would have your superintendent as an administrator, co-ordinating the whole thing, and the senior medical officer would have the medical duties more completely in his hand.

11,378. *Chairman*: I think we may put it in this way that in view of the character of these institutions it is almost indispensable that the person who is at the head of the institution should at least have medical qualifications?—Quite.

11,379. Because even the administrative questions which he has to determine have medical implications?—Yes.

11,380. And if he be both a doctor and a man possessing those qualifications he is probably the right man there. The real criticism upon the existing régime is that in view of the very great medical responsibility which he has as medical superintendent, his other duties may be liable to divert his attention from what is primarily his function, that of attending the medical welfare of the patients?—Quite. His other duties, of course, are very pressing undoubtedly.

11,381. And then the difficulty arises partly from this, that those other duties are related to matters which in turn are related to the treatment of the patients?—Quite.

11,382. If by rules and regulations it were possible to bring about a delegation of duties to relieve the medical superintendent of a certain amount of administrative work by imposing it in terms upon subordinates, would it not be possible to diminish the volume of his administrative work?—Well, of course, my personal view, from a business point of view, is that that would be a mistake. I think your head man in a huge organisation must primarily be an administrator with the medical qualifications you suggest. I would rather see not the practical administration switched off to subordinates so much as the medical administration switched off to another competent head, who is to be technically second in command, but recognised as the senior medical officer. It is a question of opinion, of course.

11,383. There is another way of achieving that end; suggestions have been made from some quarters that institutions of this sort ought to have associated with them a consultative alienist?—Of course that is suggested, and it is a very desirable thing, but that would not meet the day to day conditions, would it?

11,384. Would it not? Take the great hospitals of this country; they have their eminent visiting consultants who attend frequently?—If that could be brought about of course it would be very desirable. I do not know whether that is a possibility.

Sir David Drummond: I do not know that it would be a practical possibility, on the lines of a general hospital.

Sir Ernest Hiley: It depends very much upon where the asylum is situate.

Chairman: Yes, it might be away from any centre, of course.

Sir Ernest Hiley: If the asylum is situate in a large town it might be possible then.

Chairman: Yes. At present, of course, they do call in a consultant, for example in a surgical case. If there is to be an operation a surgeon is brought down, if it is a grave case.

Sir Ernest Hiley: Yes.

11,385. *Chairman*: I am not altogether attracted by your idea of a sort of *imperium in imperio*, that is to say, a medical man who is not the superintendent, but who is to have certain of the powers of the medical superintendent—would you not be very liable to have a conflict between him and the superintendent?—I do not know, any more than you have at present. As long as the head is defined he will generally work with the next in command; I think the danger arises where there is that lack of definition, where there is not a definite head.

11,386. Then you do not suggest that this second medical officer should be independent of the medical superintendent?—No, that he should be under him, but that he should have definitely deputed to him certain medical functions.

11,387. *Earl Russell*: First lieutenant?—Quite, and I think to some extent it would be necessary to recognise his position in any new legislation.

11,388. Why need you recognise his position if he is still to be under the medical superintendent? It is understood he is the man who is in charge of the whole medical supervision. It would only apply in an asylum where there are a good many other medical officers, anyhow?—In the big asylums, yes. Take the simple question of discharge; when he has made up his mind, is there any advantage in his going to the medical superintendent and detailing the facts all over again?

11,389. If the medical officer is to be trusted, the superintendent will take his word for it?—Still there is that consultation.

11,390. *Chairman*: Who would be the officer responsible to the visiting committee—would the visiting committee rely upon this person, or would they rely upon the medical superintendent who had consulted this person?—No, our suggestion is that his position in medical matters would be so clear that he would be in touch with the visiting committee, and he would be the one to attend the meetings, and we suggest therefore that he should have power in certain cases to act.

11,391. I think you would get difficulties there. After all, the visiting committee would expect to see the head of the institution.

Earl Russell: They can always both attend. But we have heard of a visiting committee which splits itself up into sections. That is where they do not meet so often.

Witness: That would be rather on all fours with this suggestion.

Earl Russell: Yes.

11,392. *Chairman*: It is not an easy problem this?—It is really difficult.

11,393. *Mr. Micklem*: It is rather a curious thing that in Section 276 the Act seems to contemplate that where there is more than one division of an asylum there should be a separate superintendent for each division, and it also contemplates that in certain cases the committee may get power to appoint superintendents who are not medical officers?—Yes, I see that is so, subsection (c). As I say, in one or two places in the Act it does seem to contemplate a senior medical officer. Here it calls him a resident medical officer.

11,394. *Earl Russell*: Yes, and he need not necessarily be the superintendent as Mr. Micklem points out under subsection (c)?—That is so.

Mr. Micklem: It looks as though the common form of appointing a medical superintendent to the asylum is wrong. There should be a separate one for each division.

Earl Russell: What is meant by a division?

11,395. *Mr. Micklem*: I suppose usually there is the division of male and female is there not, in the

9 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

large asylums?—Yes, but is that the division contemplated here?

Earl Russell: I cannot help thinking it is build-ings in separate places.

Witness: I do not know whether the Commission has access to the qualifications of the present medical superintendents taken as a whole, but one has a sort of feeling that they are much more administrative than medical. I do not know whether that is a true suggestion to put forward.

11,396. *Chairman*: I think you may take it that many of them would have the tendency to concentrate on their administrative duties rather than upon their medical duties?—And, further, their training has been administrative rather than medical.

11,397. *Sir David Drummond*: That is the practice?—Yes.

11,398. *Chairman*: And one can quite see how important it is that the medical side should be predominant. As we are now looking more and more to the treatment of these patients from a medical point of view, the medical qualifications and the opportunities of showing medical skill become more and more important?—Yes.

11,399. Therefore this question of the medical superintendent's functions is very intimately related to the whole question of treatment, is it not?—Very, and I suppose it is admitted on all hands that you have got to divide these functions in some way; the only question is how.

11,400. Yes. You have put your views before us, as usual very moderately, but I think you have still left us with a puzzle?

11,401. *Sir Humphry Rolleston*: Would not Mr. Parker's view really be met if, admitting that it is necessary for a good medical superintendent to have control over the different branches of treatment, he delegated the detail of the administrative work, as he very often does, I believe, to stewards, and people of that kind?—One's experience of delegation is that the responsibility still remains with the delegator. He may save himself a certain amount of routine work, but he cannot dismiss the matter from his mind. It is the hardest thing in the world really to delegate and to get rid of responsibility at the same time.

11,402. *Mr. Snell*: Have you thought of the alternative suggestion that the medical superintendent should have, as he has now, final control over the medical side; and that then there should be appointed a trained administrator to take all the other side off his hands?—We certainly have considered that. Of course, it must be that, or the course we are suggesting; the question is which is the better, and on the whole, for what it is worth, our opinion is that the administration, that is to say, all the daily work which is so urgent, should be in the hands of the senior man. But I am quite prepared to hear the other view argued, and perhaps it may be the better solution.

11,403. *Chairman*: I do not know that we get much help from the analogy of the general hospital here. Of course, in a general hospital one knows there is a superintendent, who is a person, very often a doctor, who resides on the premises, and has an office and clerks and all the rest of it. On the other hand, the actual treatment of the patients is confided to the doctors in charge of the wards, that is to say, the young resident physicians and surgeons; and then there are the eminent physicians and surgeons attached to the place; but the superintendent in his office, of course, never interferes in any way with the visiting surgeon or physician, who goes there every day and attends to the patients there with the house doctors, except in so far as relates to the domestic arrangements and things of that sort. But that system does not present an analogy to the mental institution, I am afraid?—We do feel very strongly that if the medical super-

intendents are to be free to devote themselves really to medical questions they should be absolved from these administrative questions.

11,404. Does not it again resolve itself into a question of the sort of men you get? We have been reading this blue book; it is extraordinarily interesting to read what a lot of scientific work is being done by some of the medical superintendents we have been discussing. If you take some of the instances given there, you will find many of them have made in the course of the year important contributions to mental science, have contributed to the technical journals, have given lectures, have instituted laboratories, and so on, and generally have made important strides in their profession, while at the same time apparently running their institutions satisfactorily. It is the individual once more we are concerned with?—Yes. Of course except in very big centres I am not sure that that local research work is as wise as central research work. The Commission of 1908 rather stressed the other point of view that the research work should be carried on in central places.

11,405. But, on the other hand, one can imagine that the medical superintendent who really cares for the medical side of his work will of course be examining cases and writing papers on them for the medical journals, and so on?—Quite. Of course that class of man would welcome the local facilities.

11,406. I was referring to that just to show this: that apparently some people—whether they are supermen or not I do not know—are able to run their institutions, and to carry on at the same time a great deal of important research work.

Sir David Drummond: That, if I may say so, is done through the subordinates in nearly every case; the superintendent interests himself, and they get different people from the different establishments to work up a certain point.

Chairman: He gets the credit of it.

Sir David Drummond: Yes, he does, but as a rule he mentions the name of the man who has done the work.

Witness: I gathered that myself, but I did not quite like to suggest it. It is so on the detailed statements that come out.

11,407. *Chairman*: I am not quite sure that would be so in every case, because here is rather an interesting reference at page 13 of the 1923 Report. Speaking of Dr. Orr, it says: "We have confidence that in his new duties and in his capacity as lecturer in mental disorders at Manchester University, he will be zealous in co-ordinating the work of the hospital with that of the neighbouring medical school and in maintaining a high standard of medical efficiency." What really happened is this: that Dr. Orr was a deputy superintendent, and then was made superintendent at Prestwich, and apparently he is at the same time lecturer in mental disorders at Manchester University. Have you got the reference?—Yes, but the detailed test is set out later at pages 89 and 91. On page 91 there is one by Dr. Martin, assistant medical officer, which rather bears out what Sir David was saying.

Sir David Drummond: I think you may accept that as a fact.

Chairman: Yes, but anyhow this gentleman is at one and the same time medical superintendent of an asylum and a lecturer in mental disorders at the Manchester University.

Sir Humphry Rolleston: That I think often occurs, but that does not necessarily strengthen the position of his efficacy at the institution.

Chairman: No, it may be the other way about.

Witness: You see the reference on page 89, "Dr. Orr, medical superintendent, and Dr. A. Corsar Sturrock, senior physician, and neurologist to the Salford Royal Hospital," and then they give their report together.

11,408. Yes. I was citing that rather for this purpose: the suggestion was that the medical superintendent is so cumbered, like Martha, with much

9 February, 1925.]

MR. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

serving, that he has no time left to consider medicine at all. Some of them apparently have enough time left to deliver lectures on the subject of their specialty?—Yes; I think we agree it must vary enormously with the class of man.

11,409. However, you are going to leave us with a problem?—I do not think it is one which we could attempt to settle, Sir.

11,410. But it is interesting to notice that after the great consideration which you and your colleagues have obviously given to the whole topic, you are not in favour of a divided head in these institutions. —I think certainly not; I think it would spell disaster.

11,411. I think that is a very important statement on your part. On the other hand, you do wish means to be taken, if they can be taken to insure that there is in every such institution some person whose business it is to attend to the medical side of the treatment of patients?—Yes, and nothing else.

11,412. Undistracted?—Undistracted, and that that person should be the responsible person for all questions of treatment and discharge, and so forth.

11,413. The last addendum is perhaps the controversial part of it, whether he should himself have those powers, or whether he should be the person who would be entitled to speak with authority, because of the special duties he has.

11,414. *Sir David Drummond*: Has not Mr. Parker rather contradicted himself, that the medical superintendent should have control of the executive, and control of the medical part, not divided—is that what you now indicate?—We are trying to indicate that the senior medical officer shall have a separate recognised position, as I have suggested, recognised even by statute on questions of discharge and that sort of thing, but that in all administrative questions he shall be under the control of the medical superintendent.

11,415. That is not exactly what you indicated in reply to the question the Chairman asked.

11,416. *Earl Russell*: When the patient is to be discharged it is a question whether the home he is to go to is a fit home?—For the medical officer.

11,417. It is not a medical question, surely?—It seems to me, if it is a borderline case, the controlling factor in reaching a decision must be what is the environment into which you are going to send your patient. I should think any medical man would take that view.

11,418. Do you attach importance to this independent position of the deputy, because I see a crop of difficulties it may raise up?—Under statute?

11,419. Yes. I see a possible crop of difficulties.—Of course that is a question of degree. All I am anxious to avoid is that the decision having been properly taken by the senior medical officer, he should then have the additional burden cast upon him of going and having a talk with the superintendent. It seems to be simply duplicating the work.

11,420. It would do for your purpose if you gave him subordinate duties?—Quite.

11,421. *Mr. Snell*: Have you considered the similarity of the position of a large mental hospital with a large workhouse, where the master of the workhouse is master, but he does not attend to the medical side.—I am afraid I am not very familiar with the workhouse administration.

Mr. Walter Stewart: Might I say that in our case, a point was emphasised that has not been brought out, and it is this, that what is so much desired is that the person on whose fiat the question of discharge really turns should be in such a position that he can devote sustained personal attention to the borderline cases which are ripe for discharge—that special class. It is a small class, but an important one from that point of view. That is what our case tries to set out.

11,422. That, of course, is a most important class of patient; because there are easy cases which obtain their discharge quite easily, and there are difficult

cases which are hopeless; but the cases really which require study are the borderline cases.—Quite.

11,423. And they require intensive study?—Personal touch.

11,424. They must be known and studied?—Yes.

Mr. Walter Stewart: Every day.

11,425. *Chairman*: And every hour, if you please, if they can be. That, of course, is very difficult to a person who is cumbered with many cares of administration?—Later on, of course, that is set up as one of the chief *desiderata* of the treatment, and we submit it is impossible under present conditions. There is Section 38 (4) which I wanted to mention, the annual statutory inspection. I only wanted to bring it to your attention that even that, as far as our evidence goes, occupies—

11,426. That is now repealed, but it is in the 1891 Act, Section 7. It is the periodical report which must be made?—The only point I want to draw your attention to there is, it is a very important examination, and as far as our evidence goes it is very often concluded in a few minutes. There, again, one supposes it is the pressure of work which prevents the medical superintendent with all his pressing duties really attending to it as closely as the Act contemplated.

11,427. Now we have come to the end of this part of your evidence which we have explored very fully, and I think we now want to take up the question of the ill-treatment of patients, and the safeguards against it. I suppose of the people who come to you with complaints quite a number complain that they have been badly treated in the institutions?—That is so, and that they have seen—especially those who have had a long period of treatment—other people badly treated; and that is a very important distinction, of course, in dealing with this class to bear in mind, that their own grievances and what they have seen other people suffer are in a very different category.

11,428. Now upon that question the patient must, of course, inevitably be to a large extent in the hands of attendants, just as in the ordinary general hospital the patient is in the hands of the nurses?—That is so.

11,429. One has to recognise, has not one, that the nursing or attending of mental cases is a peculiarly exacting and difficult task?—Yes.

11,430. I think one ought to pay tribute to the persons who have devoted their lives to this work, which must be distressing, and is certainly not very well-paid work, who have done good service; but you must inevitably, I suppose, when you are dealing with something like 15,000 people, have a number of cases where you get unsatisfactory attendants, just as you have unsatisfactory nurses in general hospitals?—I think, if I may say so, that that puts it very clearly, that it is inevitable in a small minority of attendants; and it is no reflection on the bulk of the attendants to draw attention to these things.

11,431. One would not like it to go out that we, as members of the public, do not appreciate the amount of self-sacrifice and sympathy which is shown by many nurses, men and women, in these institutions. One recognises that it is a peculiarly difficult and exacting line of public service. On the other hand, you yourself have had instances, you tell us, and the Board of Control have had instances, and many well substantiated instances, where the attendants have given way, if you please, to irritation, or have been negligent, and where ill-treatment has resulted. I suppose the real problem is to see that these cases are brought, and should always be brought, to the knowledge of some responsible person at the earliest moment so that they can be dealt with. That seems to me to be the real point?—That goes to the root of the matter.

11,432. And the difficulty is just this, that patients, either because of their disabilities or for other reasons, may be afraid to bring their case before a constituted authority, or if they do, may not have it satisfactorily heard and may be over-borne?—Both those features

9 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

are present in a great number of our cases. A lot of our evidence says this, that from the fact that complaints never lead to any amelioration and sometimes result in reprisals, a patient after a time ceases to complain, he recognises it is better not to; and a case comes into my mind here where after some years one patient changed and went to a new asylum and there he said he was particularly careful not to be a complainer in the new place, and in the result he started with a fresh sheet and got on very much better. That is one class of case; and, of course, the other class of case is that in which patients say that the complaints are not investigated. Of course, in many cases they are investigated on the spot—or in some cases—I should not say many, and there is always a difficulty that apparently the complainer is in the minority of one. I was very much struck on that point by a statement, I think, which was made by Lord Justice Atkin in the Everett case, where he said in effect: of course, a jury, as a jury, were quite entitled if they chose to put aside the consensus of evidence from many of the asylum attendants on the ground that they were all interested; and, of course, there is that factor in human nature which you have got to take into account.

11,433. Yes, but how are you to obviate that? It is to be obviated, is it not, by improving the various means of contact between the patient and outside authorities. The improvement of visitation, making it a reality, is of course one means, is it not?—Yes. I think, if I may say so, in our view the most important means is by improving the status of the attendants, and that has been very fully dealt with in the departmental report, and they bring out there very clearly this fact, that there is a floating population of attendants going through all these asylums who do not make a vocation of nursing; therefore, they are quite untrained, and I think it is more than likely that it is amongst that class that you get violence resulting from loss of temper, and so on.

11,434. *Earl Russell*: So long as there is this fear of reprisals, no amount of contact with people outside will make them complain?—Unless it can be a private complaint.

11,435. *Chairman*: If it is to be acted on, it must be known in some way that the complaint has arisen?—Yes, but I think patients would take the risk of that. What they dislike so much is complaining before the attendants.

11,436. Still, suppose there was a complaint made about an attendant, quite a well-founded one, and it reached the properly constituted authority, it reached the medical superintendent; he calls the attendant up, and he is satisfied that there is ground for complaint; he reprimands him, and the attendant goes back to the ward, pretty angry at the whole matter, and says: "I will teach A.B. in future to make complaints about me." I am putting the case in its most crude form. There would not be very much protection there, would there, for the patient?—No, there would not; one realises that however privately the original complaint is made, if it is investigated it probably comes back again in some form.

11,437. Of course, in some instances the attendant is dismissed on the spot?—Absolutely summarily dismissed.

11,438. *Earl Russell*: And the patient is safe?—Yes, and the patient is safe.

11,439. *Chairman*: On the one hand the attendant is a reasonable person, he will take an admonition in good spirit; on the other hand you always will have some people who do not like being reprimanded, however deserved it may be?—Quite.

11,440. And accordingly they would be apt to visit it on the patient?—Yes.

11,441. *Earl Russell*: It seems to me if you make complaints even privately, when they come to be acted upon you would be bound to remove the patient to another ward to avoid the chance of reprisals?—That is a most valuable suggestion, too, and as far

as our evidence goes, it does not seem to me very much acted on.

11,442. *Chairman*: We have had one or two instances of that, that the patient said she could not get on with the attendants in that place, and was moved to another ward where matters were quite different?—And, of course, there are cases where for that reason patients are moved to different asylums, and with very beneficial results. That may apply, and in certain cases does apply, also to junior doctors. You may get an antipathy growing up, and of course that is where your superintendent's sympathy comes in—those are factors which he will take into consideration.

11,443. But it is quite true that where you are dealing with these psychological conditions you may have unreasonable antipathies, but they are nevertheless very present to the minds of the persons who suffer from them.

Earl Russell: They are perfectly real.

11,444. *Chairman*: They are real, though they may be unfounded, in the sense that the person who entertains them suffers just as much as if they were well grounded?—Quite.

11,445. *Earl Russell*: The difficulty here is that the superintendent, with the best will in the world, if the attendants do not speak the truth, is left in a hopeless difficulty; it is almost impossible for him to act on the unsupported word of the patient?—Of course one realises that, and one realises too that these complaints of physical violence are really rather extraordinary, they all agree in this, that they take place out of sight, in many places either in a side room, or else in the boot room, curiously enough. We have that on several of our proofs, that the boot room is a convenient place where this sort of chastisement is administered, and it is presumably a small room and out of sight of the other attendants, and so forth. It is a very difficult question, of course.

11,446. *Chairman*: Is it not rather difficult to imagine that attendants would deliberately proceed to chastise a grown patient as you have described. I can understand an attendant being goaded to exasperation by a very annoying patient, and in a moment of forgetfulness hitting back; but it really is difficult to imagine a properly qualified attendant taking a patient away and deliberately kicking him or hitting him in a defenceless condition. It may happen. You may have persons who would be so brutal as to do that, but it is difficult to imagine that it would happen often?—We have evidence which does not leave a doubt that it occurs, if I may give you a personal experience there of one of the big London asylums. I was personally taking evidence from a person down at my home in the country and from another patient in London; they had known each other in this asylum, but they did not know, either of them, that I was in touch with the other, and I got from their lips almost identical accounts of violence in the administration of purgatives. In one case the man was assaulted there and then in the ward and pommelled in the stomach; in the other case the second person was removed to a side room and there assaulted by two attendants, and our evidence of it always takes the same form, pommelling in the stomach; in fact, hitting below the belt.

11,447. *Earl Russell*: Because it does not show?—Because it does not show, and one is not prepared to say so definitely, but there does seem to be some connection between that and kneeling on the stomach and broken ribs that we shall come to.

11,448. *Chairman*: What do you suggest is the object of that ill-treatment? Is it vindictiveness?—I am afraid it is a method of maintaining discipline. When we come to consider other matters you will find there are methods of maintaining discipline, and up to a point I suppose discipline is one of the hardest things to maintain in these institutions, but it should not be maintained in that way, of course.

11,449. Of course not?—The impression it leaves on one's mind is that in these cases it is really a battle

9 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

of wills, and the patient's will has in the end to give way.

11,450. Of course the patient's will may be irrational—that may just be the trouble?—It may be; that is why we are anxious to call these individuals before you, for you to judge for yourselves if their wills are irrational.

Earl Russell: Still, of course, whether irrational or not, that is not the way to cure them.

11,451. *Chairman*: Plainly not. Assuming the occurrence of some such cases, and we know that such cases have occurred, what we are concerned with is not to "sup on horrors," but to know how horrors may be prevented. What is your suggestion of reform?—We can only make two, I think, one I have indicated—the obvious one of improving your nursing staff, making it a vocational calling, and giving such terms as will attract the right class of person. The other is to try to bring about a prompt investigation, and one would certainly say an investigation by people who are not interested—an independent investigation.

11,452. But beyond these general suggestions, you have not anything specific to suggest?—Of course there is that other suggestion that has been made, a system of glass panels in the doors, which I believe is in force in many asylums but is not universal, which enables supervision to take place at any time in a ward; but then that does not touch this question of side rooms, where most of these assaults take place.

11,453. *Earl Russell*: I daresay you heard a superintendent say in answer to me, that he did not expect to be called upon to act as a detective in his asylum; but do you think it would be done by appointing somebody who would be called a disciplinary officer, and who would see himself whether this goes on?—I am afraid it would be a very invidious position.

11,454. I quite see that, a very responsible one, because he might injure an attendant?—I think that would certainly be so.

11,455. *Chairman*: Have you any view on the subject of having women nurses on the male side?—Yes; I think that all we have heard is very much to its advantage.

11,456. It has been suggested that the influence of women as nurses in mental hospitals, as in general hospitals, is refining?—I think the evidence in favour of it is overwhelming.

11,457. But I understand that your complaints of violence are by no means confined to the male attendants. You have cases also of female attendants who have shown violence to female patients?—We have said that one of the causes may be that moving population which passes through the hospitals. No doubt you get a percentage of very unsatisfactory attendants. We have undoubtedly cases of that where nurses in permanent employ have been reported on time and time again.

11,458. *Earl Russell*: Of course you want to find them out in the shortest possible time?—You ought to.

Earl Russell: You want to.

11,459. *Chairman*: These are persons who should be eliminated from the service; they should never have been in it. Then we may pass now to the question of the use of drugs in mental hospitals?—Before we pass from that I should like to refer to Dr. Edwards' statement in connection with female nursing and the absence of broken ribs. Also I do want to draw your attention to this, the views advanced, I suppose it is by different Commissioners, on this same question of broken ribs. At page 218 in the Board of Control's report you get this view "There has been no serious casualty during the period under review, which speaks well for the care and kindness with which the nursing staff treat the patients." If you turn on to the next page you will find: "Serious casualties involving fractures of bones have occurred in six instances—in five through accidental falls in the wards, and in the sixth through fighting with another male patient." We do think it is unfortunate that

people in the position of Commissioners should make use of that double argument, that where there are no casualties it points to the care of the attendants, and almost invariably the other point that where there are casualties the attendants are not concerned.

11,460. *Mr. Snell*: Have you considered this point, Mr. Parker: Is it not the fact that at least some forms of mental disease make the bones extremely brittle, and that a very small amount of compulsion might result in a fracture?—In certain cases that is so, but I believe it is in a very small minority of epileptic cases.

Chairman: I understand it occurs in general paralysis of the insane.

Sir Humphry Rolleston: Dr. Edwards qualified his remark here with the reservation that Mr. Snell has called attention to.

Chairman: Yes.

Witness: Of course you will bear in mind that these accidents do in some asylums run to very large proportions, even on the number of patients. At page 184, Bexley, you find this: "There have been 23 serious but non-fatal casualties involving fractures or dislocations of bones, the majority of which were due to accidental falls." Of course there again the percentage does vary most enormously.

11,461. Of course one has to recognise that you are dealing with a population which contains at least a considerable element of violent people, and people who have to be restrained whether they like it or not. I mean the conditions under which a large proportion of the population live there are not normal conditions, and restraint is always a matter of violence, and violence is frequently accompanied with damage, and therefore one would expect in this population inevitably a certain amount of damage done?—I agree, there must be a percentage, but the point I am making is that it varies to such an extraordinary degree that one looks for the possibility of other causes. For instance, you have 23 in this case, and I think I am right in saying that at Claybury, which is a modern institution, there were none.

11,462. *Sir Ernest Hiley*: How many patients were there in the case of the 23 casualties?—2,140, at Bexley.

11,463. *Chairman*: Which page is that?—The number of patients is given at the top of page 184. At Claybury the number is 2,447.

11,464. Of course it is difficult to argue from those premises?—Of course I would not for a moment argue from those premises alone. They are supported in a sense by the detailed evidence.

Mr. Walter Stewart: It was Dr. Edwards who said "I was struck with the number of turbulent patients controlled by female nurses," so that violence and turbulence are not necessarily accompanied by violence on the other side according to that.

Chairman: No. Now let us pass to the question of drugs.

Witness: On the question of the use of drugs, except on croton oil, which we desire to draw your special attention to, we do not propose to offer any technical evidence, but we hope you may see your way to get it from elsewhere. We do draw attention, as an example, to the use of the drug hyoscine. That is brought out in the Cobb report. It is described by Dr. Stoddart, who gave evidence before you, in one of his standard works as a "refined substitute for hitting the patient on the head with a club." I do not know how far that is accurate, but we believe it to be a very powerful drug. It is used in certain asylums, notably in Prestwich; and in others, which are set out on pages 114, 116 and 117 of the Cobb Report, it is not used at all, and that is indicative again, we suggest, of a state of affairs which would not exist if you had a strong central body.

11,465. Of course one must recognise that sedatives are one of the recognised methods of treatment. It is a palliative rather than a curative treatment.

Earl Russell: Is hyoscine a sedative?

9 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

Sir David Drummond: Certainly, it is a very powerful sedative.

Chairman: At any rate it reduces a person who is in a state of excitement to calm, and that must always be one of the resorts in the treatment of violent cases, of course.

Witness: I agree, but the point one wants to make is that some of these sedatives are more violent apparently than others, and for that reason are discarded in most institutions, whereas their use is still maintained in others.

11,466. *Sir Humphry Rolleston*: With regard to the quotation about hyosine—"a substitute for hitting the patient on the head" I am really asking for information—is that a quotation from Dr. Stoddart's book?—That is a quotation from Dr. Lomax's book, and he tells me he took it out of Dr. Stoddart's book.

11,467. Wherever it comes from, I think that most medical men would say that the reason why hyosine is not used more freely is that it is rather uncertain in its effect. The inference I should draw, if I were a layman, from reading "a substitute for hitting the patient on the head" would be that it gave rise to very painful results.

Chairman: I read it to mean that he was stunned.

Witness: I read it to mean immediate unconsciousness—very quick acting.

11,468. *Sir Humphry Rolleston*: I think that is an exaggeration. The reason why medical men do not use it is that sometimes it makes the patient sleepy, and sometimes it has no effect?—I am only quoting the mental expert on it.

11,469. *Chairman*: Anyhow, we here are not going into a disquisition on the *materia medica*. Of course, in a mental hospital, as in a general hospital, there must be a full equipment of the drugs which are to be used in the treatment of those cases, and as the cases are frequently cases of mental disturbance one would naturally find a predominating use of the drugs which are of a sedative character, and so on, and all the appropriate *materia medica* for that form of ailment. I do not think very much arises for discussion on that point unless your suggestion is that there is an abuse of sedatives?—Of course we do get these suggestions, that powerful drugs are used to put a patient into a state in which he cannot do himself justice if people are coming to visit him. Of course one realises that is a very serious accusation to make.

11,470. *Earl Russell*: That is going back to Charles Reade?—It is going back to Charles Reade. All I can tell you is that those statements are made to us with apparent force behind them, but short of calling the witnesses before you I do not think it would be proper for us to say anything more.

11,471. *Chairman*: I think it is quite right to indicate risks, but so far as the administration of these sedatives is concerned that must be a matter for the doctors themselves. As to whether the use of them can be abused is another matter?—There is just this point which I would like to put before you, having regard to the frequency with which urgency orders are now used and the fact that the patient then does come under the influence of drugs, whether it is likely that he does himself full justice at subsequent interviews with the magistrate or anybody else. I am not suggesting any wrong use of drugs, but whether in fact anybody who has been through that treatment and has been torn up by the roots from his home is likely to do himself justice. It seems to us to be an additional argument for not allowing these urgency orders to become the practice because you are interfering with the patient's environment, and with his physical condition.

11,472. I see what you mean. Now here is a subject which is dealt with at great length in Dr. Lomax's book, the question of the use of croton oil?—Yes.

11,473. I do not know whether I might shorten this topic with you. I do not know how far my colleagues have considered the question, but I was very struck

in the Cobb Report with the result of some questions that they had addressed to a considerable number of institutions, I think it was 22 institutions in all, I am not sure that I have got the number correct, and the return they got was that in about 15 of those institutions this particular purgative was never used at all?—That is so.

11,474. It is difficult not to jump to the conclusion, therefore, that it is possible to conduct an institution satisfactorily without resort to the use of this drug at all. It is a natural enough inference to draw, is it not?—Unquestionably, yes; that is purely on medical grounds.

11,475. Purely on medical grounds. On the other hand, we have had no evidence, or at least very little evidence, about this croton oil, and I am bound to say I knew very little about it until I came here. Is it part of the view of the Society for Lunacy Reform that this drug should be proscribed altogether?—I think so, unless you get medical evidence that there are cases in which it must be used, and then of course it would have to be used under very restricted control. The view we want to bring before you is that it is used not for medicinal purposes at all.

Earl Russell: As you are not a doctor, I wish our medical colleagues would tell us if it is called a brutal purge.

Sir David Drummond: If it is used in a sufficient dose, of course it is.

Earl Russell: Is it used much in private practice?

Sir David Drummond: No.

Chairman: I understand it is only used in the most obdurate cases of constipation.

Witness: That is so. Dr. Lomax deals with it.

11,476. *Earl Russell*: Probably if I sum it up as a brutal purge that will be about right?—I have tried it myself. I have some in my pocket; would you like to see it?

Chairman: Yes, I should. (A sample of croton oil was handed to the Chairman.)

11,477. *Sir David Drummond*: What is the dose?—Two minims.

11,478. Did you try that?—Yes.

11,479. *Chairman*: It does not seem to be in the dispensary at all in quite a number of the institutions one has been in?—That is the point, but it has been very largely used in asylum practice in the past, and as a result it has a reputation which strikes terror into patients, and that reputation lives on in asylums; and in those asylums where it is still used, we want to try to show you that it is not used for a medicinal purpose. I have a case here where I have no doubt at all it was ordered by the doctor in such quantities that it looks as if it were for punitive purposes.

11,480. It is hardly within our province to proscribe a medicine altogether which is in the British Pharmacopoeia, and which may be necessary in particular cases. It is a peculiar concomitant of insanity that pronounced constipation is a feature of it. It is due to the sedentary life of the patients, no doubt?—On the evidence we have got I question whether it is ever used for that purpose. We have no evidence that it is.

11,481. It does not seem to be necessary for that purpose, because so many institutions get on without it?—Exactly.

11,482. And therefore you say that where it is still found and is still used, the inference is that it is not being used for medical or therapeutic but for punitive purposes?—Yes, and I think we go further than that and say it is a warning signal, to look at the rest of the executive of that particular institution. If they are still so old-fashioned as to employ those sort of methods it is rather a warning signal.

11,483. I think, if I may say so, that is quite a fair way to put it. If you find an asylum using croton oil at all, or to any material extent: have a look at that asylum.—Yes, it puts one on enquiry.

11,484. You say that where it is still used, you have come to the conclusion that it is being used now rather

9 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

for the purposes of punishment than for purposes of cure?—That is so, and I want, if I may, to put before you a case which only came into our possession two weeks ago, but which really seems to me to prove that contention very nearly up to the hilt. I have got some copies of the medicine card and the case book, which I should like to hand round.

11.485. If you please. I have one; you were good enough to send one in to the Secretary of the Commission, and I have that copy before me.—If you please, Sir. (*Copies of the Medicine Card and the Case Book were handed in.*)

11.486. Now we need not take the name of the place or the name of the patient, because it is quite immaterial for your purpose?—Quite. Shall I just give you the outline of the case?

11.487. If you please?—That is a case of a patient in 1919 who had a slight altercation with a sweep in his house, and he called in the police, and the police arrested him instead of the sweep. The case went to the police court and was remanded to Brixton, was under observation there, and ultimately Quarter Sessions dealt with it as a case with a history of epilepsy, and as a case to be certified; and under those circumstances he went to the asylum. He was examined of course in the usual way on his entry there, and found to be suffering from heart, and we have got a very detailed medical statement of all his symptoms, which showed a history of typhoid and intermittent fainting fits, and some epilepsy; his disposition, which I think is important, is set out in answer to certain specific questions as "Cheerful, not specially excitable, rarely passionate, hopeful on the whole, bold, not rash or reckless or gloomy, rather reserved and obstinate, and brooding latterly. Not lazy, indifferent, fearful or sleepy." He was an educated bank clerk who had visited, in his holidays, Switzerland, Scotland, Ireland, New York and Morocco, so that he was a man used to some of the amenities of life. The other important thing to notice about this patient on his medical history as set out when he went in is that the bowels were active—perhaps I might hand those details to the Medical Commissioners, they might wish to look at them in greater detail.

11.488. *Chairman*: If you would. (*The same were handed in.*)—This case went into the asylum on the 14th April, 1919, and he spent the usual few days in the infirmary, and was transferred from the infirmary to a ward on the 25th April; and after objections and irritability, which he showed at first, on the medical sheet on the 14th May he is reported as being "much quieter and more amenable, still argumentative, but much less trouble. General health pretty good, and no fits since admission." And then without any record on the medical history we get from the medicine card that on the 28th May he is given a two minim dose of croton oil. That is repeated again at the end of a week, on the 2nd June, and of that of course there is no explanation. You will see that on the 14th June he is overhauled, and the heart's action is noted as irregular. On the 5th July you have got this entry: "Very restless, resistive, and abusive yesterday and complained of his food. To-day he refused his sedative mixture, and it was necessary to give it by tube. In bed in a padded room." Well, Sir, we know from the visitors to that patient that the only complaint he made of his food was that he did not get enough to eat. Therefore one is at a loss to supply any reason for his complaining of his food unless he suspected it to be drugged, which is a very frequent complaint; but if you turn to the medicine card you find on that date, July 5th, he was not given a sedative, but another two minims of croton oil, and on that date that was administered by tube. He was transferred the next day to the refractory ward. I want to pause there to show you that this case confirms what we have had from innumerable patients, that the minute there is any sort of clash with the authorities in the asylums on the question of food, medicine, or anything else, this is the treatment which

is in fact meted out to them. There is no sort of reason there for forcible administration of drugs, and the fact that the patient refuses his food one day would be no justification for forcible administration of food the next day. If I may interpose a remark here, I should like to say this: no doubt it was not with this object, but the British Medical Association in Clause 69 do make this proposal. They say this: "There is some uncertainty at present as to the right of the medical officer or medical attendant to administer medical treatment to a patient under a reception order against the patient's wishes, even though the friends approve of the treatment proposed; this uncertainty should be cleared up." Now, of course, they are raising a very difficult question, and we should like you to have in mind at this point what the ultimate application of any statutory power might be, if it was once laid down that the forcible administration of drugs was permissible. I do not suggest, of course, that that is what is in view, but I do want to press on you very strongly the danger that would arise if forcible administration of drugs were allowed by the law.

11.489. On this special matter of croton oil. I have been through the case of this patient, and I find that croton oil was administered on several occasions to him. Now what inference do you ask us to draw from that?—On the croton oil point I am going to show you that it was administered in different doses. I am going to suggest that whereas one minim might be a proper medicinal dose to start a treatment, if in fact he needed any treatment, where you find three minims given without any reasons attached to them, you get a clear indication of punitive treatment. The other aspect I want you to follow in this case is this system of seclusion—relegation to an inferior ward and seclusion. Shall we deal with croton oil first?

11.490. If you please?—On the 1st September he was in seclusion in a padded cell, where he remained five months "He threw a chamber at attendant A—to-day" and he was given a dose of croton oil. There is not necessarily any connection between those two things, except when you get repeated entries of that sort you find there is a connection. Then you pass on to the 23rd September "Put to bed again yesterday. Very threatening and resistive, accused the attendants of stealing things from him and tried to throw attendant H— while putting him to bed." Three minims of croton oil. We submit there that is almost irrefutable proof that croton oil is being administered as a punishment, carefully graduated in doses to meet the offence committed by the patient.

11.491. *Sir David Drummond*: It is just possible that constipation may have synchronised with the mental excitement?—That is a possibility, Sir David, but if you look at the medicine card you will find occasions on which a mild cathartic was prescribed, and I submit it is almost impossible that constipation should have synchronised on all these occasions with a breach of discipline.

11.492. *Chairman*: But, on the other hand, I notice an administration of croton oil does not always synchronise with bad behaviour. For instance, take the 14th August, 1919, "Very restless and abusive at times. Is in single room on account of his aggressive habits." There is no croton oil given to him when he is evidently behaving very violently?—I am afraid if you get to that stage when you administer croton oil on every occasion when violence is shown you would kill a man. I am asking you to assume that, when you find successive entries all dealing with those conditions. You will find another one, and it is the last one I am going to ask you to look at, the 2nd May, 1920, where again you get "Transferred yesterday to 11 ward" (that is the refractory ward) "has lately been exhibiting many signs of violence and struck M.O. in the face."—3 minims of croton oil. Now that dose was administered in the same month as the patient died.

11.493. *Sir David Drummond*: I might just point out at this stage that I have before me the record of the necropsy and with regard to the bowel I find:

9 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

"Small intestine healthy. Large intestine mucous membrane normal"—so that obviously there was no serious effect produced by croton oil on this patient?—I am not suggesting that these periodic doses would necessarily affect the mucous membrane; I am suggesting that croton oil was given in quantities to fit the crime unquestionably.

11,494. *Chairman*: But you are not doing yourself quite justice in this last instance, because you have given us the entry of the 2nd May, 1920, in which he struck the medical officer in the face. The dose of croton oil was given on the 1st May, 1920?—You will see the entry on the 2nd May begins "Transferred 'yesterday' to 11 ward," and I think the inference was he was transferred for striking the medical officer, and croton oil was given on the day he was transferred. That is a matter of inference, of course, but I think undoubtedly it all took place on the 1st May; and I think you have something there even worse than a drumhead court martial. There was no enquiry here. Then I want to take you to what, in my mind, is the most pathetic entry in this case, that is on the 13th May, "Became very excited yesterday making ridiculous statements as to his physical health not being attended to." I want to ask the medical Commissioners here whether they consider the treatment given to this patient was suitable for a heart patient. Of course I have not dealt with the treatment he received in full. Then it goes on "He suddenly went into a state of petit mal when speaking. This lasted fully five minutes. He has again stated that he will commit violence to Dr. W—— if he gets the chance." The evidence we have is that that man then or just before knew he was fighting for his sanity; he had been relegated to this separate cell for the second time, and he said when he went down "If I go back to this place I will lose my sanity," and I am afraid at this time he undoubtedly began to realise that his physical health was endangering his life; and, so far from being evidence of insanity, I do submit it is the most natural statement he could make that if he could get at the doctor who imposed these conditions upon him he would use violence. It is a statement with which I sympathise, and I expect every member of the Commission does too. He died on the 26th and the post mortem shows that he died from fatty degeneration of the heart.

11,495. *Chairman*: "He died from an epileptic fit while suffering from fatty degeneration of the heart and death was due to natural causes."—That is the Coroner's inquest?

11,496. *Yes*.—The medical report was only fatty degeneration. Then evidence was given at the inquest which coupled with it the epileptic fit. I do not want to say anything more; I think the documents speak for themselves there. The other point I want you to have before you is this relegation to a refractory ward, because this is the only case in which we have been able to obtain original documents, and it absolutely bears out what is again and again stated in all these proofs that any breach of discipline is, in fact, dealt with in this way. In this case, of course, the conditions were deplorable. This man had just under five months in a padded cell; he was deprived of everything; even the tooth brush, which figures on his medical card when he was first admitted, was removed from him; his spectacles were removed; he had no chair in the room.

11,497. *Earl Russell*: But surely, with that case book in front of you, you call that a bit more than a breach of discipline, do not you? He was apparently a very violent and dangerous patient?—On July 5th?

11,498. He seems to have been having his fits at times?—All the entry is that he was "abusive yesterday and complained of his food. To-day he refused his sedative mixture."

11,499. *Chairman*: I do not see from the case book that he was in a padded cell for five months. On the 5th July he is stated to be in the padded room. Then on the next day he is transferred to the refractory

ward for administrative purposes?—He was then confined in a side room, and he was visited there frequently by Dr. White, who is present. You will see all the entries after that are "In bed," "In bed," which means on a mattress on the floor, and there is the evidence of Dr. White, who did visit this man, as to the exact conditions under which he remained there for five months.

Earl Russell: The best thing they can say about him before that is that he was rather less aggressive.

11,500. *Mr. Micklem*: How did you get these facts?—The documents were handed to me a fortnight ago by a certain newspaper which got them on discovery in a contemplated action. They had to be disclosed in an action, and that is the only method at present under which you can get access to any of these asylum documents.

11,501. *Chairman*: Reading the account of the case I must say it looks as if it were a case, a very pronounced case, of insanity from the outset. It starts at the very beginning on admission "He is suffering from insanity and epilepsy. He has strong delusions of a persecutory type and believes he was wrongfully arrested by the police because of revelations made to them by a friend in whom he placed confidence, and who although dead communicated with him by means of marks placed on newspaper articles; he suffers from epileptic fits of the major variety and after them becomes confused and irritable. He is in fair health."—I am not suggesting that he was wrongfully confined; I am suggesting that for a heart patient the treatment he received was most inappropriate, and I think I can make this clear to you. His five months isolation in this cell was only terminated by outside influence, and be it said to the credit of the medical superintendent that when Dr. White brought this case before the medical superintendent, as she did on the 6th December, 1919, he was at once removed from this solitary confinement back to his original ward.

Earl Russell: He seems to have been quite a dangerous patient.

11,502. *Mr. Micklem*: What was the action brought after his death?—It was a newspaper statement made which then gave rise to a libel action.

11,503. *Mr. Snell*: But your argument is that this administration of croton oil did somehow happen to synchronise with the fact that he had been guilty of indiscipline?—Yes, and all our evidence shows that that in some cases, or else relegation to inferior wards, always synchronises with such breaches of discipline, complaints or something of that sort.

11,504. That is really all you want to prove, is it not?—That is all I want to prove, and further here you have it administered in punitive quantities.

11,505. *Chairman*: Was the libel on the medical superintendent?—As a matter of fact a general statement was made in the paper about this case, and the asylum was identified.

11,506. Charging the medical superintendent with negligence?—And the medical superintendent took action. I have not got the statement here. It was setting out the details of this case, with no reference to croton oil.

11,507. Was the action withdrawn?—The action was stopped on terms that the evidence might be tendered to this Commission when it sat. I should not say "on terms," but the terms of the apology included that condition.

11,508. Did the person who made these observations about this asylum apologise for having done so?—No, the editor of the paper printed an apology.

11,509. *Sir David Drummond*: There are two points emerging from the papers submitted to us which I think I would like to draw your attention to. The first is with regard to the copy here of the medicine card—the first item is a gross error—it would have killed the patient straight away in all probability if he got that dose. I can only assume this was an error in copying, but it is just possible there may be other errors in it?—You have the original medical card before you.

9 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

11,510. In the copy it is eight times the dose that the patient actually got. The next point is that there is no evidence at all in the statement that the patient had fatty degeneration of the heart. It is obvious that the fat was external, fat outside the heart, and not fatty degeneration at all?—Of course, we do not profess to say whether having regard to the medical facts disclosed the treatment was suitable or not; we suggest it was not. That is a subsidiary point on which you have your own views, no doubt.

11,511. I say there is no evidence at all in the report of the necropsy that the patient had heart disease—or practically no evidence of it?—There is this entry just after he went in on June 14th, "Heart's action irregular."

11,512. That may be; that is a very common thing?—And there is the medical history of the case.

11,513. *Chairman*: We have the point on croton oil in this instance, and we have the point that the patient was more than once sent to the refractory ward?—He came up again on December 6th, and then he was sent back again.

Earl Russell: Prior to his death.

11,514. *Chairman*: I see on the 2nd May, 1920, he was transferred to Ward 11. Just on that, you agreed with me that discipline of course must be maintained in these institutions. The refractory ward sounds unpleasant. It is a ward, is it not, where the patients are under constant supervision. There are a number of them together in the ward, and there are certain attendants who must be there all the time?—I do not know whether that obtains in all asylums, but of course some of them have more than one refractory ward.

11,515. What is the particular point about it that you object to?—What we object to is that for a symptom, which we believe to be symptomatic of the patient's complaint, he is not only sent down to the inferior ward, but treated with solitary confinement for five months, and we suggest that that is not either necessary or proper treatment.

11,516. When you talk of an inferior ward it is a different ward, because it is a ward in which a different system of management obtains?—It is much more than that, is it not? It is a ward where the patient would be mixed with all sorts of more excitable cases.

11,517. The associations would be less pleasant. He would be with other patients of a violent character?—Yes.

11,518. I mean to say violent cases are congregated there and they are under observation. I do not quite see why you should say that that is a wrong form

of discipline. You say to a man, "Now if you are going to be violent like this, you will have to go where all the other violent men are"?—But with respect those were not the conditions; the conditions were that this unfortunate patient had refused his food one day and the second day he refused his sedative. We do not know why he refused his food; he may have supposed it to have been drugged. Upon that he is first forcibly given a sedative—it is not a sedative at all, according to the medicine card, it is croton oil. If we are assuming anything we may assume he suspected he was being drugged again, and in those circumstances I think his refusing to take it was justified.

Chairman: We must take the whole story. He is described as restless, resistive and abusive.

11,519. *Earl Russell*: He was obviously on the face of that report a troublesome patient, was he not?—Yes.

11,520. Very troublesome?—I do not know about very troublesome, but is it not exactly the case where if you are giving medicinal treatment, you ought to be able to put it in charge of an attendant?

11,521. Why should he stop in a quiet ward and disturb it?—Why was he ever permitted to come back into that ward immediately attention was drawn to his position from outside?

Earl Russell: Because it was better?

11,522. *Chairman*: One of the things we have to aim at is to see that patients who are noisy are not left with the quieter ones. This unhappy gentleman seems rather to have classified himself as a violent person, because from the record it is quite obvious that he was at times a very violent and abusive person. Was it not right that he should be put with that class of person?—I think conceivably it was right to relegate him to another ward, but when that is coupled with a dose of this powerful drug, and when on top of that he is put into solitary confinement, as he was, then I submit that those conditions become very serious. I do not think they can be justified on medical grounds.

11,523. I think it is extremely difficult to draw an inference merely from a case paper?—I would not attempt to draw the inference from that particular case, but as you go through your entries you find croton oil and this sort of thing always synchronising.

11,524. You find there that on several occasions in this hospital to this patient there was administered croton oil; and you find that the administration of croton oil coincides with outbursts of violence, from which you ask us to draw the inference that it was given to him, not for medicinal purposes, but for punishment?—That is the point.

(The Witness withdrew.)

(Adjourned to to-morrow at 10.30.)

5, OLD PALACE YARD,
WESTMINSTER, S.W.1.

TWENTIETH DAY.

Tuesday, 10th February, 1925.

MEMBERS PRESENT :

THE RT. HON. H. P. MACMILLAN, K.C. (*Chairman*).
THE EARL RUSSELL.
SIR THOMAS HUTCHISON, BART.
SIR HUMPHRY ROLLESTON, BART, K.C.B., M.D.
SIR ERNEST HILEY, K.B.E.
SIR DAVID DRUMMOND, C.B.E., M.D.
MR. N. MICKLEM, K.C.
MR. H. SNELL, M.P.
MRS. C. J. MATHEW.
MISS MADELEINE SYMONS.

MR. P. BARTER (*Secretary*).

MR. W. FAIRLEY (*Assistant Secretary*).

MR. ROBERT MONTGOMERY BIRCH PARKER, recalled and further examined.

11,525. *Chairman*: Mr. Parker, I think we shall be able to cover the rest of your *précis* to-day?—I hope so.

11,526. Last night when we adjourned you had been making your point to us upon the abuse of drugs, that is to say, the use of drugs, not for their proper and legitimate purpose of treatment, but for punitive purposes, and you had given us an illustration, supported by documents, to show that the apprehension that such cases did occur was founded on instances which have come to your knowledge?—That is so. May I say this, that the inference we have drawn from a great number of cases was confirmed by the first case with actual documents attached which came before us.

11,527. On this subject of croton oil I do not know that we need delay very much for this reason, which I ventured to put yesterday, that I was much more impressed with the fact that in the Cobb Report it appeared, I think, that in no less than 15 hospitals it was not used, from which I in turn drew an inference that if 15 institutions can do without this very strong drug, there does not seem any particular reason why it should be necessary to other institutions?—I quite agree.

11,528. That was the inference that naturally one drew. Of course we shall have the assistance of our medical colleagues on the question of the utility of the drug in any case. On that you very properly say you do not tender evidence as a medical man. But from a general point of view it does seem to me very significant that quite a large number of institutions find it unnecessary to resort to it for any purpose, medical or punitive. But what would be the best form of recommendation to make? One might take the course of saying that certain drugs should not be used in any institution?—We feel that is quite a medical question.

11,529. I quite agree. I do not know that it would be fitting for us to exclude one of the drugs which is in the British Pharmacopœia from use?—Quite; but we urge this point very strongly, that having regard to the use of drugs that has been disclosed, we do submit that the total amount of drugs used in asylums should be the subject of an annual return, as it would afford a check upon the treatment carried out in various institutions.

11,530. The suggestion you are making is very much on the lines of what was running through my own mind, that what is really wanted is a series of regulations of a much more precise character dealing with the use of drugs in asylums, which would, no doubt,

involve records and returns, but one wants to get at the start the control of the use of drugs.

Earl Russell: That would be within the powers of the Board of Control.

Chairman: Yes, or at any rate within the enhanced powers of the Board of Control.

Witness: I think it is in their powers now to call for such an annual return.

Chairman: I want to go further: that they should be given more executive powers over the use of drugs.

11,531. *Sir David Drummond*: Over what period did these 15 institutions not use croton oil?—I think I can give you the reference. It is in the Appendix to the Cobb Report.

11,532. *Chairman*: It is a thing that struck me very much when I read it?—Page 114, I think, is the reference.

11,533. Thank you.—There are various schedules. The first is Schedule D. That was a test of two weeks, one in 1921 and the other in 1922, and it was from an analysis of those returns that I found two of these institutions showed large weekly doses. Those are the institutions marked "G" and "P."

11,534. *Sir David Drummond*: Yes, I have it here.—And others one or two doses weekly, and in 15 cases none used.

11,535. What I mean to say is over what period was none used. There must have been a time when it was used in these institutions, and then it was given up. Do you know that?

Mr. Walter Stewart: It is at the top. "Weeks ending 13th July, 1921, and the 5th February, 1922."

Chairman: Then it is only a return for the week.

Witness: Those are two test weeks taken.

11,536. *Sir David Drummond*: That was after Dr. Lomax's book was published?—That is so.

Sir David Drummond: That is to say, when the matter was ventilated and made public the various institutions enquired whether they could do without it

Chairman: That is quite true

Sir David Drummond: I think we ought to have that before us.

Chairman: And also it is quite right to have in mind, as Mr. Stewart pointed out, that these were weeks taken, I presume, at random, but at the same time very short periods.

Sir Ernest Hiley: You will see a remark on page 115 about another mental hospital as to croton oil: "None used for 10 years."

10 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

Chairman: Yes.

Witness: Then, if you turn over to page 116 you will find a report on a Metropolitan mental hospital, about three-quarters of the way down: "Croton oil, 1919, 1 ounce; 1920, 2 ounces (capsules); 1921, nil." That is a full three years' return. Then on the next page, there is a Welsh mental hospital. There the analysis is under two heads for the same years, 1919 to 1921. Under part A none; under Part B 1 ounce.

11,537. *Chairman:* And the next institution had half an ounce in three years?—Yes.

11,538. *Sir David Drummond:* They are giving it up, as it were, and it naturally will be given up in the course of time?—Undoubtedly.

11,539. *Chairman:* In the case of one or two institutions which I have been to, I went specially to the dispensary to make that enquiry myself, naturally; and in one it was not known at all. The dispenser said, "I do not think we have any." It certainly had not been dispensed by him.—We quite agree that that is the position. Of course, in the asylums disclosed there, there is a use in about 10 per cent.—that is the point. That being so, one looks with alarm at that other case I put before you of the Prestwich asylum, where the use of it was so prodigious, running to 2,400 doses a year. Of course, we do not know whether that has stopped since 1921; but the reason we bring that case before you is that we want to base on it a criticism on the whole type of enquiry which takes place on these abuses. I hope you will listen to the evidence on that because it seems to us that it is most serious that where Commissioners are sent up, as they were in that case to Prestwich, to report on a definite period of time, that is, the end of 1917 to the summer of 1919—that is a period when Dr. Lomax was there—their investigations should be directed to quite a different period, and that people in that responsible position should put their names to a report which is set out in this Cobb Appendix, and which suggests that croton oil is not being used in bulk, and that its use is decreasing very rapidly.

11,540. I am satisfied even on the Cobb Report itself, however, that croton oil was being used in large quantities in that particular institution.—Of course, that is established by the report. What alarms us, and I think alarms the public, is the clear proof that though the Commissioner's minds were directed to this point the report they gave shirked all the issues. *That is a very serious suggestion to make, but we are prepared to show that from the report. We do not necessarily impugn the bona fides of the two Commissioners who signed that report, but we do impugn the adequacy of their investigation.

11,541. I do not know that we are here to sit in judgment upon another Committee, and how it chose to conduct its affairs. Our business is to see that we conduct our affairs satisfactorily.—Exactly. It is that administration which raises so many issues. If on a clear question of fact of this sort you get a responsible body shirking all the issues, what weight are you to put on their report on more debatable matters?

11,542. *Earl Russell:* What you are suggesting, to put it at the lowest, is that the Board of Control did not function adequately in this case?—Clearly not.

11,543. *Chairman:* Mr. Parker is entitled to make the point that it is illustrative. His criticisms on this report are illustrative of his general criticisms of the way in which investigations are carried out

by the Board of Control?—Yes. It goes to the whole root of the administration; and if I may add this—I put my personal view—on a reading of the Cobb Report, and a reading of Dr. Lomax's book, I was so struck by the unfairness of the comments, and the bias shown by that report, that it was largely that which led me to devote a great deal of time to an investigation of the subject.

11,544. I have said already that I did not think it would be fitting for us, sitting as a Royal Commission with very different powers, to enter upon the question as to whether a Departmental Committee did, or did not, discharge its duty properly. You are perfectly entitled to say that that kind of enquiry is of very little public value?—That is the point.

Chairman: We have read it, and we are also to have the advantage of Dr. Lomax's reply to this report. These people, I think, must be allowed to fight out their own dispute upon it.

11,545. *Earl Russell:* (To the witness.) What you mean is that it shakes public confidence in the protection afforded by the Board of Control?—Absolutely.

11,546. *Chairman:* That comment I appreciate?—I assume this in their favour, that perhaps that report was signed by these two Commissioners without a full investigation, which might be wrong; but I do comment very severely on the fact that when you have another committee, the Cobb Committee, that had the fact brought to their attention that Commissioners say the use of croton oil is declining, and then they get evidence put before them which shows that the actual use is about three times that quantity. . . .

11,547. May I bring this to a point? I think I can help you. So far as the report is concerned it is a report made by a Departmental Committee appointed by the Minister of Health. Three gentlemen are appointed to it, two of whom are well-known mental alienists, and one of whom we have seen here already. Upon that of course the question of the adequacy or inadequacy of the report is a matter between the Minister and the persons he has selected to make that report. But where I think you may venture to make your comment perhaps with some force is on a report which is contained in an appendix to that document, and which is a report by two members of the Board of Control. That is a different point, if I may say so. In the appendix there is on page 89 a report by Dr. Bond and Dr. Rotherham, upon their visit to Prestwich asylum on various days, and in that report they deal with a number of the topics in Dr. Lomax's book. If I may say so, I think the criticism you are entitled to make there is: This is a report by two members of the Board of Control, and you are entitled to say, if you please, that having read that report you think that the public may well question the independence of these gentlemen in carrying out their particular investigation?—Yes. I can put the point quite shortly. You will see on page 93 that, having been requested to direct their attention to Dr. Lomax's period, the end of 1917 to the summer of 1919, they go out of their way to set out figures for the year 1914, for April 1917 to September 1917—(those are the two periods when Dr. Lomax was not there)—and then for the first six months of Dr. Lomax's presence there, October 1917 to March 1918; and they give the figures for these three periods of 6 months: 540 doses used in the first period, 396 in the second, 333 in the third, and then in brackets "(of which Dr. Lomax prescribed 253)." Now the only inference which anybody can draw from those figures is that the use of croton oil was declining, and that if it had not been for Dr. Lomax himself prescribing it, its use would be almost negligible in the last period.

11,548. *Earl Russell:* At the same time it is a legitimate comment, if it is true, that Dr. Lomax himself prescribed the enormous proportion of doses?—That is a point, and I am going to suggest to

* Note.—Since giving evidence Mr. Parker has informed the Commission that, after communicating with the Board of Control, the National Society for Lunacy Reform are satisfied that the figures quoted by the Commissioners in their Report on Prestwich Asylum were meant to have reference to that part of the Asylum with which Dr. Lomax was concerned only, and not to the whole Asylum, and that the six months periods selected by them for comparison, which seemed irrelevant, were selected in good faith.

10 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

you that it is a most unfair suggestion to make. When they made that report, if they had directed their enquiries to it, they would have known what subsequently came out, that the purchases in 1919 were 2995 two minim doses (I am quoting now from page 112) and 1,000 half minimum doses; that is 3,995 doses in 1919. Those are authenticated figures from the Ministry of Health, and I do submit that is one of the years they are asked to report upon.

11,549. *Mr. Mickleth*: Does not that report cover the whole of the time they were directed to report upon?—Their report does not.

11,550. It only touches six months of it?—In only touches the first six months. When one knows that in the last year of Dr. Lomax's residence there were figures available to them showing purchases of nearly 4,000 doses a year, I submit it is the most amazing thing that people in a responsible position could have put forward that report. I am assuming they did it in ignorance of the facts, and I submit it is a question for this Commission to ascertain from those gentlemen who was responsible for giving them such misleading facts. I want also to make this further observation that when these facts were disclosed before the Cobb Committee some seven months later, it is inconceivable to me as a member of the public that no comment should be made upon them; but they were all side tracked; the Cobb Committee does not attempt to deal with them. That is, on the issue of the consumption. There is one other point which I very much want to put before you. Of course the real gravamen of Dr. Lomax's criticism on this particular point was that this drug was administered in the food to patients. Now the Commissioners do not attempt to deal with that point. When you turn to the Cobb Report, they pick many less important points out of Dr. Lomax's evidence, but they do not attempt to deal with that point; and we feel that it is probably the most important point in his criticism; that if, in fact, it is established, as we believe it will be established, to your satisfaction, that it is a regular medical practice to administer drugs in the food, the least that should be done is that that should be admitted. Of course you get there the basis of what is always urged as an indication of insanity, namely, the patients saying their food is poisoned. Croton oil is a poison; if used to any excess it is a very virulent poison, and though its use is being discontinued, I have not the slightest doubt in my mind that for years it has been the practice in all asylums to administer croton oil in food. I do not want to enlarge on the cruelty of that system; it may be necessary in some cases, in very rare cases, but we all know the sort of results in a household if food does get contaminated, if cooking utensils are not clean, or anything like that; it disorganises a household; people will refuse food for weeks afterwards, because they think that is the cause of their trouble. I do submit most strongly that in asylums, where the food is not too adequate, it is a terrible position that patients should acquire the knowledge that their food is drugged, and, as Dr. Lomax says, for days they will look at their food until they are forced by hunger to take it. Once you start that suspicion in their minds, where are you going to stop it?

11,551. *Sir David Drummond*: Is it your contention that drugs should not be administered in food?—I do not think we can go as far as that; it is a medical question. I do not know that we can say in all cases that the patient should be told. Obviously in some cases he should not be told, but I think it should be done with very great care.

11,552. *Earl Russell*: It is not the normal practice to administer drugs in food?—It is not.

11,553. *Chairman*: One knows of advertisements in which people are recommended to try it?—The case I put before you yesterday is quite typical. The patient refuses his food one day; he refuses his sedative the next; he is given it forcibly by tube at once; it is not a sedative, as entered in the case book; it is croton oil.

11,554. I think we appreciate the point, Mr. Parker. The question really is: What is the best method of eliminating the risk of abuse? That is always the question one must focus one's attention upon. It does rather seem to me that the best remedy without an undue interference in the clinical treatment of cases, is by regulation, and, as you suggest reports and returns as to the quantity of each drug which is used, and probably more stringent rules as to the keeping of records in dispensaries, and as to the issuing of drugs on the doctor's prescription in each case. Of course there is a good deal of that already. How far it is carried out is a different matter. Possibly more stringent regulation in that respect, checked by returns, affords the best safeguard. I do not think mere returns by themselves are adequate. They would merely tell you what had been done; but we want more than that surely?—We want much more than that. The first point is this: Is it to go forth as the definite medical view that for adequate treatment they must have permission to administer drugs in food? That is the first point to clear up. It has been denied in a great many quarters; I do not know whether by responsible people it is denied, but we should like to know whether that is the medical point of view, that adequate treatment does entail the drugging of food. If it does, then of course we shall submit that that drugging of food must only take place under the most careful restrictions.

11,555. I think it would be very difficult to lay down an absolute rule in a matter of that sort, because a very common delusion on the part of a patient is that he is being poisoned, and also a great difficulty in the treatment of these cases is their resistance to treatment.—We recognise that.

11,556. You want, of course, to get as little antagonism between the doctor and the patient and the nurse as possible. No doubt it is a concealed method of treatment to put the drugs in the food, but in that way it may be possible to get an otherwise recalcitrant person to take what is a most important medicine for him.—It is very difficult, I realise, to draw the line. There must be a type of case that will resist. But we submit that far the greater number of cases are people who are quite competent to say whether they wish to take these drugs or not. Again we come back to the issue raised by the British Medical Association: Is it to be legal in asylums to give drugs?

11,557. *Earl Russell*: I understand that in private panel practice the patients clamour for medicine?—It depends upon the medicine.

11,558. *Chairman*: We have your view upon that point, Mr. Parker. I would only make one observation on the Cobb Report, and particularly on the passages to which you have referred. I appreciate your criticism; of course one sees at once the point of your criticism. I am going to make the general observation that the elucidation of this whole topic is very liable to become controversial. I do not think there is any topic that is so exposed to controversy as this one. I am afraid it is a tendency of human nature that if attacks are made, if I may say so, sometimes in unmeasured language, the defence is liable to be in the same tone; and one knows so well, from controversies in other regions, that if you abuse a man he becomes abusive in return; and, instead of getting what you really want to get, a calm consideration of the whole situation, the merits of the dispute are often lost in what we may call a desire to score and obtain a victory one over the other, as the case be.—I think you have summarised the position exactly, if I may say so.

11,559. It has been our endeavour in this very important enquiry to try and eliminate as far as possible what one may call exaggerations, and to get the facts in the mood which is appropriate for reform, which is a calm and deliberative mood. I do not think I am paying you an undue compliment when I say that you have assisted us very much by

10 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

the attitude you have adopted throughout these proceedings, because you have dealt with each of the topics exactly in that spirit; but at the same time one must make a certain amount of allowance for persons who are attacked sometimes in unmeasured language, and in human nature you will find a certain amount of unfairness on each side.—I am the first to admit that on both sides.

11,560. And therefore for our present purpose my endeavour, and the endeavour of us all, is to approach these very difficult and anxious questions really with as calm a judgment as one can possibly import into them, and to eliminate the “stunt” element altogether. I am sure you appreciate that?—I do.

Sir David Drummond: I think before passing away from this croton oil question it should be pointed out that croton oil is not the only drastic purgative that is employed. We are dealing with it on the assumption that it is the only one used. There are others which are just as drastic.

11,561. *Chairman:* Yes, but I think Mr. Parker was using croton oil as an illustration of the way in which the use of drugs may be abused in institutions for punitive purposes, or administered in undesirable ways.—That is so.

Sir David Drummond: There is no evidence that those hospitals treated their patients in this way.

Chairman: We have a record of some of the drugs used.

11,562. *Sir David Drummond:* None of the purgatives were used at all—just the sedatives?—If I may say so, I quite recognise that the object is to effect an improvement, and that except for drawing attention to particular points it is not much use criticising what is past; our whole efforts are to provide for the future.

11,563. *Chairman:* Do not minimise your own point, if I may say so. We can only learn from past experience. Past experience is the best index of the points at which the present system is defective?—Surely, the only index.

11,564. But upon this point even laymen know that the use of purgatives is very necessary in asylum treatment because of the condition of life there, and also because, of course (again I speak as a layman) purgatives are one of the methods of removing the toxins which are often the cause or accompaniment of mental disturbance. You selected croton oil, I take it, simply because it was a very conspicuous drug, and a very violent drug?—Yes, and I think an objectionable drug as far as one can judge as a layman; that is to say, unnecessarily violent, and I think medical opinion confirms that.

11,565. But Sir David's point is this, I take it, that suppose croton oil were forbidden altogether, shall we say an unscrupulous dispenser might use some other purgative known to the British Pharmacopœia which might be just as unpleasant?—There are such purgatives, I believe, but can they be administered in the same way?

11,566. *Sir David Drummond:* On yes, just in the same way?—In food?

Sir David Drummond: Yes, administered practically in the same way.

Earl Russell: The limits of medical ingenuity are not reached, Mr. Parker.

Chairman: Yes, but Mr. Parker has a general point which we quite appreciate. Of course, Sir David's point is a sound one: that regulation must not merely take the form of a substitution of some other equally violent and offensive drug as croton oil.

Witness: Quite.

11,567. There we have your general point on the use of medicines. Now let us pass on to a number of other points. You have mentioned quite a number of miscellaneous topics, and I daresay there is no harm in taking them in their order. You pass on to the subject of latrines?—Yes. Just on the question of purgatives generally I want to draw your attention

to this—of course it is somewhat the same point—that the practice does apparently prevail, and prevails to the knowledge of the Board of Control though they do not approve of it, in certain institutions, of giving weekly doses of purgatives, whether they are required or not, from stock bottles.

11,568. It sounds a little like Dotheboy's Hall?—It does, that passed through my mind. It is a survival of an old practice which was considered useful. Now, Sir, in certain asylums that leads regularly to very violent scenes. We propose in our evidence to put that before you, that this weekly dosing, whether it is required or not, is most objectionable to patients, and I am referring to both men and women in this connection. There again it should be stopped, and particularly in a matter of that sort as a layman I see no sort of justification for forcing a purgative upon a patient.

11,569. Indiscriminately?—Indiscriminately, or except in very urgent cases at all. I daresay medical men will not quite agree with that, but I mean in the normal case where a man is not *in extremis* in any way the individual is a good judge as to whether he requires a purgative or not. It has been urged that croton oil and such things are invaluable in certain extreme cases, but in the normal life of the individual, we submit it is rather a serious proposition that you shall not only give a purgative, but that you shall be entitled to give it if necessary by throwing a man on his back and pouring it down his throat, which is what in fact happens.

11,570. There are some people who unfortunately are very careless about their habits; and mental disturbance, I understand, is rather closely associated with auto-intoxication through failure to remove the spent products from the body?—Quite.

11,571. Take the case of a patient, let us say, whose bowels fail to move for a day or two—

Sir David Drummond: Six weeks sometimes.

11,572. *Chairman:* Of course that would be one of the obstinate cases, but taking the more normal case of a person who for two or three days has failed to evacuate his bowels, he might say: “I will not take your medicine.” What are you to do in that case? Are you just to allow him to go on accumulating and let the case get worse?—No. Of course we recognise that there must be a point at which the doctor is justified in interfering. May I give you a quotation on this from the Board of Control Report on page 136?

11,573. If you please.—They say: “In examining into certain of the records that are kept I found that aperient medicines are issued to the wards in large stock bottles, and are given to the patients without any written medical order. This is a matter that requires immediate attention, and I draw attention to it”—they give the name. There is another reference of the same sort at the bottom of page 240: “Aperient medicines are still issued to the wards in stock bottles, and are given to patients on a general medical order. This system appears to me to be open to considerable abuse, and I would again urge that only the doses ordered by writing by a medical officer should be sent to the wards”. Of course these are exceptional cases, and the Board of Control quite fairly see the abuse.

11,574. *Earl Russell:* There one might be entirely with you, but you must remember that in all ordinary lectures on health the importance of internal cleanliness is impressed upon you, and particularly so, as the Chairman says, in these cases which are largely cases of auto-intoxication.—Yes, I am trying to put before you the routine administration without medical order. I say that should be stopped. It does, in fact, lead to violence, and is the beginning in some of our cases of a sort of downward course; the patient becomes resistive.

11,575. *Chairman:* Of course it is quite improper that 50 people should all receive the same dose on the same day in the week, because their conditions would vary infinitely. One patient may be a person whose

10 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

habits are perfectly regular, and that that patient should receive the same dose as a confirmed constipated case is not in conformity with the regimen at all?—Quite; and throughout our evidence I do not think I am putting it too high when I say that the majority of institutions did practise that. Of course some of our evidence goes back a great number of years. I believe that authority is now setting its face against it very sternly.

11,576. Again, one always has to deal with the cases of backward institutions. What we have recognised throughout has been that many of the institutions in this country are in the vanguard of reform; but then you have to legislate in this matter, as in all matters, not for the people who are willing to do right and are anxious to improve themselves, but for people who are recalcitrant.—Exactly. I quite recognise that it is an administrative point, and with a directing central body it will no doubt be altered.

11,577. If the gentlemen making this report had not only drawn the attention of the Board of Control to the matter, but had said: "This is a case in which an effective direction should be issued to that hospital that no such treatment is to continue and that for the future every purgative dose is to be prescribed for and given to the patient who requires it"—of course if they had power to do that kind of thing, then your purpose would be achieved?—Yes, and there is one more point I should like to make. In one asylum I visited I found that there was a very strict rule that all doses not utilised for any purpose had to be returned to the dispensary the same night. That should be a regulation undoubtedly, because it goes to the root of another point, where these drugs may accumulate in wards and then are put to improper use by the attendants.

11,578. In that way I think you complete the circle?—Quite.

11,579. May we pass now to the question of the use of latrines?—With regard to latrines, we wish to draw your attention to two points; one is that, generally speaking, we believe the accommodation is still inadequate, and that is recognised by the authorities now. Secondly, there does seem to be an extraordinary practice of locking the latrines at stated periods in many institutions and also of reserving certain ones, which are not, I believe, meant for the use of the attendants, for their use. Both those points are brought out.

11,580. *Earl Russell*: During what sort of hours in the morning do you mean they are locked?—Apparently from 9 to 11 it is quite a common thing to lock the latrines. Of course, especially when purgatives are being given, a routine order of that sort becomes ridiculous.

Chairman: I cannot see why access to these places should not be available at all times.

11,581. *Mr. Snell*: Do you suggest they may be locked and yet an attendant is available to open them?—We distinctly suggest that. I have one case in mind where a patient wished to go to the latrine as it was in course of being locked, and the attendant declined to let him in; he said: "No, my rule is to lock this at 9 o'clock."

11,582. May not this important administrative point be involved that the latrines have to be watched a good deal?—I agree. That man went to the head attendant and told him that his case was one of urgent necessity and the reply was: "Oh, you are a cantankerous sort of fellow and you can wait." Of course, that waiting had deplorable results which were at once reported. The patient was taken before the doctor, the attendants were sent for; they did not deny it; they referred to their instructions, and the patient thought that concluded the matter. Not a bit of it. The same evening, when he went back to his ward from the exercising court he found himself relegated to the wet and dirty ward, where he remained for upwards of a month in the most disgusting surroundings. That is a very serious state of things.

Chairman: I think so. I can see no reason at all why a patient should not have access to the

necessary places as and when required. Of course, as Mr. Snell has said, we quite recognise that they have to be under observation no doubt.

Earl Russell: In some cases, in suicidal cases and cases of that sort, but a great many do not require observing.

11,583. *Chairman*: There is this difficulty, of course—it arises in civil life outside asylums altogether. One knows that the use of these places has to be regulated in all factories, because it is not unknown that a workman may spend a quarter of an hour even in the uncongenial atmosphere of a latrine smoking a cigarette and reading the sporting news.—I can assure you it was not unknown in the Army.

11,584. And there is, of course, the difficulty that some of the patients might like to linger in these uncongenial surroundings for an undue time, not for the real purposes of Nature but for other purposes. That, of course, is just one of the difficulties you have to face in dealing with an abnormal population, but your main point is that where Nature requires an outlet an outlet must be provided?—Quite, and it should be an appropriate outlet.

11,585. But while there may be a morning drill of this sort, and it may be that the places have to be closed for a certain time for cleaning and so on, the effective point seems to me to be that any person should be entitled to go to the attendant and say they require the use of this place, and that the attendant's duty should be to make it available?—Yes, I think that is the reason, if one analyses it; it is for administrative purposes in order to prepare them for the usual morning inspection.

11,586. The place must be cleaned, of course?—Yes.

11,587. *Earl Russell*: Mr. Parker means a little more than that. He means it may be shown nice and tidy when the inspectors come round.—I think that is the reason they are closed, in order that they may be prepared for the morning inspection.

11,588. *Chairman*: You find in every institution that people have to brace themselves up for the morning inspection?—Yes, but I do think if it entails closing for long hours, the inspection should not require that; they should be reasonably clean and not in a spotless condition. It is not much good closing a place for two hours, and then opening it and saying, "This is its normal condition."

11,589. One of the complaints I have come across in a certain number of cases—though I do not think you allude to it—is that in these places sanitary paper is not provided?—We have numerous complaints of that sort.

11,590. On that subject I made one or two inquiries, but the real difficulty is this: if you put one of those attractive rolls of paper in a latrine it seems to have an irresistible fascination for many patients who proceed to unroll the whole of it in the room, while others take it away in large quantities and use it for correspondence. Difficulties of that sort, although they sound trivial, seem to be the real difficulties. Apparently the practice in some institutions is that the paper is provided for the patient when the patient goes in—a limited quantity of paper. I do not quite know how one is going to get over that difficulty?—I think that is the solution. Of course, one realises that it entails a great deal of extra trouble, but still the alternative is a very horrible one, and I think that trouble should be taken. If you cannot control a general issue, I think it is obvious that there should be a personal issue.

Earl Russell: I think you must serve it out in limited quantities.

Chairman: I think that is how it is done in well-ordered institutions.

Earl Russell: Of course one recognises that it means more trouble for the attendants, and you have always got to put a little pressure on when more trouble is involved.

10 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

Chairman: But apparently it cannot be met by putting supplies in these places in the same way as in an ordinary railway lavatory.

Witness: One realises that. I think if it were available on demand at any time, that would meet it. 11,591. However, though a small point, it is just one of those little things that in the life of the asylum may give rise to great grievances?—It does.

11,592. It is a sort of thing that may be dwelt upon and magnified into a very great grievance?—It is a matter of daily necessity, of course. That is the point.

11,593. Now the next point is a very large issue, and that is the question of discipline in these institutions. As you recognise, discipline has to be maintained in them, and persons in charge have a difficult task in that respect. What is your general view of the policy in this matter?—The first thing that strikes us is this: In the total absence of any statutory provision discipline is necessary—I mean, punishment may be necessary in an asylum; it seems quite obvious that in certain cases it must be necessary—control and even punishment. That leads us to this point: what percentage of the patients in an institution are capable of appreciating punishment? We believe that quite a large number of patients in any institution are quite capable of appreciating the necessity for punishment.

11,594. Of course, retributive punishment is quite out of place in an asylum. Reformatory punishment may be appropriate and necessary?—Exactly.

11,595. *Earl Russell:* I should like to know what you mean by “punishment”?—Of course we realise that a great many acts are due to the condition of the patient, but there are cases of outbreaks undoubtedly which in our view would merit punishment of some sort.

11,596. *Chairman:* It is not the punitive idea so much as this:—that you want to introduce motives into minds which may be imperfectly organised minds but still are susceptible of understanding things up to a point. You want to introduce a motive for good conduct. You may induce good conduct by rewards, and you may induce good conduct also by deterrents. That puts it in a sentence, does it not?—That puts it.

11,597. Rewards, as one knows, are to some extent resorted to. There are certain special facilities given; more liberty is given for one thing; that is a big thing; liberty is given to the well-behaved patients to go about the grounds and, indeed, to go out of the place altogether sometimes?—Yes.

11,598. And small rewards, such as a ration of tobacco for the men or tea for the ladies, and things of that sort. That is a system of rewards. The motive of getting some little comfort or luxury is a motive, I take it, that a very large number of the inhabitants of asylums can appreciate quite well, notwithstanding that their minds may be disordered?—I am sure they do.

11,599. The other aspect of it is rather the question of a deterrent with which your *précis* is concerned. The minds of these patients, like the minds of people outside asylums, may be deterred from doing wrong by fear of punishment. Punishment may be a much more difficult thing to administer fairly when you are dealing with persons whose conduct is not necessarily due to wickedness or naughtiness, but due to symptoms actually of their pathological condition?—Quite.

11,600. I take it that the only legitimate use of punishment is to introduce that motive into the mind of the patient—that he must not do certain things which are subversive of discipline, because unpleasant consequences will follow?—I agree.

11,601. What forms of punishment in that sense—deterrent punishment—are in your view legitimate?—We feel that one has to look at the present system first, and there the arbiters on questions of this sort are any of the junior doctors or possibly right up to the medical superintendent, though that is rare apparently; and we think it is a very deplorable thing that the doctor in charge of the case, whose whole purpose is to build up a personal contact with the

patient, should be the person to administer the punishment. He may be the person to report on the conditions which merit punishment, but it does seem to us that he should not be the person to administer it. Then, of course, we look round to see if there is anybody who would be in a more available position. The first thing that strikes one is that on questions of serious insubordination the visiting committee might function. As far as our evidence goes in those matters, they never do. Punishment seems to take this form—a loss of privileges, seclusion, or relegation to a lower ward. That does not take you very far. We look on relegation to a lower ward as a deplorable form of punishment. It is setting back the patient's recovery by just so long as he is kept there—by putting him in very terrible surroundings.

11,602. *Earl Russell:* Not necessarily?—Well, I am quoting again from a great mass of evidence that when patients, as they think unjustly, for some trivial offence at any rate, are relegated to lower conditions, it is the most irritating and demoralising experience.

11,603. Yes, you talk now of a case where it is done unjustly and lightly, but you can think of cases where it is a proper thing?—Where the classification of the case demands it, obviously.

11,604. *Chairman:* Suppose you have—and one has seen it—an institution where classification is carried out as far as it can be under existing conditions, and you have one group of patients who have their own ward and who are for the most part well-behaved, quiet people, conducting themselves very reasonably. One of those patients unfortunately (it may be due to a purely pathological condition) becomes violent, abusive and obscene. You would be the first to recognise the undesirability of that patient remaining among the others. That patient must be relegated to another ward and consequently re-classification takes place; the re-classification will take him to the refractory ward because that is the very place where these people are, but he will resent that very much indeed possibly. What is to be done?—In that case one can make no comment; he is properly re-classified. We are on the type of case where there is milder insubordination. When the Harnett case was before the Courts it was a matter of very great interest. In one case a patient who was, in our view, quite fit to be set at liberty, made some incautious remarks in the ward he was in, criticising the asylum administration; he went down the same night back to the refractory ward—insubordination!

11,605. *Earl Russell:* Are you quite sure that is all he did?—I hope he will be one of the next witnesses before you. It is a point upon which you will form your own judgment. Personally I had him under very close observation for some months after he came out, and I am satisfied that he was detained much longer than was necessary.

11,606. *Chairman:* Of course, so much depends upon how that is done. If it is a question of a patient criticising the institution, that is one thing; but if it is a case of a patient starting an agitation, it is another thing?—Exactly, one sees that difficulty.

11,607. You know how very easily you may set fire to the tow in such cases. I mean comparatively small things may give rise to very grave difficulties in matters of discipline?—I fully recognise that side of it and that is why I say it must be a difficult thing to maintain discipline in an asylum, but I question whether the present method is the best method of maintaining it, the method by which the doctor only has those remedies available to him.

11,608. Of course there must be a great many comparatively small things from day to day with regard to which it would not be appropriate to call in the visiting committee. Suppose a female patient became a little violent and flung a teacup in the attendant's face (that does happen, one knows), and the appropriate remedy was to say: “Well, you will not get your allowance of tea next week”; it would be rather using a steam hammer to crack nuts to

10 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

bring in a couple of members of the visiting committee to adjudicate upon such a matter. It is just like one of those things which in a nursery have to be dealt with there and then?—I am not suggesting that, but when you come to the more serious breaches which do seem to entail relegation to lower wards and confinement sometimes for very long periods without books or anything, we say it is more drastic treatment than any prison would give.

11,609. Let us take seclusion now. Seclusion, I understand, ought not to be allowed and is not allowed except on the order of the medical officer in charge of the case. Is not that so?—We find it very difficult to ascertain what seclusion really is. Apparently it is a term the exact definition for which is again under consideration.

11,610. Let us take the sort of normal case of seclusion—what you have seen and we have all seen—the removal of a patient from the general company and the placing of the patient in a side room or, if necessary, in a padded cell in solitary confinement. That is the typical seclusion, of course?—Yes.

11,611. Is it not in practice only permitted where the medical officer in charge of the case directs it to be done?—I think that in an emergency an attendant would take those steps, but it is then confirmed by the medical officer. Our point, however, is rather this, that the confirmation takes place on the statement of the attendant. The medical officer coming round in the evening hears that So-and-So has been insubordinate, has shown signs of violence, and has been put in seclusion. Now there does not in a great number of cases appear to be any investigation of those facts. In fact, a lot of our evidence shows that it is a personal matter between the patient and the attendant, and the attendant is empowered to take this action, and I am afraid it is very often confirmed offhand. There the patient remains for an indefinite time until somebody thinks—it may be a month or six weeks or three months—it is time that he went up to a better ward again.

11,612. *Earl Russell*: Surely the doctor would consider the next day and the day after whether he was quiet enough to be let out again?—One would suppose so, but our evidence shows again and again that seclusion does take place, or confinement does take place, for very lengthy periods for apparently very trivial reasons. May I give you a definition of "seclusion"? The only one I have been able to find is in the 54th Report of the Board of Control, and it is there defined as "the enforced isolation of a patient by day between the hours of 7 a.m. and 7 p.m. by closing by any means whatsoever the doors of the room in which the patient is." It is quoted in the Cobb Report also at page 36. The point there, you notice, is whether the door is closed, and we get a great deal of evidence of people being in confinement but the door is left open, and it crosses one's mind whether those cases are entered in the asylum records as cases of seclusion.

11,613. I suppose you would not object to a case of seclusion which I saw in one asylum; it was rather a refractory ward. There were a dozen patients at tea, fairly quiet, and there was one man in bed in a side room with the door open, very noisy and shouting all the time; apparently the patients having tea were taking no notice, but of course he really was secluded; he would not have been allowed to leave his room. You would not object to that, would you?—Would his case be entered on the records as "secluded"?

11,614. That I cannot tell you.—That is the important point. All through these Board of Control reports you get a special report on seclusion, that it took place for so many hours during 12 months; and one cannot help wondering how many cases are in fact entered, and how many cases there are where you may get weeks or months of seclusion which are not considered technically seclusion, because the door is not closed.

11,615. *Chairman*: That point is at present under consideration in Regulations which are being revised by the Board of Control. The criterion of seclusion is the difficulty, and the question whether a person is secluded with the door open or locked or on the latch—all these refinements enter into it. I suppose you would have to have a very precise definition of what is "seclusion" in order that the returns should be reliable?—There is a comment by an attendant who had long experience—the man from whose statement I quoted yesterday. This refers to a registered hospital, and he says: "Patients would be placed in side rooms (in seclusion) upon the reports of the attendants, without any proper inquiry by the doctors. The patients were in the attendant's power. According to the Commissioners' Rules patients were not supposed to be kept in strict seclusion for lengthy periods during the day. The doors of the side rooms are supposed to be left open. This rule would be ignored, and patients kept in the side rooms with the door shut practically all day, and misleading entries made in the seclusion book. There is no check kept on the attendant's reports concerning a patient's conduct. Those reports, although perhaps untrue and actuated by ill-feeling, are invariably accepted by the medical officers as correct, and entered in the report book accordingly. The patient of course has no opportunity of knowing anything of these reports." That goes a little further than the question of reports.

11,616. We must carry along with this in our minds another aspect of the case altogether, and that is that it is of course most detrimental to patients who are quieter to be mixed with patients who are very violent and who are being restrained in their presence. Nothing could be more painful to a number of well-behaved patients to see the unpleasant process of one of their number, who had unfortunately become violent, being restrained in their presence, shrieking, if you please, and generally creating a disturbance. It is essential that such a person should at the first moment be removed from the company of those people with whom she or he is. That, indeed, is one of the main reforms which is desired, that the better patients should not be associated with painful sights and sounds. Therefore it is plain that cases of this sort which would have to be put into separate confinement must be dealt with in some such fashion. I understand that in point of fact the numbers of really violent cases are surprisingly few—far fewer than the public imagine. The public have wrong ideas of what happens in an asylum and think that everybody there is shrieking and raving. Of course that is not so at all. A very large proportion of the inhabitants of an asylum are persons who are able to behave themselves quite satisfactorily, with some supervision. Therefore the class of cases that require seclusion must always be very limited and ought to be very limited. But I understand, and I believe it to be the case, that seclusion, except in the case of an actual emergency, is always on the order of a medical officer. The point is whether the present rules require that such seclusion should always be upon the order of a medical officer, except of course in an emergency, and I understand that even then an emergency step cannot be taken by one of the ordinary attendants, but only by a head nurse or head attendant?—I think that is so.

11,617. Whether that is observed, of course is a different question, but we are concerned just now with what are the existing rules?—I quite agree that it must be by the order of the medical officer, but I rather make this suggestion, that if it is going to be for a lengthy period and to deal with those cases you have mentioned, violent cases, it would be very useful that another authority, the visiting committee or members of the visiting committee, should be called in to ratify. What I want you to have in mind is long periods of seclusion, weeks and months, apparently for no adequate cause.

11,618. *Earl Russell*: Or without formally ratifying, it might serve the purpose if all cases of seclusion

10 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

were reported to the next meeting of the visiting committee, and a point made of their seeing them personally?—That would help enormously.

11,619. *Mr. Snell*: Do you suggest that the removal of punishment should be left to the visiting committee also, because it seems to me that waiting for a visiting committee to come might involve detention in a lower ward a great deal longer than was necessary?—I quite agree, because they only visit at periods of two months.

11,620. *Earl Russell*: Sometimes? — Sometimes oftener, sometimes less. I quite agree with Mr. Snell's point. Of course if one depended upon the visiting committee and their periodical visits, it would not be an entire remedy. It would be a help; but one cannot help feeling that members of the visiting committee in regard to these matters should function much oftener.

Chairman: I think Lord Russell's suggestion that all cases of seclusion should be reported and that such cases should be gone into by the visiting committee would help.

Earl Russell: It at once puts you on your inquiry, of course.

Mrs. Mathew: Is it not the fact, Mr. Chairman, that that book with the hours of seclusion is put before the visiting committee?

Chairman: Yes. Mr. Parker's point is whether they are adequate records. It is required to be, but the point that has been raised is whether the existing definition of "seclusion" is such as to ensure that every case of real seclusion in point of fact finds its way into the book. Is not that it?

Witness: That is so.

11,621: You suggest that the doctor should be dissociated from the punitive element, and I appreciate that point. But if seclusion is to be resorted to, you know seclusion is not necessarily punishment at all; seclusion may be part of the treatment—in a sense it is classification carried to the last degree. I am not sure that you can put seclusion into the category of punishment at all. It could be used as punishment, I agree; but, on the other hand, it may be and must be in some instances part of the routine of treatment—that a patient has to be kept apart from others?—Surely that would only apply to very noisy patients. I mean where their condition demands it, would not the appropriate treatment be to put them back in the infirmary ward?

11,622. The kind of case I am thinking of is a patient with violent homicidal tendencies; the kind of patient about whom you are told "You had better not go near that person." There are of course a certain number of people of that sort, fortunately very few, whom you cannot trust anyone near; unfortunately they are really in the condition of beasts.

Sir David Drummond: But isolation, when you come to the treatment of early cases, is a most important factor—away from friends, away from other patients, and so forth.

Chairman: Quiet, and even solitude, may have a composing effect. I rather demur to the idea of treating seclusion as if seclusion itself were a punitive method.

Witness: I hope you do not think we suggest that. We quite realise that seclusion is a very important medical aspect in proper cases. What we do suggest is that confinement for lengthy periods is used for punishment, and we are not at all sure that it ever finds its way on to the records of seclusion.

11,623. *Mr. Snell*: On that point is it not the fact that cases of seclusion have to be reported to the Board of Control, and does not that give you the security you want?—They are never reported to the Board of Control if they do not get on to the asylum records in the first instance; they cannot be.

11,624. The case of a person being in seclusion for months and months together presumably would get on to the asylum records and come before the Board of Control?—That is precisely what we do not know. We think they do not. May I give you this reference

to "seclusion" from the Cobb Report? They visited Prestwich and they say this: "At the time of our visit to Prestwich no patient was in seclusion. We inquired, however, into the allegation that patients are occasionally secluded without due record being made. We found that the doors are fitted with a light catch, by means of which the nurse can shut the door—without locking it. There is ground for believing that very occasionally and for very short periods (*e.g.*, at meal times) the nurses may close the door in this way and not record it as seclusion. In our view, however, this practice is a form of unauthorised and unrecorded seclusion. We have been informed that the Commissioners of the Board of Control have also commented on this. The practice is open to considerable objection, and we hope that the responsible authorities will take cognizance of it."

11,625. *Chairman*: Well, Mr. Parker, that is the whole story. You want the responsible authorities to take cognizance of it, and that would ensure all cases being put on the record?—That is the case.

11,626. Now we come to what I think is the last main heading of your evidence, and that is what you describe as "Environment." That is really the "life" of the asylum, is it not?

11,627. *Earl Russell*: Before you go to that, might I on this point direct Mr. Parker's attention to page 26? I do not much like your page 26 altogether, but you say here about the various things patients do—"always they go to swell the growing records which prolong a patient's detention." Surely if a patient does anything which is material enough to be entered in the case book, it should be entered, should it not?—I quite agree, subject to this, that we do think the patient's point of view should be recorded. If you get an *ex parte* entry by an attendant, we suggest they are quite often very untrustworthy.

11,628. Surely the entries in the case book are not made by the attendants?—I am afraid they are made by the doctor on the attendant's information.

11,629. We had a case before us in which the patient was put in the case book as having struck another patient, and the patient's reason and explanation were given in the entry. Still, if there is a true record of the patient's condition, it is a thing that ought to be in the case book, is it not?—Absolutely.

11,630. You rather speak of it as if it were wrong to put these things in the case book. Surely they only prolong his detention if they show he is insane?—The point I was trying to make there is that from the records we get—of course, we have not access to the case books, we have only seen one—but from the patients' statements, we find over and over again that administrative changes have taken place which, in his view, have been unnecessary. He knows the reason; he has either complained or has committed some trivial offence, and we presume those are recorded in the case book. The point we make is that we think the patient should have been heard before that record was made against him—heard by the doctor, at any rate. That does not always take place. If it is an administrative point, then we come back to the suggestion that they should be heard by a member of the visiting committee.

11,631. That is not quite what you say here. You say a little lower down, near the bottom of the page, that "punishment to begin with is always indefinite 'pending the doctor's pleasure,' in itself an irritating and depressing feature." Is not that "pending the doctor's pleasure" rather an *ex parte* way of putting it? It must depend upon what the doctor thinks of the patient?—I am dealing there with cases in which, we submit, seclusion is being used as punishment, and I do feel from reading these reports that the patient does get lost sight of, while he is in this seclusion. I think when you hear the evidence, we shall make good that criticism.

11,632. But I am asking you about the phrase "pending the doctor's pleasure." You put it there as if it were an improper thing. Does it not mean,

10 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

until the doctor considers the patient is fit to be let out?—No, not where seclusion is being used for punishment.

11,633. *Chairman*: I am afraid Mr. Parker means not "pleasure" but "caprice"?—I really do mean that. They are unfairly kept in confinement for periods which are much too lengthy for the offences they have committed. I think that under the present system these cases cannot come up for review every day. I think once a patient gets down into a lower ward he may be kept there until he has got a clean record for some time.

Earl Russell: I want to get exactly what the allegation against the doctor here is.

11,634. *Sir Ernest Hiley*: Where is the quotation taken from?—It is my own drafting, and somebody has added the inverted commas.

Earl Russell: It seems to me an unfortunate phrase. I should like to know what you really mean by it.

11,635. *Sir David Drummond*: It is not your intention to bring a wholesale charge against doctors in the asylums?—Not the least.

11,636. You do in a sense; you say: "Of such matters the medical superintendent and his medical staff are sole and jealous arbiters."—That may be tested by the case I put before you yesterday, where a patient was relegated for five months to solitary confinement, and the moment the superintendent's attention was called to it from an outside source he at once interfered, presumably with the subordinate doctor, and had that patient brought up again to the ward he had been in before. One is bound to suggest on those facts that there was an improper exercise of power, not by one subordinate doctor, because this man was under several doctors. One is bound to suggest that if outside influence had not been introduced that man would have remained there for a very much longer period.

11,637. But you treat it as if your charges in that section were wholesale, not that these abuses were occasional?—I do not want to suggest that, but I do want to put before you the point of view I am representing, and that is the point of view of patients who do say that the system is abused.

11,638. *Chairman*: If I may say so, with regard to Mr. Parker's evidence generally, we have treated Mr. Parker's *précis* here as an indication of the points he wants to bring before us; but I, for one, should not wish to tie Mr. Parker down to any individual phrase he has used in the *précis* because his official evidence is the evidence appearing on the shorthand note. In the case of many other witnesses who have preceded you there have been passages which were not reproduced in the note—sometimes the language was unfortunate. I take it your real evidence before us is the evidence you are giving now and which is upon the note?—I am trying to indicate to you the point of view put to us by the patients, and I have said more than once that that must be tested by you as a Commission, by having the patients before you.

Earl Russell: I only called your attention to it because I thought for the moment you had departed from that reasoned calm which the Chairman has mentioned.

11,639. *Chairman*: I have endeavoured to use a certain moderating influence—I hope usefully. However, before we pass to this last topic of environment, let us consider a very general aspect of the whole thing. Each asylum or institution is a community by itself, a peculiar community, in which persons, owing to their misfortune, have to be under a certain system of control, intended to be for their benefit and their protection and for the protection of the public. We have this little community. It is manifest that under any system, however perfect on paper, the fortunes of that community must to a considerable extent be at the mercy of those who are placed in charge of it?—Yes.

11,640. We have to recognise that. One is reluctant to over-elaborate the rules and regulations affecting the daily life of that community. I take an analogy, not a very perfect one, of a large school, let us say. If the scholars in the school were always occupied in considering whether certain of the assistant masters had broken "subsection 2 of the rule 14 regulating the hours of play," or something of that sort, of course the whole purpose of the school would be defeated and you would get a lot of amateur lawyers instead of a lot of pupils. Similarly, one feels with regard to any institution of this sort, and it is not peculiar to asylums, that there must be a large measure of confidence reposed in the persons who have to run it. I imagine many school boys have a burning sense of injustice with regard to the punishments that are imposed upon them, and sometimes they are unjustly imposed I am afraid, but you cannot convert the business of the school into a series of miniature courts martial. The remedy is to have a good school with a good tone and with good masters and good people in charge of it. That is the real remedy. All the rest of it on paper, the rules and regulations, may be admirable, but if you do not have a good person in charge, no amount of regulation will make the place a happy or fortunate institution?—We are all agreed on that, and the criticism that I have made against the doctors is not a criticism against the medical profession. It is a criticism that the type of doctor employed in many of these places is quite inadequately trained. You have had medical superintendents before you who say that their knowledge on these matters is grotesque—that was Dr. Devine I think, and I think it is admitted that the supply of adequately trained men is short.

11,641. That kind of criticism is useful and very much to the purpose, but we must avoid the risk in our Recommendations of running to the opposite extreme, and instead of engaging the patients as far as possible in recreation and interesting occupations of which you speak, converting them rather into people who are hunting for rules and regulations and trying to catch out those in charge for having broken this or that regulation. You would then give the institution all that appearance of formality which we want to avoid, because we wish to produce as far as we can normal and happy conditions?—Quite, and there is this point, if I may interpose it, that at present we feel that the individual medical officer is asked to look after far too many patients, and therefore he is precluded from giving the individual attention to a case which he would naturally wish to do.

11,642. Again you are pushing an open door there?—But it is on those facts we base our criticism.

11,643. And of course your criticism is valuable as showing that under the present system you cannot secure those main objects to which I have alluded?—That is so.

11,644. But whether the redress is to be found in accepting the present institutions and elaborating the precautionary rules or not is another question. I have an apprehension in my mind that if you make these places over-elaborate in their regulations, well, you just topple over into the other kind of abuse?—I think it is a very great danger.

11,645. Take the point of the superintendent, or his assistants, who have so many forms to prepare and fill up just now, which undoubtedly divert them to a large extent from their main object: if we are always calling for and prescribing more forms and more detailed supervision, we are still further aggravating that very drawback?—Quite. I rather have this feeling that it is quite conceivable now that the time has come when some of the old forms might very well be dispensed with. It happens in all other businesses as far as one knows, if you get a gradual accumulation of returns, at last there comes a point at which you must put your pen through those which are out of date.

11,646. The cellars of Whitehall are full of dead stock of that sort?—That is so.

10 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

11,647. One must always bear in mind—and I think it is a general point in considering all your evidence—that in an anxiety to safeguard the occurrence of occasional abuses, one may just step over the borderline and introduce a different kind but quite as serious an abuse in the sense of over regulation or over elaboration; and a man who is not trusted is generally not so good an administrator?—I fully appreciate that.

11,648. Of course there you get into the personal question. If we had ideal medical superintendents probably none of us would be sitting here just now, but in an imperfect world we cannot have perfect functionaries. We have however always got to bear in mind the balancing between the protective element on the one hand and over elaboration on the other hand, which defeats itself. I really have just been thinking aloud with you over it, in order that one may get one's general ideas in order on the subject?—If I may say so, I think our views are entirely on the side of practical administration and we realise one may be snowed under with forms, and we realise also that they are a distraction to medical superintendents of these institutions. They are very voluminous, I believe.

11,649. Now let us come to the question of environment. The first point that you take up has been alluded to more than once, and that is the treatment of patients. I use the word "treatment" in its more or less technical aspect. It has been said that asylums hitherto have been rather places of mere detention, where the citizen was kept apart from his fellows lest he should do harm to himself and the public, and that there has been a tendency to lose sight of the curative aspect. The asylum is not merely a prison or detention place, or ought not to be, but it ought to be a place where the patient is cured, if possible, just as a general hospital is a place for the cure of patients. Upon that part of the case, when what has gone wrong really is the conduct of the individual, is it not very difficult to avoid regarding treatment as largely a matter of the regulation of conduct? I mean to say in a general hospital of course conduct is not the question at all; it is the particular disease or casualty that is in question; but, where you are dealing with persons of disordered mind, and whose disordered conduct is the evidence of their disordered mind, is not one of the main forms of treatment the orderly and regular life of the institution?—In general terms I should agree that regularity of life in certain cases might be and is a very valuable form of cure.

11,650. First of all, take the case of the person at home who has reached a state of mental disturbance, possibly due to domestic worries: the very removal of that person from the surroundings which have been the cause of the disturbance is in itself a first step towards cure, is it not?—Yes, subject to the surroundings into which you remove him being right—removal from the old surroundings is no doubt beneficial.

11,651. But it must be removal to circumstances which are appropriate?—Exactly.

11,652. True, but there is a first step, so to speak. I should imagine that the taking away of a person—take a pauper case—from dirty, unpleasant and insanitary surroundings into a well-ordered institution would in itself be treatment, would it not?—Entirely beneficial.

11,653. Now, apart from that, I have been struck with this in dealing with mental disease, whether it is the case that medical science has not overtaken it yet I do not know, but one hears comparatively little, even in the best institutions, of treatment in the specific sense. In the case of ordinary ailments there is medical treatment, all kinds of things, the use of drugs and all the other expedients which are utilised in a general hospital, all the surgical treatment, dressings, and so on. Apart from the regimen of the life of the institution, what is it that you contemplate as the treatment which should be afforded in asylums for mental

cases? What is it that is lacking, because I would like very much to have your comment upon that?—We say that the first thing which is lacking is sympathy.

11,654. "Sympathy" is not in the British Pharmacopoeia?—It is not, but that is the broad comment—that the conditions may on the surface appear to be very satisfactory. The asylum I went over was in such magnificent order that it reminded me of a battleship. I do not think I could have found a speck of dust in it, and I am not exaggerating; but whether that extreme order is indicative of the happiness of the inmates is another point. That is the big complaint—the harshness of the treatment. By "harshness" I mean the conditions under which the inmates are forced to live; the absence of certain things to which they have been used, diet, confinement, questions of exercise, and so on, which we deal with in detail.

11,655. Might one use the phrase "the rigidity of the method"?—The rigidity and the absence of occupation, and I could not help being struck as I walked through this place (I do not know whether the same point has occurred to you) with the vacancy of the patients; they simply had nothing to do. I do not think one in ten was doing anything. It is true that in this case a meal time was approaching, and it might have been a special occasion, but that is the complaint which runs all through our evidence.

Earl Russell: I should be very glad to know what you suggest those who are normally not employed could do. We have noticed it, of course, too. What would you suggest?

11,656. *Chairman*: It is quite conspicuous?—We shall come to that as we deal with each head, shall we? The human element seems to be the big one.

11,657. Of course, one has got to reckon with this, that institutional treatment at its best can never be the same as home treatment?—I absolutely agree with that, and that is the basic difficulty, but I think this is a comment—that the more you break these places up into smaller units the more you will get that individual element introduced.

11,658. That I understand, but you will never make an institution the same as a private house.—You will never make it a home any more than you can make an hotel a home; it cannot be done.

11,659. Of course, people do talk of "home from home," but you can try to reproduce, possibly more effectively, those conditions?—You can break down the extreme rigidity of some of these institutions; it is being done at the present moment in lots of ways.

11,660. Even in a general hospital, when one visits the wards of a general hospital there is very much the same spick and spanness to be seen, and even rigidity, if you please, in the management of it; you have to submit yourself to that. That is why many people find the discipline even of a general hospital irksome. That is a general point. Then you urge the provision of better facilities, more recreation and occupation. What other heads have you in mind? None of these seem to be to me directly medical?—Of course, there is the very important question of classification, which I think is admitted on all hands to be deficient at the moment, and that exposes patients to constant irritation, which, from a medical point of view, is the worst possible thing they could be exposed to; that again is admitted, I think.

11,661. We are still in this region of classifying patients, amusing patients, and sympathising, if you please, with patients; none of these things are distinctively medical. One has heard the question asked more than once: what are the curative expedients available in these institutions? Do not you merely keep the patient there, and keep him tidy and orderly, and keep him employed, imperfectly employed, if you like? You do not find in asylums the same element of medical processes of cure, and are there any really?

10 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

That is what I am trying to get at. Are there any methods?—If I may give you a personal view it is this: That one divides cases roughly into two halves—those which are suffering from physical complaints, diseases of the body or brain; and those which are suffering more generally from some pure disease of the mind. For the first class one sees that medical science can and does in these institutions give relief, and they are experimenting in various directions. Take the question of injections of malaria for general paralysis of the insane.

11,662. And there can be considerable improvements in the matter of dentistry, for instance. These are the physical concomitants, but who can minister unto a mind diseased?—That is the other side of the problem. That is where, as it seems to me, the public point of view is at issue with the medical point of view. You pass unquestionably (and it crops up in all these cases) into questions of delusion, spiritual experiences, religious experiences, and all that type of case; and it is there where I think the public are at issue with the medical profession; because, if I may say so with all respect, the medical profession is concerned with the material aspects of the body, and it has approached these other aspects of the mind in a very careful and leisurely fashion. If I may give you one instance—take a question like hypnotism. Hypnotism was in fact used as long ago as 1847, I think it was, by reputable medical men.

11,663. *Sir David Drummond*: Long before that?—Long before, of course, but not for this purpose and for major operations.

11,664. Mesmer in 1784?—Not, I think, for operations.

11,665. Not for operations?—But it was in fact used at that date; it was 50 years before the medical profession, as a profession, accepted hypnotism as a fact. Up to that point they fought against it. They then accepted it as a fact, and now they claim it as a function which should only be exercised by medical men. I am only instancing that to show how slowly the changes which are in the public mind are acquired by the professional mind.

11,666. *Chairman*: Yes, every reform of that sort has to fight its way to acceptance; some are discarded on the way, and some achieve it. It is probably desirable that these methods should pass through the probationary period because of the great danger of the abuse of these things?—Quite.

11,667. We are dealing with the most delicate mechanism of the human mind, and it is one of those things where incalculable harm may be done by the abuse of those very discoveries which have been made?—Of course when you come to that class of case I submit that the study of the human mind is one which has engrossed humanity for centuries, and it cannot be dealt with by a short series of lectures. That is the big point: whether you will ever get, as you have said, a cure for that class of case in institutions. I do not think you ever will.

11,668. It seems so comparatively easy in the practice of a general hospital. A case of pneumonia is brought in, and there is a certain prescribed method of treatment. A patient receives all those well-known remedies, and benefits as a rule by them. A case of mental disturbance is brought in. You cannot at once say, "This is a case in which various forms of treatment will produce a beneficial result." You cannot tell; you are dealing with an idiosyncrasy. —Yes, you can say that these experiences you have had we describe as hallucinations, and as long as you continue to have them you will be kept in detention. A great number of our cases turn just on that point, and that is the medical point of view; but curiously enough when that type of case comes before a jury, as it has done in the last half century, you will always find a much wider application given to that class of facts, and the jury will not accept it as a necessary indication of insanity; and that is the important point, if I may say so, which runs through a great number of these cases. The conflict of opinion between the man in the street on the one side and the medical opinion on the other side—and that is

why in basing our case we have urged throughout, it being impracticable to get a jury to function, that what we have called the legal opinion, as representative of the lay opinion, shall always form part of the adjudication.

11,669. *Earl Russell*: You are a long way from treatment, I am afraid.—I am afraid for the moment we are, on this point.

11,670. *Chairman*: If there is a complaint that there is a want of curative treatment in asylums at the present moment, what are the suggestions of your Society on that subject? What is lacking, in your view?—We have dealt with the physical cases. On the mental cases I think the only suggestion we can make is greater freedom, and to point to all these cases in the Board of Control's Report, where greater freedom has been given and has resulted immediately in such beneficial results.

11,671. *Earl Russell*: And more medical officers?—And more medical officers, to give that personal touch which we suggest is absent.

11,672. *Sir David Drummond*: And you recognise that the suggestion that they should be given greater freedom does not arise from your Society; it is the Board of Control who generally recognise it?—No, it does not; subject to this, that that recognition is quite recent apparently.

11,673. It has been coming for a good many years now.—This is rather our comment, that it has come with a rush, quite recently, and, as we suggest, partly as the result of outside comment.

11,674. *Chairman*: You refer to page 65 of the report of the Committee on the Administration of Public Mental Hospitals of 1923. I do not know that we need get that on the note, because of course that is before us, but the importance of the investigation of each individual patient's case is there brought out. That is the point. Individual care of the case and study of the case?—Quite, and the comment we make there is that that quotation ends with these words, "These, and the endeavour to free the patient from mental worry are all parts of the 'treatment' which all our mental hospitals provide." Now we want to suggest that what is set out is an ideal form of treatment, which mental hospitals may be aiming at; but very few of them provide, as we shall try to show you, either the whole of these things, or any great part of them.

11,675. The great part of that treatment seems to be treatment distinctive to mental cases, as distinguished from general hospital cases?—Quite.

11,676. Now let us take the environment in the sense of the equipment. Shall we just get on the note the suggestions that you have upon that? You want better reception equipment, do you not?—That has been dealt with, of course, very fully before you.

11,677. Then I notice one matter of detail, "Provision of verandahs."—May I interpose and say that we put before you again suggestions which have been made by the Board of Control for the purposes of comparison, taken from page 213 of their Report. Of course obviously all those suggestions are excellent. They represent medical opinion of the day.

11,678. Then we may take it that that report embodies really most of the reforms of environment which you also advocate?—Of medical treatment. If you look at them they hardly go to environment: "The installation of apparatus for continuous baths; an operating room; room for dental surgery; development of the clinical laboratory; provision of medical officers' clinical room; X-ray installation; increased sanitary and lavatory accommodation; a nurses' home." They hardly touch environment. They are definite heads of medical treatment and administration.

11,679. Now all these things are recommended, I understand, by the Board of Control Report?—Yes, they were recommended in the case of the Oxford asylum when it was being reconditioned.

11,680. And you recommend these things also?—So far as we can express an opinion of course they seem excellent.

10 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

11,681. *Mr. Micklem*: Under the provisions of the Act there is no power resident anywhere, is there, to provide these things unless the local authority choose of their motion to introduce them?—That is so; they can only be recommended, and all these things come back to the local authority, and of course are controlled by questions of finance.

11,682. I mean under the Act the Secretary of State is referred to; the Minister of Health has no power, has he, at the moment?—No.

Chairman: He can only withhold his approval from plans.

Earl Russell: And give consent to a loan to the local authority.

Sir Ernest Hiley: That is in the initial stages of the building of the asylum; this is much later on.

Chairman: Yes, this is equipment to a large extent.

11,683. *Mr. Micklem*: Where equipment is concerned there is no authority. It is really a question of the local authority being prepared to spend the money?—Purely financial, I believe.

11,684. *Chairman*: I think the only substantive duty imposed upon the local authority is the provision of adequate accommodation, but it does not carry it the length of equipment?—Structure.

11,685. That means the place where you can put people, but it does not carry you much further than that?—No.

11,686. *Mr. Micklem*: When plans have once been approved and passed and buildings erected he has no further power under the Act?—As far as I know none whatever.

11,687. *Earl Russell*: I think any substantial change has to be approved?—I believe all structural questions go back, as you say, Lord Russell, for approval, but none of these points of equipment, as far as I know.

11,688. *Chairman*: Of course that control will enable something to be done in ensuring that the buildings conform to more modern ideas and so on, but it hardly touches at all, as far as I can see, the question of equipment?—No, it does not; and perhaps in this connection I may put this before you, that as one reads these reports one naturally finds the richer centres, the towns, and so on, are the most advanced in equipment; and especially when one passes to the west country, it is there that equipment and general treatment seems to be so far behindhand. The point I wanted to raise on that was whether you will ever get any wholesale change in conditions unless you get some form of central finance to assist the poorer neighbourhoods.

Earl Russell: I see just one effect it would have: they could veto an establishment of 2,500 inhabitants.

Chairman: Yes.

Sir Ernest Hiley: There is no power for a mandamus to go against a local authority for not providing a dental surgery or anything of that sort.

Chairman: No. The only section that would support a mandamus I think, Sir Ernest, is Section 247: "If the Commissioners report to a Secretary of State that any local authority has failed to satisfy the requirements of the Act as regards asylum accommodation, the Secretary of State may require the local authority to provide such accommodation in such manner as he may direct, and the local authority shall forthwith carry the requisition into effect." but, as you point out that does not extend at all to the detail of the equipment of the institution.

Sir Ernest Hiley: No.

Chairman: And I suppose we shall always have varying degrees of efficiency among the institutions.

Earl Russell: It is rather a curious provision in Section 247, if you look at the end—if they have failed in their duty, apparently the Secretary of State can direct exactly what kind of asylum they shall build, "and the local authority shall forthwith carry the requisition into effect."

Chairman: Yes: I doubt if that will extend to the internal equipment of the institution.

Earl Russell: It might extend to the details in the building, the provision of verandahs, and so on.

11,689. *Chairman*: It might do that. (To the Witness): Now these excellent things that are enumerated have the approval of your Society as well as of the Board of Control, and I think you point to this, that the provision of these things has an immediate and obvious effect on the recovery rate?—It should at once. I think the figures are on page 97 in the Report of 1923; the figure is 71.6 per cent.

11,690. About double the average rate was secured in Oxford?—Yes, based on nearly eight months' experience.

11,691. At Oxford they have these facilities and advantages?—Yes.

11,692. You also refer to the report on Netley at page 318?—Yes; there apparently there is no pressure on the accommodation. Shall I read what they say there—it is quite short?

11,693. If you please.—They say: "The admissions, including 13 officers, numbered 249, of whom 112 were overseas cases and 137 were received from home ports. This total is about a third less than during the previous year and, while, numerically considered, it lessens the field for clinical observation, the reduction has the advantage of permitting a more extended and individual study of patients, and of offering a better opportunity for recovery without resort to certification—a period of from two to three months' residence being now generally practicable, which is, I trust, capable of extension in selected cases." There again the recovery rate is remarkably high, 89.6 per cent.

11,694. Your general inference is that the recovery rate responds to improved modern treatment. It must be almost a truism, must it not?—Yes. While on the question of the recovery rates we wish to put this point of view before you: that they are for some reason which we cannot fathom calculated on the admissions, while the death rate is calculated on the whole population of the asylum, and, as has been pointed out to you by some superintendents, it is a very fallacious form of return. I think it was the superintendent of Portsmouth who said that he thought his recovery rate was going to be very low because his permanent cases were becoming very numerous. I have tried to work it out in my own mind, and I have failed completely to see why you should calculate the recovery rate on admissions. One does wonder what it leads to, because you may get 100 admissions in a year, none of whom go out, and yet you get a recovery rate of people going out who may have been there two or three years. The substance of it is this: what is the average period of detention of a patient in an asylum? At first glance if you hear the recovery rate is 35 per cent, you think it means one in three goes out in the year, but I believe that is very far from the truth. I have a sort of idea, as far as I can get at it, that the average period of detention is a matter of years. It is an impossible figure to get at, because of course there is the question of deaths at the same time. I do not know whether you have had any evidence before you which clears up that point.

Chairman: No, I do not think we have.

11,695. *Earl Russell*: I think I am just as confused as you are about the average figures.—I hesitate to say it, but what is in my mind is that the average period of detention is three or four years. I cannot substantiate that; that is the impression left on my mind.

11,696. We have a return coming showing us the number of people discharged after five years and after ten years' detention.—That will help.

11,697. *Sir David Drummond*: Is not that unavoidable? Here you are mixing up incurable patients and curable patients; and you are calling for a return which mixes up these two classes. It is almost impossible to get the exact facts.—I quite see the difficulty, but I submit it is very important to ascertain that one point: What is the average detention of a patient?

11,698. *Chairman*: What you really want to know is how many patients go into an institution, how long they stay there, and how many of them re-

10 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

cover, and in what time they recover? Now one can imagine, starting *de novo*, opening an institution, that you could prepare your records quite easily on that basis, and then you would be able to show your recoveries, because the incurable cases would be the cases which had been there five or ten years, as the case may be, but you would get a conspectus in this way: what are the prospects of a person going into that institution coming out? If you started in the first year and 100 patients are put in, and assume they are all first cases; then, at the end of the year, I should like to know how many of those 100 people left the institution in the course of the year.—That is the important point, is it not?

Chairman: And how long was each in?

Sir Ernest Hiley: Must you not also, if you are going to get to the ideal of having individual attention for each case, keep that fact in mind in considering any of the returns and the rate of discharge?

Sir David Drummond: Do you think that would be very serviceable? The 100 patients might be all incurables. Until we have more perfect classification and can divide up the cases into the curable and incurable, nothing is to be gained by a return of this sort.

Chairman: I see that point. Suppose that by a misfortune the 100 cases they started with in the institution were all incurable, at the end of the year the recovery rate would be nil.

11,699. *Earl Russell:* The only use of these statistics is to show that they cure a certain percentage in a certain time, and if they are to be of any use you must eliminate the incurables. If you have an asylum of 1,000 in which 600 are incurable it is no good taking your figures on 1,000, because no amount of treatment will affect the 600?—Any figures must be based on the fact that in a big institution you will get an average. All these figures are based on that assumption: that any given place will give you, within certain limits, an average. Answering Lord Russell's question, it seems to us that the basic fact to arrive at in the admissions in any one year is what is the percentage of recoveries of those cases within that first year. Then I think you might carry it possibly into the second year, and after that they would pass into the category of permanent cases.

11,700. What I am saying is that you must not take it on the total asylum population if it is to mean anything?—I agree.

11,701. *Chairman:* Of course, again statistics are of no value in themselves, although people often think they are. The value of statistics is that one may get a clue to what is going on?—They give you a comparative basis.

11,702. You want to get reliable statistics in order to see whether improvement is in effect being maintained?—I think if you found that one institution discharged 25 per cent. of the admissions and another institution only discharged five you would get that.

Sir David Drummond: That would be of no value at all, because the institution that only discharged five might have had a larger proportion of the incurable cases. Might I say this that the general hospitals returns are not on the whole of the patients admitted; they are on the specific kind of cases, pneumonias, so many recover; fractures of the leg, in so many months or weeks, so many recover; they are all specific forms of disease. That is how we can get at the question of whether we are improving.

Earl Russell: But you would get it if you separated the admissions into curables and incurables.

Chairman: If you could diagnose the incurable at sight, but it must be very difficult to do it.

Sir Humphry Rolleston: I think it is quite obvious that if any investigation of this kind is to be made it must be made by a trained statistician. There are so many fallacies, that any figures taken by myself, for instance, would not command respect. They ought to be taken by a trained statistician. I am

quite sure if Mr. Parker is going to get any value out of this investigation, it must be in the hands of a statistician who is equivalent to a chartered accountant.

11,703 *Chairman:* However, this is a side track to some extent. We were considering with you the various improvements which could be effected?—Mr. Stewart asks me to put this point to you, that at present the discharge rates in private institutions I believe are not disclosed, and we suggest that whatever the basis is, that would form an interesting return; to see how they compare with the public institutions.

11,704. Yes, we will note that. I do not think we need go into detail on the next page or two of your *précis*. You point out, of course, the advantages of fresh air, and the advantages of verandahs, and so on. You may take it that we appreciate those points?—Quite.

11,705. But the medical staff is, of course, a very important thing, and I think you perhaps have omitted to point out that the Board of Control are very urgent on the subject of increasing the subordinate medical staff under the medical superintendent?—We appreciate that.

11,706. So we need not labour that. Then, on the other hand, with regard to the nursing staff, which you deal with at some length, that has been, as we know, the subject of a recent departmental report which goes into it very exhaustively. That is in our hands; we have read it very carefully. I do not suppose we can really add very much to that, can we?—No. There is just one point there. You will notice in that Nursing Report the Committee deal with the average number of nursing staff who have the final certificate, or have passed the preliminary examination. We just want to put before you that leaving it there does not quite represent the true position. When you come to analyse the different institutions, you find that in some the percentage of the trained staff is one per cent. Of course that is the extreme. We have prepared from the Board of Control Report an analysis which perhaps I may hand in. (*Handing in the same.*) The only comment I want to make upon it is that in about 19 of the 90 odd institutions reported on by the Board of Control the certificated percentage on the staff is below 12 per cent. Of course one realises again that according to their locality, it would be much more difficult in some places to get a skilled nursing staff; and that raises the question whether it would be possible to provide some method of feeding the more remote localities from a central body.

11,707. Your comment there is really just the comment which arises always upon averages. There is nothing more fallacious than an average, of course?—No.

11,708. I mean to say to tell me your income is £3,000 and mine is £1,000, add the two together and say the average of our incomes is £2,000 a year is not much consolation to me, and yet that is perfectly accurate from the statistical point of view?—Of course it is most unconvincing.

11,709. Averages must always be dealt with with discretion.—We suggest to you that some of these patients get decimal points of the medical attendance during the year.

11,710. I think you may take it that we shall give careful consideration to that Report on the nursing staff; it is very full and very interesting, so that I do not think we need delay with that. Upon that I think you desire to emphasise the importance of the staff being adequately remunerated, and of the career being made attractive to the best class of person?—Being made truly vocational. That is the finding of the Committee, of course.

11,711. Now let us pass on to a different matter, the daily experiences of patients. Apparently in some institutions the bathing accommodation is unsatisfactory.—Are you leaving the question of diet?

11,712. Have I missed it?—Yes.

10 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

11,713. I beg your pardon. Please deal with that. There is an important point there.—We only want to make one or two observations on the question of diet. That again, of course, as you know, has been in the hands of a Departmental Committee.

11,714. Yes, I have had that report.—The only comment I want to make there is that they showed that when they started their investigations in 1922, I think it was, no less than 50 per cent., rather over 50 per cent., of the institutions of this country were serving a diet of bread and margarine for tea and breakfast throughout the week. Of course we understand very big improvements have been introduced in that respect, but that is the foundation of very bitter complaints, that the diet has been very bad; and, of course, in certain institutions does remain very unattractive. Again if we had a central authority with directing power one cannot conceive that that state of things would be allowed to continue.

11,715. You draw attention to the very small allowance.—We find it impossible to believe that a sum of 5s. a week is adequate to maintain a person who hypothetically is a sick person. On the other hand we admit that very learned people have put forward a schedule in that Committee's Report which shows that it can be done. You may remember they drew up an ideal dietary, and circulated it to a great number of asylums and asked them to report on the costs, and a great many of them could not come anywhere near the 5s., but they reported that 5s. was adequate. We ask you to test that by the general knowledge one has that the cost of living has gone up enormously. I have got here, if I may give them to you, the returns of one asylum (the one I have mentioned before) which are valuable in this way that they set out a comparison of the weekly cost per head under various heads for 10 consecutive years, from 1914 to 1924. That is a class of return which I have not found anywhere else.

11,716. Where did you get it?—This is in the Hertfordshire County Asylum Report.

11,717. Perhaps you might hand that in to us later.—Yes, if you please. That gives these rather curious figures, that the cost of provisions before the war was 4s. 3'60d. weekly. In 1924 the cost was 5s. 4'90d.; that, roughly speaking, is an increase of 25 per cent. on the cost of food provided for the patients. Now in the same time the salaries and wages in 1914 amounted to 3s. 9d. weekly cost; in 1924 they amounted to 11s. 11d., an increase of some 200 per cent. It certainly struck me as very startling that, taking the average cost of an asylum, and I think this one conforms to most of them, (it works out at about 23s. or 24s. a week) the big increase had been in salaries and wages, that is to say, the necessities of the outside public, whereas the necessities of the inside inmates have only increased 25 per cent. I am not making of course any charge against the asylum, but that does raise the point. If the patients had been more articulate and had had trades unions, or anything of that sort, it might have been different. We may be within reach of that; we have a patients' paper, and that is the first step towards a union.

(After a short adjournment.)

11,730. *Chairman*: Mr. Parker, we may pass to the question of baths now, and there again I do not think we need delay long. Most of the disadvantages that at present exist are due to the fact of inadequate accommodation, it would appear; it is said that there is not sufficient bathing accommodation, and that it is too public?—That is the point, it is too public. You have had a good deal of evidence given you on that point by medical superintendents.

11,731. Yes, we have had a lot about that, and they have all expressed their desire, as far as they can, to give reasonable privacy?—I think conditions are slowly changing, but I suppose again the controlling factor is finance.

11,732. I do not think we need delay upon that, because the desirability of it, of course, is obvious?—Yes.

11,718. You could have a patients' strike and all the other concomitants?—You had a case in Ireland of the patients running their own asylum, I think, quite recently.

11,719. But the striking point there is this, is it not, that whereas 4s. 3d. before the war was the outlay on patients' diet per head, the figure now does not correspond with the increased cost of the main items of food?—That is so. The day I was there I was very much struck with the goodness of the dinner; I do not know how it is done at the figure. Of course there is a big farm run in connection with that particular institution.

11,720. *Mr. Snell*: Do you know if the price value is given to the products grown on their farm?—Yes; I tried to get at that, and I think it was 3d. a week.

11,721. Do they charge that food they grow to the dietary cost?—Here is the figure. They give a credit of 3'37d. per week in respect of the farm and garden produce.

11,722. *Chairman*: Is that all? I should have thought there would have been a much larger contribution to the dietary by the farm than would be represented by 3d. a week?—That is given to me as the correct figure.

11,723. *Mr. Snell*: Is that included, or is it in addition?—It is treated here as a deduction, so that I think it is included in the figure I have quoted to you, and then deducted in the form of a credit, being a balance in favour of the farm and garden. It is a little difficult to follow these accounts, but I think that is the position.

11,724. *Chairman*: It is curious. You say that, judged by the test of your own experience, and your own inspection, you thought the meals were satisfactory?—Yes, on that one occasion I was there.

11,725. I suppose you were paying a surprise visit, were you?—No.

11,726. Was it dressed up for you, do you mean?—No, I do not suggest that for a moment. It is only fair to say that I was very much struck with the excellence of the lunch that was being served that day. For instance, it was only about a few weeks ago they were having green peas. I do not know where green peas come from at this time of year.

11,727. From bottles or tins generally?—Exactly, but it was a surprise to see them being served. In that connection Mr. Stewart asks me to remind you of the figures given by Mr. Senior dealing with the cost of diet in his institution. The figure for the attendants was 13s. 6d. and for the patients 4s. 6d., which again shows an extraordinary discrepancy.

11,728. *Earl Russell*: There are not, of course, as many attendants to cater for?—But surely they are catered for by the central kitchen.

11,729. *Chairman*: The food will all come from the same kitchen?—Yes.

Chairman: These allusions to lunch have suggested to us that it is time for adjournment, Mr. Parker.

Mr. Parker: If you please, Sir.

11,733. Now I would like you to give us some of your views on the question of occupation and amusements, unless there is any other matter you wish to touch upon?—There is just one point which I should like to draw attention to, showing the great divergence in practice, and that is the question of shaving. It is at page 244 of the Board of Control Report; there is this amazing statement: "None of the male patients are shaved, and those who desire to be have to resort to the use of pumice stone. I hope that arrangements may be made for those men who desire to be shaved to be supplied with safety razors." Of course it seems almost incredible that there is still an institution in the country where the pre-Roman practice of using pumice stone is not only in vogue but insisted upon, and that institution, like so many of them of course, has ex-service men there; and to

10 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

them, I submit, it must be peculiarly distasteful after their training in the army to have to submit to those sort of conditions. And it is not an isolated state of things. There is another reference at the bottom of page 266. Those are two which crop up: "None of the male patients are shaved, and the introduction of safety razors would I am sure be appreciated by them." There again one is lost in amazement to find conditions of that sort still existing. You will notice in one case it is a west country institute.

11,734. And the other is Brighton?—Yes, but I think it is probably a county institution again.

11,735. I suppose there is some difficulty with regard to razors?—Still it is a problem which is dealt with in the great majority of asylums, not daily, of course, but at reasonable intervals. There is this aspect of it, of course, the patients complain bitterly that they are forced into a condition first of uncleanness, and, secondly, that their appearance militates very much against them. A man who is growing a beard and is introduced to a magistrate under those conditions of course does not make the most favourable impression, and it is a very vital interview to him.

11,736. *Earl Russell*: You know what people look like if they come up after a couple of days on remand?—Certainly; it does create a very unfavourable effect.

11,737. *Chairman*: All one has got to do with the safety razor is to unscrew it and take the blade out and then the patient can cut his throat?—Still, they are provided in many institutions.

11,738. And it is recommended by the Board of Control?—Recommended, but I do not know whether the recommendation has been accepted again. Then there is one other point in the case of the City of Hull Hospital, page 278—we rather want to call your attention to that, because there, coming from the mouth of one of the visitors, is exactly the class of complaint we get from all our patients. This is a case where one of the lady visitors paid a surprise visit at seven o'clock in the morning, and she found the following state of things—the allegations are set out in the middle of page 279—" (1) bathing arrangements (over-crowding of bath-rooms, more than one person bathed in same water, lack of decency and privacy, use of soft-soap and use of enamel utensil to rinse the head); (2) disorderly and dirty condition of lavatories; (3) clothing (ragged condition, inadequacy of supply, clothes worn one day by one patient but by another the next day); (4) laundry appliances inadequate and clothing merely rough-dried; (5) dirty crockery; (6) general kitchen (insufficient staff, dirty vessels, untidiness); (7) over-crowding of observation dormitory (erroneously referred to as that of No. 4); (8) sick-rooms comfortable; (9) single-rooms dungeon-like and confinement therein as punishment; and (10) neglect and cruelty on part of nurses."

11,739. These were the allegations?—Those were the allegations, and they were subjected to scrutiny, of course, by the visiting committee, who apparently issued a report which we have not obtained, but the comment I want to make is this, that there in the mouth of a visitor is exactly the type of complaint that runs through so many of our proofs, and we do take that as a very strong corroboration of the accuracy of our witnesses. I may say that these proofs came before me long before I read this Board of Control Report, and where one finds exactly the same class of allegation made it does tend to confirm our evidence. Of course whether some of them were disproved or not I do not know, but it is the type of complaint I want to draw your attention to.

11,740. *Chairman*: Yes, by the Commissioners who visited, while they found some of the matters alleged to exist, they found at any rate when they went that some of them had been remedied?—The Commissioners in that case declined to interfere until the local visiting committee had reported, and they in fact paid their visit some three months later, and I think they

say that they thought it would be best if they confined their remarks to the then condition of the asylum and its future control.

11,741. We could if desired see the report of the visiting committee?—That is what I thought; it is possibly a document you might obtain. On page 27 they say: "This report has been published and a copy can be obtained by anyone who wishes to peruse it." We do not know from whom.

11,742. We might perhaps take a note to get that report. Now let us pass to the question of occupation and recreation. We will all agree that these two matters are very important from the point of view of the treatment of patients, and you spoke yourself of the patients whom you saw unoccupied and listless. Of course the difficulty is to know how to occupy some kinds of patients. I suppose in the institution you visited there were a considerable number of patients occupied in some way or other, either in laundries or outdoor work or gardening?—Actually I did not see many of them because, as I said, it was approaching the dinner hour, and possibly they were not at their work.

11,743. Is there not necessarily a certain residue of the persons whom you find it very difficult to occupy?—That must be so, but of course the first difficulty is this that you get a class of case, not a very serious case, in these institutions who is asked to work, and one type will accept the work joyfully as a relaxation to his thoughts. The other type which one is familiar with says "No; I am not going to work under trade union rates. I am not going to do skilled work here unless it is paid for," and he deliberately sits down and does nothing. I do not think you can suggest he should be compelled to work, but we think you might in connection with this work stimulate it by offering some more adequate reward than is given at present. A little extra tobacco, I forgot how much, is given for regular work, and a little extra tea in the sewing rooms, but there are asylums where methods are being tried for giving some financial inducement.

11,744. *Earl Russell*: If his objection were a trade union objection he might be put on a different class of work?—Mr. Stewart reminds me of course that some of them would not infringe their own occupation, but might take up some general work. We do not know. It does seem to us practical (again a question of finance) to give that stimulus in the shape of some financial reward. Of course, in licensed houses there are, as you know, something in the nature of canteens where patients can supplement their diet; and, as we are told again and again, in these asylums patients do go terribly hungry, and they rely to a very large extent on the visits of their friends to bring in extra food. That only applies to a certain number. We think it would ameliorate their condition considerably if a canteen were available where they could spend a few pence if they were put in the way of earning those few pence.

11,745. That is extra stimulus for those you can get to work, but what about the class you cannot interest—those who will sit about?—I am afraid we can do nothing for them, except to put more periodicals and books in their way.

11,746. There are a great many whom you simply cannot stimulate?—It is part of their mental condition, of course. There is another suggestion put forward by the Board of Control, and that is the question of animals; one knows that is a great distraction. One Commissioner is keen on the breeding of canaries. That does raise another point that there is a total absence of animal life in most of these asylums, except possibly an asylum cat.

11,747. In my time in London every London asylum had canaries?—Quite. That is commented on again; it seems to be dropping off. I asked a superintendent about that question of birds, and he said: "The old supply has fallen off, and nobody has given us any more." That was in a county asylum.

11,748. *Miss Madeleine Symons*: Have you had complaints as to the quantity and quality of books and

10 February, 1925.]

MR. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

periodicals?—Yes; general complaints. I think the supply is very unequal in asylums. Our evidence really amounts to this, that in many institutions patients are thrown completely on their own supplies.

11,749. *Earl Russell*: You remember what one superintendent told us—he said you could get books and papers sent to a hospital, but that the public took no interest in asylums; that it was very difficult to get things sent to them?—Yes, I remember that; but should a supply of that sort of thing depend upon the public? Where you are treating mental cases, is it not one of the first medical objects to supply them with some distraction?

11,750. Certainly one might think they should have a library of their own, but they have a library in some asylums?—Yes; it varies very much.

11,751. *Chairman*: Mr. Parker deals with that in a moment. I think we might exhaust the topic of occupation and work. On the question of work you point out further that, while it might be improved by a system of small rewards, asylums are by no means uniform in providing for work?—Of course we find that again. We quote largely from the Board of Control Report to draw your attention to it. I refer to pages 131, 270, and 176 as showing divergencies in institutions in the matter of providing employment, and on this point even where workshops have been provided under practical conditions they are not used, which seems to indicate something wrong. That point again was discussed with one superintendent, and he seemed to think that the question of workshops was limited to useful work, like the repair of asylum boots, and that better class of work is done outside. Of course that is hardly the point.

11,752. No; you want occupation?—You want occupation, and not necessarily in the routine administration of the asylum; there are lots of other forms of occupation.

Chairman: I have seen them at Christmas time engaged in making Christmas decorations out of paper, and so on, quite an attractive occupation, that class of thing which is not remunerative work at all.

Dr. Sara White: Would you allow me to say there is a Brabazon fund specially intended in the first instance for workshops in the Birmingham asylum—a fund for supplying materials. Half a dozen ladies or gentlemen would come once a week and arrange employment for men or women, and the women appreciated it greatly. When I was there the matron chose them, and they were only too delighted to come, and they took a great interest. One circumstance which weighs against that is that all the patients' belongings were taken from them. I think Mr. Parker did not mention that.

Chairman: I have the point which of course is quite a sound one. If you could get people to interest the patients and instruct them in crafts, basket-making and, on the women's side, embroidery and things of that sort, though it might not be very economic employment it would be interesting and a distraction.

Dr. Sara White: This fund supplies the material.

Chairman: Voluntary effort seems to supply the material in this instance, but it would require an instructor if you could get him to come.

Witness: Yes. I think that has been recognised from time to time by the Board of Control. There are institutions in which attempts are made in that direction, but they are very few. I am told that at Severalls asylum in the eastern counties that principle is adopted.

11,753. I personally should have thought it was exceedingly valuable. It is a question of the employment being itself curative. If one can devise interesting occupations which will take the patients out of themselves it is worth doing, even if it costs money to do it?—To the lay mind that would seem one of the only methods in which you can advance, and it ought to be adopted almost independently of cost.

11,754. I was visiting a place the other day where ex-service men are, and I was greatly struck with one or two shops where basketmaking and other

things were going on, and men were working vigorously and were obviously interested in their work. They were cases well on the way to recovery; they were turning out some very fine work, some beautiful work?—Yes, and of course there again if you could attach some financial inducement you would rope in a much larger number.

11,755. *Miss Madeleine Symons*: I saw an institution where they were teaching women to make cigarette cases and to do bookbinding, and they were selling their own work, and the patients told me they got more orders than they could meet?—That is very interesting.

11,756. *Chairman*: There was one instance I came across where a man, who is a very serious case at intervals, was a very clever draftsman, and he was making a little money by making portraits of his fellow patients and they were very good I am told. But there is room for development along those lines?—Yes. Of course there is another point that comes into my mind, the case of a lady who was very skilled at embroidery, and so forth, and her services were very freely utilised by the Staff. Of course they were not paid for—one has to guard against that sort of thing.

11,757. Do you think that is wrong?—The suggestion is that the work was not entirely voluntary, that it passed beyond the voluntary stage, so that it was difficult to break off.

11,758. *Earl Russell*: Apart from that suggestion of course it would be good for her mental health?—Quite.

11,759. *Chairman*: And give her more feeling of self respect—if she were doing work which was useful, rather than if she were doing artificial work?—Always subject to this, that voluntary work must not be made compulsory.

11,760. Quite. Now we may pass to books and libraries, and there you have a quotation from the Board of Control Report at page 232?—Yes; "There appeared throughout the wards to be a great dearth of books and bound periodicals."

11,761. There you find also the want of cage birds referred to "and we should like to see some cage birds distributed through the day room"?—Yes, and they refer again to it at pages 138 and 153.

11,762. But on books and periodicals you want, of course, to have a good library, the question is how you are to get it; it costs money?—Once it is recognised that these are really the most valuable curative agencies for a diseased mind apart from physical ailments, one would have thought it was an expenditure which could be most easily justified.

11,763. I appreciate that; the literature would probably have to be chosen with some care; and the issuing of the books would have to be supervised.

Earl Russell: Miss Symons suggests that there is no reason why these institutions should not have their own library of 100, 200 or 300 books and interchange them, so that, in effect, they would have a library of many thousands if they would only co-operate.

Chairman: That method is pursued in the case of the Commissioners of the Northern Lights, where an interchange of books and periodicals takes place between the various lighthouses, but they also receive from members of the public quite a number of copies of magazines and illustrated papers.

Earl Russell: I think with a little organisation you could get up a very large circulation in this way.

11,764. *Chairman*: I am sure many clubs would be glad to send a good many of their periodicals at the end of the month. This is a thing which might be assisted, if I may say so, by a voluntary organisation such as yours.—Quite. Sending supplementary supplies?

11,765. Yes.—Of course one feels that one could never entirely rely upon a voluntary system. You might supplement, but really the thing ought to be dealt with by a central control.

Chairman: There must be an ordinary library in each institution.

10 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

11,766. *Earl Russell*: But it is a question of getting, as a medical superintendent said, the public to realise that these things would be useful in asylums?—Yes.

Sir Ernest Hiley: The difficulty is in the counties more than in the towns. The towns have generally got the Free Library where there is a surplus of books to draw upon; but in the counties, where they have nothing to fall back upon in the way of a Free Library, that is where the voluntary organisation would be useful.

11,767. *Chairman*: Yes, but I think it is part of the general policy which we have heard advocated by Mr. Parker and others. If you can get the public to take an interest in the asylums you will find that they will send their benefactions to them. One reads in the report of every general hospital at the end of the year the thanks of the institution for all kinds of gifts. It seems to me that that supplements in a most valuable way the strict letter of the law, and just gives that feeling of interest in the inmates which one would like to foster. If I might, with respect, commend it to your Society, that is a piece of public work that would be of great value, to make people anxious to send contributions.—We shall bear that suggestion very carefully in mind.

11,768. I think there is a great fund of goodwill in this country which only has to be tapped. If people know it is a good thing, you will get a response in this country.—Yes, but is there not just this: to make that help continuous you would have to get at the personal element, that is to say, occasional visits. One has that feeling. I do not know that they are encouraged at present. I am not sure if I presented myself at the doors of any asylum and simply said "I want to come in and look round" that I should be welcome.

11,769. We had one medical superintendent who said that he attached enormous value to a special lady visitor.

11,770. *Earl Russell*: Try one or two places where you are not too well known and see if they will let you in?—I will.

11,771. *Chairman*: People are human; if they thought you were coming for the purpose of making a case against them, of course you would not be received very cordially. I am not at all sure after your evidence here you would not be welcomed in quite a number of them.—Just on that point it may be of interest to you that in this particular report which you ask me to hand in, I find that the expenditure there on periodicals and books was £135 a year, and on amusements £43 17s. That is in that one institution. That is given amongst miscellaneous expenditure, which runs to £3,765.

11,772. Do you think that is on the meagre side?—It does not seem a very big expenditure. I think there are there about 1,100 patients, but in that particular institution I am bound to say the supply of books was quite good, and they were easily accessible in the wards.

11,773. *Earl Russell*: One does not know how much of it goes to periodicals, but if it is £130 a year in books it is a very fair amount.—That would mean a large supply of books, but I was rather struck with the absence of newspapers; I think I only saw one as I walked through; and there again I do not know what the supply is, but I think it ought to be quite a free supply. If one paper has to be handed round among 50 or 60 people it does not go very far.

11,774. *Chairman*: That is quite a good point. You deal next with the very important question of parole. Again I suggest that you need not labour that, because we have heard a great deal of evidence, all one way, on the value of parole.—Yes; the only point I want to make again is the divergence.

11,775. I think we might get on the note the references?—The cases where it is very freely used are reported in the Board of Control Report at pages 263, 289, and 183, and the converse of that at pages 204 and 272, and there is another reference on page 177.

11,776. I think the one at page 272 is just worth noting in passing, because that seems a very extreme case: "We notice," says the visiting Commissioner, "that no patients are allowed parole, even within the grounds of the hospital, and that no patients are allowed to sit up later at night than the ordinary patients." That seems a very extreme case?—Yes; and then you have another very extreme case on page 177: "I was surprised to hear that no patients are allowed parole, and that on only one day in the year are patients taken for walks outside the grounds." That simply shows, as I say, that every institution is really a law unto itself; it does what it likes at present.

11,777. It is rather a comment upon the suggestion that there is a system in operation. In every way there seems to be rather a lack of system?—Of course that is the comment made by the Cobb Report, that there is no system, and they take Dr. Lomax to task on that, but when we refer to the system we do not refer to it quite in the same sense. On this question of sitting up, of course there again that is dealt with in the Nursing Report, I think; and we come down to the question of money, that is to say, that sitting up seems to imply, in a lot of institutions, running the nursing staff in two shifts in order to bring in the extra hours, and in that really seems to lie the objection to it. But they recognise that it is a very great hardship, especially on convalescent cases, to be compulsorily sent to bed on a summer's afternoon, with daylight saving, at seven or half-past seven. The changes are coming in very slowly, and there again if there were directory powers one hopes it might be made compulsorily. It seems no answer, as one of the superintendents said to you: "We have lately given these facilities and have found they are not availed of." Of course if you have trained people for years to go to bed at six o'clock they are not likely to avail themselves of it.

11,778. *Earl Russell*: In connection with that point, at what hour are they brought out of bed in the morning?—It seems to vary from 6.30 to 7.

11,779. In theory, being insane patients, they can stop in bed if they choose, and have their breakfast in bed if they insist on it?—I do not think so ever. As far as our information goes, if a patient fails to get up, it means the refractory ward at once, and we had a very strong case of that in a licensed house. I think I may say with certainty he will go to the refractory ward on a point of discipline. I do not think I am putting it too high, but on that point, as far as our evidence goes, that is what it suggests.

11,780. *Chairman*: I suppose you must have more or less definite hours for getting up and going to bed, because if you have a large number of patients to dress you must marshal them in a certain order; one has to be the earliest and one has to be the last, and so on?—I am not complaining of that. To maintain the routine, patients must get up unless they are ill.

11,781. I asked a patient a question about going to bed at 7 p.m. She went to bed at 7, and I said: "Do not you think that is far too early?" Curiously enough she said: "I do not think so, because I have worked pretty hard all day, and I am rather glad to get to bed." But I do not think she was a person who would have occupied her time very much, and might be not quite the case you are figuring of a patient who wished to sit up and read?—And then there is the important corollary that, of course, after a tea of bread and margarine, sitting up at night without any refreshment is not an attractive performance.

11,782. And with no prospect of a meal till next morning at eight o'clock?—Yes; that is so. They are now beginning to give what is called a light supper, but when the Dietary Report was made that was given in less than 6 per cent. of the institutions. I have found the reference in the Nursing Report which I think is worth putting before you: "The special requirements of mental patients demand due consideration of the recreation and social life of the hospital; especially does this require that the patients' day should not be unduly curtailed, and there is need

10 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

to avoid the too prevalent practice of bedding patients at so early an hour as eight or even seven p.m. Indeed the time of bedding patients is a point upon which most existing schemes fail. The need to reduce the hours to a workable basis either necessitates the serious hardship entailed in putting physically healthy persons to bed by 7.30 p.m., or, alternatively, where this is overcome by means of two full eight hour day shifts, the scheme is wasteful and extravagant in staff. The number of patients who can profitably be kept up until nine or ten p.m. probably in no hospital exceeds 50 or 60 per cent. So there is a practical difficulty." We always come back to the question of uneconomic expense.

11,783. Then you deal with seclusion in side rooms—I think we have covered that?—We have dealt with that except one point, and that is the construction of asylums now. It has been put before you, I think, that it is extremely regrettable that it should be necessary to have these side rooms opening on the living wards; and I was very much struck again in the Hertfordshire asylum, which is really beautifully laid out to find in their newest ward, which has just been built since the war, that a side room opening on the dormitory is in evidence. I discussed that with the superintendent, and he said from one point of view it was most objectionable and disturbing to the patients, but it lent itself to easier supervision. If you had side rooms in a separate place that would complicate the difficulties.

11,784. *Earl Russell*: The real cause of it is economy of staff?—Economy of staff again, and I think we have got a reference to that; I cannot put my finger on it, but I think that is recognised also by the Board of Control, that it is a painful experience for patients, and it does seem a pity that any fresh construction should be allowed on those lines if that is the only object of it, because it is a matter of constant complaint. Here was a beautiful new reception ward with three side rooms opening off one end and beds in close proximity to the side rooms. You have a violent patient, you have either got to let him disturb the whole of the ward, or you have to drug him; and that is recognised in the Nursing Report, that far too free use is made of drugs to obviate that very difficulty; but it is a constructional point, and a question of capital expenditure.

11,785. *Chairman*: And staff?—And staff.

11,786. I think on this point the evidence we have had has been more or less one way, that you want to keep the violent noisy cases away from the quiet cases, because of the obviously detrimental effect of the noisy cases on the quiet cases. It stands to reason?—Yes. Then there is one more point on this question of side rooms, and that is their actual condition. Of course in many institutions they are still terribly deficient in light and air. That again is recognised by the Board of Control Report, and our evidence shows that especially in the case of women and also some men, where they are exposed to long periods of darkness in the winter, perhaps from seven at night to early the next morning without a glimmer of light, that is a very terrifying condition, especially to a patient in any state of mental excitement.

Earl Russell: Will you not give these two references to the Board of Control Report?

11,787. *Chairman*: I was going to suggest to Mr. Parker—in support of what you have been saying you might give us the references?—The first one is page 48—then pages 253, 258 and 139.

11,788. Associated with this question to some extent is the question of classification, and we are agreed, are we not, that improved classification, facilities for classification, is a very important question?—That probably lies, I suppose, at the root of reform, but it also involves fresh construction in the existing institutions.

11,789. And that again relates itself to finance?—Exactly.

11,790. I do not suppose that, however persuaded we are, we can do more than the Board of Control themselves have done: i.e., recommend this as

urgently as possible in the matter of construction of premises?—There again, we are not quite satisfied that the best use is being made of the existing facilities in classification. We rather suggest that attention might be more directed to that. For instance, as a sort of example there is an institution referred to on page 176 where the Board of Control point out this. "The number of patients on suicidal parchments show a percentage of 13 per cent., or nearly six times as high as the average in all mental hospitals. While fully aware of Dr. Simpson's views on this matter, we hope that all these cases are reconsidered sufficiently often so as to ensure that patients not actively suicidal are not unnecessarily harassed by a too constant espionage." Of course you realise at once that there is an idiosyncrasy, I should expect, on the part of the medical superintendent in classifying suicides very freely, and the Board of Control is powerless to interfere except by this general criticism; from the patient's point of view that of course is serious.

11,791. And you draw attention to a paragraph on page 239 of the same Report, upon the mixed character of patients: "They appear to be in excellent health, and throughout the building were very quiet and orderly in behaviour, even though in almost every ward the patients are of a very mixed character, as is shown by the fact that in all but two wards on the female, and one on the male side, there are acutely suicidal patients, epileptics and troublesome patients mixed with others who are quiet and even convalescent." That is adduced by you to show that classification even in the existing premises is not always carried out?—No; and again it has this further bearing, that though it comes so late in the day it supplements and confirms the evidence we have had from our patients. I have stressed that point, because we have submitted that evidence to as careful a scrutiny as possible; and where we find it confirmed again and again by these reports, we do suggest that it is very reliable evidence.

11,792. And again it is not a matter that really brooks much argument, because it is agreed that classification is at the root of reformed treatment?—Yes, and if I may put this to you: possibly again it is an economy in staff to keep these patients mixed, because patients do exercise considerable control over each other. If there is a shortage of staff, I can well see that it may be from a superintendent's point of view a necessary policy to have sane patients to take a turn in a ward with patients of another calibre. I can see practical advantages in that from the point of view of administration, but it seems to be very wrong from the point of view of treatment.

11,793. With only one qualification, and that is this, that I could imagine that patients well on the way to recovery would introduce a more or less hopeful feeling into the atmosphere of the community; one would not like the patients all to be patients aggregated together who were of one type, and possibly a hopeless type. If patients are on the way to recovery, I am told that they exercise a very considerable beneficial effect upon the others. One is recognised to be getting better, and the others say "If that fellow is going out soon, I hope I will be going too"?—Of course that does raise a very difficult point, whether you are justified in exposing a recovering patient to those people because of the help he would be to other people. One is inclined to say "No, the duty is to the individual and not to the community in the institution." Of course there again we find patients who seem to have a very good form of classification; they refer to a certain type of the cases as the lost cases, and another type of cases as the sensible cases, of whom the best are people you can converse with quite freely, and they say they should not be detained. That does seem to me quite a useful general classification. Mr. Stewart points out to me again that, unless those ripening for discharge are in a class by themselves, they are not likely to come under the sustained observation of the medical staff.

10 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

11,794. One of the most up-to-date institutions I have heard of has a series of villas, and the patient progresses from one to the other as he recovers, until he reaches one at the end in which the conditions are almost entirely unrestricted; that is the last stage before release; it is found the best plan apparently to keep the different stages together—I mean those belonging to each stage in a separate building?—Quite, and that seems to have the additional advantage of the introduction of change—the constant movement.

11,795. You travel from stage to stage, and you should recognise your promotion from building A. to building B. as a stage in your recovery?—In progress, yes, and we feel that, apart from separate villas, it might not be impossible, even with existing buildings, to create smaller wards.

11,796. And grading?—And grading.

11,797. Then you have a page in your *précis* on the Board of Control, but I am sure we have covered that in what has gone before?—I think we have.

11,798. We have gone into that fully. The next passages relate to definitions of sanity which, you remember, you took earlier?—Yes. It has been pointed out to me there that the definitions I have given you of sanity, in the view of some of our members, are really definitions governing the right of detention. I feel myself that the two things are very much the same, but I was asked to put that view before you.

11,799. We have already pointed out that all practical definitions are rather definitions arising from the consequences of the mental state than explanatory of the cause of that state?—Quite.

11,800. Then I am going to suggest with regard to the two concluding pages of your *précis*, that you should hand those in, because I understand that these are the considered submissions of your Society, as you have framed them yourself?—As they were framed some weeks ago, I do not know whether you would allow us, perhaps, to revise them slightly, in view of the evidence we have heard given here?

11,801. Certainly; but I think they should be put on the note in your own language; therefore, I am going to suggest that those paragraphs in which you sum up your considerations should be handed in by you.—If you please.

The following is the extract from Mr. Parker's *précis*:—

"Conclusion.

"The submissions which the Society wish particularly to emphasise in conclusion are as follows:—

"1. *Early Treatment.*—The immediate provision of voluntary hostels free from detention in any form, supported by subsidy from the State and controlled by the Minister of Health through local Health authorities, with no association with the Board of Control or any other Board or Department of State controlling Lunacy administration.

"2. The early adaptation of Hospital wards to deal with incipient mental cases or temporary cases such as those arising from illnesses with rise of temperature.

"3. The adaptation of Infirmary wards to permit of better classification and conditions.

"4. *Legal.*—No deprivation of liberty without investigation by the judicial authority.

"5. The unification of the methods of certification and the issue of reception orders.

"6. The elimination of all unnecessary distinctions between private and pauper patients.

"7. No extra fees to be payable to permanently employed officers functioning in certification.

"8. Provisions to secure that the judicial authority shall in all matters act judicially on the lines indicated in the case submitted by the Society, and not in an administrative capacity.

"9. Full disclosure to the patient or his representative of the allegations made against his sanity.

"10. The patient at all stages to have a statutory right to representation.

"11. A clearer definition of the term "Lunatic" or "of unsound mind," and that a definite standard of insanity be specifically laid down, based upon the protection of the public and of the individual.

"12. That the mental standard required for discharge should be the same as the standard for certification.

"13. That the report of the Medical Practitioner be privileged only if given in good faith and with reasonable care, and that all evidence given at the judicial enquiry shall be given on oath and subject to cross-examination.

"14. That every patient under detention have the statutory right of examination by a judicial authority at least once a year, or at any time upon special cause being shown by him or someone acting on his behalf, as set out in the form of procedure suggested in the Society's case.

"15. The Right of Appeal to Quarter Sessions.

"16. *Institutional Treatment.*—The establishment of a new and more representative Central Authority with definite powers of direction, acting through assistant District Commissioners, who shall be trained administrators and not medical men.

"17. The urgent necessity of applying generally the improved methods of curative treatment now available, and improving the general environment of patients.

"18. The limitation, where possible, of the numbers permitted in any one institution.

"19. Improved classification of patients in all institutions.

"20. The increase of the medical staff and nursing staff to permit of better and more individual treatment.

"21. The strengthening of existing visiting committees with such additional statutory provisions as will ensure their functioning.

"22. A statutory provision that authorised visitors independent of lunacy administration and licensed as in the case of prison visitors, shall be appointed by the Home Secretary.

"23. The introduction of the judicial authority within Asylums with authority to discharge, investigate complaints and act as an additional safeguard to the patients.

"24. The statutory right of independent medical and legal access to a patient without permission of the Board of Control.

"25. Some provisions that the senior medical officer shall not be charged with responsibility for administrative duties, i.e. that the present duties of the Medical Superintendent be divided.

"26. No punishment under the guise of "Curative treatment."

"27. Closer supervision of the use of powerful drugs and a record of their consumption.

"28. Improved facilities for correspondence and notification to patients of their Statutory rights.

"29. *Discharge.*—Further provisions to ensure that the existing methods of discharge are freely utilised in practice and that more liberal maintenance is granted.

"30. The introduction of the judicial authority as an additional method of discharge.

"31. *Licensed Houses.*—That no additional licences be granted.

"32. That no existing licences be renewed except upon terms that particulars required in the case of Public Companies be filed at Somerset House.

"33. *After Treatment.*—Provision for more liberal financial aid and extended opportunity of after treatment, in convalescent homes or elsewhere."

10 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

11,802. Then another document has been handed to us along with this *précis*, which is of quite a different character, and I confess I am a little puzzled to know what to do with it. It is called "The case prepared by the National Society for Lunacy Reform." Have you read that through?—Yes; that forms part of our submissions to you. I have referred to it once or twice; in fact a great deal of it is incorporated in what I refer to as my proof.

11,803. I am bound to say there is a good deal in it that does not seem really to be very helpful to us. There are places where there are attempted draft sections, which are quite useful efforts in the way of formulating proposals. On the other hand, there is a good deal of comment which does not seem to be of very great value to us?—If I may say so, that was an attempt to put before you the sort of opening Counsel should have made if he had been permitted to address you, a general argument, and also the concrete case which I have endeavoured to deal with, and the procedure which we felt might be of some assistance; but I rather gather your recommendations may go even further than that if you recommend new legislation.

11,804. Then we are to treat this as if it had been an opening speech, so to speak?—If you will, Sir. Mr. Stewart tells me that there are constructive proposals in that which I have not quite fully developed, and perhaps you would allow him to address you on those.

11,805. No, we shall not. My real reason for making this comment is that it seems to me that the document does partake very much of a Counsel's opening statement in many respects, which is all very well when addressed to a Court of Law, but which is really not helpful to us. I will tell you what I have in mind. It is full of rhetorical passages of this sort: on one of the pages I read this: "Whatever may still remain in doubt one fact stands out clear and unchallenged (except perhaps by the Board of Control) and that is that not only is there on the part of the Public a haunting dread and suspicion concerning the institutions controlled by the Board, but the patients who have had first hand experience of the environment in asylums, think and speak of those experiences in terms of unmitigated abhorrence. There is no need to stress the gloomy details of the picture disclosed to the startled senses of the recently certified 'patient' as for the first time the doors of the asylum close on him. The impression produced by the strange sounds and the foul odours and pervading atmosphere of gloom might well prove sufficient to turn the brain of even a normal man or woman condemned for an indefinite period to play the part of an involuntary detail in a picture which needs the genius of a Dante or Lombroso to faithfully depict it." Is that really the least helpful to our deliberations, Mr. Parker?—Well, Sir, the substance underlying it I am quite prepared to endorse, and I have attempted to do so because, if I may put it in this way, taking the patients that come before us, the thing that does strike one most fundamentally is that very sense of horror of the treatment they have undergone. I have seen men come out of the trenches, and I have seen patients come out from these asylums, and there is very little to choose between them.

11,806. What I am rather thinking of is this: the publication of sensational matter of that sort is calculated to do a very great deal of harm?—I do not think we are asking you to publish it. That is the reason it is put before you in written form.

11,807. A great many people have to go to asylums, as we know, and if all their relatives thought that every patient encountered in asylums foul stench and all the rest of it, as described in the passage I have read from this document, it would create a most unhappy impression. For instance, take the institution you yourself have been describing to us in Hertfordshire. When you entered that institution were you greeted with "strange sounds, foul odours, and a

pervading atmosphere of gloom"?—No, I was not, but I put it before you as a model institution, supplied by a wealthy county.

11,808. But this is made applicable to people generally in asylums at the present moment?—I do not think it is intended to be that, but when you come to hear our evidence it does go much further than that.

11,809. *Earl Russell*: What you call the substratum is entirely obscured by the tropical foliage?—Yes.

Chairman: You would be able to establish, and we would accept—indeed you need not labour the point—that most unpleasant and most distressing things do occur, and that there are instances of neglect, and, if you please, cruelty. What I am so concerned with is this, that the impression should not go abroad that the entire management of the asylums in this country is characterised by these features. The fact that incidents of a deplorable type occur in certain institutions, or have occurred, should not be put forward to the public as if that were typical of the way in which the treatment of the insane in this country is controlled.

Sir David Drummond: You are just voicing, Mr. Chairman, what I endeavoured to bring out with regard to the medical faculty appertaining to the asylums. There may be officers who do not carry out their duties in such a manner as the Board of Control or we would desire, but the impression the *précis* gives is that they are all the same.

11,810. *Chairman*: That is what I think is a little unfortunate, because you would create an impression at large, not that you were merely combating the abuses of the system, which is a most legitimate task, and a task upon which we are all engaged here, but it would give an ill-balanced picture of the existing situation. Now you have been the first person to give credit where credit was due; and it is naturally most discouraging to people who are anxious to do their best if they are lumped with the people who are not doing their best. I should prefer to keep a more balanced and fairer judgment, and without in the least discounting the drawbacks of the existing system, or the cases in which it has lamentably broken down, at the same time to give reasonable recognition to the efforts of those who have devoted their lives to this work, and who have earned the gratitude, I think I may say without exaggeration, of hundreds if not of thousands of patients?—As a Society, of course, we quite assent to that, and we have tried to put our evidence upon that basis, that very great credit is due to the medical profession for the reforms they have brought about, and are bringing about.

11,811. And I think you might include the staff also?—Yes, subject always to this comment that there is a danger that they may dwell more upon the improvements effected, without bearing in mind what relation those improvements have to the growth of improvements in the outside world. Quite admitting that conditions to-day are 50 per cent. better in asylums than they were 20 or 30 years ago, what are the conditions outside? Have they not improved more than 50 per cent.?

11,812. Do not imagine that I do not recognise that for propaganda purposes you have to paint a picture, but while for propaganda purposes that may be quite legitimate, our purpose of course is not propaganda. Our purpose, as I said earlier to-day, is a more calm investigation of the actual defects of the existing law. However, you have told us exactly how we are to regard this second document, and I do not think we need delay over it. I only wanted to say that it gave to my mind a rather ill-balanced view of the present position, that it laid all the stress upon the shadows and none upon the light; whereas throughout your own evidence you have, if I may say so, adopted a different course, and have most fairly recognised instances where credit was due, while not in the least minimising the importance of the reforms which you have at heart. As far as I am concerned, I should

10 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

like to thank you very much indeed for your assistance to us, and some of my colleagues may now like to ask you a few questions.

11,813. *Earl Russell*: You have been so very fully examined that I really only have one question to put. That arises out of something which you said, I think, at your last appearance but one. You remember you were talking about what should happen in the case of a convalescent patient who had become sane, who was not certifiable but whom it was not desirable to discharge in his own interests?—Yes.

11,814. And I think the ultimate conclusion you came to, if I remember aright, was that he should be technically discharged, but remain, if he was sane and thought fit to do so, as a voluntary boarder?—That was one solution I remember.

11,815. I have just drafted a form of words, because unless we get these things in words it is always difficult to know whether we mean the same thing. I would like to read this to see if it carries out what your idea is—I am not saying I agree with it: “The superintendent of an asylum or other person having the charge of a lunatic shall discharge such lunatic from detention if he becomes of sound mind, and able to take care of himself”—(I pause there to say that in looking through the Act I cannot find that there is any clear indication of that in the Act itself; it is rather by implication that the patient is to be discharged)—“either forthwith or at the next meeting of the visiting committee, if such meeting is to be held within fourteen days. Any person detaining any such recovered lunatic against his will shall be guilty of a misdemeanour.” That is really what you ask, is it not?—Yes, in substance.

11,816. Then I have put in a saving clause covering the other point, to this effect: “If the patient is unfit to take care of himself from physical and not from mental causes, the superintendent or other authority may retain such patient for ordinary hospital treatment, with the consent of the patient, but shall discharge him from being under certificate.” Does that meet what you were suggesting the other day as desirable?—I am a little bit puzzled about the words “from physical causes.” It seems to me that if the causes are purely physical, the natural thing would be for that patient to go to a hospital. I do not see any advantage to him from remaining in an institution where we have been told that the treatment for “physical causes” is not half so good as in a hospital.

11,817. Would you not give him an option of staying in the hospital if he desires it?—I see no objection to giving him an option. I am not again quite clear whether, if the accommodation is limited, it would be fair to cumber institutions with any great number of these sort of cases.

11,818. No, but what I am trying rather to provide for is where I think you differed from the existing practice, and that is the last week or fortnight or three weeks of convalescence, where a superintendent would not let a patient go because he did not think it was in his interests, although the patient was not certifiable.—I think your suggested clauses are most helpful, because they are optional.

11,819. What I want to know is whether they meet your point?—I think they meet it entirely, because it is optional to the patient.

11,820. *Mrs. Mathew*: About the question of diet, Mr. Parker, would you suggest that the local authority should have perhaps less say in matters of diet? Is it the local authority that settles that these patients shall only cost 5s. per head per week for food?—At present entirely, and we rather visualise this, that if the dietary scale suggested, or any other dietary scale is adopted, the central authority would then impose upon all the local authorities the necessity of supplying that scale of diet. Of course the cost of it would vary enormously in different localities. That comes out very clearly on the cost of the proposed diet at the end of the Dietary Report; the

differences in the cost of any commodity are quite extraordinary, they vary 50 and 100 per cent.

11,821. Yes, but on that perhaps a county asylum might help a town asylum a little bit. I do not know what they produce.—By the interchange of their own produce?

11,822. Yes, they might.—They might. I am not quite sure that it would be economic, because you see the supply is very limited and it is periodic only.

11,823. I have seen one institution, and I was rather struck by the diet which was so very, shall we say, economical and free from fat, and no butter was used whatever. You have not found any great fault with that, but personally I think that is rather a flaw in the present regimen of diet.—I think it is, and on that question of diet there is just this further point. We can get no very satisfactory evidence that the infirmary diet in these institutions is very much better than that of the general patients. I do not want to suggest it is not, but the sort of impression we get is that there is nothing like the standard in the infirmary ward of a mental institution that there would be in a hospital.

11,824. And of course all these people are ill?—As a layman one would suppose that the first basis of building up their mental health would be to build up their physical health, and that is why we have drawn attention to this extraordinarily low scale of diet. I cannot conceive as a layman that with it you can get the adequate basis from the medical point of view on which to work your cure.

11,825. So that you are thereby rather handicapping the cure of the patient?—It seems to me most distinctly so.

11,826. *Sir David Drummond*: You will stop me, Mr. Chairman, if this matter has already been fully elucidated, but I am not quite clear in my own mind what Mr. Parker would say with regard to the condition of the patient who is to be discharged—that is to say, does he propose to discharge the patient the moment he becomes what we should call uncertifiable? This is a point we discussed before, but I think we ought to be clear upon it.—I welcome the opportunity of saying that our recommendation is that at that point discharge should take place, that there is no legal justification for detaining the patient, because you think that by treatment you can still further improve his mental condition. If you can persuade him to take that treatment voluntarily, do so by all means, but we think it is a very serious proposition that because he has not quite come up to a rather ideal standard of mentality, admitting that medical assistance can improve that, he should be compelled to undergo a still further period of detention.

11,827. He has passed the stage when he would be certified, but he is far from recovered. That is a practical point?—I think it is a practical point, and the suggestion we make is that when he reaches the first stage he should be discharged, even at the risk of his coming back again.

11,828. *Chairman*: Let me put it in this more or less graphic way, Mr. Parker: we will take the progress of a case, and, just as in every other disease, it will have its incipient stage, that is to say, let us put it that for the first week of the onset the case was not a certifiable case but a recognisable case of mental disorder. Then it enters upon a stage when lawyers and doctors would together agree that the case was certifiable, and let us assume that that stage lasts three months. At the end of the three months it passes into the stage of recovery, and for the concluding week the patient is in this condition: no longer certifiable, but in process of recovery. Thus there is a stage during which you have to invoke the law in order to get the necessary powers of control and detention, and then you have the period in which the disease is passing off, and in which the case is no longer certifiable, but is not yet recovered. The episode which is the period of legal detention is peculiar to this ailment of course. If it were not an

10 February, 1925.]

Mr. ROBERT MONTGOMERY BIRCH PARKER.

[Continued.]

ailment requiring the interference with the liberty of the subject, the ordinary patient would enter the hospital at the onset of the disease and remain till the recovery from the disease; but because this ailment requires a period of compulsory detention it seems odd that the patient should be turned out of the place to which he has been sent for treatment and recovery, before recovery is in fact completed?—I see your point. Of course, if that last period was only a week, one might concede it.

11,829. It might be much longer, of course?—But we do not feel we can concede such a big principle as this that a patient may be legally detained when in fact he is no longer certifiable, with the object of doing him good. I think Lord Russell's clauses would meet that case.

Sir David Drummond: But there are so many cases with regard to which the medical superintendent will tell you that in a fortnight or three weeks they will have the acute symptoms back again, or in less than a week they will have the acute symptoms back again.

Earl Russell: But surely in that case he would be certifiable, would he not?

Sir David Drummond: Not if there was a court of enquiry, and a lawyer and a magistrate came in and talked to the man. They would find him in a state in which they would say: "I do not think this man is certifiable."

11,830. *Sir Humphry Rolleston*: You would accept the evidence in a case like that of the medical superintendent, if the person was subject to paroxysms?—I was going to suggest that that was a periodic case; and it seems to me that any authority would at once then say: "If it is a periodic case we must let a period elapse." But then I can give a case where the periods were much longer, and the man came out; the periods have extended in that case to three or four years since he has had any trouble of any sort.

Chairman: Personally, as a lawyer, I find it difficult to reconcile the idea of a person being detained who is not certifiable; that seems to me to be fundamental to this question; but on the other hand I equally recognise that in the treatment of mental disease, as in the treatment of every other form of disease, the welfare of the patient is the main thing. The compulsory detention is only an episode, an unfortunate but necessary episode, in the treatment of this particular form of disease. This may help the problem which I see is pressing upon Sir David, who is thinking of the patient's point of view much more than the legal aspect of it: *ex hypothesi*, this patient has ceased to be certifiable in the legal sense; that is to say, he has passed into the zone of convalescence; it rather seems to me then that the patient who has reached that stage is a patient who has regained a sufficient degree of sanity to recognise that his own recovery is for his own welfare and would be the last person to insist upon leaving, if the doctor said to him: "You are getting on very well, but these are

things it takes some time to recover from. Would you not be better for staying on here for a few weeks?" This person is no longer of unsound mind, and is therefore able to appreciate the argument, and such a person would probably be prone to accept the advice and stay on.

Sir David Drummond: He may be of unsound mind and not certifiable.

11,831. *Chairman*: I qualified my proposition,—not of unsound mind, but has recovered so far that he is able to appreciate things in a way that a certifiable person would not. (*To the witness*): That may cover a good many of the cases, may it not?—I think it would; and, as far as one can gauge the patient's view, if the patient was told "You are no longer certifiable, but you are detained for two weeks under statutory regulations for convalescence," I do not believe anyone would raise the slightest objection. It is happening every day in practice.

11,832. *Earl Russell*: Did you say "detained"?—Yes; I think they would recognise compulsory detention for a short period for convalescence. As far as our evidence goes, that does happen.

11,833. *Chairman*: Let us also take along with it all the other elements you have in mind. There is, of course, the question of temporary release on parole, which helps in this matter. There seems to me to be probably a very small residue of cases in which the difficulty might arise; the only type of case would be where a patient, ceasing to be certifiable, had conceived a dislike to the institution or had a very eager desire to get home, prematurely in his own interests, and insisted on going out, although the medical adviser said "You are making the greatest mistake in doing so, in your own interest." Such a person would no longer be detainable against his will, and he might do himself some injury. I doubt if it is possible to cover that case, consistently with the law on the subject, unless there is some such expedient of saying there may be a period of qualified detention at the expiration of the period of compulsory detention?—That would meet it, to a large extent; and then we hope, of course, that the After Care Associations would be available for that case.

11,834. *Earl Russell*: You see the immense difficulty of a hard and fast line—of saying "He is not certifiable, and that finishes it"?—I do; but we have been rather suggesting that that line shall be hard and fast with a very limited qualification.

Earl Russell: I know. I am trying to get you to broaden it a little bit.

Chairman: Then, Mr. Parker, that concludes our examination. May I repeat what I said before? You have assisted us most materially in every way in our labours. We shall pay great attention to the recommendations you have made to us.

Witness: May I say, Sir, that the Society are greatly indebted to the Commissioners for the time they have been good enough to devote to the hearing of our evidence?

Chairman: I do not think for a moment that it has been lost, if I may say so.

Witness: Thank you.

(The Witness withdrew.)

(Adjourned to Tuesday, 24th February, 1925.)

ROYAL COMMISSION ON LUNACY AND MENTAL DISORDER.

MINUTES OF EVIDENCE

TAKEN BEFORE THE

ROYAL COMMISSION ON LUNACY AND MENTAL DISORDER.

PART II.

MINUTES OF EVIDENCE TAKEN ON DAYS 21—42

(24th FEBRUARY, 1925—11th DECEMBER, 1925).

Questions 11,835—21,659.



LONDON :

PRINTED & PUBLISHED BY HIS MAJESTY'S STATIONERY OFFICE.

To be purchased directly from H.M. STATIONERY OFFICE at the following addresses :

Adastral House, Kingsway, London, W.C.2; 28, Abingdon Street, London, S.W.1;

York Street, Manchester; 1, St. Andrew's Crescent, Cardiff;

or 120, George Street, Edinburgh;

or through any Bookseller.

1926

Price £1 1s. Net.

TABLE OF CONTENTS.

MINUTES OF EVIDENCE.

Day.	Name.	Designation.	Questions.	Page.
21st Day ... 24th Feb., 1925.	Mr. WALTER BLOOD	President, National Asylum Workers Union.	11,835-12,451	507
	Mr. GEORGE GIBSON	Secretary of the Union		
	Miss MAUD WIESE	Member of the Union ...		
22nd Day ... 25th Feb., 1925.	Dr. MONTAGU LOMAX, M.R.C.S. ...	Medical practitioner	12,452-13,004	532
23rd Day ... 10th Mar., 1925.	Ald. J. G. TAGGART, J.P.	Representing the Mental Hos- pitals Association.	13,005-13,357	559
	Ald. Sir WILLIAM HODGSON	Representing the Mental Hos- pitals Association and the County Councils Association.	13,358-13,499	573
24th Day ... 11th Mar., 1925.	Dr. R. LANGDON-DOWN, M.B., M.R.C.P.	Representing the British Medical Association.	13,500-13,719	581
	Dr. J. W. BONE, M.B., C.M....			
	Dr. C. O. HAWTHORNE, M.D., F.R.C.P.			
	Dr. E. G. W. MASTERMAN, M.D., F.R.C.S.			
	Dr. CHRISTINE MURRELL, M.D. Sir JENNER VERRALL, LL.D., L.R.C.P., M.R.C.S.			
25th Day ... 21st Mar., 1925.	Mrs. M.	Former patient	13,720-14,192	594
	Mr. P.	" "	14,193-14,349	610
	Mr. E.	" "	14,350-14,393	617
26th Day ...	Miss C.	Former patient	14,394-14,600	619
23rd Mar., 1925.	Mr. B.	" "	14,601-14,732	626
	Miss B.	" "	14,733-14,900	630
27th Day ... 17th April, 1925.	Sir H. ARTHUR ROSE, D.S.O. ...	Chairman, General Board of Control, Scotland.	14,901-15,683	637
	Dr. HAMILTON C. MARR	Senior Commissioner ...		
28th Day ... 18th April, 1925.	Prof. GEORGE M. ROBERTSON, M.D., F.R.C.P. (Edin.).	Physician Superintendent, Royal Hospital, Morning- side, Edinburgh.	15,684-16,261	665
29th Day ... 20th April, 1925.	Dr. JOHN D. COMRIE, M.A., M.D., B.Sc., F.R.C.P. (Edin.).	Senior Assistant Physician, Royal Infirmary, Edinburgh.	16,262-16,469	689
	Dr. JOHN CARSWELL, F.R.F.P.S. (Glasgow), L.R.C.P. (Edin.).	Consultant	16,470-16,598	698
30th Day ... 4th May, 1925.	Dr. R. H. COLE, M.D., F.R.C.P.	Representing the Medico- Psychological Association.	16,559-17,097	705
	Dr. M. A. COLLINS, O.B.E., M.D.			
	Dr. E. GOODALL, C.B.E., M.D., F.R.C.P.			
	Dr. J. R. LORD, C.B.E., M.B.			
	Dr. W. F. MENZIES, M.B., B.Sc., F.R.C.P.			
31st Day ... 5th May, 1925.	Sir FREDERICK MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S.	Representing the Medico- Psychological Association.	17,098-17,287	733
	Dr. R. WORTH, O.B.E., M.B.			
	Dr. R. H. COLE, M.D., F.R.C.P.			
	Dr. M. A. COLLINS, O.B.E., M.D.			
	Dr. E. GOODALL, C.B.E., M.D., F.R.C.P.			
32nd Day ... 22nd May, 1925.	Dr. J. R. LORD, C.B.E., M.B.	Representing the National Council for Mental Hygiene.	17,288-17,433	746
	Sir FREDERICK MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S.			
	Dr. R. WORTH, O.B.E., M.B.			
	Dr. R. FARQUHAR BUZZARD, M.D., F.R.C.P.	Representing the Bishops of England.	17,434-17,553	755
	Dr. H. CRICHTON MILLER, M.D.			
	Dr. R. WORTH, O.B.E., M.B.			
	The Rt. Revd. THE LORD BISHOP OF CHELMSFORD.	Chaplain of Cane Hill and Hanwell Mental Hospitals.	17,554-17,629	760
	The Rev. W. E. C. BARNES, M.A. ...	Director of Public Prose- cutions.	17,630-17,763	764
33rd Day ... 25th May, 1925.	Sir ARCHIBALD BODKIN, K.C.B. ...	Lord Chancellor's Visitor ...	17,764-18,024	770
	The LORD SANDHURST	Master in Lunacy	18,025-18,247	782
	Mr. G. M. HILDYARD, K.C.			

Day.	Name.	Designation.	Questions.	Page.
34th Day ... 19th June, 1925.	Mrs. F. M. GLANVILL... ..	Member of the Wandsworth Board of Guardians.	13,248-18,389	790
	Mr. GEORGE HILL	Member of the Wandsworth Board of Guardians.		
	Dr. R. WITHERS GILMOUR, M.B., B.Sc., M.R.C.S., L.R.C.P.	Physician in Charge, St. Luke's Clinic, Middlesex Hospital,	18,390-18,500	797
35th Day ... 22nd June, 1925.	The COUNTESS OF CHICHESTER ...	President, Lady Chichester Hospital.	18,501-18,759	801
	Dr. HELEN BOYLE, M.D. (Brux), L.R.C.P.	Senior Physician, Lady Chichester Hospital.		
	Dr. EDWARD MAPOTHER, M.R.C.P., F.R.C.S.	Medical Superintendent, Maudsley Hospital.	18,760-19,001	813
36th Day ... 10th July, 1925.	The Hon. WILLIAM SIDNEY, J.P.	Representing the London County Council.	19,002-19,411	823
	Mrs. ROSE DUNN GARDNER, J.P.			
37th Day ... 11th July, 1925.	Sir LEWIS BEARD	Representing the Association of Municipal Corporations.	19,412-19,565	840
38th Day ... 20th Oct., 1925.	Miss H.	Former nurse-probationer ...	19,566-19,811	849
	Mr. M.	Former attendant	19,812-20,038	857
	Mr. O.	Former patient	20,039-20,237	864
	Mr. W.	" "	20,238-20,315	870
39th Day ... 21st Oct., 1925.	Mr. L.	Former patient	20,316-20,427	875
	Miss G.	" "	20,428-20,559	882
	Mrs. G.	" "	20,560-20,621	889
	Mr. Y.	" "	20,622-20,688	894
40th Day ... 10th Nov., 1925.	Sir MAURICE CRAIG, C.B.E., M.D., F.R.C.P.	Consultant	20,689-21,000	897
	Dr. FREDERICK LUCIEN GOLLA, M.B., F.R.C.P.	Director of the Pathological Laboratory, Mental Hospitals Department, London County Council.	21,001-21,098	911
	Dr. ALFRED FRANK TREDGOLD, M.D., F.R.S. (Edin.).	Representing the Central Association for Mental Welfare.	21,099-21,259	915
	Miss FLORENCE ANDREW ...			
	Miss EVELYN FOX ...			
41st Day ... 10th Dec., 1925.	Sir FREDERICK WILLIS, K.B.E., C.B.	Chairman of the Board of Control.	21,260-21,400	923
	Mr. S. J. FRASER MACLEOD, K.C. ...	Legal Commissioner... ..		
	Dr. C. H. BOND, C.B.E., D.Sc., M.D., F.R.P.	Medical Commissioner ...		
42nd Day ... 11th Dec., 1925.	Mr. H. W. S. FRANCIS, O.B.E. ...	Assistant Secretary, Ministry of Health.	21,401-21,569	931

Note.—The Appendices to the Evidence are printed separately in Part III.

ROYAL COMMISSION ON LUNACY AND MENTAL DISORDER.

TWENTY-FIRST DAY.

Tuesday, 24th February, 1925.

MEMBERS PRESENT:

MR. N. MICKLEM, K.C. (*in the Chair*).
THE EARL RUSSELL.
SIR HUMPHRY ROLLESTON, BART., K.C.B., M.D.
SIR DAVID DRUMMOND, C.B.E., M.D.
MR. H. SNELL, M.P.
MRS. C. J. MATHEW.
MISS MADELEINE SYMONS.
MR. P. BARTER (*Secretary*).
MR. W. FAIRLEY (*Assistant Secretary*).

Mr. WALTER BLOOD (President, National Asylum Secretary, N.A.W.U.), and Miss MAUD WIESE (R.M.N.), called and examined.

11,835. *Deputy-Chairman*: This morning we are to take the evidence of the members of the nursing staff, a point of view we have not hitherto considered. I understand the witnesses are first, Mr. Walter Blood, who is the President of the National Asylum Workers' Union, and that Mr. Blood and the other two witnesses present are all representatives of the Union?—(*Mr. Walter Blood*): Yes.

11,836. Are you to be the spokesman, Mr. Blood?—No, Mr. Gibson, the Secretary, will be the spokesman.

11,837. Then we shall have the main evidence from Mr. Gibson and supplementary evidence from Mr. Blood and Miss Maud Wiese?—(*Mr. Gibson*): That is so.

11,838. If you please. Now we will just consider, first, your qualifications, Mr. Gibson. At the present moment you are the General Secretary, and you have been General Secretary of the Union since 1913?—That is so.

11,839. As I understand, before that you were Honorary General Secretary for some 3½ years, and during that time you were actively engaged in the nursing service?—Yes.

11,840. And you are the holder of the Medico-Psychological Preliminary Certificate?—Yes.

11,841. I suppose before you took your final certificate you accepted this office?—There was no curriculum of training when I entered the service at the institution I was in, and in my service I did not have an opportunity to take the final certificate.

11,842. Then perhaps I may deal with the other two witnesses. Mr. Blood, you are the President of the National Asylum Workers' Union?—(*Mr. Blood*): I am.

11,843. At the moment you are staff nurse at the Rowditch Mental Hospital at Derby?—Yes.

11,844. You are a holder of the First Aid, and Preliminary and Final certificates of the Medico-Psychological Association?—Yes.

11,845. And you have had 14½ years' mental nursing service?—That is so.

11,846. Miss Maud Wiese, you are a registered mental nurse?—(*Miss Wiese*): Yes.

11,847. You are at the moment head nurse in the London County Council Mental Hospital at Claybury?—Yes.

11,848. You are the holder of the First Aid, Home Nursing and Medico-Psychological certificates, and a member of the General Nursing Council, and you are also a member of the National Executive Council of the National Asylum Workers' Union?—Yes.

11,849. *Sir Humphry Rolleston*: Might we know what a head nurse is. That is not the same as matron, is it?—(*Mr. Gibson*): A head nurse is the intermediate rank between that of charge nurse of a ward and matron. The head nurse supervises a number of wards.

11,850. *Deputy-Chairman*: A number of charge nurses?—Yes.

11,851. And above the head nurse would be the matron and the deputy matron, I suppose, at the Claybury Mental Hospital?—(*Miss Wiese*): Yes, that is so.

11,852. Now, Mr. Gibson, I notice that your *précis* deals with a very large number of topics. Some of them relate, of course, directly to the nursing staff, some relate to the patients, and some to the general lunacy law and the practice. I think after you have told us something about your Union, it would be desirable that we should deal with your *précis* in that order, taking matters referring to the nursing staff first, then matters referring to the patients, and ultimately your suggestions as to modifications which you would suggest in the general law and practice. Will you tell us about your Union? What does the Union consist of? I see you have over 11,000 members in England, Scotland and Wales?—Yes.

11,853. And those members are drawn from some 128 institutions?—Yes.

11,854. I suppose that means that you represent a large majority of the workers?—Yes, a considerable majority of the staffs.

24 February, 1925.] Mr. WALTER BLOOD, Mr. GEORGE GIBSON and Miss MAUD WIESE. [Continued.]

11,855. Have you any idea what proportion of the asylum workers you represent?—I should imagine about 60 per cent. of the total staffs.

11,856. And I observe that your Union comprises more sections than one—there is the officers' section and the workers' section?—Yes.

11,857. What does the officers' section consist of?—The distinguishing factor between the two is that the officers' section is not called upon to obey any rule regarding the withdrawal of labour unless they do so voluntarily; they are a self-governing section.

11,858. *Earl Russell*: "Withdrawing labour" is a polite term for a strike, is it?—Yes; the officers' section is a self-governing section. They are not bound by a vote of the ordinary members; they must vote themselves separately on any question.

11,859. *Deputy-Chairman*: Then taking the ordinary members, are they bound by the vote of the officers, or by the vote of the general Union?—The ordinary members are bound by the vote of the ordinary members.

11,860. You have not supplied us with your rules?—I will hand in copies.

11,861. It might be desirable, I think, for us to see the rules. Can you tell me what are your activities? What does the Union do?—Our object as defined is to promote better relationships between employers and employed, and to improve the status of the nursing staffs.

11,862. I suppose that is the general object really, to improve the status of the nursing staff?—Yes.

11,863. Do you have annual, or six-monthly meetings?—We have annual conferences at which every branch of the Union is represented; and the governing committee meets periodically.

11,864. How many branches have you got?—We have 106 branches.

11,865. Does each separate institution constitute a branch?—Providing it has sufficient members. We have institutions that prefer to be sections of the central branch.

11,866. Those would be the smaller ones?—Yes.

11,867. But with regard to the larger institutions, there would be a separate branch formed in each?—Exactly.

11,868. And then for your annual meeting there would be representatives sent from the several branches?—Yes.

11,869. Are the members bound by the resolutions that are carried at your general meetings?—The annual general meeting is the governing body of the Union, and the members are bound by any alteration of rules made there in conformity with the rules.

11,870. Do you take any particular steps to get members of the different staffs to join the Union?—Well, Sir, we take what steps are possible.

11,871. I gather from information that appears, not in your *précis* but elsewhere, that you run a magazine, amongst other things?—We do.

11,872. A free and independent Press?—Yes, of which I am not the editor.

11,873. I suppose in that free and independent Press you get an expression of the views held by the Union, criticisms of the Board of Control, of the public, and of the medical staffs, and so on—everything?—Yes.

11,874. Is that a monthly publication?—A monthly publication.

11,875. *Earl Russell*: Do all your members get it free, or do they have to subscribe specially?—All our members get it free, and many non-members get it on terms.

11,876. *Deputy-Chairman*: They buy it?—Yes.

11,877. Now let me pass to questions more particularly relating to the nursing staff. I suppose, speaking generally, the probationers who come into the hospitals have had no previous experience at all?—I think that is so in 95 per cent. of the cases.

11,878. The exceptional cases would probably be where some higher position had to be filled, and

nurses were wanted who had had a general nursing experience, or something of that kind?—That does take place in some instances. General trained nurses are sometimes engaged to take charge posts, or as assistant matrons, or occasionally matrons' posts.

11,879. Would there be any other cases where there had been previous training, do you think, except those?—There might occasionally. There sometimes is a case where a nurse has been in the Poor Law service, and has acquired a certain amount of experience, although not certificated, and may transfer to a mental hospital.

11,880. Now I suppose all probationers are taken in at the present time as weekly servants, are they not?—Monthly, as a rule.

11,881. So that a month's notice would be required on either side?—On either side.

11,882. But they would either be weekly or monthly, I suppose. There are no cases where your probationers are taken for a term of years?—In some cases the terms are that during the probationary period they may be weekly, but I think invariably when they are appointed they are on a monthly contract.

11,883. Would there be a written contract always entered into with them?—A signed contract, as a rule. They have to sign what is termed the obligation form.

11,884. Now, referring to your memorandum, you have set out for us what would be the ordinary duties of a probationer on appointment; we can take them, of course, quite shortly. In the first place, he would at once be appointed to ward duties, and would be under the direction of a charge nurse?—Yes.

11,885. His first duties would be to fetch coals, light fires, assist in ward cleaning, and so on?—Yes.

11,886. And he would get his general duties and responsibilities explained to him by the charge nurse?—Yes.

11,887. Now taking a day's duty, at 6.30 or 7 a.m. (I suppose that varies according to the particular asylum,) he would assist in getting the patients out of bed and dressed, carrying fuel, and so on, and assist in washing patients; then breakfast at 7.30 or 8 o'clock; then taking patients' meals from the kitchen, ward cleaning, bed-making, floor polishing, washing, and so on, and then patrolling in the airing court or in charge of one or more special cases?—Yes.

11,888. At 12 o'clock preparation for dinner, some patients again requiring washing; dinner generally over by 2 o'clock; staff tea at five o'clock; patients' tea at 5.30 or 6; after tea he may spend half an hour encouraging the patients to play games; then at 7 or 7.30 bed time. In some instances nurses would finish at 7, others at 7.30 or 8, and in a few institutions, where the three-shift system is in vogue, the staff are on duty till 9.30 or 10?—Yes.

11,889. Now in the case of the ordinary hospital the probationer would be taken on for what may be called a long day, a 12-hours' day.—Are you referring now to the general hospital?

11,890. A general hospital?—I believe it is so in the majority of cases, yes.

11,891. They would not ordinarily begin on a three-shift system—an 8-hours' day?—There are about 21 institutions in the country, mental hospitals, where they are at present working on a three-shift system, and if a probationer joined any one of those he would immediately fall into the routine.

11,892. But the routine which you have indicated here would be the routine of the majority of the hospitals?—Yes.

11,893. When you say some 20 hospitals have adopted the three-shift system, those, I think, are the London County Council hospitals, are they not?—They number nine of them.

11,894. And are the others scattered over the country?—Scattered over the country.

24 February, 1925.] Mr. WALTER BLOOD, Mr. GEORGE GIBSON and Miss MAUD WIESE. [Continued.]

11,895. Then after this preliminary probationary period the nurse would be placed on the staff and would commence his studies for the Medico-Psychological Association's examinations?—Yes.

11,896. If he remain after three months I suppose he still remains a junior probationer?—He remains a probationer so far as classification is concerned, but so far as the contract of service is concerned he is placed on the permanent staff.

11,897. Is he what is called sometimes in these reports a senior probationer then?—No. The difference is one of terminology. A nurse is always a probationer until he has qualified by certificate, but legally he becomes one of the permanent staff; that is to say, he is appointed as an established officer and commences to contribute under the provisions of the Asylums Officers' Superannuation Act.

11,898. He becomes a staff nurse for the purposes of the Superannuation Act—that is the 1909 Act?—Yes, and frequently his contract alters, and from a weekly contract it becomes a monthly one.

11,899. Then you say he begins his studies for the Medico-Psychological examination; that is always assuming, of course, that he is in a hospital where there is training for that certificate?—I think in all the county mental hospitals and borough mental hospitals now they have a syllabus of training. The list has only been completed within the last 12 months, but now they all have a system of training.

11,900. Would a probationer, a member of the staff of that kind, have a definite time allotted to him for study, or does he take his study as he can get it between his staff duties?—It varies considerably. As a rule they have to study in their own time. There are some places where they permit them to take, say, half of the studies in their own time and half in the time of the authorities.

11,901. I observe you say he may occasionally have to accept responsibility for patients in the ward; but, generally speaking, he would have some form of ward duty, I suppose, all through the day?—He always has ward duty. What I mean is he may occasionally be left alone with a number of patients, either in the ward or in the airing courts, or have three or four special cases allotted to him to supervise.

11,902. After three months he has arrived at a stage when he might from time to time be left alone with a particular class of patients?—He may do that within the first three months, and sometimes does.

11,903. Then he proceeds with his studies and does his work, and after three years, if he succeeds in passing the final examination, he becomes a staff nurse.—Quite.

11,904. Let us suppose he does not pass his examinations. Assume that at the end of three years he has only passed the preliminary examination, what would be his position?—The position is this, that if he has made due endeavour, and if the authorities think that temperamentally he is likely to be a satisfactory nurse, they will permit him to continue trying in the hope that he will pass within the next two or three years.

11,905. Will he become a staff nurse then?—No.

11,906. Supposing that at a later period, at the end of another two years, he has not passed the examination, will he still be retained on the staff, or would he have to leave the asylum?—He might be retained.

11,907. I suppose there must be a very considerable class of men and women who find it quite impossible from their lack of early education, or whatever it may be, to pass the Medico-Psychological examination—it does not strike one as being the easiest thing in the world to do?—The syllabus is very difficult and some of the tuition is not too efficient.

11,908. I will come to deal with that a little later, but what would happen in those cases where the nurses were unable to take the final examination? Would they, as a rule, stay on in the asylum?—In the past it has been the rule that they did stay on

in the asylum. At the present time it is becoming, on the other hand, the general rule that they are given notice on the ground that they are not likely to become efficient nurses.

11,909. Now that the profession of mental nursing is becoming looked upon more as a vocation, and the training, I suppose, speaking generally, is very much improving, a change is taking place in the position of these people—they may have to retire more frequently than they used?—Yes.

11,910. But assuming he gets the certificates he gets appointed as a staff nurse?—Yes.

11,911. And at a shortly later period he becomes a charge nurse—I understand that is a higher position?—Yes.

11,912. What exactly is the meaning of a charge nurse?—A charge nurse is a nurse who is responsible for a ward; that is, responsible for the patients, for the staff of the ward, and for the stock and utensils in the ward. Every ward carries its own stock rooms, patients' clothing, bedding, towels, and all that sort of thing.

11,913. It is an entirely separate unit of its own?—Yes; and the charge nurse supervises the whole ward.

11,914. And that involves, amongst other things, a considerable amount of clerical work, does it not?—It involves a fair amount of clerical work, yes.

11,915. You speak here of keeping the ward list—is that a wardlist of materials, or of patients?—There is a ward stock list which is of materials; then there is generally a ward book in which a roll of the patients is kept, and also a report of daily changes in their bodily or physical condition, temperatures, and any incidents that may occur.

11,916. And it is the duty of the charge nurse to keep those lists?—Yes.

11,917. Then there is the diet list and the medical list; with regard to the medical list, does that include the orders which are given by the doctors?—And a list of patients who are on special medicines.

11,918. And probably the medicines supplied, and so on?—Quite.

11,919. Then there is a casualty book, and other ward books. Speaking generally the charge nurse is in entire control for the time being of the ward, of course, always subject to the directions of the superior, the matron or the deputy matron, or of the head nurse or the male side?—Yes.

11,920. I suppose the information you have been giving us so far applies equally to the male and female sides?—They are both run in entirely a similar fashion.

11,921. Then there may be sick nursing to be done in the infirmary or hospital ward—would that be part of the duty of the charge nurse? I suppose that is only really referring to the general duties of the nurses just as anywhere else?—In the infirmary ward the charge nurse would, as a matter of practice, supervise all the sick nursing—would spend most of his time in the sick dormitory.

11,922. And, of course, as you point out, the wards will vary very largely in their size and in the type of patients, and so on; and in all cases there will be a very considerable responsibility thrown upon the shoulders of the nurses, particularly of the nurses who are in charge. One can see it is an extraordinarily difficult and important post?—Quite.

11,923. Am I right in this, that the view of your Union is that it is an extremely important thing that good probationers should be obtained?—We are entirely of that view.

11,924. Could you indicate upon what lines special inducements could be held out to probationers—how are you to obtain this good class that you desire—what would be the special inducements that you think should be held out?—I think the special inducements to commence with ought to be reasonable remuneration, and better ultimate prospects.

11,925. Would not one very material thing be if you could induce the probationers to look upon this

24 February, 1925.] Mr. WALTER BLOOD, Mr. GEORGE GIBSON and Miss MAUD WIESE. [Continued.]

as their ultimate vocation in life, and assure them of good systematic training for that vocation?—Well, Sir, I think I can only answer that by asking you a question. Are you likely to get people to take it up as their ultimate vocation in life, if the prospects are not satisfactory?

11,926. No, that is true enough, but, on the other hand, if once it is looked upon as an important professional vocation it is reasonably clear that there will ultimately be good posts. I mean that the whole position of the nurses would be improved?—I am afraid I cannot agree with you.

11,927. You do not think that is so?—I think the recently issued report of the Departmental Committee goes to prove that the posts will not be improved; as a matter of fact they may be made considerably worse.

11,928. Are you thinking of the pay?—Financially and otherwise.

11,929. Do you think it would be an inducement to nurses to know that they would get a good systematic training in their work?—Decidedly, providing the training is going to lead to something.

11,930. We shall have presently to consider a little more carefully this question of remuneration, but do not you think it would be an inducement if the remuneration were made largely to depend upon the passing of the examinations and the acquiring of certificates?—I think that we have always taken the line that training is essential, and that we have endeavoured to increase the remuneration for obtaining the certificate; but so long as the authorities are permitted to retain an untrained staff, I do not agree that the remuneration should be made conditional upon obtaining a certificate.

11,931. Do you mean to suggest that the untrained staff should be on precisely the same footing, so far as regards the remuneration, as the obviously skilled staff, if I may put it so?—Not exactly, but I do mean this, that if after five years they retain untrained staffs in the service they should not be able to retain them at a much lower rate than the trained staff; otherwise the tendency would be to retain them for the economical advantage that the authorities would obtain.

11,932. I see you say that you are desirous that training should be given. You say that unfortunately it is only within the last three years or so that training has become general?—That is so.

11,933. And that has been partly at the request of your Union, and partly on the recommendation of the Joint Conciliation Committee?—Of which we are parties.

11,934. You are one party?—Yes.

11,935. I suppose the other party represents the Mental Hospitals Association?—Yes.

11,936. Put broadly they represent the employers, and you represent the employees?—Yes.

11,937. And you suggest that in some of the places the tuition at the moment is extremely casual?—That is so.

11,938. We may assume that it is not equally good in all places, but am I right in saying that the training now in the larger hospitals is enormously improved?—It has very considerably improved. I think in one or two of the smaller hospitals the lack of efficiency in training is due to the weakness of the medical staff; they are not strong enough in number. I know that was the case at one institution, Carmarthen, where they only had a medical superintendent, and one assistant medical officer for over 600 patients.

11,939. In a case of that kind I suppose you think it would be desirable that some assistance should be got from outside?—No, I do not think it is necessary. I think it is desirable that one or two members of the staff should be appointed as sister tutors.

11,940. But to take this case of Carmarthen, I do not know of course the particulars myself of that institution, but I gathered from what you said that the medical staff was so small there that it would be very difficult for them to carry out their medical

duties in the hospital, and at the same time to give a reasonable time for training the staff?—Quite.

11,941. In a case of that kind it might be a great advantage for them to get outside assistance for the purpose of training, might it not?—No; I think the remedy there was to appoint another assistant medical officer. I think the medical staff was too weak to do their duty to the patients, apart from training.

11,942. Now let us look at the schedule which you have given us of the syllabus for the training for mental nurses, and those nursing mental defectives. It looks as though the nurses who pass through this examination have to do a very considerable amount of reading and study?—A very considerable amount.

11,943. I do not quite follow what is the distinction, what is the meaning of the syllabus of training for mental nurses, and those nursing mental defectives?—The mental nurses are those employed in looking after the certified insane. The mental defectives are those people who are detained in institutions which are established under the Mental Deficiency Act.

11,944. Yes, I see. Then the note says that all sections except XIII apply to mental nurses. Those are the ones we have to deal with?—Yes.

11,945. And I see Section XIII deals with particular technical matters connected with mental deficiency as distinguished from lunacy. Is that so?—Yes.

11,946. Now this syllabus, as we observe, is a difficult and complicated matter. For the first examination, sections I and II have to be passed?—Quite.

11,947. The first section dealing with the general duties of a nurse in a mental hospital, and section II dealing with anatomy and physiology?—The first three sections have to be passed at the first examination.

11,948. Section III is first aid?—Yes.

11,949. And those form the preliminary examination?—Yes.

11,950. Is there not a separate certificate for First Aid?—I want to make one correction in that. The intermediate examination has now been abolished and where there were previously three examinations there now are only two. The first five sections form the preliminary and the remaining sections form the final. Up till this year there have been three examinations—within the last two years.

11,951. There used to be a certificate for First Aid, and then a certificate for the first examination?—The First Aid certificate was really a St. John's certificate, and it had no connection with the Medico-Psychological Association.

11,952. As far as the Medico-Psychological examination is concerned that was just one of the sections of the preliminary examination?—Yes.

11,953. Now there is no intermediate examination?—A preliminary and a final.

11,954. You say the preliminary deals with subjects down to the end of section V.?—Yes.

11,955. Is it possible for the examinees to take the sections separately. Can they pass at one examination for instance, under section I., in the general duties of the nurse, and then at a later examination in anatomy or physiology, or must they take all the subjects together?—They must pass at the first examination in a paper that may be set on all the first five sections.

11,956. There are not separate papers set in each section?—No; there is an oral and a written examination, and questions in both of them may come from any or all of the five sections.

11,957. So that the nurse entering for the examination must be prepared to pass in all those sections at the same time?—Quite.

11,958. Then you say there is an oral as well as a written examination?—Yes.

11,959. Then from section VI to the end, excluding section XIII, that is the final examination?—Yes.

11,960. And there again does the same apply—you must pass in everything at the same time?—Yes.

24 February, 1925.] Mr. WALTER BLOOD, Mr. GEORGE GIBSON and Miss MAUD WIESE. [Continued.]

11,961. Now I must say, looking at these papers as an outsider, and with no medical knowledge, but knowing something about examinations, it does seem to me that these nurses have a rather formidable task before them when they begin?—Extremely difficult.

11,962. And by the time they have finished and have passed the examination they ought to have a very considerable knowledge of the body and of nursing, and of medicine and so on. Now only comparatively few do obtain this certificate, do they?—I think you will find some idea of the numbers if you refer to the report of the Departmental Committee which was appointed to inquire into the nursing service in county and borough mental hospitals. They refer in their report to the number of nurses for all certificates.

11,963. I am obliged to you. There are two separate certificates which nurses obtain now, are there not? A mental nurse might obtain a certificate under the General Nursing Council?—Yes.

11,964. As I understand it, Miss Wiese has both certificates?—(Miss Wiese): Yes.

11,965. And there is the Medico-Psychological certificate?—Yes. The tendency is to take the Medico-Psychological examination because it is cheaper. (Mr. Gibson): The syllabus is precisely the same. (Miss Wiese): It is practically based on the old Medico-Psychological syllabus of training.

11,966. Must you pass an examination in each case if you are to hold the two certificates?—It is not essential. A nurse who has taken the Medico-Psychological certificate is able to become a State registered nurse without sitting for an examination up to July of this year.

11,967. She can be put on the register?—Yes.

11,968. Now I observe it says at the top of page 11 of the Report of the Departmental Committee "The total number of nursing certificates granted by the Association up to the 31st March, 1924, was 17,429, including 146 as respects mental deficiency"—that is the second class?—Yes.

11,969. Now taking the 17,429, on referring to page 12, I do not quite follow how the numbers apply. Looking at page 12, it would appear as though the charge nurses with final certificates were 510 male, 635 female, deputy charges 326, and 241, total 1,588 male and 1,155 female. Does the figure of 17,429 represent all the certificates that have been given from the very beginning?—Since the inception of the examinations.

11,970. Of course, a very large number of those nurses have passed on to other work, and so on?—Quite.

11,971. You draw attention somewhere to a note of the Departmental Committee on the returns for 1923. "We ascertained that as many as 50 per cent. of the men can claim over five years' service at their hospital in contrast with only 20 per cent. of the women"?—Yes.

11,972. And that, "on the other hand, while there are scarcely 11 per cent. of the men with under one year's service, there are no less than 32 per cent. of the women who have not yet completed a year at the hospital where they are at present employed."—It is on page 13 of the Departmental Committee's Report.

11,973. Then it goes on to say: "If the percentages expressing the numbers who have passed one or both examinations are recalculated upon the numbers of those who by their duration of service may fairly be expected to have so passed—a sufficiently approximate mode of calculation—proportions much more favourable to the women then emerge; thus, it would appear then that, of those with over five years' service, 56 per cent. of the men and 70 per cent. of the women are certificated in mental nursing, and that, of those with over one year's service, 25 per cent. of the men and 22 per cent. of

the women have passed the preliminary examination." It appears from these figures that a very large number of the nurses who stay on for five years do pass the examination?—Yes, but is not that an extraordinary method of calculation, considering that a very large proportion of the nurses do not stay on? That is like saying if I reach 100 I shall reach a century.

11,974. I suppose many of them stay on because they get the certificate, do not they?—I really cannot agree with that process of reasoning.

11,975. They acquire a certain definite and high standard of service. You see it would look as though in the case of female nurses 70 per cent. of those over five years have taken the certificate?—Yes, but when you consider that 32 per cent. of the female nurses have not 12 months' service, what proportion is that going to be of the actual number of staffs?

11,976. You cannot tell from that; that is one of the extraordinary things, that the female staff apparently is constantly changing and fluctuating?—Exactly.

11,977. They are voluntarily resigning in most cases?—And sometimes being dismissed.

11,978. You show the way in which they are constantly fluctuating; you have set out certain extracts from the Scottish Board of Control Returns?—Yes.

11,979. Have you got any figures corresponding with those?—The English Board of Control only publish percentages, and the Scottish Board of Control do not publish percentages, because I am afraid they would form dreadful figures, so they give the actual numbers.

11,980. Could you refer me in the English figures to the percentages?—Yes, they are in the extract you have read on page 13: "As many as 50 per cent. of the men can claim over five years' service at their hospital in contrast with only 20 per cent. of the women. On the other hand, while there are scarcely 11 per cent. of the men with under one year's service, there are no less than 32 per cent. of the women who have not yet completed a year." If you continue downwards you will find that the extraordinary process of reasoning adopted by the Departmental Committee is this, that of the 20 per cent. of the women who stay over five years, 70 per cent. of the 20 per cent. have the Medico-Psychological certificate, so they say that is splendid.

11,981. So it is; the argument is right, is it not? But, of course, that does not account for the number of resignations within the five years?—I should imagine if they made the conditions of the service so bad that only 5 per cent. of the women would stay over five years they might have still better figures.

11,982. But just consider that for a moment. The conditions of service on the female side are as satisfactory, are they not, as they are on the male side?—Proportionately, yes.

11,983. You do not say that the male side is made more attractive than the female side?—Yes, I do.

11,984. In what respect?—My experience of the administration of mental hospitals is that the male side works much smoother—has more method of working—much more method.

11,985. But it is a strange thing that even if that is so, if there be a little more method, there are only 11 per cent. of the men under one year's service, and 32 per cent. of the women have not yet completed the year?—I think that proves my point, that conditions on the male side are more satisfactory.

11,986. But in what respect?—It is rather an awkward question to answer. What I mean is this: in a large institution like a mental hospital a great deal depends upon the supervision of either side by the matron or the head attendant, and, in practice, there are few matrons who are satisfactory. That is saying a lot, but it is so. What I mean is this. I find that almost daily we get complaints from female nurses who say they never know when they are going to have a day off duty. They may be told

in the morning, "Oh, nurse, you will have to take this afternoon off," or it may be that frequently they are told at a day's notice, "You have to go on your annual leave." On the male side, on the contrary, the general rule is that there is a proper leave roster posted, the men know when they are going to have a day off duty, or their annual leave, and they can make preparations for it.

11,987. The administration by a male nurse is better, you think, generally speaking, than administration by a matron?—I think it is much superior. If I may put it in the words of a medical superintendent whom I spoke to recently, he said, "I can go away for a month and be quite certain that the male side would work smoothly, but," he said, "I could not go away and leave the female side for 24 hours."

11,988. *Sir David Drummond*: Does that reflect on the matron or the nurses?—I think it reflects on the system. I think the tendency on the female side is to keep officers in the service who are too old for the work. I do not think any woman is capable of satisfactorily performing the duties in a mental hospital after the age of 45; I think there are physical and psychological things in the structure of a woman which prevent her from being efficient after that age.

11,989. *Deputy-Chairman*: After the age of 45?—Yes.

11,990. Do you think the constant changes on the female side are mainly due to lack of good administration by the matrons?—I would not say mainly; that is a contributory cause. There are several causes: the unsatisfactory prospects and the very difficult nature of the work.

11,991. Now let us just consider the unsatisfactory prospects. Has not any female nurse who passes her examination and who is on the staff a prospect of getting a good position as nurse?—I do not know about a good position; she may get a fair position as a charge nurse. (*Miss Wiese*): If I may say so, the tendency now is only to appoint nurses with additional training in general nursing to posts of administration.

11,992. But, Miss Wiese, do not a considerable number of the mental nurses now who have taken their Medico-Psychological certificate proceed very often to general nursing?—(*Mr. Gibson*): They cannot get the facilities. (*Miss Wiese*): It is very difficult; it is only a few enthusiastic people who are prepared to do a probationary period of five years, and very often six or seven.

11,993. You mean you have to start again?—Yes.

11,994. Are there not arrangements made now in different places to assist the nurses?—Very few are willing to do it. (*Mr. Gibson*): A circular was sent out by the General Nursing Council to over 400 general hospitals asking them whether they were prepared to accept mental nurses for general training, and only 22 of over 400 replied in the affirmative, and about 9 of those 22 were exceedingly half-hearted in their replies. (*Miss Wiese*): And one or two have withdrawn since.

11,995. We have had some evidence of cases where arrangements have been made between mental hospitals and general hospitals for the interchange of nurses, and for nurses going for their general training after entering the mental service?—(*Mr. Gibson*): Yes, I believe you had that evidence from Dr. Yellowlees of The Retreat at York, but you see The Retreat is in a privileged position as a mental hospital. The Retreat chooses its cases. For instance, Dr. Yellowlees said they did not take epileptics, probably the most unpleasant type of patient there is. They have made private arrangements. The Retreat as a rule do not keep their mental nurses on after they have completed training.

11,996. Is there any reason why the general hospitals should not welcome nurses from the mental hospitals?—I do not think there is a good reason, but unfortunately they do not welcome them.

11,997. *Sir David Drummond*: They prefer women to commence training *ab initio*, and they have so many applications that it is very difficult to take on a new type of applicant, as it were?—(*Miss Wiese*): I do not think that is the position now; I think most matrons will admit that there is a difficulty in getting nurses. (*Mr. Gibson*): That is true; that is a general complaint. (*Miss Wiese*): One or two of the large London hospitals would have a long waiting list, but the majority have not. There is a difficulty in getting probationers in general hospitals. I think possibly another difficulty might be that a trained mental nurse would be expected to be taken on at the hospital as a second year probationer nurse. It does not give a nurse the same opportunity. (*Mr. Gibson*): And, of course, there is another difficulty, and that is that the mental nurse who has served a period of probation, and has had perhaps four years established service under the Asylums Officers' Superannuation Act scarcely wishes, even if she were able, to sacrifice two or three years in a general hospital, which may not count for superannuation purposes.

11,998. *Deputy-Chairman*: When you say "which may not," do you mean which does not?—Which would not, unless special arrangements were made.

11,999. But you would not lose your superannuation benefits, would you, by transfer?—No, she would not lose the previous service, but she would lose the service she had at the general hospital.

12,000. Two or three years?—Yes, but two or three years out of a woman's life is a lot.

12,001. Now let us pass on to consider the question of remuneration. Recommendations have been made by your Joint Conciliation Committee as to the remuneration which should obtain. May I take it, in the first place, that there cannot be said to be any general standard of remuneration in the hospitals at the present time?—No, there is no general standard. These figures can be taken as an average guide.

12,002. Quite. Now, there are two forms of remuneration as I understand it. In a very large number of hospitals there is a salary paid, and all maintenance found?—That is salary and what are called emoluments.

12,003. You put maintenance as part of emoluments?—Yes.

12,004. I should put it that there is a direct cash salary paid, and then the nurse has everything found, including washing, board and lodging?—Yes.

12,005. Now, if you turn to page 29 of the Departmental Committee's Report, they deal there with the figures. These are figures for 1922 it is true, but one may assume they are not very different now. Now, for purposes of their own the Departmental Committee set out there the salaries paid in mental hospitals and those paid in general hospitals to women only?—Yes.

12,006. Of course, they say that is not with a desire to suggest that the mental hospital nurses ought to be paid the same as the general hospital nurses; they recognise the extreme difference and character of their work, and so on. If you look at that you will observe that there is a very considerable difference of standard at the hospitals. Taking the probationers: women—the minimum they put at £50, maximum at £69 15s. That would look as though there is no standard of wages. Then men, £71 and £98. Now to one knowing very little about this matter, it would appear that the initial salary offered the probationer is a reasonably high salary, is it not, if you assume that the probationer is to have everything found by way of board and lodging and washing. Those would seem to be reasonable salaries would they not?—I do not think it is too high; I do not think it is high enough. You see there is a very distinct difference between a nurse who is employed in a general hospital and a nurse who is employed in a mental hospital.

24 February, 1925.] Mr. WALTER BLOOD, Mr. GEORGE GIBSON and Miss MAUD WIESE.

[Continued.]

12,007. Yes, I appreciate that.—Nurses who are employed in a general hospital know that, with reasonable application, at the end of three years they are members of a profession, and they have some freedom of action; that never does apply to the trained mental nurse.

12,008. I do not quite follow that. I appreciate, of course, to a large extent, what you say: but take the case of a trained mental nurse. Is there not a very large demand in this country outside the hospitals for trained mental nurses?—No. There is a demand by one or two nursing co-operations, but the nurse who enters them is simply devoting her time, in my view, principally to the welfare of the co-operation, and not for herself. They find there a post perhaps of looking after a private case. While she is engaged in looking after that case she is making a reasonable salary. When she comes out of work she has to live in a hostel provided by the co-operation, and she has no more money left.

12,009. You are dealing with cases where they have private nursing, where the fees are paid by the society?—No, the fees are paid by the individual.

12,010. By the patient?—By the patient engaging the nurse, but the nurse, according to her contract, has, when out of employment, to live in the hostel provided by the co-operation.

12,011. But do the co-operation find the patients?—They find the patients; they take a percentage of the nurse's salary when she has a case.

12,012. The patients are members in some way of the co-operation?—No.

12,013. I do not quite follow the position.—“Co operation” there is a misnomer; it is there, but it does not, in fact, exist. It really means that they have started a private nursing organisation, and they call it co-operation.

12,014. It really is a private nursing home?—Yes.

12,015. Who send out nurses to private patients?—Exactly.

12,016. I was thinking you meant rather nursing amongst the comparatively poor who were members of the co-operative society?—No.

12,017. But there must be a very large amount of that private nursing in the country?—I do not think there is a very large amount.

12,018. One can imagine a case of a private patient suddenly becoming insane and requiring considerable nursing, perhaps more than one nurse. Do you think that the doctors in attendance would have no difficulty whatever in procuring at once what nursing they wanted?—They could procure what nursing they wanted, there is no doubt about that; but they could not procure that nurse from a county mental hospital.

12,019. What I am driving at is this: Is there really not a very large amount of work to be done by a person who is trained as a mental nurse, who has left the hospital and engages in private nursing?—No, I do not think so; I do not think there is a great amount of work. I think what work there is is principally conducted through these private nursing societies, and the average individual does not have an opportunity. (Miss Wiese): In my experience very few mental nurses are attracted by private mental cases—very few.

12,020. Take the case of a mental nurse who has left the asylum and who has still to make her living: Would not she naturally look in the direction of private nursing?—Yes, and invariably she gives it up after a year or two and comes back to the county mental hospital.

12,021. Sir David Drummond: Not invariably?—That has been my experience. Just imagine what it means. Very often they have to live with the patients and live with them practically all day; very little time off duty. (Mr. Gibson): The position is this, that in the case of such a nursing co-operation, the more nurses they have on the staff the more money they make, because they charge a percentage on the fees they get for the nurse, and the result is

they try to get as many people as possible, and not necessarily all certificated people, on their staff, so as to keep their hostels full. The nurse finds generally, when she is on a case, she makes a reasonable amount of money.

12,022. Deputy-Chairman: It looks to me as though you are suggesting that there is a class of middlemen who take all the profits and leave the nurses nothing?—I think it is so, and the same practice obtains in the general nursing homes which sends out nurses. I believe one of His Majesty's Judges expressed that opinion in a case two or three years ago.

12,023. I understand Miss Wiese's experience is that private nursing is so unpleasant that after a comparatively short time the nurses have to throw it over?—(Miss Wiese): That is my experience of many nurses who have left Claybury and have gone into it; sometimes they get a mild sort of case and make it their home, but very rarely. (Mr. Gibson): Of course, if a case is a difficult one it may mean 24 hours' duty a day, because it is very seldom they get two nurses. They get no relief.

12,024. On the other hand, of course, one does hear of cases of three or four nurses being required in private nursing?—There are very few; very few people have enough money.

12,025. I suppose that class of private nursing, I will not say is well paid, because that, of course, is a relative term, but it is highly paid, is it not?—I think the remuneration is fairly attractive in that class of nursing, while they are working. The difficulty is they do not work regularly.

12,026. You suggest that they are rather taken in hand by the middleman, so to speak?—That is the complaint that we generally receive.

12,027. Now I was putting to you the figures of the Departmental Committee. I gather that your Union is against that method of payment altogether, is it not?—Yes, the method of payment by salary and emoluments?

12,028. Yes, for some reason or other you do not like it?—We are speaking from experience. Our experience was that when we had the system of payment by salary and emoluments, a very high, in fact a fictitious, value was placed upon the emoluments; the emoluments were valued for the purpose of superannuation at £30, £40 and £50 per annum. One had to pay a deduction in cash for superannuation purposes on that valuation, but in actual practice we never received anything like the value of the emoluments—in other words, the accommodation and the food were unsatisfactory.

12,029. Then the plan which you prefer is that where there is living in, for instance, the nurse shall pay for whatever she has?—We prefer that the remuneration shall be fixed, and that the deduction shall be made for such services as are given by the authorities. Then the nurses are in a position to know whether they are getting value for their money.

12,030. But then how do you assess the payments which are to be made by the nurses for food and so on?—In these recommendations of the Joint Conciliation Committee you will find it provided: “payment for board and lodging”—that is on page 8, section XI. “That those members of the staff who are required to be resident and those who are required to take their meals in the institution, be charged for the lodging, laundry, and actual board, as the case may be, which they receive, the basis of the charge to be made, to be, in respect of board, the cost to the institution concerned, and in respect of lodging and laundry, the value of such emoluments as scheduled for the purpose of contribution under the Asylums Officers' Superannuation Act, 1909.”

12,031. I do not know quite what the last means?—That last means that under the Superannuation Act a schedule has to be posted in the institution showing the value of various emoluments as set out for the purpose of the Act.

24 February, 1925.] Mr. WALTER BLOOD, Mr. GEORGE GIBSON and Miss MAUD WIESE. [Continued.]

12,032. Lodging and laundry?—Lodging and laundry.

12,033. How do they, as a matter of fact, get at the basis of the charge in respect of board?—The clerk or the steward as a rule bases it on the actual cost of the commodities, adding a little charge for services and for crockery, and so forth.

12,034. Of course, one knows that these figures are ascertained for all purposes, for the purpose of ascertaining how much is spent on food, and so on?—Yes.

12,035. While on that point, is the nurses' food in these establishments substantially the same as the patients' food?—No, the breakfast and tea meals as a rule are considerably superior. With regard to the dinners I do not think they are as a rule very much better—not in the best institutions.

12,036. The dinner would be about the same?—Yes.

12,037. In what respect are breakfasts and tea superior?—The patients' meals for breakfast and tea in my view have always been extremely unsatisfactory, principally bread and margarine and tea or cocoa; it applies to both meals.

12,038. I do not know that we can carry the point further so far as the wages are concerned. The Union is very strongly of opinion that the best form is a cash payment to cover everything?—Yes.

12,039. And is against the system of remuneration plus emoluments?—Yes, and if I may add, we do think that considering the difficulty of the examination and the nature of the work, when a person reaches the rank of staff nurse the remuneration should be adequate. If you will refer again to the Report of the Departmental Committee, the maximum wage they recommend for a male charge nurse is £135 per annum.

12,040. Would you mind giving me the page? Are those the figures given on page 30?—I have not found it myself yet, Sir, but I know it is there. In any case the figure is £135 a year, which is equivalent to £2 8s. per week.

12,041. £135 a year for a staff nurse?—For a male charge nurse.

12,042. Of course that is on the footing that everything is found for him in the way of board, maintenance, and so on?—Supposing you add £1 a week, and say that that is the value of the emoluments, you get a maximum of £3 8s. for a male charge nurse. That is considerably less than the minimum of any probationer police constable.

12,043. Not in the country?—Considerably less from Land's End to John o' Groat's.

12,044. Is that so?—Yes. I may point out this difficulty—if the charge nurse when he qualifies at one institution wants to transfer to another, he frequently finds a great amount of difficulty in it. I have a copy of a letter here. A member of ours made application to an institution for a post, he was a qualified male mental nurse, certificated, had been a pathological assistant for a number of years, and the reply he got was to this effect: "If appointed he would receive pay for his Medico-Psychological certificate, but his past asylum experience would not be counted except for the purpose of superannuation. If therefore he is prepared to commence as an ordinary probationer, if appointed, his application shall receive due consideration." That is the sort of encouragement they get to remain on in the service.

12,045. I suppose that was a case where there were a good many other applicants, was it not?—I do not think so. It was not applying for a specific post at all. He merely writes to an institution saying he desires a change.

12,046. But is it not rather like a case where the other institution had other applicants besides himself, and they had to consider his position with regard to the others. I do not know, of course. As you read it, it does seem rather a hard case?—It is not an uncommon case.

12,047. Now tell me, in your scheme of wages, the Joint Committee's scheme, do you make any special

provision for skilled nursing?—Yes, if you will refer to the recommendations.

12,048. By the way, I suppose these figures that appear on your scale should be increased by the very considerable bonus at the present moment?—The bonus varies from 2s. 6d. to about 2ls.

12,049. But the average bonus would be 18s. or 20s., would it not?—Not as much as that, about 10s.

12,050. Where do you provide that skilled nurses, persons who have obtained certificates, and so on, should obtain more than the ordinary nurse?—You will find in the scale "Proficiency pay".

12,051. On page 7?—This scale was drafted when there were three examinations.

12,052. Now you would probably alter the figure?—Now it is 3s. for preliminary and 3s. for the final certificate.

12,053. Miss Madeleine Symons: Are not the newer proposals at the very end on the single sheet?—Yes, those are the proposals of course after the system of examination was altered.

12,054. Deputy-Chairman: Now let us consider shortly another matter, the hours of duty. I think your Union have some strong views about that?—We have.

12,055. Would you put them before us quite shortly?—Our view is that the patients cannot receive adequate treatment so long as they are bedded at 7 o'clock, or 7.15 in the evening. We have found in practice that it is impossible to keep them up any longer except by working a three-shift system. I do not mean by that three rigid eight-hour shifts. As they work it in the London institutions they work a 96-hour fortnight, and one long day per week. That system allows of the patients having a live day of 15 hours.

12,056. I suppose you have got to differentiate between the patients, have you not? There would be a considerable proportion of the patients who would only be too happy to be in bed by seven or eight o'clock, and there would be a considerable proportion who would be only too happy to be in bed by nine or ten o'clock?—I agree, but I do not think there is a considerable proportion who would like to be in bed by half past seven. There are many who would like to be who ought not to be allowed. In an ordinary mental hospital not more than 10 per cent. of the cases are bed cases. That is just an average I am striking. I should not think of the others that it is good for any but a small proportion to be in bed by seven o'clock on any night, and particularly in the summer time.

12,057. The disease these people suffer from is an extraordinary and strange disease, and I suppose in many cases the mere fact of getting quiet rest, if they can get quiet rest, might be good for them?—That is just the difficulty. I believe the use of hypnotics would be much reduced if they kept up the patients in the evening and gave them some exercise or recreation. Imagine a paranoiac patient suffering from a fixed delusion, and who is labouring under that delusion: he is put to bed at 7 o'clock at night in June; he is lying worrying about his trouble all the time. I think if that patient were walked round the airing court, or permitted to indulge in some recreation outside, or games inside, he would be much more likely to get to sleep.

12,058. Let us assume he wanted to get to bed, what would you say?—I should say certainly not; I should not allow him to go to bed.

12,059. I suppose in an immense variety of forms of ailment there must be a very large variety in the form of treatment. It is impossible to lay down rules one way or the other?—Decidedly.

12,060. Your suggestion is that under the system too many are bedded off at too early an hour?—My suggestion is that in many of the mental hospitals all the patients without exception are bedded at 7 o'clock in the evening.

12,061. Is that so now in many hospitals?—That is so now, and they are in bed till 6.30 or 7 the following morning.

24 February, 1925.] Mr. WALTER BLOOD, Mr. GEORGE GIBSON and Miss MAUD WIESE. [Continued.]

12,062. That is not the rule in most of the larger hospitals at the present time, is it?—In many of them it is.

12,063. Compulsory bed time 7.30?—Compulsory bed time at 7, and 7.15.

12,064. *Sir David Drummond*: Does that apply to summer?—That applies to summer, too.

12,065. *Deputy-Chairman*: All the year round? Does that apply now, Mr. Blood, in your hospital at Derby?—(*Mr. Blood*): No, there is a proportion that stay up to a quarter to nine for recreation.

12,066. Not later than that?—No.

12,067. Anybody who likes to stay up there can stay up?—Yes, if he is a fit patient. They go to another ward and they play games. In the summer time they go out on the cricket ground.

12,068. How does that apply in the case of Claybury?—(*Miss Wiese*): They have a three-shift system; the London County Council are progressive as regards the mental hospitals.

12,069. They have what you call a three-shift system?—Yes, and the patients are allowed to stay up till a quarter past nine as long as they are in bed at half past, and it works fairly satisfactorily.

12,070. *Sir Humphry Rolleston*: Would Mr. Gibson be able to provide us with a list of hospitals which adopt the practice of compulsory bedding at 7 o'clock?—(*Mr. Gibson*): I think that information could be more authoritatively got from the Board of Control.

12,071. Mr. Gibson spoke with some knowledge on that, so I assume that is based on figures you could get for us?—Yes, I can get you a list.

12,072. *Deputy-Chairman*: I think the evidence we have had will indicate that that is not a very common practice now?—I am prepared to submit to you a list. (*Miss Wiese*): Is it possible to arrange this only on the three-shift system?—I do not think so.

12,073. I think it has been worked in other cases where they do not have the three-shift system?—I do not see how. (*Mr. Gibson*): The danger in these other places is that they let a small proportion of selected patients stay up. I do not think that is satisfactory.

12,074. I said there are enormous varieties of the ailment and there must be equally different treatments for them, you cannot lay down a rule; you would not wish to lay down a rule?—I do not suggest a rule at all, but I do suggest this, that if the doctor says in his opinion this patient would be better up, he should be kept up, and it should be not a matter of choice for the patient.

12,075. Do you mind explaining to me exactly what you mean by the three-shift system. Is it an eight-hour day system?—In practice it works like this. In the case of the London County Council: people who are on the morning turn will come on at 6.30 or 7 and be on till 1.30; 7 to 1.30, as a matter of fact, I think it is.

12,076. That is 6½ hours.—That is for five days in the week. Then on the sixth day they work from 7 in the morning until 9 or 9.30 at night, they do a double turn.

12,077. Is that the three-shift system?—Yes. In the afternoon they come on at 1 o'clock till 9 or 9.30 for five days in the week, and on one day of the week they do a double turn too.

12,078. Just let us consider that. In any case where that is worked the patients in a particular ward are under a double set of officials each day?—Yes.

12,079. May there not be some objection to that? Is it not an advantage that the charge nurse, whoever it may be, should be able to follow them through the course of the day?—I think the advantages considerably outweigh the disadvantages. (*Miss Wiese*): It might be said it would be a considerable advantage to stay on day and night and never go off. It would not be possible, would it?

12,080. That is putting an extreme case, but I suppose in all nursing that would be so. Nursing is one of those forms of service that does require, and may

require, a very considerable amount of time; the long hours that are spent over it may be of enormous advantage to the patient, however trying they may be to the nurse.—(*Mr. Gibson*): May I put it in this way: you are bound to change your staff at some time. The position appears to be this: that we must seek the method of changing the staff that is least detrimental to the patients. We find under the present system (we have figures which we have already discussed) that only 20 per cent. of the women have over five years' service; that in itself implies a considerable amount of changing of staff.

12,081. Is not that mainly changing of staff in what may be called the lower grades of the staff?—I do not think so.

12,082. It does not mean that there is a constant shifting of the staff nurses?—Not necessarily, but it does mean in point of fact a good number of changes amongst the staff nurses.

12,083. It is the probationers who go, is it not?—And staff nurses among the female nursing staff too.

12,084. I interrupted you; I am sorry.—Changes in the nursing staff necessitated by changes in the personnel are the type of change which is worse for the patient. If you get probationers and new nurses coming in every day to a ward who do not know the patients personally, those are the type of people who create trouble. They do not know how to handle a patient who is subject to difficulties. But, if, under the system in vogue in the London County institutions we get, as we do get, a ward staffed with the same staff daily, and the handing over is done while the patients are seated at their mid-day meal, there is no confusion involved in the change at all. What happens is this: the morning staff is on duty till 1.30—the afternoon staff come on at one. The patients are seated at their dinner meal and the change over is effected without disturbing them. I want to point out that the afternoon staff that comes on is the same staff that was on the day before, and the day before that, and the week before was on in the morning, and that in point of fact this system makes each ward responsible for its own reliefs. When the charge nurse on the afternoon shift is off duty the charge nurse on the morning shift is on duty all day, and *vice versa*. Now under the other system, the long day system, the head attendant who wants to conduct his reliefs has to go round to his probationer and say "To-morrow you will relieve in Ward 6," and the unfortunate probationer walks into Ward 6—he does not know the patients—and does a day's duty. The following day he is relieving in Ward 7, and the day after that he is in Ward 1, and those are the changes which are worst for the patients.

12,085. Is there anything in this: The doctor would naturally come round twice in the day, would he not? He would get a report of the nurse in the morning and see the patients in the morning, and would see them again in the afternoon?—Yes.

12,086. Now when he saw them again in the afternoon, under your system they would be in charge of a new set of nurses; there would be nobody who would make a report to him in the afternoon of changes which might have taken place in the condition of any of the patients during the day?—There is the ward report book. When he came round in the morning he would have all the clinical notes available for him, and they would be available in the afternoon. Any extraordinary occurrence would be noted.

12,087. I was not thinking of extraordinary occurrences, but I suppose the charge nurses would watch a number of patients very carefully through the day, and would be making their report?—I think that is conveying a wrong impression of a charge nurse's duties. With the exception of the infirm ward the charge nurse does not have the patient under personal observation, with the exception of a small part of the day. Patients turn out to the airing court, or walk out at probably 9 o'clock in the

24 February, 1925.] Mr. WALTER BLOOD, Mr. GEORGE GIBSON and Miss MAUD WIESE. [Continued.]

morning, and the charge nurse is rarely with them; and then after dinner they turn out again; so that to talk about the personal observation of the charge nurse is really a misconception.

12,088. I am putting the point which seems to be rather stressed by the Departmental Committee, but I think that is rather their view. The way they put it is rather better than I do. They say "Patients may suffer from lack of continuity of observation and treatment." Do you think it is easy to exaggerate it?—I think they have exaggerated it, because I do not see how it is possible for a charge nurse to keep patients under continual observation.

12,089. They make a point, do they not, which perhaps will affect your Union more closely. They suggest it may have an effect on the staff numbers; they say "on account of the greatly increased cost of shorter hours, there is a tendency unduly to limit the numbers of staff on duty at any one time, thereby adding to the strain and anxiety placed upon the nurses, as well as reducing individual attention to patients to the lowest limit?"—I think that point of view has been underlined throughout the report, although they only put it at the end—the question of cost.

12,090. It is of course a question that has to be considered?—Undoubtedly, and it is a very serious problem.

12,091. The trouble with most of the questions we are confronted with is the financial problem largely?—Quite, but I do not agree that the proper solution is to lengthen the day in order to put more nurses on duty. I have been told by several medical superintendents who have the long system of hours that their difficulty is to have a sufficient number of staff on at the critical periods. The mid-day meal is one of them. Under the system in operation in London they have a double staff on at the dinner meal.

12,092. Because they are shifting over then?—Yes, changing over. Incidentally, Sir, if, as is implied in this Report, hospitals have to be kept understaffed because of the cost (that is the implication, I think), it is desirable that the hours should be shortened in order that they can put up with the strain. I know when I joined the service we used to start work at 6 in the morning, and on our short day we worked till half-past 7 in the evening, once a week till 10, and about once a month till 11 at night. We had three days off in the month.

12,093. Did you not have a day and a-half in the week?—No, two weekdays and one Sunday in the month; and on those days when you had a trying day it was almost impossible to put up with it during the last two or three hours in the evening.

12,094. But that state of things has entirely changed now, has it not?—I do not agree.

12,095. You would not find any hospitals now where the nurses were working for those hours, and where they only got those days off?—They would have more leave, but the long days have not altered.

12,096. That difficulty occurs in places, no doubt?—They have more weekly leave.

12,097. A good many workers would prefer that, would they not? They would rather have, if they could get it, two days off or one and a-half days off in a week?—I think in the rural areas, particularly in the case of the female staff, the majority of them would prefer having two days off in the week; but I should prefer them to have the three-shift system for the benefit of the patients. (*Miss Wiese*): There is a special reason for that. Many of their homes are in Scotland or Ireland, and it means that they have a longer annual leave in that case, and they are able to have longer at home, otherwise they prefer shorter leave.

12,098. I suppose they cannot add their weekly leave to their holiday?—A few days, but it is not usual. (*Mr. Gibson*): As a rule they cannot.

12,099. As a rule now, the time they get is a month in the summer?—Not a month. Three weeks is the maximum leave.

12,100. Now shall we just deal with a matter in which you apparently take a very great interest, and I understand Miss Wiese particularly wishes to give evidence before the Commission on it, namely, the question of the employment of female nurses in male wards. On that matter a certain amount of evidence has already been given to the Commission by doctors and others who have tried this system. I do not know what other members of the Commission may have thought, but personally I have been rather impressed with the view that they take—that the introduction of female nursing to the male side has been extremely beneficial in its results in some cases. I do not think they suggest that there is not a certain class of patient who must be dealt with or a certain class of work which must be done by men, and which cannot be done by women; but the introduction of female nursing on the male side has been tried and apparently with, as I say, extremely beneficial results. Now the view which I understand your Union, and particularly Miss Wiese, wishes to express, is the opposite of that?—Mr. Chairman, I have listened to some of the evidence on that point, but you must remember that more than 50 per cent. of the medical superintendents in England and Wales are opposed to it. You have only heard the views of people who are in favour of it. My view of it is this: it is rather a difficult point to discuss in public, but I have yet to see the medical superintendent who would ask his wife or his daughter to do it.

12,101. I am not quite sure that that is the true test, is it?—I think it is. You see there is a danger unfortunately. You know the very large number of male patients who are suffering from venereal infection, and there is a considerably larger number who are sexually abnormal. If they were normal people one would not think of denying them the attendance of female nurses, but I am afraid of the consequences, of the possibilities, if the system is extended. They have had it in operation extensively in Scotland, and I have submitted a table here in Schedule 2 of our *précis*, from which it will appear that it has not been particularly successful.

12,102. Let us look at that schedule. When I read it I was not very much impressed by it. There are two schedules that you put in connected with this. In Schedule 1 you have extracted from the Board of Control Reports particulars of suicides and attacks made by patients on other patients?—That is so.

12,103. I gather that the point of that extract is that the medical diagnosis at the present day is so far at fault that the doctors themselves are not able to say whether a man is suicidal or not, or at all events they may make grave mistakes.—The point of that schedule is this: that I hold it is not possible for a doctor to prophesy the conduct of an insane patient.

12,104. It is not possible to diagnose with certainty what he will do?—Yes, quite.

12,105. Out of 286 suicides which took place in nine years 93 were patients regarded apparently by the medical profession as not suicidal?—Yes, that is so.

12,106. And accordingly one of your arguments with regard to the use of female nurses on the male side is that you cannot prognosticate what will happen in any particular case?—Exactly.

12,107. Are you there dealing, not so much with cases of suicide, as with these unfortunate cases where the insanity is due to a venereal disease, or where people themselves are sexually abnormal?—Where the effect is to make them sexually abnormal. If you will refer to Schedule 1 again you will find in one case, 1921, there was a death from scalding at Wakefield. In that case a female, a young girl, was sent to wash a male patient who was in a filthy condition.

24 February, 1925.] Mr. WALTER BLOOD, Mr. GEORGE GIBSON and Miss MAUD WIESE. [Continued.]

She left him to two male patients; they turned on the hot water and threw buckets of scalding water over him and he died. The nurse was dismissed—three of them were dismissed, and properly so.

12,108. But that is an illustration of an unfortunate occurrence. It does not go to the root of the question, does it?—No, but I suggest to you it is not exactly a proper duty to call upon a young girl to do, and yet it is an essential duty in male wards.

12,109. Yes, but you have got to consider the nurses and the patients. I mean one would not send a young girl to do washing of that kind. The doctors who advocate female nursing in male wards would look upon this as stupid, as anybody else would. Again, that does not go to the root of the matter at all?—But this was carried out in pursuit of a doctor's orders and instructions.

12,110. You know the nurses in an ordinary hospital have extraordinarily uncomfortable and unpleasant things to do from the point of view of the ordinary person?—Surely nothing of that nature?

12,111. Well, there are doctors on the Commission who know more about this than I do, but you may assume that the nurses have very uncomfortable duties to perform in an ordinary hospital, and they must necessarily have very unpleasant duties to perform in a mental hospital, but the one or two particular instances such as you give do not seem to me to go to the root of the matter. You must remember this, that on the male side it is possible considerably to classify the patients. They are not all of the same nature. One would imagine that female nursing might be extremely good in respect of certain classes, and yet might be dangerous in other classes which could be avoided by classification?—I am suggesting that the doctors cannot possibly classify them so exactly as that, and the distinction between a general hospital and a mental hospital is this: in a general hospital there is no fear of assault or abuse in the performance of their duties, whereas in a mental hospital that is an every day occurrence.

12,112. That would be so, speaking generally, I suppose?—I think Miss Wiese's experience has been that she has had to put up with it when working in a male ward. (Miss Wiese): And also a patient in a general hospital is able to do things for himself that a woman has to do in the case of a mental male patient, most objectionable things. I cannot say all I feel about it here.

12,113. You have had practical experience of this?—Yes, and I feel very strongly about it. I do not think women ought to be allowed to do it.

12,114. *Sir David Drummond*: May I ask Mr. Gibson a question? What is the bearing of the incidence of syphilis in the patient's case upon this question we are now considering?—The bearing is this: I think in very many of the cases where there is a history of syphilitic infection they are sexually abnormal, and I think also in military hospitals they generally have male orderlies to handle such cases.

12,115. Yes, but I cannot see the bearing, as you put it; 5 per cent. of the cases are due to syphilis, and that is a reason why women should not nurse these cases?—Quite. I think that an insane patient suffering from syphilis is in quite a different category from a sane patient. He has to have things done for him that a sane patient can do for himself.

12,116. Are you speaking of secondary syphilis, or of tertiary events?—I am speaking generally, of the general paralytics.

12,117. I know. I quite fail to see the bearing of the fact that a patient has syphilis upon this question at all. I can understand the abnormal sexual instinct.—If I may put it in this way: there is a general hospital in London where they started a ward for the treatment of incipient general paralysis of the insane cases. They found that the nurses would not work in it. It is the subconscious effect on the female nurses.

12,118. I think we all agree with the Chairman that the question very largely turns upon classification.

12,119. *Deputy-Chairman*: I am going to ask Miss Wiese this question. You have had actual experience of this, as I understand?—(Miss Wiese): Yes.

12,120. And, in your view, there is no more repulsive or degrading work for women than this work of nursing male mental patients?—Many of them.

12,121. You suggest that the patient regards the nurse so much from a sexual point of view?—Yes, many of them do.

12,122. Without any sense of decency of any kind?—Yes.

12,123. And you suggest that is so in the case of people who would be classified as unobtrusive and quiet cases?—Yes; quite feeble old men will insist upon undressing themselves, and that sort of thing.

12,124. You were three years in a male infirmary ward?—Yes.

12,125. That male infirmary ward was in a mental hospital, was it?—Yes; that was during the war, when most of the men had gone to the front, and the staff was depleted. There were four wards opened and staffed by women, but as soon as the men came back, back went the women. I do not know why.

12,126. Was it in the hospital where you are at Claybury?—Yes.

12,127. *Miss Madeleine Symons*: Miss Wiese, have you found that the view you have expressed is the general view of the women members of your Union who have nursed on the male side?—It certainly is the view of my colleagues who work with me.

12,128. At Claybury?—I cannot say I have met many women in other hospitals who have done this work.

12,129. *Deputy-Chairman*: Has this question been at all discussed by the Union?—(Mr. Gibson): Yes, frequently.

12,130. Have you issued questionnaires to your branches about it?—Yes.

12,131. Have you got a general response in general agreement about it?—They are generally agreed that it is a practice that is objectionable.

12,132. Have you been present here a good deal while the evidence has been given?—Yes.

12,133. Again, we have had some very striking evidence by one or two men of great experience?—You have had evidence on this point from Dr. Edwards of Camberwell House. There, again, you have a private licensed house, and, if I may say so, without any suggestion of being offensive, there is the question of private gain to be considered there—female nurses are cheaper. There is also this point of view, that in a private licensed house they can, and do, choose the type of patient.

12,134. *Sir David Drummond*: That is classification again?—Well, it is classification in a way. I mean to say they simply do not admit certain types of cases. They say: "No, we will not take epileptics or general paralytics."

12,135. *Deputy-Chairman*: Dr. Edwards of Camberwell House is very strongly in favour of it, is he not?—Yes.

12,136. In that particular hospital there would be a good many cases of general paralysis of the insane?—I do not know, but I think there are some cases that they do not take. I am not certain about that point.

12,137. As far as my recollection goes, the impression left on my mind was that in every case where the doctors had tried it they had found it satisfactory?—The way I have heard it put is this: the doctors said that where they had tried it the wards were much quieter, but that occurred in this manner. In the case I am referring to I have knowledge of the wards. They filled the wards with

quiet cases when they put in female nurses. Of course they were much quieter. Another case is an asylum in the north of England where they experimented with female nurses. They put the female nurses into a ward where previously they had all the phthisical patients segregated; a large number of the patients suffering from phthisis were unsuitable to be nursed by female nurses, so they immediately distributed them all over the male wards. That is a question of fact. I can give you the name of the institution.

12,138. It does not sound to me very likely.—It occurred. As a matter of fact, I went up and interviewed the Committee, and the Committee, against the wish of the medical superintendent, put male nurses back in this ward and restored the phthisical cases. When you bring female nurses on to the male side and put them into a ward and specially select the cases, it means, of necessity, that you must scatter in the other wards cases which are not suitable to be there, because you cannot classify the patients according to a disease, not even according to a mental disease. I do not know what the ultimate basis of classification will be, but I am perfectly certain it cannot be according to the mental infirmity.

12,139. It cannot at the present moment?—And never will be. I cannot imagine, for instance, how it would be possible to run a ward with no other type of patient in it but general paralytics or a ward with no other type of case but cases of melancholia.

12,140. You mean you will never get a perfect classification?—You cannot classify on the basis of mental infirmity. They will probably have to be classified on the basis of conduct, but if you classify on the basis of conduct for the purpose of bringing in female nurses in one ward in which you have well-conducted patients, you will have to scatter the patients suffering from infectious disease throughout the other wards, simply because they are not suitable to go and stay where the females are.

12,141. It strikes one that may or may not be so. I do not see why you should say necessarily it would be so?—I say in practice it has been so.

12,142. That again seems to be a question of arrangement?—I am afraid the ramifications of an arrangement to suit all these cases make it out of the question.

12,143. Now you set out a second schedule which you rather suggest shows that the result has not been satisfactory where the women have been introduced?—The second schedule struck me as rather remarkable, considering that it was over a period of years, because we have always understood that institutions in Scotland were much superior to the institutions in England, that is, mental hospitals, and there is no doubt that the Lunacy Law in Scotland is superior; but since the War, it is a remarkable fact that the death rates in Scotland are higher and the recovery rates lower than in England. That is not one year. Taking it on the average for six years, 1918 to 1923, you will find that the recovery rates in Scotland are lower and the death rates are higher.

12,144. Certainly in the last four years the death rates in Scotland have been higher.—Yes. Of course, 1918 was an abnormal year.

12,145. I suppose these death rates per cent. are calculated on the actual number of people in the asylums?—The average number resident during the year.

Deputy-Chairman: Those are intelligible; but when one comes to look on the other side, I confess they do not carry much weight: "Recovery rates calculated on direct admissions."

12,146. *Sir David Drummond:* Do you think it reasonable? In arguing against the employment of female nurses, you speak of the relative death rate, or rather the recovery rate in England and Scotland. If the results count for anything, the effect of the

employment of female nurses is disastrous. Then you turn over and you find that after all, the difference between England and Scotland is not very great. It is 26 and 23, 31 and 26, 31 and 39, 31 and 30, 31 and 28, 31 and 30?—Will you refer to the death rates?

12,147. No, I am speaking of the recoveries. You do not mean to ascribe it to the employment of women nurses, do you?—No, not entirely.

12,148. That is what you do here at the top of page 4. If the results count for anything, the effect of the employment of female nurses upon the patients is disastrous?—The point of view is this; we have been told that where they have employed female nurses in male wards it has been a great advantage, and it is a much more common custom in Scotland than in England. When we find in practice that the death rates in Scotland have been considerably higher (you have in 1920, 10·2 as against 8·7 in England; in 1921, 11·1 as against 8·4; in 1922, 11·2 as against 9; and in 1923, 9·6 as against 7·7) I can scarcely find where the advantage comes in.

12,149. But you would not ascribe it to the employment of women nurses?—Not entirely; but I do say, on the other hand, that I cannot see where they can prove that any advantage has accrued. There appears to be a considerable disadvantage.

12,150. *Sir Humphry Rolleston:* Do you know when the introduction of female nursing in cottage hospitals took place?—It took place a long time ago, but in general practice it has only been in the last three years that it has increased to any proportion. I think that, before the War, in Scotland they generally had a high recovery rate, and in England the death rate was about the same.

12,151. And during the War there was a larger incidence of female nursing?—I think during the War and since.

12,152. Have you calculated the incidence of female nursing in certain hospitals with the recovery rates?—The point which I wanted to make was not so much that female nursing was the cause of this, but the bringing in of female nurses meant the scattering of phthisical cases throughout the institution, and the spread of infection, and in practice I say that that did occur; in order to select patients by conduct they had to send patients, who otherwise would have been segregated, into other wards.

12,153. *Deputy-Chairman:* Now there is only one other matter I want to deal with in your *précis* relating to the staff, and that is your suggestion that special diseases common to mental hospitals should be scheduled as industrial diseases under the Workmen's Compensation Act for the purpose of protecting the staffs?—Yes. If I may explain that, the point is this: under the present arrangement there are very many mental hospitals where the staff, immediately they go off sick, go on half pay; in some other cases they have one week's full pay, and then they go on half pay.

12,154. Is that by arrangement with the hospital, do you mean?—No. Most of the mental hospitals have been exempted from the provisions of the Health Insurance Act by guaranteeing what the Commissioners consider to be equivalent benefits. Some of them have said, "We will pay half pay for three months in the case of illness." It seems unfair to me and disastrous to the nursing spirit, if you ask a nurse to nurse a case of colitis, and if they contract it themselves, you say, "You go on half pay," and yet that actually occurs. It seems rather unfair to a nurse. Sometimes where the disease looks like being disabling they give them a month's notice, return their superannuation contribution and finish with them.

12,155. Under the Superannuation Act of 1909, is there no provision except for superannuation?—After the first 10 years of service—not during the first 10 years.

24 February, 1925.] Mr. WALTER BLOOD, Mr. GEORGE GIBSON and Miss MAUD WIESE. [Continued.]

12,156. During the first 10 years is nothing provided?—No, except that they return the superannuation contributions.

12,157. Nothing else?—Nothing else.

12,158. But if you got the benefit of the Workmen's Compensation Act in the case of death, would you not be in some danger of losing your benefits under the Superannuation Act?—I do not think so. Under the Workmen's Compensation Act I think the maximum benefit permitted is half pay, and in the case of commutation of a pension any other sum received is taken into account.

12,159. I forget how it is awarded in the case of death under the Workmen's Compensation Act?—In the case of a lump sum payment, I believe any payment out of the funds of the institution is taken into account. I am not prepared to dogmatise on that point.

12,160. It looks to me as though in the case of death the two Acts might overlap and you might get into some trouble.—During the first ten years of service there is no provision for payment in the case of an officer who dies in the service.

12,161. The figures given in your schedule do not seem to show that these can be treated as industrial diseases if you take colitis and typhoid.—They do not die from them, it is very infrequent, but they frequently have them as a disabling disease for a period of weeks.

12,162. The death claims for phthisis, of course, are very considerable?—Yes.

12,163. But it would not do, I imagine, from a medical point of view to put down all these cases of deaths as though the infection were taken from the patients?—I do not ask that. I mention in the other schedules the particular diseases to which they are liable. We have ten cases here of partial disablement—cases of enteric.

12,164. But you do not put down colitis there?—These payments are only made in respect of patients who have been ill for 13 weeks.

12,165. Does your Union make payments in these cases to your members?—Yes.

12,166. And certain payments are made by the hospitals, are they not?—Yes.

12,167. Then I suppose you supplement those?—If they have an illness for a period of 13 weeks we make what is called a partial disablement grant to them.

12,168. Perhaps you will not forget to let us have a copy of your rules.—I will most certainly send you a copy.

12,169. *Sir Humphry Rolleston*: Before we leave this subject of the partial disablement claims, might we have the numbers to which these 501 cases refer? I think that is rather important.—(*Mr. Gibson*): They are from the total membership of the Union, from those who have complied with the rules.

12,170. From 11,000 members, that is the number?—Yes.

12,174. *Deputy-Chairman*: That is four years?—Yes. It is an average of 125 claims per annum. I want to make it clear that these have no reference to any case of illness for a period of less than 13 weeks.

12,172. *Mrs. Mather*: Men and women?—Yes.

12,173. *Miss Madeleine Symons*: Your trade union benefits are all together, are they? All your members contribute to the provident benefits?—Yes.

12,174. *Deputy-Chairman*: That is four years?—Yes. It is an average of 125 claims per annum. I want to make it clear that these have no reference to any case of illness for a period of less than 13 weeks.

12,175. Now, Miss Wiese, would you kindly add what you want to say about the female nursing?—(*Miss Wiese*): The General Nursing Council will probably take over the examinations of mental nurses. One of their rules is that nurses must obtain six

months' practical bedside nursing. In most mental hospitals it is exceedingly difficult for matrons to enable their probationer nurses to have this training. If women are going to do sick nursing in male wards it is going to be obvious that the male nurses will not get very much training so as to enable them to sit for the State examination. There is that point, and it is a very big question.

12,176. But there must be comparatively few men nurses applying for the General Nursing Council's certificate?—We want more to become proficient, and to pass their examinations. (*Mr. Gibson*): There are very few of either sex. The General Nursing Council registers mental nurses. That is one of the provisions for the registration of a mental nurse, he must have had six months' clinical work. (*Miss Wiese*): Yes, or before he can sit for the examination at all he must have had this experience.

12,177. Before he can sit for the Medico-Psychological or the Nursing Council examination?—No, the State examination; and it is very essential that he should have had that experience. That is one of the drawbacks.

12,178. Are there many men who apply for that certificate?—We want to induce them to.

12,179. I do not quite follow what advantage they get by that?—What if the M.P.A. give it up, as they will do in time? (*Mr. Gibson*): The General Nursing Council is now a statutory body, with powers conferred upon it by statute.

12,180. The suggestion is that they will ultimately supersede the other?—Yes.

12,181. I want now, Mr. Gibson, if I may, to consider for a moment the relationship subsisting between the nursing staff and the patients. It is not the easiest thing in the world for you to give me the facts, or for me to put questions, but may I first put a question in a very general form? I do not know whether you can answer this so well perhaps as Mr. Blood. What I want to know is: What should you say is the normal atmosphere of a mental hospital? Is it that of a hospital, or is it that of a prison, if you understand what I mean?—(*Mr. Blood*): I think it is decidedly the atmosphere of a hospital.

12,182. That is to say, it is a place where the welfare and comfort of the persons who are being nursed are looked after, and are in the minds of the nurses throughout?—Decidedly so.

12,183. You are speaking of your own experience, of course?—Yes.

12,184. You have been a great many years at Rowditch?—Yes.

12,185. Of course you all know the sort of reports that are made, the sort of statements that are made about the cruelty of the attendants, and so on. All you can do, of course, is to tell us what your personal experience of these places is?—(*Mr. Gibson*): The atmosphere I have found is generally perfectly friendly, but I think there are some things about the present organisation of a mental hospital which somewhat militate against the proper atmosphere. I know that the relationships generally between the staff and the patients are perfectly good. As a matter of fact we have had on occasions difficulty about members of the staff who have taken patients out to football matches and concerts quite voluntarily in their own time, and in one or two cases they have lost them and got into trouble.

21,186. But, speaking generally, of the atmosphere of these places, Mr. Gibson—you, of course, have visited a large number of them?—I have worked in them too.

12,187. And you know an enormous number of workers in these places. What is your view as to their regard for the welfare and comfort of the people in their charge?—I think the general charges of cruelty are absolutely unfounded, but I am perfectly

24 February, 1925.] Mr. WALTER BLOOD, Mr. GEORGE GIBSON and Miss MAUD WIESE. [Continued.]

prepared to admit that occasionally cases happen, and I am afraid that until you change human nature they will happen. The provocation sometimes is very trying. I remember on one occasion having to restrain a medical man, who was going to take on a patient who had been challenging him to fight every day for about six weeks.

12,188. The provocation, of course, in certain cases is almost unbearable, and human nature being what it is, from time to time there will be an outbreak on the part of an attendant?—I think that is the case, Sir, particularly with junior attendants, not because of their own fault, but of their misfortune. They do not know exactly what they have come to do, and they do not realise the patients' position and peculiarities. They are put into a ward on duty immediately. I perfectly well remember the first day I commenced in an asylum I was put into a ward full of chronic demented. There was one patient in that ward who used to play draughts and chess a great deal, but he had a delusion that anyone switching on the electric light was putting current through his body. I switched on the electric light without knowing of this peculiarity, and the draught board just missed my head. I think it is unfortunate that there are so many changes in the staff. There are figures in the Board of Control's Report where they have had cases of assault, and they usually find it happens with junior members of the staff.

12,189. Personally I have had very small experience, but the small experience I have had has rather suggested to me, when I have seen the inside of one of these places, that it was almost like a home rather than like a prison, and that the patients and attendants were on the best of terms; but a suggestion has been made, you know, that it is impossible to pay a surprise visit at all to these institutions?—In practice I think it is impossible to pay a surprise visit.

12,190. They say that if one of the members of the Board of Control comes round, or if one of the members of this Commission comes round, it gets known, and in a very short time there is a sudden transformation so that the normal life of the inside of the place can never be seen by an official. Do you think there is any truth in that suggestion?—I would not go so far as that. In my experience we generally did know when the Commissioners were coming; invariably we know. If they were within 100 miles we were told so on the telephone, they came in the uniform of the profession, tall hats and frock coats, and if we did not get to know on the telephone that they were in the vicinity, the hotel they stayed at was always known, and the hotel manager immediately telephoned up and told us who was there.

12,191. In the case you were indicating, were any special steps taken?—I will be perfectly frank. What happened was this: they went round and they changed the patients' neckties, and those who had not the best of jackets got better clothing. I want to put the position exactly as I saw it. I hold no brief for the administration at all. But there was no such thing as cleaning out rooms; you had not the time to do it; but you could smarten up the patients; and in particular, books and periodicals were laid upon the table which would not have been there had the Commissioners not come, and the general air of the place in that way was improved.

12,192. Mr. Blood, what has been your experience of that?—(Mr. Gibson): Mr. Blood is still in the service. (Mr. Blood): I have found that a little, but I remember last year when the Commissioner came round he went round a ward and found them bathing in the bath room, and the dormitory was all upset, the clean linen had just been fetched from the laundry, and everything was upside down. He said how pleased he was to find them just as he wanted to. We do sometimes get to know that the Commissioners are about, in fact we are expecting them

now, but, generally speaking, we have not the time to make any preparation.

12,193. Generally speaking, would any visitor see the hospital practically in its normal condition?—Certainly.

12,194. Do you think that the charge that the attendants are indifferent to the welfare and comfort of their patients is well founded?—I do not, I think it is decidedly ill-founded.

12,195. In your experience?—Yes.

12,196. You would not expect that either, would you, Mr. Gibson?—(Mr. Gibson): I entirely disagree with that charge. (Miss Wiese): I absolutely disagree with it. I find that nurses interested in their work will do any mortal thing for the patients' comfort. A question was raised about the letters of the patients. No one suggested that the nurses very often write letters for the patients, as I have done, and the nurses in my ward have very often done so. (Mr. Gibson): It is not evidence, but it may be of interest. There are two patients in Manchester who were at the institution when I was there and they are still very great personal friends of mine.

12,197. It is suggested sometimes that there is no form of remedial treatment in the wards at all?—(Mr. Blood): That is rather lacking, I must admit.

12,198. But when you say it is rather lacking can you suggest that anything could be done which is not done?—I think it is usually lacking through the lack of staff. You have not sufficient staff to see to the condition of the patients, the cleanliness of the patients and of the ward, and to take the patients out for fresh air. You have hardly the staff to do that irrespective of any curative treatment.

12,199. You are understaffed for the purposes of ordinary routine daily work?—Yes. (Mr. Gibson): It appears to me that the lack of remedial treatment is due to the lack of medical knowledge on the subject. They might go further by providing more recreation and more indoor amusements for the patients.

12,200. I understand that Mr. Blood's suggestion is that that would be possible if you could increase your staff. (Mr. Blood): Yes.

12,201. But when it comes to a question of any alleged systematic ill-treatment, what do you say to that?—It is entirely unfounded. (Miss Wiese): I always find that nurses will avoid conflict where possible, but when patients attack each other something must be done. It is nothing at meal times to see patients throw mugs at each other; you must intervene then. The patient resists, and there is trouble in that way more often than not, but my experience is that we always avoid it where possible. More often than not the patient gets the best of it; that is my experience. (Mr. Blood): My experience also is that there is usually some happening in the first place for this alleged cruelty to follow on. I have a patient in my place who has a delusion that I have killed his father and buried him under his room floor. Consequently that patient is constantly watching for an opportunity to find me by myself, and on two occasions he has attacked me, once within the last week. That again is owing to the lack of staff. Another case is this: a dormitory with 50 to 60 patients in bed; the nurse responsible for the cleanliness of that dormitory has the instruction that he must encourage the patients to make their beds when they get up. He went to one of the patients in the morning to get him to make his bed. Without another word that patient struck the attendant and knocked him down on the floor and followed up the attack. What is that nurse to do? As a matter of good fortune it so happened that in both cases there were other attendants who came and restrained the patient. It is a question of self-preservation really, without any cruelty. I think that is where the alleged cruelty comes in. The patients exaggerate what has happened; the public

24 February, 1925.] Mr. WALTER BLOOD, Mr. GEORGE GIBSON and Miss MAUD WIESE. [Continued.]

get to know of it, and from that you get your alleged cruelty. (Mr. Gibson): I think I might put it in this way: as a well-known newspaper proprietor

used to put it to his reporters, "When a dog bites a man it is not news, but when a man bites a dog it is."

(After a short adjournment.)

12,202. *Deputy-Chairman*: Mr. Blood, I should like an expression of opinion from you on this matter. It has been suggested that from time to time the patients incur the displeasure of some of the attendants, by reason of their conduct, no doubt, and it is suggested that in those cases, when the time comes for the patients' discharge to be considered, the attendants or the nurses will keep back these patients, so that they do not get a proper chance of being seen by the visiting committees or by the doctors. What do you say with regard to that?—(Mr. Blood): I do not think it is possible for it to be done, because the patients have free access to any visitor or to the medical superintendent to say anything. I have never known it happen in my experience, and I have never known any hostility on the part of the attendant towards the patient.

12,203. No animosity between the two?—Or any animosity.

12,204. It has been suggested that there is sometimes such a feeling of animosity, that the patient has been goaded from being a quiet and reasonable person into a refractory subject. Has any instance of that kind come to your knowledge?—I do not think I know a case of that description.

12,205. *Earl Russell*: There may be some impatience with troublesome and dirty patients?—Yes, but in that case they would not be patients capable of causing any actual violence; they are usually of a demented character.

12,206. *Deputy-Chairman*: Of course, from time to time, there must of necessity be cases of impatience and retaliation, human beings what they are. That is a very different matter?—(Mr. Gibson): I think you referred to patients ready for discharge?

12,207. Yes.—One cannot imagine any patient ready for discharge being dirty or in a demented state, and liable to animosity on that account. Part of my experience is that nurses are not consulted at all about discharge. I have felt many a time that I would like to recommend a patient for discharge.

12,208. In your experience did you ever know of nurses keeping back patients from getting their discharge?—No, not at all. Of course, I never actually did duty in a convalescent ward. My routine was that so soon as the patient showed any reasonable improvement he was removed to one or other of the convalescent wards.

12,209. *Earl Russell*: Would that be thought a liberty, if an attendant called attention to the general improvement of the patients?—I do not say that is a general rule, but it has been asked where you got your medical degree, if you ventured to express an opinion without being asked.

12,210. *Deputy-Chairman*: It is suggested that sometimes patients have been detained from discharge because they are so useful in the institution. What do you say with regard to that, Mr. Blood?—(Mr. Blood): I should not think it has happened. To my knowledge it has never happened. There are some useful patients that would not be able to look after themselves if they were outside, but it is really for their own benefit if they are kept. While they are under the institution's administration they are quite all right, while there is someone just to see they are regular in their meals.

12,211. Do you think there is any truth in the charge that they are kept back, although they ought to be discharged, because they are useful?—Certainly not.

12,212. Now you, Mr. Blood, as a nurse of many years' experience, could answer this question: Do you think that there is, as far as you can judge, an excessive use of sedatives, or purgatives, in the case of these inmates?—No. In my experience I have never known croton oil used at all; it has never been used in the hospital where I have been at all. I believe for some years there was some in the surgery, but it was never used in my experience since I have been there. The only draught that is given is a sleeping draught, a weak sleeping draught; that is sometimes given, but very seldom indeed, and that is only in the case of a maniacal patient.

12,213. Perhaps I might ask you that same question, Miss Wiese, with regard to sedatives and purgatives in your experience?—(Miss Wiese): They are never given unless they are absolutely necessary. Even if a patient is put on it, a nurse is allowed to use her own discretion as to whether she gives it.

12,214. As a rule, would a nurse have a discretion in those matters?—Most nurses would. (Mr. Gibson): Discretion in withholding, not discretion in giving. (Miss Wiese): She is allowed only to give the maximum dose, but usually she withholds that. Besides, it has more effect if the patient does not have it regularly.

12,215. But the nurse would be acting under the doctor's directions?—Certainly; even an aperient is only given subject to the doctor's approval. He has to sign for each dose given. (Mr. Gibson): If I may say so, the custom has altered considerably in these matters. About 20 years ago the custom was to have a stock bottle of aperients and sedatives. The general practice to-day is that every dose of medicine is prescribed and is sent from the dispensary, labelled with the patient's name.

12,216. *Earl Russell*: And is it the practice to return into stock such doses as are not administered?—Yes.

12,217. *Deputy-Chairman*: Now, there is one other question about the patients and the visiting committee. In your case, Mr. Blood, you have a visiting committee who make periodical visits?—(Mr. Blood): Yes, once a month.

12,218. In your experience of these visits, are they what would be called effective visits—that is to say, can the patients get an interview with the committee?—Certainly. The visitors come into the ward, and the patients are there; they have free access to the visiting committee, and the visiting committee have free access to the patients in the respective wards. They go from ward to ward.

12,219. You know it is suggested that these visits are perfectly casual. They come into a ward and look round, chat to one or two people, and perhaps take no heed of the conditions of the patients themselves?—In my experience they take a very great heed of the condition of the patients.

12,220. Of course, you can only speak for your own institution?—Yes.

12,221. Miss Wiese, does that apply also in your case?—(Miss Wiese): I think so, in most cases. If there is a real grievance the patient would write to the visiting committee, and they would see that patient. On the other hand, if the visiting committee heeded every case of complaint, they would probably spend three weeks in each institution. They have often to cut off a conversation.

12,222. But, as far as you can judge too, they do their duty in that respect? They can see at once that with many patients it is idle to proceed further. Do you think there would be any reasonable and ordinary chance of a patient who really was fit for

24 February, 1925.] Mr. WALTER BLOOD, Mr. GEORGE GIBSON and Miss MAUD WIESE.

[Continued.]

discharge not being able to get at the visiting committee to procure his discharge?—I have never known a patient who is well enough to go kept back either by the nurse, the doctor, or the visiting committee. As regards that, when a patient is admitted she sees the medical officer weekly for three weeks, and then monthly for three months, and then every three months, so that she is always under observation, practically.

12,223. Mr. Gibson, you understand why I put these supplementary questions?—(Mr. Gibson): Quite.

12,224. Because really the most material evidence for us is the evidence of what is happening to-day in institutions?—Quite so. There is one point before you depart from that. We were discussing the question of cruelty, before lunch. I should like to refer you to pages 189 and 190 of the book called "The Experiences of an Asylum Doctor," by Dr. Lomax. I have been much impressed with the *précis* of one or two allegations of cruelty sent to me. I have been impressed with the fact that they are generally third party charges.

12,225. Is it under the head of cruelty to which you refer?—It is here; may I read it; it is very short?

12,226. If you please.—He is speaking of his experience in his mental hospital work, and he says: "As I have throughout this book commented adversely upon so many features of asylum administration, I should like to put it upon record that in my experience the character and behaviour of the male attendants with whom I had to do, for I had little experience of the female attendants, especially of the Head Attendants and Ward Charges, left on the whole a distinctly favourable impression upon my mind. They had their faults, of course, and I have not hesitated to mention such of these as, in my opinion, militated against their efficiency. But these seemed to me to be much more due to the defects of the system which they had to administer and under which they were trained, and to the monotony and dreariness of their life, with its many repulsive sights and sounds, than to any deficiency of kindness and good nature."

12,227. I am much obliged. Do you wish to add anything further on that?—That is the only reference I want to make particularly about that matter. I thought it was desirable.

12,228. In the suggestions you make, one relates to the dietary of the patients?—Yes.

12,229. Perhaps, Mr. Gibson, you could say generally what the view of the attendants is on the matter?—There has been some improvement since the War in the best institutions, in those in the large urban and industrial areas, but many of the institutions in the rural districts are still very deficient in that matter. We feel in particular that the morning and evening meals should be improved, and above all there ought to be a supper provided.

12,230. You mean that it is too long to go from tea to breakfast?—Much too long, especially when the last meal consists of bread and margarine, as it does at present.

12,231. Is not that at present rather a rare occurrence? Are there not other provisions added?—I do not think so. I think it is fairly common yet.

12,232. How would that work out in your establishment, Mr. Blood?—(Mr. Blood): At my institution I have the pleasure of saying that I am quite satisfied that the dietary is quite sufficient and good, and of very high quality, and they do get supper, they get a variation at breakfast, meat and bacon, at tea, cake and scones.

12,233. Earl Russell: What do you say about the difficulty that was raised on that point of serving a late meal?—(Mr. Gibson): You refer to Dr. Barham's point? A supper meal does not need a staff in the kitchen at all. I think the Commission have had an opportunity of seeing the domestic arrangements

in these large institutions. The dry rations for supper can easily be drawn during the day, and all that is required is a member of the staff and a patient to go up and bring down two cans of tea for each ward. Under the same Council that Dr. Barham works, supper is provided at one or two institutions.

12,234. You say there is no practical difficulty?—No practical difficulty whatever.

12,235. Mr. Snell: It is a cold supper with tea?—Yes. In the old days when we had dances buns were provided; they were drawn during the day and when the patients came back from the dance coffee was brought down from the kitchen and they had buns and coffee.

12,236. Are you suggesting that that should be a real meal, or something to go to bed with?—If they were given something before they went to bed, it would be very beneficial to the patients.

12,237. Deputy-Chairman: In the best of institutions they are now making the sort of provision you think is wise?—Not the supper provision. Those who have gone to bed would not get it.

12,238. For instance, we have it in the case of Mr. Blood's institution.—I think if you follow it further and ask Mr. Blood whether they all get it, you will find they do not. (Mr. Blood): In the mental hospital I am employed at they do get a supper.

12,239. It is suggested by Mr. Gibson that those who have gone to bed would not get supper?—There are not many gone to bed. They are on special diet in the sick ward. (Mr. Gibson): That may be taken as exceptional. (Mr. Blood): It is an exceptional thing, of course.

12,240. Assuming that to be exceptional, if it were made general, that, of course, would meet your suggestion?—(Mr. Gibson): Quite.

12,241. Now a question as to the clothing of the patients in institutions.—Before you go to that I would like to refer you to a statement made by the medical superintendent of a Staffordshire institution. He said it was no good medical superintendents or the Board of Control recommending things; Committees are now out for saving on the patients' dietary. I think that reference was made at a conference held between the Board of Control and medical superintendents and the chairmen of visiting committees.

12,242. What that statement means is this, is it not, that it is no good having a merely advisory body, you want to have a directing power?—Exactly.

12,243. And that applies to other things besides this—not merely the question of diet, but a good many other matters of interest?—Yes.

12,244. Now with regard to the question of clothing: in the majority of the institutions the patients can have their private clothes, cannot they?—I do not think so, not in practice; it is very infrequent that they can.

12,245. If not, they are not supplied with uniform, are they?—It is not a uniform, but in general it is fustian clothing, and the male clothing when it is new is fairly presentable, but you have many extremely dirty cases; the clothing has to be washed, and it is washed in an ordinary laundry and mangled, and it comes out shapeless. I am sure that has a very bad effect on patients of any refinement of feeling when they are dressed up in clothing of that description.

12,246. Yes, one knows the effect of that sort of thing. You think there is room for improvement there?—I think there is room for very considerable improvement. If better clothing were provided initially, and if it were dry cleaned and pressed it would be very much better.

12,247. Then you suggest that in many cases further provision is necessary for the recreation of patients, bowling greens, tennis courts, and so on. I suppose that is so?—I particularly refer to outdoor recreation. The Commission have heard a good deal about the cricket and football matches, but in practice there are

24 February, 1925.] Mr. WALTER BLOOD, Mr. GEORGE GIBSON and Miss MAUD WIESE. [Continued.]

only 11 people who can play cricket, and 11 people who can play football.

12,248. A good many look on?—A good many look on. It is very distressing to see them looking on. It is very distressing walking round these airing courts hour upon hour with nothing to do.

12,249. You suggest that many of those would be able to play on a bowling green?—Bowling is a game that could be easily played, and they could be under supervision while they were playing. In the case of bowling and tennis I think the facilities could very well be increased.

12,250. Like other institutions we know of, if you could spend sufficient money on them you could very much improve the general condition and amenities, and so on?—Quite.

12,251. You make a suggestion too that there should be more payment than is now made for work which is done?—I think that emanated from Dr. Lomax originally, but I am very much in favour of it.

12,252. I think another doctor suggested it before Dr. Lomax, but, however, it has been suggested. At the present time, the payments are very small?—At the present time what generally happens is that the charge nurse of a ward is given a certain amount of thin twist tobacco, and on the female side it may be snuff and tea, and the working patients are given a small amount per week. They do not all use it, and it has appeared to me that if they were given a credit voucher and allowed to exchange it at the stores for anything they wanted, even to supplement their diet, it would be a desirable principle to be adopted.

12,253. Then you suggest the abolition of nurses' key chains. That is a new point to me?—In most of the institutions the nurses' keys have to be guarded of course against loss, and there is a huge chain on them that would almost hold a steamship. It appears to give a prison like air to the institution. It almost appears as if there were a baton on the end of it.

12,254. *Earl Russell*: That is perfectly true, but, on the other hand, you must have means to prevent the patients grabbing the keys?—Quite. I think a leather chain would be less obtrusive and would serve the same purpose. (*Miss Wiese*): In the London County Council mental hospitals a linen belt is used, which is just a small strip made of dress material to hold the keys. Most of the nurses carry them in their pockets.

12,255. Is that strong enough to resist a pull by a violent patient who might try to steal them?—It is not strong enough for that.

12,256. It is not much use, is it?—Still, we have had no casualties from them. I think it is much more desirable than a long chain dangling about with a pair of scissors attached to the end.

12,257. Also it makes a jangling noise when you move about?—Yes. I think it is a necessary improvement.

Deputy-Chairman: It is a small matter, but one which should be considered.

12,258. *Mr. Snell*: Is there any wish on the part of the patients to have the keys?—(*Miss Wiese*): Yes; but they usually go for the nurses' hair more than the keys.

12,259. The point in their mind is that if they could get the keys they could get out—is that it?—(*Mr. Gibson*): Exactly; yes.

12,260. *Deputy-Chairman*: Now I think I have dealt with the main points in your *précis* relating to the nursing staff and to the patients. You do, in addition, make certain suggestions as to possible amendments in the general law and practice of lunacy?—Yes.

12,261. If there is anything you specially want to tell us, do so by all means, but I am not quite sure that you can give us very much assistance there?—Of course we have not gone into the technicalities of the lunacy laws; it is not our business, but it has appeared to us that it is unfortunate that there should be so many different controlling authorities

dealing with the administration—the Lord Chancellor, the Board of Control, and various other people, and we think that the law should be centrally directed.

12,262. Putting it quite shortly, is this what you suggest. At the present time you say there is a multiplicity of these local authorities?—And of central authorities.

12,263. Well, a multiplicity of central authorities to some extent, but the main difficulty would be the autonomous local bodies. They would make their own provisions and go their own way?—Yes.

12,264. Your suggestion is that there should be more power given to some central body, without indicating exactly what that should be, whether it should be the Board of Control, or some jurisdiction under the Ministry of Health, or some other body; but you think there should be some more directing power given to affect all the hospitals—is that right?—Most emphatically I do. I think the central body should have more power, and should have power to withhold the Government grant.

12,265. *Earl Russell*: So far as the national authority is concerned, it does in fact resolve itself into the Board of Control?—It does.

12,266. So that you have not much there to complain of in practice?—I think the Board of Control personnel should be strengthened.

12,267. So far as there being the one body, they practically do advise these other bodies when there is anything to be done?—Unfortunately their advice is only advice; they have no statutory authority.

12,268. *Mr. Snell*: Is it the opinion of the Asylum Workers' Union that the powers of the Board of Control should be increased so that they would have coercive as well as advisory powers?—Yes, we think, as in the case of the police service, there should be power to withhold the Government grant where an institution does not satisfy them that it is efficiently conducted.

12,269. *Earl Russell*: That is, in fact, our usual method of controlling local authorities?—Yes.

12,270. *Deputy-Chairman*: But where we are dealing with the local authorities and these mental hospitals there is no grant made to them year by year; they provide the whole cost from their own funds?—No, there is a grant; not made to the local authority, but made to the board of guardians under the Local Government Act of 1888.

12,271. To the board of guardians in respect of their particular patients?—Yes, but we are suggesting that the board of guardians should be cut out of this matter altogether; that the Government should contribute to the maintenance of the patients.

12,272. *Earl Russell*: And that the grant should be made to the county or the borough, as the case may be?—Yes.

12,273. *Deputy-Chairman*: I was thinking of the case of an ordinary mental hospital which has been built by a local authority pursuant to the Act. They are responsible entirely for the maintenance and upkeep, and for finding the money. In respect of their Poor Law payments they will get an allowance from the guardians?—The guardians receive an allowance of 4s. a head.

12,274. You would like that the Board of Control should be given not merely advisory powers in the case of these local authorities, but directing powers, as I understand?—Yes.

12,275. To say a thing shall be done?—Yes.

12,276. *Earl Russell*: That, you realise, is carrying it a little further than withholding the grant?—I think withholding the grant would be the instrument for making it effective.

12,277. Yes, but, on the other hand, if you gave them directory powers you could enforce it equally by a mandamus, if necessary. Are you suggesting that they should have power of control over the local authorities?—Only to the extent of withholding the grant if they were not satisfied that the administration was efficiently conducted.

24 February, 1925.] Mr. WALTER BLOOD, Mr. GEORGE GIBSON and Miss MAUD WIESE.

[Continued.]

12,278. Not beyond that?—Not beyond that.

12,279. *Mr. Snell*: Suppose you have a local authority that is backward and inefficient, would it not be advisable in your opinion that the Board of Control should be able to enforce efficiency upon such an institution?—I think, even under the existing machinery, in such an acute emergency they could do it.

12,280. *Earl Russell*: Only by the force of public opinion?—No; I believe that, in an emergency, under the existing law they are able to take over the administration of the institution themselves.

12,281. I would be glad if you would show me the section?—In an emergency.

12,282. *Deputy-Chairman*: I think I know the section you are referring to, but it does not go as far as that?—I was under the impression it did.

12,283. I think you are referring to Section 247: "If the Commissioners report to a Secretary of State that any local authority has failed to satisfy the requirements of this Act as regards asylum accommodation, the Secretary of State may require the local authority to provide such accommodation in such manner as he may direct." That is the only section of the Act that touches it, and that only relates to providing the asylum accommodation.

12,284. *Earl Russell*: That only extends to the capital expenditure?—I was rather under the impression they had a wider power than that.

12,285. *Deputy-Chairman*: I see you suggest, failing complete nationalisation of hospitals, the Government grant should be increased to 50 per cent. of the maintenance cost. There is no Government grant at the present time?—There is a Government grant under the Local Government Act to the board of guardians, which, in effect, is a subsidy in the case of certified lunatics. In the case of mental defectives, the Government do pay 50 per cent., and I can scarcely see the reason for the distinction.

12,286. Your suggestion is that in the case of the insane under the Lunacy laws they should be put on the same footing as in the case of the mental defectives under the Mental Deficiency Act?—Yes.

12,287. *Earl Russell*: Is there any reason why the Government should pay any part of the cost. Is it not a matter of ordinary local administration?—I think not, because the incidence of lunacy does not fall equally on all parts of the country.

12,288. I agree that is the answer—on the principle of equalisation of rates in London you mean?—Quite.

12,289. *Deputy-Chairman*: I do not know that there is any other matter I need trouble you with except one. You want to get rid of private hospitals?—There is the question of outdoor clinics. Would you like me to refer to that?

12,290. The question of private mental hospitals first, please?—In my view I do not think it is desirable that there should be an opportunity of making profit out of the treatment of a disease which affects the mind.

12,291. But why should you say that? Take the case of a man of considerable means who is afflicted in body or in mind, or in both, and he can, by making sufficient payments, procure just that amount of comfort which he wants with his means, and which, if these hospitals were not there to provide it, he could get nowhere?—I did not suggest the abolition of private hospitals; I suggest the abolition of profit-making institutions. The West Riding County Council run a private hospital. What I do object to is the idea of conducting a place entirely for the purpose of profit.

12,292. *Earl Russell*: Assuming we agree with you, what is the maximum charge at any of the county hospitals?—I think the maximum charge is three guineas a week.

12,293. Supposing you have the case of a man who wishes to pay 10 or 20 guineas?—I do not think he would get anything better.

12,294. *Deputy-Chairman*: He has a very large income, he can pay 50 guineas a week, as easily as he

can pay five?—In my researches into the Lunacy law I have not found that they always consult the wishes of the patient.

12,295. But, on the other hand, you do not want to deprive a man of a privilege which he can get for himself, and which he may desire?—In all the evidence I have heard, there have been questions about profit making and the friends being interested parties.

12,296. You must be under the impression that these places are not properly conducted, or something of that kind?—I am under this impression from what I have heard, that frequently the patients pay for services which are not given.

12,297. You may suggest that, but I do not know why you should wish to deprive anybody who cared to make the payments of the opportunity of making them, if he desires those privileges?—I do not want to deprive him of the opportunity of getting the best attention. I want to deprive other people of the opportunity of exploiting.

12,298. *Earl Russell*: Assuming for the moment we agree with you that these places should be abolished, what are you going to do to provide for the case of a man who wants expensive and luxurious accommodation, and is prepared to pay for it?—I think the local authorities can perfectly well do it, or he can do it, if he has the means.

12,299. That is exactly what he may not wish to do?—In that case I think the local authority should take over the administration of the private institution.

12,300. *Deputy-Chairman*: A rich father has a son troubled in this way, and he knows there is a doctor running a mental hospital where one can get every care and attention, and the father is prepared to pay for it. Do you say there is some objection to that form of relief being obtained?—Yes, I say so for this reason, that after the son is put into this mental hospital he may be paying for and not getting the services for which he is paying. Supposing I say that I know of cases where large fees have been paid for special purposes, and what has been paid for has not been supplied. Supposing I say I can prove that?

12,301. *Earl Russell*: I should be prepared to believe you, but still I ask you how are you going to provide for what is a public demand. Supposing we asked the question, the Master in Lunacy would say "Yes, I have in my care scores of people who want this expensive accommodation". How are you going to meet the legitimate demand on their part?—I think there are places who charge that, and there are some registered hospitals which do not limit their fees.

12,302. There are, but there are unfortunately too few of them.—Many of the others surely can be taken over and administered by the County Council. If the West Riding can run a private institution, I do not see why the others should not.

12,303. *Sir David Drummond*: Is it reasonable to argue from the particular to the general?—You say you know of some in which the patients do not get all they pay for, and therefore none of them should be allowed. Is that a reasonable position to take up?—I think when we know that there are some, we may assume that the temptation is always there where profit is to be made; and where you have a demented case, for instance, and you have the relatives paying for the services of a special nurse, it is the easiest thing in the world to put that patient in a general ward with 10 or 11 other patients and not to supply the special nurse who is paid for.

12,304. *Earl Russell*: We agree, but that is simply a piece of swindling which happens in other business contracts.—In other business contracts the contract is entered into between two sane parties, and they have the law to resort to. Where you have on the one side an insane person who has not the ability to protect himself, I think the law should enter in.

12,305. But they have the Master in Lunacy and they have a solicitor or somebody who can see to these

24 February, 1925.] Mr. WALTER BLOOD, Mr. GEORGE GIBSON and Miss MAUD WIESE. [Continued.]

things?—They have the Master in Lunacy, and they have their relatives. Let the relatives come to a place where they are paying for a special nurse. What happens? When they arrive at the door the special nurse is there. That is no protection in practice if it is a case of chronic dementia. I have duty sheets and lists of patients in a certain institution, and I can show you the names of five patients who day after day were deprived of the services of the special nurses while the relatives were paying for them.

12,306. *Mr. Snell*: May we just understand really where we are in this matter? Is it your opinion that in a properly conducted public mental hospital a patient, whether he is rich or poor, would get treatment adequate for his need?—Absolutely.

12,307. He would get as efficient treatment in a public institution as he would in any institution, no matter what he paid?—That is my opinion.

12,308. Would you say that a patient would necessarily have a better chance of being cured because he or his father wanted certain special luxuries for him?—I do not think so at all.

12,309. Then the third point is: Would you say that because of the danger that exists, or which may exist, of private profit making, it would be advisable to restrict the liberty of patients to go where they liked or their relatives to send them where they liked?—I think that they should not be allowed to enter institutions run for the purpose of private gain.

12,310. The fourth question is: Suppose this luxury which is desired by patients or relatives is necessary for the cure of a patient, that would be a criticism on every lower standard?—Entirely. If these luxuries were essential to the treatment, it means that cheaper treatment is not adequate.

12,311. Then every other patient ought to have treatment equal to that.—I did not say the luxuries were essential. I said if they were essential.

12,312. *Earl Russell*: I want to ask you this. Do you make the same objection to single care—sending a patient to one doctor whose sole charge he is?—Yes, I think I would.

12,313. *Sir David Drummond*: But, Mr. Gibson. I do not quite follow you. A man with a small income pays 3 or 4 guineas to the hospital, which you agree would be all right. That would be just the same as 10, 15 or 20 guineas to a richer man. Why should you not object to the poor man sending his patient to a place where they make a charge?—I do not think I did object in that manner.

12,314. It is purely relative. The rich man sends his son to a place where the charge is 10 guineas, and the poor man to a place where the charge is 3 guineas. You admit that that would be all right?—No, no. I think you are misconstruing my evidence.

12,315. You quoted a mental hospital where they did run a private side?—But I pointed out that it was administered by a County Council and was not run for gain.

12,316. Supposing these places are properly administered, what is your objection then?—That they are run for the purpose of private gain, which places temptation in the way.

12,317. *Sir Humphry Rolleston*: Have you a considerable body of evidence showing the undesirable nature of institutions where there is the temptation of making a profit out of the patients?—I cannot say I have a very considerable body of evidence.

12,318. You put it in the forefront of your evidence?—We have a lot of complaints, but the evidence is limited, for this reason: that they come and make the statements, but they do not often wish to be implicated in cases.

12,319. *Earl Russell*: Statements from patients or from attendants?—From members of the staff. Another reason is this: we find that in many of the private institutions the staff are constantly leaving. I suggested to the Deputy-Chairman of the Commission earlier on that he might ask the Board of Control for a return of the length of service. There are some

who seem to make a feature of getting rid of anybody who has been there longer than three months.

12,320. *Deputy-Chairman*: Amongst your members there would be members from all these private houses?—No; very few.

12,321. *Earl Russell*: What do you suggest is the sinister meaning of their getting rid of them after three months?—I think they get to know too much about the administration.

12,322. You mean they begin to compare treatment and cases?—Yes, quite. I suggest, for instance, that occasionally a patient, whose friends are paying extra for him for carriage drives, has a run to the station in the ordinary car, and his friends are charged 10s. 6d. for it.

12,323. *Sir David Drummond*: Is the payment made to the attendants on the same level or above or below the level of public institutions?—It varies very considerably. Some are as good; some are worse; but there is a tendency in the profit-making institutions for the staff frequently to rely upon getting remuneration from the patients' friends. It is an undesirable tendency.

12,324. *Deputy-Chairman*: There was one other matter you wanted to mention. I think I had finished my questions; but you have had in your mind some reference to clinics which you wanted to be opened for the reception of early cases?—On that point we think that the powers of local visiting committees are too circumscribed. Their duties only commence after the patient has been certified insane; and we think they should be given powers as mental health authorities, just as you have public health authorities; and their duty should be to provide outdoor clinics, both at mental hospitals, and general hospitals, where possible, and to advise people who may be in the early stages of insanity—not certifiable; to give them advice and outdoor treatment. We think they should be empowered to send out certified nurses from stations to private cases—even into a workman's home; it might be a case of puerperal insanity, and the mental nurse in a home might save the necessity of sending the patient away from the home.

12,325. *Earl Russell*: That would not be very desirable for the children in the home?—It might not be; but, on the other hand, is it desirable to take the mother away and entirely by reason of her mental state have her classified as a lunatic, and years after it is said to the children: "Your mother was a lunatic"?

12,326. It is desirable that she should be treated.—I am not suggesting that they should send a nurse to the home without medical advice; we suggest they should have the power to do so.

12,327. *Deputy-Chairman*: We have had the suggestion of clinics being instituted. You have heard the evidence. May I take it that generally speaking you agree with the views put forward in its favour?—Generally speaking; in general hospitals as well as in mental hospitals.

12,328. You would like to see clinics opened in connection with both of them?—Quite. There is one other point I want to draw the attention of the Commission to before you proceed further. That is, we have a recommendation to make regarding confining the medical authority to medical affairs, but we still think that he should remain the actual disciplinary authority with power of suspension only.

12,329. You think that the medical superintendent at the present moment has too much to do?—I think he has too much to do, and, apart from that, I find that a very few able medical men are temperamentally fitted to control a large institution and all its administrative affairs; very excellent men technically in their profession; temperamentally not the right people for controlling affairs.

12,330. Are you speaking now of men who have been actually appointed to the position?—I am speaking now of one or two who have been actually appointed.

24 February, 1925.] Mr. WALTER BLOOD, Mr. GEORGE GIBSON and Miss MAUD WIESE. [Continued.]

12,331. It really comes to this, that some able medical superintendents are better administrators than others?—It comes to the point that some able medical men are not administrators at all.

Deputy-Chairman: There may be some truth in that.

12,332. *Earl Russell*: It is very likely to be the case with eminent scientific men?—Quite. If I might refer the Commission to the Report of the Select Committee of 1911, which considered Lord Wolmer's Asylums Officers (Employment, Pensions and Superannuation) Bill, at page 7 of that Report you will find that they recommend: "that the power of dismissal should be retained in the hands of the visiting committee, ought to be universal; and your Committee have amended Clause 4 accordingly."

12,333. That is practically universal, is it not?—No. In practice, the power is delegated to the superintendent.

12,334. I thought the superintendent only suspended to the next meeting?—In London it is so; in most of the other asylums the power is delegated to him. It may be of interest to refer to the Report of the Board of Control when they were less sophisticated; that is going back a long time, to 1843 and 1844. I believe it is the first Report of the Board of Control issued. They say: "We consider that the appointment and dismissal of servants is a trust of great importance, which is vested in the visiting justices for the purpose of checking any undue power or influence being used by the superintendent over the servants of an asylum." Now, Sir, three weeks ago a female nurse in the Midlands was dismissed, for singing in the messroom during her breakfast hour, by the medical superintendent.

12,335. *Mr. Snell*: Is singing supposed to be bad for the patients?—I do not know.

12,336. *Deputy-Chairman*: I do not suppose that that case is a case upon which you base your general suggestion?—I merely make that as an observation. I base my case on the fact that a Select Committee of the House has thought fit that the powers should be removed, after hearing the evidence.

12,337. I suppose something turns, does it not, upon the size of the establishment? It may be that in these very large establishments an enormous amount of administrative work is thrown upon the medical superintendent. The amount of work he can get through himself will vary, of course, with different medical superintendents, and the way he can delegate it will vary a good deal?—I think it is so even in the smaller institutions. You see, after all, with the exception of Canterbury, in the small ones of round about 600 or 700 patients even, there is a lot of work.

12,338. You appreciate that where you have an institution of 600 or 700 patients it is necessary to have a head?—Undoubtedly.

12,339. *Sir Humphry Rolleston*: Does it appear to the attendants that, on the whole, they are more likely to get fairer treatment from a visiting committee than they would from a medical superintendent? Is that the feeling in the background?—It appeals to us in this matter: we think that if an attendant is heard by the committee he has an opportunity of preparing and presenting his case in a reasonable manner, which may not be the case with a medical man who, professionally of great attainments, may not have the temperament to trouble about what he considers the minor troubles of an attendant.

12,340. *Earl Russell*: You also have the opportunity of course of avoiding any personal opinion and of getting more than one opinion upon the case; but can you conceive it being pleasant for the attendant to remain in service when the medical man said he ought to be dismissed and the visiting committee said he should not?—That might be unpleasant for him,

12,341. *Mr. Snell*: You have no objection to his being suspended pending decision by the committee?—No. I suggest that the power of suspension should be left to the superintendent. If you refer to a somewhat analogous Report, that is, the Report of the Committee on the Police Service, I think you will find there that they recommend that a policeman should be given permission to appear before a Watch Committee and be represented before being dismissed. We had a case the other day where a man at one of the institutions in Warwickshire, with 23 years' service, was reduced from charge attendant to a lower rank, at a loss of over £3 a month in pay, because he said he agreed with some criticism of the institution that had been published. He had not written the criticism, but he said he thought it was a fair criticism.

12,342. Do you mean he had expressed that publicly?—Yes.

12,343. *Deputy-Chairman*: In that case, you would like some sort of court of appeal, such as the visiting committee?—Yes. Mind you, in this case the man appeared before the committee, but entirely without warning and without a representative.

12,344. Could he not put his case?—What opportunity has the average attendant of doing so, especially if he has no previous warning? He is called in to the committee; the medical superintendent and the law clerk are there; the case has been heard before he appears; he commences at a disadvantage, to start with.

12,345. *Miss Madeleine Symons*: Mr. Gibson, I think the pension age is 55?—Yes.

12,346. I was wondering whether you could tell us when you pay sickness benefit or disablement benefit, whether many of them in fact break down before they reach that age?—There is no doubt that, particularly amongst the female staffs, many do break down; many are quite unable to stand it. On that point the Select Committee of 1911 quoted Dr. Cooke, a member of the Lunacy Commission then, who said that hardly any woman can stand being in an asylum from the age of 18 to 55; and they recommend that in the case of the female staffs superannuation should be granted after 25 years' service.

12,347. Irrespective of age?—Yes.

12,348. How long has the three-shift system been working in the hospitals that have adopted it?—In the London County Council institutions, from about July 1919.

12,349. I was wondering whether it had been working long enough for you to be able to compare the records of health or length of service in the hospitals that adopted shorter hours?—I do not think it has been working long enough to enable us to do that although the average of service in the London County Council institutions is more favourable than in the others, because the conditions of employment are rather better.

12,350. *Earl Russell*: But the others used to be terrible, of course?—Yes, they were.

12,351. *Miss Madeleine Symons*: Then you told us I think, that you objected to a very much lower salary being paid to uncertificated nurses while hospitals were still allowed to employ them?—Quite.

12,352. The point, of course, is obvious—that you were afraid of the unfair competition?—That they would continue to be employed.

12,353. Are we to take it from that, that you would be in favour of a system under which no uncertificated nurses were employed?—Yes; that is, so far as new entries to the services are concerned. I think we make that clear in our recommendations on the Conciliation Committee.

12,354. You have not made it clear from your evidence.—We are quite in favour of that.

12,355. Could you or your colleagues tell us from your experience whether you know of cases in which drugs have been administered to patients in food? I do not mean necessarily and properly administered,

24 February, 1925.] Mr. WALTER BLOOD, Mr. GEORGE GIBSON and Miss MAUD WIESE. [Continued.]

but administered in food?—In my own experience, I have known croton oil administered in tea. It was used very seldom. I can only speak for the institution I was at; but it was the only drug I know of that has been administered in food.

12,356. Do your colleagues, with more recent experience, know of that being done?—(Miss Wiese): I have not known of it. If it is done, it is done without the authority of the medical superintendent. (Mr. Gibson): If I may say so, the delusion of being drugged is not peculiar to insane people. I remember in the Army the gunners in the battery complained that they had been drugged. If they had, the cook must have had some grudge against them; it was quite unofficial. (Miss Wiese): Very often sedatives are given in a tube feed; there is that. (Mr. Gibson): That is to avoid the duplication of administering a feeding tube. (Miss Wiese): It is very necessary, because very often at night two patients can make one dormitory a hell, when other people want to sleep.

12,357. Have you any information generally from your members about the accommodation provided for nurses—I am thinking particularly of the women nurses?—(Mr. Gibson): I think they ought to be housed in nursing homes; many of them at present have to sleep two, three and four in a room; and, in some cases, they have to sleep in cubicles, not in single rooms, and frequently in rooms adjoining dormitories. (Miss Wiese): That means that very seldom they get a good night's rest; and they are ready to be called in an emergency. (Mr. Gibson): The reason for that is that the night staff is available if any trouble arises.

12,358. Do you think that improved accommodation would have a great bearing upon the question of length of service?—Yes. I think most of the mental hospital authorities to-day are willing to improve the accommodation; the difficulty, of course, is building costs—capital charges. (Miss Wiese): In my opinion, it is very necessary. As a matter of fact, I slept in a room attached to a ward until within the last two years, and I have felt quite differently on duty since sleeping away from the patients.

12,359. Do your members favour living out, where possible? Of course, in many cases it is not possible?—(Mr. Gibson): Yes, we do favour it.

12,360. For men and women?—For men and women. For women, of course, it is very difficult to secure the accommodation very often.

12,361. Earl Russell: Yes, asylums are very often in remote parts of the country?—Yes, and inconveniently situated.

12,362. Miss Madeleine Symons: I wonder if you or Miss Wiese could tell us whether you think sufficient is done for providing recreation and indoor occupation for the women patients who are not working in the normal way?—(Miss Wiese): Yes, I do. They usually read and do crochet work; we have a cinema, and there is a play on Saturday.

12,363. Earl Russell: But one play once a week is not enough?—I mean in the wards they have games and books; and most of them do their own private work, for which they get paid.

12,364. Miss Madeleine Symons: Do you mean handicraft?—Yes.

12,365. Earl Russell: Are they paid in money or paid in tea?—In money mostly. It is against the rules, but it is done none the less.

12,366. Miss Madeleine Symons: It is against the rules? There is not any organised system by which they are occupied?—No. Of course, that is coming along. Many of the mental hospitals are engaging occupational therapeutists and teaching mat making, and that sort of thing, and I suppose it will become general. (Mr. Gibson): I do not think there is sufficient organised amusement and recreation for patients on either side in the wards and in the airing courts. I think a good deal more could be done; and in particular up-to-date periodicals should be supplied. They generally get them in the wards when they are three

months old. (Miss Wiese): We are fairly fortunate under the London County Council; we have a fair number of periodicals.

12,367. Earl Russell: I want to pursue the subject of private licensed houses a little further; I do not think we have quite exhausted it yet. Of course, we recognise that there is always a conflict between duty and interest in these places necessarily. Now you have said that one of the things that happens is that a patient does not get what he has paid for?—(Mr. Gibson): Yes.

12,368. That is to say, the contract is not honestly carried out, to put it quite frankly.—Yes.

12,369. Have you any other charge to make against them, such, for instance, as keeping patients longer than they should, on account of payments made?—I have no evidence upon that point at all.

12,370. Is there anything else you could suggest against them beyond that?—There is nothing else. What I have suggested is sufficient, I think.

12,371. I do not know that that in itself is necessarily sufficient to condemn them, merely that people are being swindled a little. But you know, of course, there are mental hospitals registered as a charity?—Yes.

12,372. But there are not many of them?—No; and I think there is one drawback to them; that is, that the management committees are not publicly elected. If I may say so, I consider that a very great drawback.

12,373. It may or it may not be. You would not say it was in the case of some of them, would you? Why should they be publicly elected when the public do not contribute to them?—In my experience the publicly-elected committee is the greatest safeguard. I am speaking now of actual happenings. I very frequently have relatives of patients referred to me who say they want to get someone out of an institution. They say: "Go and see Gibson." They come to me; I say: "What institution is your relative in?" They tell me. I say: "Now go and get hold of the borough representative and ask him to take steps for you," and they do; and of course they get a personal enquiry into the patient's case.

12,374. But have you quite considered what you mean? In the case of a private registered hospital, who is the public to be that is to elect? Where is your constituency?—I do not know how you are going to work the franchise, but, on the other hand, it seems desirable that there should be some form of public control. I have seen advertisements in newspapers for a member of a committee.

12,375. You get some form of control in the Board of Control.—I think these arrangements are unsatisfactory.

12,376. What evils do you think result from a committee being not elected publicly?—In practice perhaps not very much enthusiasm for the work, and a tendency to give the medical superintendent entire control, not to exercise their functions.

12,377. Do you think perhaps that would be met if you had a representative of the local authority always on the committee?—I think it would improve things.

12,378. That would give you some touch with what you call the public?—Yes.

12,379. And he would be a person who could be approached, probably?—I think that would be an improvement.

12,380. I do not want to dwell upon them, but there they are. It is obvious that you are not likely to get many more of them established, if you abolish them.—No, I do not think we will.

12,381. It involves considerable capital expenditure, out of which no profit is to be made. Therefore, it is in nobody's interest to provide it, except as a charity. There are a certain number of people who want the comfort that is to be obtained by the payment of 10 or 20 guineas a week, and you cannot guarantee that local authorities will provide accommodation that may never be wanted, because you

24 February, 1925.] Mr. WALTER BLOOD, Mr. GEORGE GIBSON and Miss MAUD WIESE. [Continued.]

cannot tell in what part of the country it will be wanted?—It appears to me that if they can afford to pay 10 or 20 guineas a week, a few miles more or less do not matter.

12,382. I do not think you can put it on all fours with the pauper lunatic case. The pauper lunatics are a charge upon the place. These people, in particular if they come from outside the area, are people to whom the local authority has no duty of any sort. You see the difficulty?—There is a difficulty, but, on the other hand, they can provide accommodation.

12,383. They can, of course, if they wish to, but do you think they would in fact do it?—I think they are willing to, if they are encouraged. The fact that some of them do provide some private accommodation surely testifies to that.

12,384. Supposing the fact was that there was a large class of people who desired this private accommodation, and particularly did not wish it to be in any way associated with a public authority, as they very well might; how are you going to meet that demand if you abolish the licensed houses?—I am afraid I shall have to appeal to my point of view and say, I think people who think so are ill-advised.

12,385. But as against that, the only serious objection you have put forward is the fear, as you think, that people do not always get what they pay for?—Quite.

12,386. If they do get good treatment and the places are properly conducted, that is not a very serious or vital objection?—I should have thought that in some cases it was.

12,387. You cannot give us any more serious objection than that as a reason why they should be abolished, however great the inconvenience?—No, I have no other suggestion.

12,388. I am very anxious to get from you anything you can tell us, because it is a subject I have been watching all through, and we have by no means made up our minds on it, if you could help us.—I am not prepared to make allegations without evidence, and I do not desire to go any further than I have done.

12,389. Are the arrangements for female bathing improved now in asylums?—I believe they are improving, but a general complaint is that the staff have to bathe far too many patients in a short space of time.

12,390. Therefore, they are hustled and under circumstances of small decency?—Yes; I have had instances given me where they have had to bathe 60 patients in 30 minutes.

12,391. Are there many asylums where there is no screening between the female patients when they are bathing?—Not so far as I am aware; most of them have screening. (Miss Wiese): There must be some observation.

12,392. Mr. Snell: Mr. Gibson, just supplementary to what Lord Russell asked you, would you regard it as satisfactory if a condition of any licence given to a licensed house was that a representative of the local authority should be given a place on their board?—I am afraid I should not; I do not think it goes far enough.

12,393. I am not thinking now of the profit-making institution, but of the registered hospital?—Yes.

12,394. You would regard that as sufficient?—Yes.

12,395. Then on the point about service, I think it is very important that we should have a right view as to why it is that the staff changes so much more rapidly in these private hospitals than in public hospitals?—I did not give figures. I gave my impression. I suggested to the Deputy-Chairman that the Commission might ask the Board of Control for figures.

12,396. May we have your advice as to why that is so, assuming that it exists? Are the conditions of service in public hospitals better than in private hospitals, taking them as a whole?—The conditions of service in the licensed houses vary considerably;

in some they are fairly well remunerated; in others badly remunerated.

12,397. Is there any difference in the pension system?—Any allowance granted, of course, is merely at the discretion of the owners of the house.

12,398. So that they would be in that respect in a worse position?—Yes, quite.

12,399. Is it at all possible that in order to gain experience to qualify for public institutions, probationers, if I may use the term, take preliminary service in private hospitals and then get out as soon as they can?—I do not think so, because many of the places are too small to give training.

12,400. The training they would give would not be a recommendation under the London County Council?—No.

12,401. Mrs. Mathew: I think you said, Mr. Gibson, that a medical superintendent asserted that it was much more difficult to organise the female staff of an asylum, and on that I wanted to ask you, is it because of the large percentage of women with less than one year's service?—I think that is the problem. It is because of the large number of changes of staff, and therefore the larger proportion of inexperienced staff. (Miss Wiese): I find that the first-year nurses are usually frightened with the examinations, and then, of course, with women there are so many other openings. One has to have a great deal of enthusiasm to stick it, really. (Mr. Gibson): The syllabus is rather alarming.

12,402. And they are constantly changing?—Yes.

12,403. Which certainly would appear to make it more difficult?—Yes.

12,404. Then the emoluments, I understand, are rated very highly, and they are deducted from the superannuation; that is to say, they do not count as salary?—The general practice in the public asylums is that there are no emoluments nowadays. The practice is that for board, lodging and laundry a deduction is made from the actual wage. The wage is an inclusive one; and a deduction is made from the actual wage in respect of any of these services supplied to members of the staff.

12,405. Earl Russell: The wage is a living out wage, to start with, and then you deduct if you live in?—Yes.

12,406. Miss Madeleine Symons: When you say, Miss Wiese, "there are many other openings for women," what do you mean exactly?—For instance, we found there was a distinct shortage of nurses when Wembley was opened; we found that the position was not nearly so difficult after it closed. (Mr. Gibson): It is very difficult to get nurses of the right type. They are finding it difficult even in the general hospitals, I think, as a rule.

12,407. Mrs. Mathew: Then I think you mentioned that the local authorities were saving on the patients' diet?—I mentioned an extract from evidence given, or from a statement made, at a Conference held between the Board of Control and the medical superintendents and chairmen of the public mental hospitals. One medical officer made the statement there that there was a tendency nowadays to save on the patients' dietary. He said it was no use the superintendents or the Board of Control recommending improved diet. May I amplify that a little?

12,408. Deputy-Chairman: Certainly.—It goes back to the early paragraphs in my *précis* where I point out the undesirability of a visiting committee having the administration of an institution and not being the rating authority. In other words, what happens is this: we find in some parts of the country where there is a progressive local authority, they are anxious to improve the diet scale of the institution; but it means an increased maintenance rate, and they are confronted by the fact that the board of guardians, whenever they put the maintenance rate up, flood them with resolutions against it; and in the case of Leeds they have actually approached the Minister of Health and asked permission to borrow

24 February, 1925.] Mr. WALTER BLOOD, Mr. GEORGE GIBSON and Miss MAUD WIESE. [Continued.]

£80,000 to build a block for the treatment of insane patients themselves, because they can keep them at a lower rate.

12,409. *Earl Russell*: Still, the local authority has control of the rate, because it is for them to say what the rate is to be?—Yes; but if you have a board of guardians who say: "You increase the maintenance rate and we will withdraw our patients," that is a potent weapon in their hands, and that has been done.

12,410. *Deputy-Chairman*: What it comes to is that there is a fight between the local authority and the board of guardians?—Quite.

12,411. And whatever work the local authority want to carry out, you say they may be thwarted by the board of guardians?—Yes.

12,412. *Mrs. Mathew*: Are you of opinion that an average of 5s. per head is sufficient for a patient's diet?—No, I do not think it is. I have already expressed the opinion that I think the diet scale should be improved, although in some of the better mental hospitals it has been considerably improved within the last two or three years.

12,413. You say that the nurses come in at the age of 18 to 25. Is it at all possible for a probationer of 18 to be left in charge of a lunatic?—Yes; nurses even in their first few weeks of service may go into a ward relieving, and they are told: "Now, look here, there are four suicidal cases here." They are either parchment or card cases; different terms and different descriptions. They are given the parchment to sign; they have to sign on the back of that: "I have seen and know patient So and So. I recognise that he or she has suicidal proclivities." And three minutes after they go in, those parchments are taken away from them again, and if anything happens while they are about, they are held responsible. I have had to go into a ward and sign 14 parchments in three minutes and say I know every patient whose name was on them.

12,414. Does a girl of 18 have to do that?—Yes, frequently.

12,415. *Sir Humphry Rolleston*: You were speaking about the outdoor clinics, Mr. Gibson, which might be associated either with a general hospital or with a mental hospital. In the experience of your members, have they got any preference as to whether it would be better to associate the clinic with an institution for the insane or associate it with a general hospital which might be in the middle of a town?—We should like to have them associated with both.

12,416. Can you name any advantages, if there are any?—I do not know that we have personal experience, but I believe you are having a witness later on, Dr. Worth, who conducts an outdoor clinic at a general hospital, and I was interested, in conversation with him, to learn what good work had been done there. I think they should be at both places. There are many patients discharged who return to a mental hospital knowing the doctors and staff, and ask for advice. There is no power to give them any assistance that would incur expenditure.

12,417. You refer to an expression of opinion that it should be possible in some way to protect patients from themselves without putting them under certificates, and you mention later on in your *précis* a period of three months?—Yes.

12,418. Have you got any suggestion to make as to how the patients could be detained without putting them under certificates?—Yes. A public health authority, I understand, in the case of an infectious disease occurring, if they are satisfied that satisfactory treatment cannot be given at the home of the patient, may order that patient to be treated in a fever hospital or a hospital for infectious diseases. I do not see why a public mental health authority could not be endowed with the same powers. I do not mean treatment in the asylum; I mean in a special place for that purpose; it may be on

the asylum grounds, if you like, but not in the same place as the certified patients.

12,419. That is obviously desirable from the point of view of any stigma which may be thought to attach?—Quite.

12,420. And you think it should be made comparable with arrangements made with regard to people suffering from infectious diseases?—Quite.

12,421. Could you prevent a patient in a scarlet fever hospital from getting out?—I do not know. I think you can.

12,422. *Deputy-Chairman*: You mean by force, not by law?—No; by law; the public health authority can. That man, I understand, must get a clean bill of health before he is entitled to demand his release.

12,423. *Sir Humphry Rolleston*: Can you prevent a person from leaving who is carrying diphtheria organisms in his throat?—If the disease is notified, you can. Is not the notification the authority to compel the patient to be taken to a fever hospital?

Earl Russell: Yes; it is, under the notification of infectious diseases.

12,424. *Sir David Drummond*: But you cannot compel a person to be taken to a private hospital if his relatives are able to deal with the patient at home?—Quite. If they are able to deal with an insane patient at home, I do not think they should take him.

12,425. *Sir Humphry Rolleston*: You say that the Lunacy laws only concern people who become insane. You are anxious that some measures should be taken to prevent insanity from the very first?—Quite. I have suggested that there should be instead of a visiting committee, a mental health authority. My idea was that that should be one of their functions. We are told, for instance, that in some parts of the country there is an undue proportion of mental cases due to inter-marriage. It does not appear to be anybody's business to make these facts known to the public, either by literature or by lectures. I think it ought to be the province of a mental health authority to do so. You have various other causes of insanity that have an undue proportion in different districts.

12,426. It is most desirable that it should be known. The question is: Who should be the people to do it? You think it ought to be mental health authority rather than the Ministry of Health or the local authorities?—The Ministry of Health have so many functions to perform; and, after all, insanity in comparison with the number of people they treat is an insignificant part of their duties. I am afraid they would not give due weight to it.

12,427. *Earl Russell*: Insanity is always one of the evils resulting from inter-marriage?—Quite, but it ought to be somebody's duty to point it out.

12,428. *Sir Humphry Rolleston*: You referred to the question of the administration of drugs, purgatives, sedatives and hypnotics by attendants. I suppose it must often happen that a doctor says: "Now if necessary give the patient this, that or the other"?—Yes.

12,429. It is left to the discretion of the attendant?—Frequently, during the evening hours the doctor says he has a noisy patient, and he will send down a draught from the surgery marked "To be used in the night, if necessary". If the patient has a good night, it is of course returned to the surgery in the morning.

12,430. Then, of course, emergencies must necessarily arise, and if a patient is very troublesome, the attendant may almost feel it is his duty to act?—There is a very strict rule in most of the institutions that no medicine can be administered without medical authority. All the medicines are sent down in labelled bottles. (*Miss Wiese*): There is always a doctor in the hospital, and the head nurse would approach him. (*Mr. Gibson*): The telephone is used in these emergencies.

12,431. There probably is very little in the suggestion that purgatives are sometimes given almost as a matter of routine by attendants?—I do not think

24 February, 1925.] Mr. WALTER BLOOD, Mr. GEORGE GIBSON and Miss MAUD WIESE. [Continued.]

it happens at all nowadays. I will say this: that in many hospitals purgatives are given almost as a matter of routine on medical authority; that is to say, that once a week you get draughts for very nearly every patient in your ward; but they are given on the medical authority.

12,432. Would the medical authority say: "Give this patient a purgative once a day or once a week until further notice"?—No. In an odd case you will get a large bottle of aperient mixture, in the case of a new patient, or a patient suffering from some specific trouble; but I am speaking now of the system of sending down once a week large numbers of labelled bottles.

12,433. The custom may vary in different hospitals, I understand?—Quite.

12,434. Now with regard to the three-shift system; one of the advantages of the shift three times a day, you told us, was that that provides what you term a 15-hour live day for the patient?—Yes.

12,435. By "live day," I suppose you mean they are free all the time?—By "live day" I mean a day on which patients are up and can be engaged in exercise or recreation during the whole of those 15 hours.

12,436. And it is easier for a patient to have a "live day" under the three-shift system than under the two-shift system?—Certainly.

12,437. I do not know sufficient about it to understand why that is so.—If you are only going to have two shifts in the 24 hours, you must obviously have those on the day-turn on for very long hours, if you are going to have the patients up 15 hours in the day; it means having the full day staff on for 15 hours.

12,438. From the point of view of responsibility, you think that is more satisfactorily borne by the three-shift staff than by the two-shift?—Yes, I think in practice it has been found to be so.

12,439. Is that the opinion of the charge nurses as a whole—if you were to take a census of opinion?—(Miss Wiese): I should think so. I think the duties now are so arduous that they would feel they could not stand the strain of the work for a long day—those who have tried the three-shift.

12,440. *Sir David Drummond*: With regard to the point *Sir Humphry* has just been asking you, Mr. Gibson, and your desire to postpone certification as long as possible, your statement is that under no circumstances should certification be resorted to until after three months?—(Mr. Gibson): That is rather an exaggeration. I mean in no circumstances except where the patient is a chronic case.

12,441. You recognise that many cases must be certified almost at once?—There are cases such as

G.P.I. and others, but I am speaking of all the doubtful cases, because I have seen some of the most acute cases we have had recover inside the space of three months.

12,442. I gather that you look upon this syllabus of subjects for examination as very stiff, very serious?—I think it is more difficult than the General Nursing syllabus.

12,443. Do you not think that it may have the effect of excluding some very capable and useful nurses, both male and female, people with all the qualities that are necessary?—It does, occasionally.

12,444. People with all the qualities that qualify them thoroughly for the work?—I am afraid that applies to any profession, Sir David.

12,445. Do you not think it does in this case?—Undoubtedly. One of the best nurses I ever knew was temperamentally incapable of passing an examination, but he was a very excellent nurse.

12,446. It strikes me that it operates adversely?—(Miss Wiese): It is a very discouraging syllabus. (Mr. Gibson): On the other hand, you must have some syllabus of training and some training standard. I know one medical superintendent who told me that were he asked to sit down and pass it, he could not; and he had been a medical superintendent for nearly 30 years.

12,447. Have you had experience of general hospital work?—(Miss Wiese): Only as a patient.

12,448. I gathered so, because I notice you say that in a general hospital the nurses' work is practically mechanical. I do not think that would be admitted if you had had experience as a nurse.—It is so very different from mental nursing.

12,449. Quite so, but I do not believe most people think that nurses in a general hospital do not use their brains.—(Mr. Gibson): But much of the work is routine.

12,450. *Mrs. Mathew*: Might I ask a further question about the examination? Might it be taken in smaller doses, so to speak?—It might be more easily absorbed in smaller doses.

12,451. Would you suggest that?—The difficulty is machinery. The Medico-Psychological Association is purely a voluntary Association, and it must be extremely costly for them to administer these examinations. On the other hand, the General Nursing Council require two guineas for their preliminary examination, and three guineas for the final, in addition to the travelling expenses of the candidate, which is far too much to require from the probationer nurse.

Deputy-Chairman: We are much obliged to you.

(The Witnesses withdrew.)

(Adjourned to to-morrow morning at 10.30 a.m.)

5, OLD PALACE YARD,
WESTMINSTER, S.W.1.

TWENTY-SECOND DAY.

Wednesday, 25th February, 1925.

MEMBERS PRESENT :

THE RT. HON. H. P. MACMILLAN, K.C. (*in the Chair*).

THE EARL RUSSELL.

SIR HUMPHRY ROLLESTON, BART., K.C.B., M.D.

SIR DAVID DRUMMOND, C.B.E., M.D.

MR. N. MICKLEM, K.C.

MR. H. SNELL, M.P.

MRS. C. J. MATHEW.

MISS MADELEINE SYMONS.

MR. P. BARTER (*Secretary*).

MR. W. FAIRLEY (*Assistant Secretary*).

Chairman: Before we begin the proceedings this morning I desire to make a statement on behalf of myself and my colleagues. The Commission have found it necessary, in view of their recent experience, to reconsider their procedure in hearing the evidence of ex-patients tendered by the National Society for Lunacy Reform. It will be recalled that the Commission invited the Society to bring before them six selected cases which might be regarded as typical. The Commission requested the views of the Society as to whether this evidence should be taken in public, having regard to the possible effect of a public examination upon the ex-patient and upon his evidence. The Society indicated that they did not anticipate that any of their witnesses would desire that their examination should be in private and expressed a preference for procedure in public. The Commission accordingly informed the Society that in the first instance the hearing of the individual cases would be conducted in public, but at the same time intimated that, if at any stage they found that the presence of the public appeared to be affecting detrimentally the value of the evidence or to be in any other way embarrassing the proceedings, they would exercise their discretion to continue the hearing in private. The National Society furnished the Commission with the names of six witnesses and the Commission made special arrangements to suit the convenience of the first witness, Mr. H., whose testimony the Society stated that they regarded as of particular importance. His case occupied the Commission on 17th, 26th and 27th January. The Commission found to their regret that their apprehensions as to the possible effect on an ex-patient of examination and cross-examination by counsel in public were justified. While the case was still before the Commission, they received a communication from the witness complaining of the inconvenience which he had suffered in his personal affairs through the publication of his evidence and asking for the protection of the Commission. This was followed by a telegram from the witness stating that he was too ill to continue the fight, and he did not in fact attend the second and third days proceedings. In addition, the Commission found that the procedure adopted had

had the result of creating an atmosphere of controversy and recrimination, which they cannot allow to recur. If the evidence of this witness had made an important contribution to the deliberations of the Commission or to public enlightenment, the position might have been different. But the expenditure of two and a half days time resulted in the eliciting of only a few material facts which the Commissioners could have themselves obtained in at most an hour or two. Considerable public expense was occasioned, and the persons against whom Mr. H. had made allegations and whom the Commission thought it proper to notify were put to much expense and inconvenience in attending to answer the charges made against them. The Commission have further taken note of the fact that the National Society have withdrawn another of the six witnesses originally tendered by them. The nature of a communication addressed to us by this intended witness sufficiently justifies this step. Leave has been asked to substitute another witness. In these circumstances the Commission decline to take the responsibility of permitting ex-patients to be exposed to the ordeal of public examination, the effects of which in any individual case it is impossible to forecast with any assurance. They are satisfied that it is not in the public interest that the procedure hitherto adopted should continue to be followed, and they have decided that in the remaining cases they will themselves examine the witnesses in private. It is not, however, intended to exclude the Chairman and Counsel of the National Society for Lunacy Reform, who are tendering the witnesses. The Commission at the same time recognise the importance of the evidence so received being made accessible to the public, and they propose to publish it along with their proceedings, with the omission only of names. The Commission desire to add that they have already devoted six days to the evidence of the National Society for Lunacy Reform and have had the benefit of the very detailed evidence of Mr. Parker which has so fully and usefully informed them of all the points upon which the Society is concerned to effect reforms. It must be borne in mind that there are many other interests still waiting to be heard. The purport of my statement will be communicated to the Press.

25 February, 1925.]

Dr. MONTAGUE LOMAX, M.R.C.S.

[Continued.]

Dr. MONTAGU LOMAX, M.R.C.S., called and examined.

12,452. *Chairman*: This morning, we have the advantage of the attendance of Dr. Montagu Lomax; and perhaps, Dr. Lomax, before we start the proceedings it might be convenient if I were to tell you the state of our information up to date, so that you may take up the thread. We have all had the advantage, if I may say so, of reading your most interesting book. We have also read the Cobb Report, and we have read your reply. I may say we have attended to them very carefully, and I do not think it would be out of place if I were to pay a tribute to the very great care you have taken in considering this whole topic and the zeal which you have shown in elucidating it. We have also had, as you are aware, the evidence of Mr. Parker, who presented to us the general case for the National Society for Lunacy Reform in very considerable detail. Of course we do not want merely to duplicate evidence which we have already heard, because it is not upon the multiplicity of witnesses, but rather upon the importance of the testimony that we rely. I have felt that it might be useful to have from you, as a special student of the matter, some enlightenment upon those topics where I understand you do not find yourself in entire agreement with Mr. Parker; so that may we see another angle of approach to these questions and receive your views upon that. There are also some topics to which you refer which Mr. Parker did not deal with, or did not, at any rate, enlarge upon. There, also, we should be glad to have your evidence, but may I ask that to-day we should as far as possible avoid merely duplicating matters which have already been very fully discussed. Then, Dr. Lomax, as we know, you are a medical practitioner, and a Member of the Royal College of Surgeons?—Yes.

12,453. I think you were for many years in general practice, were you not?—Yes.

12,454. Are you still in general practice?—No.

12,455. Have you retired now?—No, I am doing mental work of a certain kind, and practise as a consultant, a small amount; my health is not good. I am not in general practice, and have not been for the last 7 or 8 years.

12,456. And I understand that your interest in this topic of Lunacy law reform really originated in the services which you gave in two asylums during the period of the war?—That is so.

12,457. It was in consequence of your experiences in those two asylums that you came to the conclusion that the present system stood in need of reform?—That is so.

12,458. If I may put to you the way the matter is impressing our minds, what we are concerned with chiefly is this:—we have had evidence, and we shall have some from you no doubt to this effect, that under the existing law, notwithstanding the numerous safeguards which it purports to afford, nevertheless, in fact, there are still possibilities of the occurrence of abuses?—Certainly.

12,459. And one's desire naturally is, if possible, to effect such reforms as will prevent the possibility of such occurrences?—Quite.

12,460. We are at one upon that idea, I think?—Quite.

12,461. We are not really so much concerned with the actual number of cases that have occurred as with this, that the present system permits of the occurrence of such cases?—Yes.

12,462. And therefore reform is desirable in the direction of altering the law so as to prevent the possibility of such occurrences?—Yes.

12,463. Now in the *précis* with which you have been good enough to furnish us you have summarised the various heads upon which you wish to address us?—Yes.

12,464. I think we might usefully go through them, if you please. At the very outset you deal with a topic of very great importance upon which we should like specially to have your views, and that is the question of the position of the medical superintendent. I have read in your book, if I may say so, the balanced

presentation of the matter. You have put the considerations on both sides on the question whether the medical superintendent should be relieved entirely of executive business, and should devote himself exclusively to medical work. I suppose you will realise that the topic is one upon which two views may be entertained?—Certainly.

12,465. But as the result of your study of the matter you have come decidedly to entertain the view that he should not have executive duties?—Absolutely. I have not any doubt at all that if the reforms which we hope will result from the enquiry take place, the medical superintendent's office will be separated entirely from the executive chief's office.

12,466. Now in that view are you, to some extent, influenced by the fact that at present many of the most important asylums are so very large?—Yes, I am.

12,467. And I observe (if I may refer to your book now and again, because that is really what has concentrated my thoughts on certain points) at page 140 you say: "The only possible remedy in my opinion for this state of affairs at least in all asylums containing more than 1,000 patients, is to separate entirely the offices of medical superintendent and executive chief"?—Yes.

12,468. If the reform which you suggest in another part of your evidence were given effect to, and if this large type of asylum of which we have a number of examples in the country ceased to exist, and in place of it we had the more modern form of villa asylum with a limited number of inmates in each institution, does your objection to the combination of the duties to some extent disappear?—I think it still exists, because my whole view is that the superintendent of an asylum, the medical superintendent, exists for the sake of his medical duties—not executive duties at all. If you combine the two, the executive duties are bound to interfere, and largely to interfere, with his other professional duties. Even in the villa asylums which you suggest, the actual asylums as a rule are not smaller; they are arranged on a different system, and the medical superintendent of those asylums—there are only two or three in the country which have what you call the villa system—

12,469. Yes, they are only in their inception?—Will still be appealed to on these questions of executive responsibility.

12,470. Now may I put to you a difficulty that is present to my own mind in considering the topic, and that is this, that the treatment of mental patients differs from the treatment of ordinary patients in this respect, that the curative treatment for persons suffering from mental disorder must necessarily depend very much upon environment, and upon the provision of means of occupation and recreation, and so on, which have to be adapted to the special requirements of the cases?—Yes.

12,471. The difficulty I have felt about it in considering the question is just this, that if that be a form really of medical treatment, the doctor who is at the head of the establishment must himself be concerned with the provision of things which an ordinary doctor has not to think of. An ordinary doctor has not to think of providing opportunities for industrial employment, or to see that there is open air work for patients, or to arrange concerts for them and things of that sort. That is not part of a general hospital doctor's work at all, but it is a very important part of the actual medical treatment of patients in asylums—you see how my mind is working?—Quite.

12,472. What one feels is this, that if you remove from the medical superintendent the control of the whole establishment you might actually cripple him in the provision of the very means which are most desirable for the treatment of those cases. Have you thought of that?—Yes, certainly.

12,473. Now what is the answer, if you can give it to us?—My answer would be this, that in everything affecting the welfare of patients, whether it is medical treatment, outdoor amusements, work, recreation,

25 February, 1925.]

Dr. MONTAGU LOMAX, M.R.C.S.

[Continued.]

and so on, the medical superintendent is obviously supreme, and that when patients for instance, are employed in workshops, or on a farm, or in any of the industries of the asylum, control over the patients must obviously lie with the medical superintendent. He has their destinies as patients to control, but the appointment of the staff in the workshop, the appointment of all the engineers and the workmen, and the farm hands, and so on, does not seem to me to be part of the superintendent's work at all.

12,474. I am always thinking of it practically. Let us take a concrete example: suppose you have a workshop—and I have seen one or two of these places where basketmaking is carried on, or some interesting occupation of that sort, and one of the workmen there, one of the supervising workmen, not a patient, turns out to be rather a tactless fellow, and does not handle the patients well; they dislike him. Would not that be a matter where the medical superintendent would have to intervene and say "My patients are not really benefiting from this occupation, because of this particular workman, who, although a very capable fellow, does not get on with my patients"?—Certainly, that is all part of his department. Wherever the patients are employed under any circumstances the medical superintendent ought to be supreme as regards their destinies. I am only stating that fact; if he did not approve of the work in the workshop he would speak to the executive chief and say "I want that man removed."

12,475. And suppose the executive chief said "I will not remove him"?—Well, that is a case which I am afraid I cannot answer. If the patients have to go into the workshop and the patients' welfare depends upon it, it comes into the sphere of operations of the superintendent. He should say "Well, that man has to go."

12,476. Perhaps the real solution of the whole matter may be, as so often, in definition?—Yes.

12,477. I do not know that anybody has yet given us a precise definition of the medical work of an asylum in contrast with its executive work. I was putting to you a difficulty that there is medical work to be done in an asylum which is of a different type from general hospital practice. Therefore perhaps the real solution may be found in a discrimination between what is properly medical work, which means something much wider in the case of the medical superintendent than it does in the case of an ordinary doctor, and the executive functions which are more or less of a clerical and administrative type, and which ought to be subordinate to the general medical welfare of the institution. Of course it is obvious at present that even under the Act the safeguards themselves involve a vast amount of clerical work?—Yes.

12,478. Some of it I suppose is useful, and some of it perhaps not very useful?—Yes.

12,479. Which must divert the mind of the medical superintendent from his primary function?—It is not only the clerical work; it is the ordering of the whole establishment from the executive point of view—I mean the alterations and repairs of buildings. Of course they are ordered by the asylums board or committee, but he looks after them. Then there is the engagement of all the various workmen, and the discharge of these people, which is entirely in his hands. I can quote you from the report of the Conference of Superintendents, which is a most interesting report, I have no doubt you have read it—in which this question was debated, and in which the medical superintendent says over and over again that he simply has not the time to attend to the patients of his institution; his executive work is so large, and so widely distributed, that he cannot give the time; he wishes he could, often.

12,480. Let me again for the moment be the critic, if I may. Take the question of alterations of buildings. Now one knows that a great deal depends from the point of view of the comfort of patients, and indeed for their cure, upon the fact that the premises should be comfortable, that they should be open and

airy, and so on, and we know about the verandahs and open air spaces. If I were a medical superintendent, I would be intensely interested, if I were getting an extension to my asylum, to see that the new buildings were places where I could get my ideas of cure carried out?—Certainly all that comes in his department; it has to do with the welfare of the patients from the medical standpoint.

12,481. At what point would you relieve him?—The papering and the painting and the engineer's work, and the electrical work and the ordering of the stores, at least the passing of the accounts of the stores. I have seen superintendents spend the whole of their morning in their office with a clerk passing accounts for tea, sugar and bacon, and so on.

12,482. That ought not to be part of their business, obviously?—Obviously it cannot be. Then having to settle altercations between the engineers in their work, inspecting all sorts of repairs and so on; surely that is not what he is appointed for.

12,483. *Earl Russell*: As regards repairs, would you relieve him after the plans had been passed?—No, I think he would have to be consulted about the plans.

12,484. Would you relieve him after the plans had been finally settled?—Except as a critic of the plans. Yes.

12,485. I say after they had been finally settled?—Yes.

12,486. *Chairman*: There is nothing more difficult than what one may call delimitation problems?—Quite.

12,487. I am very much concerned with this point of view, that the medical superintendent should not be excluded from control of any matters which he thinks really relate to the welfare of his patients?—Certainly not.

12,488. And it is so difficult to pursue those matters, because taking even so trivial a matter as wall papers, I do not know whether you will agree with me or not, but I think the wall paper in a room may have an enormous effect on one's mind?—Enormous; I wish it was studied more.

12,489. Some wall papers make people quite ill?—And make patients quite ill too.

12,490. On the other hand, one has the refreshment of seeing a room that is papered with paper of one colour which is restful to the eye. I feel that the medical superintendent often must descend to matters which an ordinary doctor might say were really trivialities?—I quite agree. It is different entirely from the sphere of an ordinary hospital doctor, but at the same time every superintendent knows quite well that there is an enormous deal of work which, if he liked, he could delegate entirely.

12,491. In your experience have you found that it depends a good deal upon the idiosyncrasies of the medical superintendent as to the extent to which he concerns himself with those matters?—Certainly.

12,492. The personal equation enters into it?—Certainly, and the fact too that it is a far more important branch of the subject for him to keep in with his visiting committee. They think much more of a superintendent who is a good executive officer than they do of him as a doctor. That is a side issue altogether. What he is there for is to economise to every extent in his power the money of the ratepayers, and they regard him as a good superintendent from that standpoint, and from that standpoint alone. He need not go into the wards all the year round, so long as he keeps the expenses down. That I think you may take is the point of view, I will not say of every asylum committee—I am speaking broadly—but I think you will find that is the attitude of nearly everybody who has to do with economic administration of asylums.

12,493. Of course it would be difficult for us to make local authorities address themselves to their problems from the proper point of view; we can only make suggestions and provide safeguards?—Quite.

12,494. But your apprehension is that the medical superintendent's mind is diverted rather towards his

25 February, 1925.]

Dr. MONTAGU LOMAX, M.R.C.S.

[Continued.]

visiting committee than towards his patients?—I am afraid it is bound to be so, and I think every attendant will tell you the same. I think Mr. Gibson, who gave evidence yesterday, would emphatically agree with me there, that the superintendent is, as a rule, obliged to keep in with his committee.

12,495. On that point what is the security of tenure of the medical superintendent?—I think there is not any at all, except at the whim of the asylum board. I think so long as he does his work to their satisfaction he may be as unpopular with the patients as he likes. He may be as difficult to remove as a clergyman in a country parish.

12,496. But what is your view on that. Would you prefer the medical superintendent to have such security of tenure as to make him more or less independent of the visiting committee?—I should, absolutely. That is why I am so strongly in favour, if it could be done, of the superintendent being appointed by the Ministry of Health.

Earl Russell: That is all very well, but if he became slack who would remove him?

12,497. *Chairman*: That was the next question I was going to ask. Security of tenure has disadvantages?—I know it has disadvantages.

12,498. Suppose the particular medical superintendent was installed and retained his office with the tenacity of a limpet, but was, in point of fact, found not to be a good medical superintendent from the point of view of patients, would it be wise to allow him to snap his fingers at the appointing authority?—He does now practically.

12,499. I thought you rather suggested he was under their thumb?—He is under their thumb to a certain extent. I mean this, that if he keeps his accounts in good order and runs the asylum economically he is fairly sure of being kept in his post until a very advanced age. There were two superintendents in the North of England, only the other day, who were over 80, having been there for 45 years, I think.

12,500. *Earl Russell*: But do you suggest that if he made strong reports recommending capital expenditure he would lose his job?—I do not think he would lose his job, but he would be warned that that was not the sort of report he was expected to make.

12,501. And if he went on making them?—Well, I do not know.

12,502. *Chairman*: That is a criticism that applies to almost every public functionary; it is not peculiar to the medical superintendent?—Quite. The medical superintendent of the type I mean, of the better class type, the earnest worker, ought to be relieved of these executive duties.

12,503. We have had evidence to that effect.—I am perfectly certain that many would be only too glad to be relieved of them.

12,504. If you could guide us to a line of demarcation between the functions which ought to be performed by the medical superintendent and those which ought to be relegated to clerks and secretaries I should be much helped?—I think it is an affair to be arranged between the superintendent and the executive chief. I am not sure. I have thought over and over again it would be better for an asylum to be governed by a lay superintendent, and for the doctor to be the senior medical director. I think it would be much better for the patients and for the asylum to have a good class of layman appointed as chief superintendent of the whole asylum as the governor of a jail is, for instance.

12,505. Again one feels just this difficulty that the medical superintendent in that case would be under the lay head of the institution; he might resent that, and he might also find that it impeded him in getting his own way, assuming he was a progressive man and had ideas which he wanted to carry out, in having to submit them to this superior officer who, being a layman, might not appreciate his point of view?—I think he ought to have an independent access in his own

department to the asylum board, quite independent of the executive chief.

12,506. *Earl Russell*: But the effect of your alteration would be that the visiting committee would come to look upon him as the medical man *par excellence*, and refer only to the other man for executive matters?—Quite.

12,507. *Sir David Drummond*: Do you mean that the layman should be the superior officer of the asylum?—As regards executive work, but, of course, not as regards the medical work. The medical superintendent must be supreme in everything affecting the patients, obviously; there is no question about that.

12,508. *Chairman*: Now, Dr. Lomax, the one comment I would make upon all that is that I cannot for the moment see that there is anything in the *régime* of a lunatic asylum that does not affect the patients one way or the other?—Absolutely right.

12,509. I feel that the whole institution ought to have for its object the welfare of its patients, and that no detail in that institution is so small that it may not affect the patients; and therefore I have great difficulty in seeing that you can withdraw any province, so to speak, of superintendence from the medical man, who ought at least to be devoted to the concerns of his patients in every one of the details of their lives?—Quite.

12,510. Is not the true solution rather to be found in this, in devising, if we can, some method whereby what I would call the routine work of passing accounts, the sort of thing you instanced a little while ago, looking after stores, looking after details of one sort and another, should be withdrawn from the medical superintendent, and placed in the hands of efficient subordinates, who would be answerable to him in the long run, but who would have a primary jurisdiction to deal with these matters themselves.

Earl Russell: And a responsibility.

12,511. *Chairman*: And a responsibility?—Quite.

12,512. As you have pointed out a great deal depends upon the individual man. Some people know how to delegate work; on the other hand, some people cannot delegate, and will not allow a single fragment of their work to escape their own hands. A great deal must always depend, must it not, upon the medical superintendent?—Quite.

12,513. And whatever demarcation we can invent you will find some men wanting to trespass over it; other men welcoming it as a relief. It is not an easy problem?—It is a most difficult one, and they are always suggesting as an analogy the captain of a ship. The captain of a ship has a purser under him, and a chief engineer.

12,514. He certainly does not keep the account books of the ship?—He does not. He does not order the food, and he does not engage the stewards.

12,515. And the first officer has charge of the cargo?—Exactly, and the captain is supreme as long as the ship is at sea, as the asylum board is supreme really over the superintendent, but, practically the superintendent is the autocrat of the asylum. The visiting committee exists to pay the bills and to see that the expenses are kept down. It is a most difficult problem, especially in a large asylum. I think if you reduce the size of asylums to about 1,000 patients each the problem is not half so hard; but in these large asylums you have no idea. Anyone will tell you, Mr. Gibson would tell you, that three-fourths of the superintendent's work is executive, more, seven-eighths I should think.

12,516. *Sir David Drummond*: Do you think that even if you reduced the asylums to 1,000 patients, it would be possible for a medical superintendent to interest himself medically and scientifically in each patient?—I think it ought to be possible, Sir. I think the medical superintendent, if he is interested in his work, should devote his whole time to the patients.

12,517. With 1,000?—With 1,000 he does not of course devote his whole time to each individual, but I think he ought to go round his wards with his officers,

25 February, 1925.]

Dr. MONTAGU LOMAX, M.R.C.S.

[Continued.]

and a number of them never do. The officers ought to go round with him; they ought to get the benefit of his advice and his experience, to consult over the difficult cases, so that when he comes to discharge them he knows all about them, and has studied their cases; but in many, many instances, a superintendent has hardly ever seen the patients at all. Even when the patients he is to discharge come up, a quarter of an hour perhaps is the most they get, and he is dependent then upon the assistant staff, and upon the attendant's reports, and not upon his personal observation. It goes very hard with him. I think you will find, if I remember rightly, it was Dr. Wolseley Lewis who said here he would be very glad to get some outside alienist to help him to discharge the patients that ought to be discharged. He said he did not want to be regarded as the jailer and the doctor of the patients. He would like to call in outside help. That was to my mind a most extraordinary statement, because if a medical superintendent is not the fit man to discharge his own patients, he is not a fit man for his post at all. He ought to know all about his patients; and to suggest that he would feel happier if he were to call in an outside alienist, or a doctor, to tell him what patients are to be discharged, seems to me to show that he sub-consciously really feels that he had not this experience of the patients that he ought to have had.

12,518. *Chairman*: Unless perhaps it was just the instinct which everybody has to shift the responsibility if they can?—Quite, but it ought to be his pride. I doubt if you will get two superintendents in the kingdom to agree to calling in an outside man to help them to make up their minds as to what patients were fit to discharge.

Earl Russell: But I think it was not put quite as you put it. I think rather his feeling was that the fact that he was the authority to let them go, or to keep them, made them feel he was their jailer. He did not like them to feel that he held the keys.

Chairman: That is quite true.

Mr. Walter Stewart: May I read the actual observation? "My view is that the cases should be passed in review by the judicial authority which originally certified, both at the period of periodical review, or in cases claiming discharge." Those were the words of Dr. Lewis.

12,519. *Chairman*: Is that what you disagree with, Dr. Lomax?—Yes, entirely. I do not think the judicial authority has anything more to do with discharging than he has with certifying a patient. It is a medical question pure and simple, and it is a medical question which the superintendent himself ought to solve and nobody else, in consultation with his staff.

12,520. We will follow that out. Of course that arises a little later on the general topic of detention?—Quite.

12,521. You served in two asylums, did you not?—Yes.

12,522. What was the size of those asylums? Prestwich was the first one you were in?—No, the last one; I was in Lincoln first.

12,523. What was the size of Lincoln?—About 2,000, I think.

12,524. One of the big ones?—Yes.

12,525. Prestwich is larger still?—Yes, almost 3,000—2,800.

12,526. Then you had experience, while you were in those asylums, of medical superintendents who were in charge of very large institutions?—Quite.

12,527. May I follow the line that Sir David was taking a moment ago, and suggest this: I suppose in every asylum there are a large number of cases which unhappily present no problem?—Quite.

12,528. I mean cases which, once having been diagnosed, have to be accepted, unhappily, as cases where there is very little prospect of recovery, and where all that can be done is to mitigate the conditions of life as far as possible?—Quite.

12,529. In your own experience, what percentage, do you think, of the cases in a hospital are in that

condition—I mean cases as to which really you do not require constant medical reconsideration?—A very large proportion—half almost.

12,530. That means, does it, when we are talking of the medical superintendent's consideration and reconsideration of individual cases, it will not be a task applicable to the whole of the inmates of the asylum?—Oh no.

12,531. Therefore we to some extent narrow down the province of his anxieties to those cases where there is a chance of recovery, and where the patient may just be in a state of transition?—Quite.

12,532. So it is really what we have called the borderland case, the borderland between the onset and the actual disease is the one type of case; the other is the borderland between recovery and disease?—Yes, and then you must include a large group of hospital cases that ought to be much larger than is the case. Many of these cases which ought to be hospital cases are not; I mean to say the superintendent's duty would be largely in having to do with the hospital cases.

12,533. Do you mean cases which although they have mental disability are suffering from some ordinary ailment?—No, not only that, but they are sufficiently ill to be in hospital. It is not only that they are ill in body, but ill in mind; advanced general paralysis, cases that are bed cases, and in which they have to be nursed most carefully; bed sores form so easily, and their bones break so easily. They are in the ordinary sense ill, but it is the result of the mental state.

12,534. Do these cases, that you call the hospital cases, constitute a large proportion of the cases within your experience in the institutions where you served?—There was always a large proportion. In fact, the asylum hospital is always full, and it ought to be much larger. It ought to include a number of cases that are not included in it. It ought to include the cases that have to be constantly under the influence of drugs. All those cases ought to be hospital cases. The cases in which the illness is taking a form that it may result in physical incapacity ought to be hospital cases, I think.

12,535. Then would you contemplate that the medical superintendent's chief medical work would be concerned with those cases which would be hospital cases on the one hand, and with those cases, on the other hand, which were approaching recovery, or requiring some special treatment of a curative nature?—Quite.

12,536. And that would not mean the entire asylum population, but only a proportion of it?—Not half of it, perhaps.

12,537. I mean one might be misled as to the extent of his work by saying there are 2,000 inmates there, and assume they were all on the same level and requiring the same degree of attention, but that is not so?—That is not so, but that raises the question of what patients you ought to have in these asylums. All these problems intersect; they cannot be separated.

12,538. I can assure you we have found that in the evidence we have had. We are told if you reform at one point you may obviate the necessity of reform at the other point, and if you reform at the other point you come back to the first point, the things are interlinked?—Yes. If a certain proportion of the asylums were devoted to acute and recoverable and hospital cases, and you got out of the way the irrecoverable, the senile, the demented and the feeble-minded, and the idiots, and so on—if you got those out of the way in some other institution, they would not require half so much care and attendance, not half the doctors and the paraphernalia of a hospital, and you would give the superintendent then time to devote himself with his staff to the early cases, very important, the recoverable, the acute, and the cases which would have to be detained in the asylum because they were violent or were dangerous.

12,539. Therefore your aim would be to eliminate from the asylum population those persons who are not a menace either to themselves or to the public,

25 February, 1925.]

Dr. MONTAGU LOMAX, M.R.C.S.

[Continued.]

and for whom the special treatment which an asylum can afford would really not be beneficial?—Quite.

12,540. And who have just become inhabitants, rather than patients?—That is it, blocking up the asylum, and taking up time and work which might be devoted to recoverable cases.

12,541. I think it is fairly obvious that a pretty considerable proportion of the asylum population consists of inhabitants rather than patients, that is to say, of persons who are resident there as a home?—As a workhouse too. Half of our asylums are partially workhouses.

12,542. May I just diverge to one point I was interested in in your suggestions upon that subject—it rather appealed to me. You suggest that there are many persons at present in asylums who might as well be in workhouses?—Yes.

12,543. Persons who, you will agree, are of feeble mind, but are not dangerous to themselves or to others?—What the British Medical Association in their excellent memorandum call “mentally ailing” in distinction to “mentally unsound.”

12,544. I have a certain sympathy with that class of inhabitant of the asylum, who possibly has been there a good many years, has settled down to the life of it. Do not you think there would be a certain harshness in sending that person away to a workhouse?—I do not say that they ought to be sent away to a workhouse; I say that the asylum is keeping them as if it was itself a workhouse. I say that many of these people ought to be sent to a sort of mental alms house, or a mental rest home. I think if you divided your asylums up into asylums proper, which dealt with the acute and all the cases you have spoken of, and sent those people who were not fit to go out into the world into this other kind of asylum, you might empty one into the other.

12,545. *Earl Russell*: An admittedly non-curative establishment?—Exactly; they would have to be past the border line. I am not speaking of those people entirely; I am speaking of people who are detained in asylums because they are useful, they are workers, and they are workers whom, perhaps, their friends do not care to have at home.

12,546. *Chairman*: I have a case in my mind, because I went and interviewed one myself. I was told that a particular patient was being improperly detained, and I went to the asylum and asked to see this patient myself alone, with one of my colleagues here; and this patient told me, because I think I got on to friendly terms with her, and she said she was very happy and very busy. I saw the head nurse, who said she was doing excellent work. Everybody liked this patient; she was obviously a very nice person. Equally obviously she was mentally deficient, but gave no trouble, was bright and helpful, and very competent within limits. The medical superintendent said to me “That patient can be discharged to-morrow, not recovered, but with perfect safety to herself and to the public, provided she has somebody to look after her. She is still a certifiable case, not the type of case where the disease has passed off, but a harmless certifiable case.” Have you thought of how that problem can be dealt with? We are assuming the case of a perfectly excellent person with a mental deficiency which would justify you, as a doctor, in certifying her, who does quite useful work in the institution, who has no relatives, because this unhappy person had no relatives whatsoever to go to. Why should she not remain there?—If she is not anxious to go out, I do not see any reason why on earth she should not stay there.

12,547. I said “Would you like to leave this place?”; she said “Yes, I would.” I asked “Why?” and she said “I would like to go into service and make a little money for myself.” I said “Suppose now I got you out to-morrow, where would you go?” Her face fell absolutely; she said “I do not know; where would you send me?” I said “If you start life again as a citizen you will have to make your way in the world.” A complete blank supervened. What is

one to do with that class of case, because it would be cruelty to send that class of case into an unsheltered world?—That class of case ought to go into a half-way house first. In my scheme I have a number of proposals; the mental observation hospital, which is a half-way house in ought also to have accommodation as a half-way house out, and those ought to be associated with After-Care Associations. Lots of these people can be sent out into the world far more safely than you think. It is done every day. I know a lady in the reform movement who took such a patient out of an asylum, who says that for the last four or five years she has been the best worker she has ever had.

12,548. I quite understand that if you could get a philanthropic person whom you could trust to take a patient of that type, who is a properly certifiable case but not dangerous at all, and really within limits quite a well doing person, and if she were taken as a domestic servant, she would probably do quite well under supervision by a kindly mistress; but there is a terrible menace to that class of person if they fall into the hands of unscrupulous people who would overwork them or exploit them?—I quite agree.

12,549. I am very apprehensive of that sort of thing?—I quite agree, but I do not think we are thinking of the same class of patient. The class of patient I mean is the class of patient who is not certifiable.

12,550. But then that class of patient cannot be kept in an asylum?—But they often are.

12,551. But they ought not to be?—That is the great point.

12,552. *Sir David Drummond*: Do you regard that case which the Chairman has just detailed, as certifiable at the time that he saw her, as far as you can judge from the Chairman's statement to you?—I do not know, I have not seen her.

12,553. You have heard the statement that she was harmless and was doing good work, I ask the question because we have had it before us. At the moment the patient may have recovered so far that she is not certifiable and must be discharged, that is the difficulty?—The difficulty depends upon how you are going to define certifiability. I say that patients should never be certifiable if they are not a danger to themselves or to others, if they are capable of earning their living outside, if they have got friends who are able to look after them, not able and willing but able—they may not be willing; that sort of patient should not be kept in an asylum unless she asks to be kept.

12,554. *Earl Russell*: Do you suggest that a patient in that condition should be sent out to friends who are not willing to look after her, and who may ill-treat her after she is out?—But she is infinitely worse treated inside. She will have freedom outside. Give the patient the opportunity of going home, or outside anywhere.

12,555. It is a little like the freedom given to a southern nigger immediately after the emancipation?—As I have said over and over again, it would not be half so bad if those patients who are kept in the asylums as workers, who are not quite normal, were paid as workers. They are not paid; they are unpaid workers. The asylum takes advantage of the fact that they are certified, that they have got control over them, and that these people's friends do not care to have them at home; and they employ them without paying them, and class them still as certifiable lunatics. That I think is against every principle of right and justice.

12,556. *Chairman*: Of course, as a lawyer, I appreciate this, that no person who is not certifiable is legally detainable in an asylum for a single moment. The whole problem, as you point out, is at what moment do you pass from a state when you are properly certifiable into a state when you have ceased to be properly certifiable. If you could define that you would have solved the most difficult problem in insanity, and I am not sure that even you can do it?—I have never tried. As I say the British Medical

25 February, 1925.]

Dr. MONTAGU LOMAX, M.R.C.S.

[Continued.]

Association have defined it rather well when they have defined people as "mentally ailing" and "mentally unsound," and I say the only definition of sanity which I am able to give is mental health. The word "sanus" means healthy, whether it is health of body or mind, the Latin word is the same. There is every degree of mental health which all of us experience but when you get certifiable insanity the legal definition of a certifiable person is a person who is dangerous to himself or to others, and the Acts have added to that: "unable to manage his own affairs." But when you get a person who is able to manage his own affairs, and whom it is perfectly safe to discharge on account of himself and other people, it strikes me that that sort of person is not certifiable, and ought not to be detained. Because his friends are unable or do not care to have him because he is a nuisance and a bother, you ought not to keep him for the rest of his life in an asylum. If you do, you are treating the asylum as partly a workhouse.

12,557. We have a little anticipated some of the matters that come later on, because the topic we have trenched on now is an exceedingly interesting one. I think you may take it that we have your view now about the medical superintendent?—May I ask if you have read the report of the Conference?

12,558. I am obliged to you for reminding me of that. Have you got the whole report?—Yes. May I read a couple of sentences out of that?

12,559. *Mr. Micklem*: Is it the Conference of the medical superintendents?—Yes.

12,560. What is the report?—It is the report of the proceedings of the Conference of Medical Superintendents and Chairmen of Visiting Committees, held under Sir Frederick Willis.

12,561. *Chairman*: I beg your pardon, I have had this, and I have read it.—And you have seen the most interesting statements?

12,562. Yes. Will you refer us to the paragraph?—If I may read what I have put down here: "Perhaps the most damaging admission of the results in combining these two offices in the same hands was made by Dr. Archdale, the Medical Superintendent of the Cambridgeshire County Mental Hospital. In his address he says: 'Is this criticism that the medical superintendent becomes changed from a physician into a mixture of prison governor and hotel manager a just one? In my opinion it is perfectly just in the majority of cases to a considerable extent. The majority of us find that the claims of administration are so many and so insistent that we are compelled to leave the principal share of medical treatment to our colleague or colleagues, and tend to become rusty in our medical knowledge . . . I take it that we are all agreed that this waste of medical talent goes on, and that it is deplorable on account both of its immediate effect on the treatment of patients and of its remote effect on the progress of our branch of medicine.' " I say that that is rather an important statement.

12,563. That is at pages 48 and 49 of the report?—Then Dr. Archdale goes on to say; "If the medical superintendent were to confine his attention to purely medical matters he would soon be almost forgotten by the committee and would very soon lose his control over the hospital. At present it is the non-medical matters which chiefly interest visiting committees." The very point which I made in my book is stated in the Conference there: "Sir Marriott Cooke, also a member of the Board of Control, agreed that the evils resulting from this medical dual control 'do no doubt occur. . . . To not a few medical superintendents the general administration of their asylums present special attractions, particularly when they find that the ability they display in that connection redounds greatly to their credit, so gradually they get more and more into the way of dealing in detail with matters which ought not to devolve upon them, but should be left to their lay officers, with a consequence that much of their energy and time are

alienated from their purely medical work, and particularly the individual treatment of their patients, which was the primary object of their appointment.' " Then Dr. Barham says exactly the same.

12,564. Do not omit the last sentence. Sir Marriott Cooke concludes with this: "If a medical superintendent will only deal with the really more important administrative matters and leave the rest to his subordinates, I am sure that it is quite possible for him to be the 'captain of the ship,' and yet to discharge his medical duties fully and satisfactorily." That is again just the question of the demarcation between what is really important in the detail work and what is not?—Quite, and the personality of the superintendent, the individual character of the superintendent.

12,565. *Earl Russell*: In that extract you read you see it is at the will of the medical superintendent whether he gives too much time to this, instead of delegating it to the people he ought to delegate it to?—Exactly. Dr. Barham says, in his statement, he can do as much or as little work as he likes; but he cannot do as much if he has to do all this other work as well.

12,566. But this deliberately says they make a choice. Unless you actually take away from them the power of supervision, I do not see how you can prevent their making that wrong choice?—They admit that.

12,567. *Chairman*: Administration is probably easier than the treatment of insane patients?—Much easier, unless you get a scientific man.

12,568. A scientific man may be an extraordinarily bad manager, but may be fascinated with his problems and make great strides in his science. On the other hand, you may have a man who is an extraordinarily good bookkeeper but not a scientific man at all?—Yes. A superintendent I know quite well confessed to me that the reason he had taken to asylum work was because he was fond of cricket. He said he had come in, he had been advised by the staff as a young man to come in, because he would get such heaps of cricket. He did; he got a heap of cricket. In time he became a superintendent, and he was not at all a bad superintendent. I have been all over his asylum; he was a very good type of asylum superintendent. He was an excellent judge of stock and farming and of crops. He would have made a splendid farmer, but he confessed to me frankly he had forgotten everything he had ever known about psychiatrics, and yet that man had a supreme and autocratic control of asylums holding 3,000 people. He was far to be preferred to an asylum superintendent who keeps in his office all the time. He used to go into his wards and he knew his patients, and they were fond of him, but as regards his particular science of medicine he had not looked at it.

12,569. You want to create a breed of medical superintendents who are endowed with qualities which you will only find in a superman?—No, I do not think so. All you want is a medical superintendent who is primarily interested in his work and nothing else, and you will never get all these abuses rectified until the superintendent is constantly to be seen in his wards, who can be seen at unexpected times, and patients know he can be got at and is accessible. At present he lives in a sort of Olympian calm, which he hardly ever leaves to come into his wards at all. I am speaking of some, not all.

12,570. *Sir David Drummond*: Have you contemplated the appointment of a medical man, not an alienist, as the executive officer?—I think it would be an excellent thing if he were appointed as an executive officer alone.

12,571. I mean that?—Quite. You see we want the medical superintendent of the patients to be absolutely interested in his work.

12,572. It obtains in Edinburgh?—You cannot imagine the enormous influence the superintendent would have over the patients and over the recovery rate of the asylum if he devoted his whole time and the time of his staff to it.

25 February, 1925.]

Dr. MONTAGU LOMAX, M.R.C.S.

[Continued.]

12,573. *Chairman*: Just on that point we have heard a good deal of the possibility of medical superintendents possessing special qualifications in the matter of psychiatrics. Are you in favour of that in the sense of having alienists as medical superintendents, rather than having competent general practitioners as medical superintendents?—No; I think the medical superintendent must be a specialist.

12,574. *Sir David Drummond*: I was not referring to the post of superintendent?—No, you suggested a medical man to be the executive officer.

12,575. As at the Edinburgh Royal Infirmary?—An excellent idea, if you got the right type of man.

Earl Russell: Of course with his medical training he would appreciate more readily the reasons why the medical superintendent wanted things done.

Sir David Drummond: Quite, that is what I have always felt.

12,576. *Earl Russell*: I would like to ask you a question about your suggestion that he would have a great influence on his recovery rate. It has been suggested to us that recovery is rather in the hands of God than in the hands of the medical superintendent?—It is, I am quite sure, in the hands of God, much more than in the hands of the medical superintendent. At the same time, if a patient felt that the superintendent was personally interested in him there is the element of hope that enters into it, the element of feeling that he is not an item, that he is not a number, and that he can get to the superintendent personally and make a friend of him. There are very few superintendents of that type, there are some; I have known splendid instances. There was a splendid man at Portsmouth, Dr. Mumby, I think he was, who died some time ago, he was a splendid instance of such a man. The difference in the asylum when that man came there, and after he died, was enormous, showing what the personal influence of a superintendent may be. Not only that, but it stimulates the staff to take an interest in their work.

12,577. *Chairman*: I think one can appreciate that very fully, but is not it the same in this profession just as in every other profession. Take the general practitioner. You know there are some doctors who are sympathetic and encouraging; others, on the other hand, are rather repellant and distressing. You cannot create dispositions and aptitudes to order. What we have to think of is rather a drier problem; it relates to the machinery. I have been thinking, while you have been talking, of the directions in which your ideals could be brought to fulfilment. Let us see where we are practically. Is it your suggestion that the selection, first of all, of the medical superintendent is a matter of very great importance?—Very great importance.

12,578. And do I understand that you propose that the selection should not be exclusively, as it is at present, in the hands of the visiting committee?—I do.

12,579. There are various expedients suggested; one is that there might be an advisory committee of the Ministry of Health, or of the Board of Control, which would assist visiting committees in obtaining appropriate officers?—Yes.

12,580. That would be in the direction of what you wish?—Quite.

12,581. Then next, you propose that persons should not be eligible for those offices unless they have shown special aptitude for this branch of science, unless they have obtained some qualification in medico-psychological science?—Certainly.

12,582. Let us follow it out further. Do I take it that you would advocate a greater security of tenure and independence of position of the medical superintendent *vis-à-vis* his visiting committee?—I think I should, yes.

12,583. Then it seems to me that we have brought it now to the point of the definition of his duties. You advocate that he should be relieved as far as possible of merely executive work, so that he may be

able to devote himself to all aspects of his purely medical work?—Yes.

12,584. I suggest to you that if there are appointed to his staff responsible subordinates who would have charge of the commissariat and of the farm and different departments, responsible charge of them, and the duty of making the necessary returns and accounts that have to be prepared, and so on, it would not be necessary to remove him from the position of supreme authority or ultimate court of appeal in his asylum; but you would accomplish what you desire by relieving his mind of a lot of trivialities and routine work which impede at the moment the performance of his real duty, which is the study and care of his patients?—Yes.

12,585. I do not know if one can express it more accurately than that?—No, I do not think one can.

12,586. Now we may pass to the next topic, which is in one sense not less important, and that is the question of the medical staff. Of course in the matter of the medical work of an asylum there must be a considerable amount of delegation, must there not?—Yes.

12,587. And the medical officer, in contradistinction to the medical superintendent, must have the immediate medical care of his own patients?—Quite.

12,588. Have you any observation to make as to the adequacy of the existing medical staffs in our asylums?—Yes, I have.

12,589. I rather gathered from your book that many of the asylums, in your view, are understaffed?—Certainly, they are.

12,590. We have had evidence from various eminent medical superintendents here to the same effect. I am afraid this is a matter of money, is it not?—Yes, I am afraid it is, and also a want of dividing up the work. It is largely a question of classification again. If you have got cases classified like acute and chronic cases you could well put 50 acute under one man and 200 chronic, and if you did that I do not think the man would be overworked at all; but when you give him, as he often has, 400 or 500 mixed up of all kinds, he cannot possibly do the work—not properly.

12,591. I think it stands to reason that if you have an institution, let us say, of 3,000, with a medical superintendent and possibly only 6 or 7 medical officers under him, each medical officer will have 500 patients. Of course it is manifestly impossible?—Absolutely impossible.

12,592. But you suggest that if there was a system of allocation, the medical officer could have under his particular charge a certain number of chronic cases who would really require little more than a kindly nod once a day?—That is so.

12,593. And have at the same time allocated to him a number of cases, recovering cases, which he could quite well overtake?—Quite.

12,594. How many do you think a medical officer could reasonably have under his charge of cases that really required attention?—It depends upon the zeal of the man, but he could have—I think 50 is enough of recoverable and acute cases, because he has a lot of clerical work to do, and the clerical work takes up hours of his time, if it is really well done. It very seldom is well done; I know I used to scamp mine over and over again. You cannot find the time. He has case books to fill up, and that takes a tremendous time if he goes into the cases carefully; if he gives individual attention to his cases, his case book will take up a large part of his time.

12,595. *Earl Russell*: Would he on the average want to make more than one or two entries a day in the case book?—No, one a day would be ample.

12,596. I mean for each patient, for the whole 50 patients?—According to the rules you only have to make one a week in the first stages, and then one a month, and then one in three months.

12,597. I mean what is the total number of entries in the case book which he has to make in a day?—It depends upon what sorts of things happen. There may be accidents and illnesses happen, and so on,

25 February, 1925.]

Dr. MONTAGU LOMAX, M.R.C.S.

[Continued.]

but he has to make a great number of them which are simply repeated week after week, month after month, chronic cases; they do not require anything particular to be said about them.

12,598. *Chairman*: I am thinking of the clinical treatment of the patients. You say that the medical officer, like the medical superintendent, has a good deal of clerical work to do which is liable to divert his energies, but assuming he keeps adequate records how many patients do you think he would be able to look after clinically?—Fifty at the most, I think.

12,599. And even so he would be pretty busy, would he not?—Yes, he would.

12,600. It would fluctuate, obviously?—Obviously.

12,601. But he might have allocated to him 50 cases requiring real attention?—Yes.

12,602. And I rather gathered you said he could also have a couple of hundred of more or less chronic cases?—Yes.

12,603. From that I infer that you think a medical officer would not be overburdened if he had 250 cases under his hand.

Mrs. Mathew: Assorted cases.

12,604. *Chairman*: Duly assorted cases on that basis, 50 requiring attention, and 200 really not requiring any special attention?—He is given wards with all sorts of cases in them, and he gets only those wards to look after. It limits his work largely. He may not have anything to do in the hospital wards at all for years and years. He may not have anything to do on the female side—he may be kept on the male side.

12,605. Apropos of that, it would be a disadvantage, of course, for a medical officer to be confined to one section of an asylum, or to one class of patient, because his experience would be narrowed thereby?—Yes.

12,606. You have to reconcile classification on the one hand with the medical officer's opportunities of training on the other hand. Probably that is reconciled in this way, by having your classification, and by having your medical officers moved from department to department, so that at each period they will have had experience of the different types of patients?—Yes.

12,607. The medical officer should for a time be in the reception ward seeing all classes of cases. Then he might perhaps be in the acute wards, and then he might be in the chronic wards, in that way passing through the institution acquiring experience in each department?—Quite.

12,608. The one medical officer could not very well have at one and the same time 50 acute cases or 50 cases requiring attention and 200 chronic cases, because they would be in different departments of the institution?—Still he could see them for all that.

12,609. *Sir David Drummond*: What about the patients in the hospital. Supposing there are a number of cases of bronchitis and pneumonia—those would take part of his time?—Quite; I do not think as a rule he has anything to do with those. I think he ought to have; I think he ought to attend to his own cases.

12,610. Who attends to these hospital cases?—It is put under the charge of a special man who has his other work as well. That is my experience. I do not know what the experience of other asylums is, but the hospital at Prestwich, for instance, is put under the charge of one man only. I had not care of the hospital at all except when I was taking duty for my senior colleague. He had the charge of them; I had not anything to do with them, and I had no responsibility over them, which I ought to have had. I should strongly recommend that a medical officer, who has cases requiring hospital treatment under his care, cases that he sends to the hospital, should retain them under his care while they are in the hospital itself, in order that he may follow them up and may study them there. He sends them now, I believe, in the majority of asylums. I do not know that; I am only speaking of my experience of these two institutions.

12,611. *Chairman*: I think we may pass now to the question of the visiting committees. These are statutory bodies, as you know, supposed to represent the local authority who are the administrators of the institutions?—Yes.

12,612. And the statute imposes certain duties of visitation upon them?—Yes.

12,613. Now have you any practical suggestions to make for the improvement of their supervision?—Yes, I have got a good number, if they were practicable, but I do not see how an outside doctor can dictate to a visiting committee as to what they ought to do. Some of the regulations by statute seem to me absurd; that statement in the Act that each member or two members of the committee have every two months to inspect and visit every part of an asylum and speak to every patient in it. That is ridiculous, I mean to say it cannot be done.

12,614. *Earl Russell*: Does it say speak to every patient in it?—See every patient; I do not think it says speak to every patient.

12,615. *Chairman*: There are two senses of the word "see" you know?—Quite. If they inspected every part of the asylum I certainly think that that should come within their duty, and that their inspections should be less formal than they are; should be unannounced, and should be unaccompanied whenever possible. As a rule the visiting committees just hurry through the wards with an attendant in charge and say a few words to anyone who chooses to stick to them. Very few patients ever do. They regard the whole thing as an absolute farce. That, I think, every attendant will tell you, and I think Mr. Gibson would tell you that most of the members of his Union regard the visits as a farce too.

12,616. *Earl Russell*: It is not my experience. I have been on a visiting committee for a great number of years, and the patients, on the contrary, flock round when you go in?—It just depends upon the visitors. If you show yourself interested and kindly disposed they will flock round you, but the visitors I have seen, as a rule, are only too anxious to get out of the wards as soon as they can; they regard it just as a routine affair. I do not see how one can say anything more.

12,617. *Mr. Micklem*: That was not quite the view taken by Mr. Gibson yesterday, and by the evidence we had?—I did not hear it, but I could quote you page after page from the Asylum Workers' Union paper in which they express the sentiments which I have about these visits.

12,618. The two nurses and Mr. Gibson did not quite take that view; they seemed to think that the visiting committee did extremely good work, and that they were effective in communicating with the patients, and so on?—Well, I am afraid that is a view I cannot speak to from experience. How can I? It is only what I have been told. You will find every patient practically without exception—I have interviewed hundreds and seen letters probably from thousands—who will tell you exactly the opposite, that they could never get the asylum committees to interest themselves in them at all except in the most perfunctory way. I know how difficult it is for laymen to interview what are called insane people, and to take the views they do.

12,619. *Earl Russell*: It is not so much the interviewing that is difficult, but when all the patients ask you that they may be let out it is quite obvious laymen cannot very effectively intervene?—Quite impossible.

12,620. *Chairman*: You see it is not much use criticising institutions which, after all, are human and fallible, unless you can suggest some method of improving them?—Quite.

12,621. We are always thinking of it from the practical point of view. We recognise that these institutions, like other institutions, must exhibit defects of various kinds, and some very pronounced ones; and we are specially concerned to see that these are, if possible, removed. Now I appreciate at once,

25 February, 1925.]

Dr. MONTAGU LOMAX, M.R.C.S.

[Continued.]

and we have had a good deal of evidence about it, that the way in which visiting committees discharge their functions must vary infinitely, vary with the dispositions of the visitors. Some people will take a special interest in that class of work, and others will be quite perfunctory, as you say, and glad to get out of it as quickly as possible. They may have a distaste for asylum visiting?—Quite.

12,622. It is very difficult to legislate for that sort of thing?—Very.

12,623. When you have provided that persons shall be selected to do this and that they shall discharge certain duties, from the legal point of view one has almost done all that can be done. One cannot compel a man to be kindly by Act of Parliament?—Quite.

12,624. I would like very much to have some suggestions, if you could help us with any, as to the improvement of this visiting system, because one appreciates that that is one of the points of contact between the asylum inmates and the public?—And the outside world.

12,625. Which, as you say, enables a patient to feel that he is not cut off, but is still in touch with the world outside?—Yes.

Mr. Walter Stewart: Would you consider this question to be put to the witness on this point; would it be desirable that the special attention of the visiting committee, of the visitors, should be directed to that border line class which is a limited one, so that they may be brought into contact with the people whom they could usefully interview.

12,626. Chairman: Yes. (To the witness): Dr. Lomax, what do you say about that suggestion? The visitation, of course, of certain classes of cases must necessarily be more or less a formality. On the other hand, the cases that give all the trouble and cause all the agitation are the cases as to which there is a question—the borderland cases. Something might be done in the way of directing the visiting committee to have special regard to such cases on the occasion of their visits, as Mr. Stewart suggests?—That is what I have suggested over and over again in articles and speeches, that the visiting committee should set aside a certain time at each of their monthly visitations to hear reports of cases of patients, to hear complaints of patients, to sit as a sort of small appeal court. If they did that, if the patients felt they could get at them they would write to them. The result at present is practically nil. We could give you evidence of thousands and thousands of letters which patients have written to visiting committees which are merely waste paper. If you could get committees to agree to sit for a certain time, say an hour each month, in which time they would personally hear any complaints of patients, and have a room set apart in which they could do it, and not be afraid to do it, the complaints would be dealt with. Half of these people are afraid of the patients.

12,627. Earl Russell: An hour would be no use in a big asylum?—It depends. The patients would have to be sifted, no doubt. I mean to say, the medical officer would sift them.

12,628. Chairman: That is the trouble again; we always come back to the responsibility of the medical officer. You would have to have the cases for the visiting committee selected?—You would.

12,629. And I feel again that we are getting into the circle if I may so put it?—You cannot get out of it.

12,630. You have at the end of the day to recognise that, because, of course, there must be a great many people who write the type of letter you mention, in whose case an interview would be idle?—Absolutely useless, a waste of time.

12,631. And probably they would be asking for an interview every time, to the detriment of cases where an interview would be greatly beneficial?—Certainly.

12,632. And giving the visiting committee just that feeling, that there is no use in going to see these cases because they are just people full of delusions, and so on, with the result that the thing becomes routine, and real cases are apt not to be considered?

—I am not speaking so much of the patients that apply to the visiting committee to be discharged; I am speaking of patients that apply to them and could and would apply on account of ill-treatment. The visiting committee would say to any patient who applied to them for discharge "That is the affair of the superintendent; you must apply to him." But I think there ought to be some appeal court to which patients could take complaints against ill-treatment by attendants, if they could.

12,633. And you think the visiting committee would do that work?—I think they are there to attend to that sort of thing.

12,634. Earl Russell: Do the patients not make those complaints to the medical superintendent?—Very seldom; they do sometimes.

12,635. Because, of course, if they do, it is his duty to report them to the committee?—Of course it is, but you find that very few complaints are made to doctors—very few indeed.

12,636. Chairman: I was rather struck with this general observation in your book. You say this on page 16: "No one can study the Lunacy Acts of 1890 and 1891, and the Mental Deficiency Act of 1913, without realising the pains taken by the legislature to safeguard the interest of lunatics and imbeciles, and to provide for their wise and humane treatment in our public asylums; but no one, with any practical knowledge of lunacy and the problems of psychiatrics, can fail to realise also that these objects have been insufficiently considered and imperfectly attained in these Acts." The effort is there, and the code is more or less elaborate. We have a special concern to see in what respect the code has proved inefficient, and we are always looking at it practically, you will appreciate. What are the suggestions from your point of view as to the visiting committee and its present deficiencies? What are we to do? Suppose you were sitting in my place just now thinking it out with the responsibility attaching to any such suggestions, what would you suggest as a means of improving the utility of visiting committees as a safeguard to inmates of asylums?—Well, if I might say so—it sounds rather queer—I should abolish the committee's dinner, in the first instance. It sounds rather immaterial, but I mean to say that that is such a feature of the visit that it seems to take up all the time. It is not only uneconomical, but it means that you have good wine and spirits and cigars, and liqueurs, and that sort of thing; they used to do; and then, if they have anybody to see afterwards—well, you know what happens after a good lunch.

12,637. I take it from you, Dr. Lomax?—I take it from my experience of visiting committees.

12,638. Earl Russell: How long did this dinner last, in your experience?—It lasted as a rule an hour to an hour and a half.

12,639. If you go to an asylum in a remote part of the country, and you propose to stay there from 11 to 3, or from 11 to 5, you must have something to eat and drink?—Of course; but as a rule asylums are not so remote as all that.

12,640. A good many I have experience of are remote?—Some are, it is quite true, and you must have something to eat, but my experience of the asylums which I was in was that the dinner was the chief function of the visiting committee, and that it took up time which might have been usefully employed in visiting the patients.

12,641. Of course, as you know, on the London County Council we were always virtuous, and it only took up an hour, and during that hour we did discuss matters connected with the asylum. The medical superintendent was with us. It was not altogether wasted.

12,642. Chairman: Perhaps if the visiting committee shared the patients' lunch it would be an improvement?—It would be a great improvement.

12,643. Earl Russell: It might diminish their numbers?—I have a suggestion here from a chaplain of one of the large asylums in the country who is

25 February, 1925.]

Dr. MONTAGU LOMAX, M.R.C.S.

[Continued.]

quite prepared to come and give evidence if he is asked. Chaplains are people who see a good deal of the inside of asylum life, and they can be of great use. He is speaking of the committee. I am afraid he is not very pleased with his own. He said "The first step, I am convinced, should be the abolition of the visiting committee as at present constituted. They should cease to pretend to control, for it is the superintendent who does that, and these hospitals should be controlled as prisons and work-houses are by the Ministry of Health." We come back again always to the sources from which these people are appointed.

12,644. I did not know that prisons were under the Ministry of Health?—No, no, he does not mean that; he says that, but he cannot mean it.

12,645. Nor are workhouses controlled by the Ministry of Health?—Quite so, but what he means is that he wants the visiting committees to be appointed by some central Department.

12,646. *Chairman*: Yes, but you observe we have both these things. The Act is an attempt at least to combine two things. It is an attempt to combine the local interests in the institution, by having a visiting committee appointed by the local authority, with supervision from headquarters through the medium of the Board of Control, so that the Act, whether it achieves its purpose or not, contemplates both local and central control by visitation?—Quite.

12,647. General suggestions to abolish visiting committees do not help one very much?—Not a bit, but the question is: How much control the Board of Control has over these asylum boards? It practically has none at all.

12,648. I am coming to that. I think there is obviously room for considerable extensions of the powers of the Board of Control. That is a matter upon which we have had much unanimous evidence, but for the moment we are on the question of the visiting committee. We have this body set up whose duty it is to visit, and it is only proper that there should be such a body, because they represent the ratepayers of the district who pay for the institution?—Yes. How are you to compel them to fulfil their duties?

12,649. Exactly?—A lady member of one of the large asylum committees wrote to me, and asked me if she could come and give evidence here. She was prepared to give some very important evidence about the difficulties she underwent on her committee. She was the only lady member on the committee, and she wanted to go through the wards on her own account, and to visit independently, to do what she was elected to do. She was told that that was out of the question; she was not appointed to do anything of the kind; she was only appointed to do what people on her committee thought the proper thing to do; that was to come to the lunch and have a talk and stroll round and go home again. She extremely resented that. She said she had been appointed to visit, and she would be glad to be able to do it, and she was told by a legal member of her board that she was not appointed to do anything of the kind. She was appointed to do it in the way they thought it should be done—not in her way.

12,650. I do not quite understand the source of that legal advice?—No. It was a legal member of her own board who told her that.

12,651. She should have just taken her own way and said, "I insist upon exercising my rights"?—She did, I believe, and she was most unpopular.

12,652. Hampden was unpopular; the reformer is always unpopular?—How are you to force the visiting committee to fulfil their duty?

12,653. If you can tell us how to do that you will have accomplished a very valuable thing?—Precisely.

12,654. *Earl Russell*: I think visiting committees are not compelled to visit the asylum more than once in two months?—That is so.

12,655. What do you say to making the visits, at any rate, monthly, and preferably fortnightly, for the purposes of discharge?—I do not think it would work.

12,656. It would not help?—It would help, but I do not think you would get those people to go on these committees. They have got a heap of things of their own to do.

12,657. Once a month is twelve times a year. In London you get committees to go once a fortnight, and people have more to do in London than in other places?—If you can succeed in doing that in the towns and in the country I think you will do very well.

12,658. Obviously it gives them more time to do the various things they should do, including the visiting?—Obviously.

12,659. *Chairman*: That is a suggestion; but it seems to me we are left with not much practical assistance beyond this: that you would like some provision made for the visiting committee to sit in the asylum at intervals for the purpose of hearing complaints by patients, and hearing them under circumstances favourable to the patients, and favourable to the investigation of the case?—Quite.

12,660. *Earl Russell*: There is one other suggestion that occurs to me. I have been looking at the section—it is not very clear. I do not know whether they have power to co-opt members outside the local authority at present, but that might be a useful power, might it not?—Yes, I think that power has been suggested in Lord Onslow's Bill.

12,661. To bring in a person who might not be a borough councillor, and yet might be an extremely useful asylum visitor?—Most useful. It is one of the things that would be most valuable, because we want to co-opt people on these committees who are willing to do a lot of voluntary work.

12,662. *Chairman*: You might in that way get some women visitors who did not care for ordinary municipal work, ordinary county council work and all that that means, but who were genuinely interested in this class of work?—Quite.

Mrs. Mathew: I think we already have them in London, Mr. Chairman.

Earl Russell: It might very well be that a person did not care to stand for elections.

Chairman: Dr. Lomax is just referring to what is already provided for in the local legislation for London, and Mrs. Mathew points out it exists in London. I was not aware of it.

Mr. Snell: We co-opt on the County Council every year.

Earl Russell: I should be glad to get that section on the notes if there is something in the private Act.

Chairman: The explanation of it is to be found under the Mental Deficiency Act. The Mental Deficiency Committee coopts, but in London the Mental Deficiency Committee is also the Asylums Committee, and, thus, you get the benefit of the coopted members. Now that is another suggestion which is valuable. Beyond that I am afraid you cannot do very much except to exhort people to do their duty.

Mr. Walter Stewart: There is already Section 204, the special visit in certain cases, to be entered on the minutes of the board, but that is only where there is a case requiring immediate investigation.

Chairman: Yes. Is not that a special visit of the Commissioners?

Earl Russell: This is the Board of Control.

Chairman: We are dealing for the moment with the visiting committee.

Mr. Walter Stewart: I beg your pardon.

Chairman: I see in London on the Mental Hospitals Committee there are five ladies who have been coopted at the present moment out of a total of ten coopted members. Five men and five women.

Witness: Would it be possible to embody in any recommendations on the subject that the visits of the committee should be much more informal and unexpected than they are, because they are known all about beforehand. It is like the inspections of the Board of Control; they are known all about beforehand and are prepared for. We know that they

25 February, 1925.]

Dr. MONTAGU LOMAX, M.R.C.S.

[Continued.]

come as a rule at lunch time, at least on the occasions of the lunch. In cases where these people go unexpectedly they often see the most extraordinary things, as you will remember in the case of Mrs. Hatfield at Hull. She was a member of her Asylum Committee under the Town Council; she called at 7 a.m. in the morning.

Earl Russell: But you see this is not primarily an inspecting body; it is a visiting body, and therefore it must come on some day when it is expected.

Mr. Micklem: Is that quite so under the Act?

Earl Russell: You mean would they have power to inspect?

Mr. Micklem: Yes.

Earl Russell: I suppose the ordinary medical superintendent might keep them out if he chose, but I should hardly imagine he would be so foolish.

12,663. *Mr. Micklem:* The provision under the Act seems to be to visit as an official committee, so that such an individual lady as you were referring to just now was probably well advised?—I do not think any law exists which can prevent anybody on those boards going at any time they like.

12,664. I think their own committee could prevent it, could it not?—I do not know.

Chairman: I should have thought that, whatever the law says, that should be made plain. A member of the visiting committee should have access at all times of the day or night, alone or in company with his colleagues, to any part of his institution.

12,665. *Mr. Micklem:* There is no provision of that kind in the Acts at the present time?—When Mrs. Hatfield of Hull went, she went at 7 o'clock in the morning, and the asylum people were not able to refuse her entry, but they kept her for about half an hour in a side room while they made some sort of preparations; but still she told me herself she did go, and she saw all the things she reported.

12,666. *Chairman:* That is rather inconsistent with your suggestion that medical superintendents and staffs are so concerned with conciliating the visitors?—Well, you do not get that type of visitor as a rule; it is the first I have ever heard of.

12,667. *Earl Russell:* That might be a method of conciliating a majority of the visitors?—That is one of the chief reasons for having women on these asylum committees. That is one of the things I make rather a point of in my book, and which has since been carried out to a large extent. I should make it imperative that on all committees you should have at least a couple of women, because, as a rule, they see farther through a door than a man does. They are much more interested in detail than a man is, and they are not to be put off by excuses as a man is. Mrs. Hatfield was not to be put off, and she was not put off, although she had a very bad time; she was a very courageous woman. She said that the result of that investigation was perfectly extraordinary in the asylum at once: the bathing was improved at once, the clothing was improved at once, and the food was improved at once, all on account of this one woman going at 7 o'clock in the morning before the asylum was up, so to speak.

Earl Russell: Of course it is always the nonconformist, the tiresome person, who gets things done.

12,668. *Chairman:* We have your point there. Now let us pass on to the question of the nurses, or attendants. We had the benefit yesterday of the evidence of Mr. Gibson and of those with him on the question of the nurses and attendants, and we have also heard a good deal from Mr. Parker on that subject. Do you think you can tell us, in more or less summary form, whether you have any addition to make to the suggestions that have emanated from these previous witnesses?—Yes, I have a few suggestions to make. I have not very much to add to what Mr. Gibson said yesterday, with which I entirely agree so far as I can from an outside standpoint, especially about the 48-hour week and the absolute necessity of taking more pains with the nursing. What I wanted to say was that I do not at all share the

opinion which has been expressed by a number of witnesses as to the great importance of these certificates for nursing. The examination standard of the nurses strikes me as being far too difficult; the subjects are too various and advanced for the ordinary nurse. I do not think she requires to know all the things that are in the schedule there. I think the hospital nurse does; but that examination there is rather stiff for the ordinary mental nurse; I do not think she wants to know half so much. I do not take the view that the certificated or badged nurse is any more useful than the uncertificated nurse, provided she has the nursing capacity, provided she has plenty of the milk of human kindness, for the recovery of the patients. The people with the badges, as a rule, think themselves very important people. A number of them, I am told, especially among the men, are rather ashamed of the badge; they know what the value of the examination is. I think if some of the doctors knew how the examinations took place, and how the nurses' papers were passed, they themselves would be rather surprised at the facility with which the examinations were passed.

12,669. Look where we get; first of all, there is the agitation that nurses should be properly trained and competent and should have some standard of efficiency. Thereupon Parliament passes an Act, and a standard is set up, and a method of examination is instituted. No sooner is that done than it is said, "Oh, well, examination is not the test for ascertaining real nursing vocation." It is just what happens so often. A remedy is suggested, and the remedy is put in operation, and then the remedy itself becomes in turn the target of criticism?—Quite. I am quite sure of this, that in asylum nursing the experience of the people who have been at it longest is not that the people with the certificates make the best nurses from the patients' point of view.

12,670. I can well believe that?—The passing of the examination in itself deters a number of would-be excellent nurses from ever coming into the service at all; they come in for a short time and they drift out. I do not think Mr. Gibson emphasised, and I do not think perhaps the members of the Commission sufficiently realise, the enormous floating population of nurses there is.

12,671. We have had statistics about that; it is most remarkable, in the case of women particularly?—I know, but some nurses do not stop for more than two days, or sometimes for a week. When in the mental hospitals, the nurses are in some cases compelled to pass examinations; but it does not touch an enormous number of this floating population who never approach within any reasonable degree of any examination or certificate at all. They have gone out of the asylum in three months, and have done perhaps infinite harm to patients in their passage. They are not touched by any of this, so that any percentages you get of nurses who have taken badges do not represent the number of nurses who have passed through the asylums in question.

12,672. As you point out, it is those birds of passage who may do the most harm while they are there, because they are inexperienced, and while they are there they will cause a great deal of unhappiness and possibly ill-treatment to the patients under their hands. How are you to stop that, because, after all, everybody must begin a profession?—Yes, I know; but I think mental nursing ought to be put on the basis of hospital nursing, and that nurses who come as probationers ought to contract to stay, say, for a year or two, as hospital nurses have to do. That would enable them to take it up in a much more serious way. Of course there ought to be a great deal more supervision over the character of nurses engaged. The nurses are engaged chiefly by advertisements in the papers, and you find often and often in these advertisements, "No experience required." You often get a class of nurse, both male and female, which is most undesirable, a class that comes because there is not anything better to do, a class that has no intention of staying, or a class that does not want

25 February, 1925.]

DR. MONTAGU LOMAX, M.R.C.S.

[Continued.]

to do any more than they can help in the time they are staying. They are not the class of nurse you get in hospitals. That in itself requires to be improved enormously, the type of nurse which asylums engage. In numbers of cases the references of these people are not taken up at all.

12,673. Let us follow it a moment. How are you to ensure a sufficient supply of persons who will take up this class of work? One has to recognise that it is work calling for peculiar qualities if it is to be properly done, great qualities of sympathy and forbearance—that class of person is limited, and not very easily obtained, and in fact you cannot tell with regard to a particular person whether they are suited to it until they have tried it.—Quite.

12,674. And you also must make the career more or less attractive if you are to get a good type of nurse. How are we to ensure that the proper class is obtained for this work?—By making the service more attractive all round, better pay and better hours of work, and better means of recreation and amusement, increasing the comfort of the nurses. Hitherto the nurses have been almost as much neglected as the patients in these asylums; they have had a very bad time indeed, not only in the war, when my own experience was gained, but both before and afterwards. I have heard accounts over and over again of asylums and of the poor accommodation which they had for nurses, the food which they had, and the hours of liberty, and so on. You heard from Mr. Gibson some of his experiences. You have got to make the asylum service more attractive. It is one of the most arduous services in the world, and one that deserves all the encouragement it can get, all the thanks of the community it can get, and you have got to make it somehow more attractive.

12,675. *Sir David Drummond*: Not imposing too severe difficulties in the matter of qualifying examinations?—Quite. That is a point which turns off hundreds of very good potential nurses from the career; it is not wanted. They want to know enough to take a diploma in the ambulance service, something of that kind, in the first place. They do not want to know psychology and psychiatrics, not certainly until the teachers are more agreed among themselves.

12,676. *Chairman*: Of course you know examinations after a time are rather apt to continue to exist for their own sake, and they also become liable to be tuned up more and more?—Quite.

12,677. The object of the examination is to ensure efficient service and to eliminate the unsuited?—Yes.

12,678. I could appreciate your point, that highly technical and theoretical knowledge may puff up the nurses with a certain feeling of pride in their own intellectual ability, but many men are most unsuited for the part of a sympathetic bedside attendant?—I am afraid it is so. Not only that, but it is the way in which the examinations and lectures are held, and in numbers of cases the lectures are often held by attendants, the head attendants, I believe. I am speaking from what I have been told; they are not only given by the doctors.

12,679. *Earl Russell*: Surely the head attendant ought to be able to give a very practical lecture?—He ought, and I think he is very often the better man of the two as regards the nursing, but it means this, that the head attendant has his favourites among the nurses, and if he has anything to do with the papers (and he is concerned a great deal, so I am told by the attendants themselves), the examinations are often more or less of a farce.

12,680. *Mr. Micklem*: Are they conducted by any central association, or are they conducted separately at each asylum?—In some instances the examinations, I believe, are in a central place.

Sir David Drummond: Centrally, I believe.

12,681. *Mr. Micklem*: But your suggestion rather is that at these examinations the result may depend to some extent upon the attendants?—I mean to say this; I have been told by attendants themselves that

some attendants find it very easy to pass the examinations, and some find it very hard, owing to the attitude of certain parties.

Earl Russell: I want to know how the attendants do get at the papers?

Mr. Gibson: If it will assist the Commission, at the examinations I have conducted the papers were set by the central authority, the examining body of the Medico-Psychological Association. But of the two examiners one is the medical superintendent, and the other examiner is a visiting examiner sent from another institution.

Chairman: Does he bring the papers down with him?

Mr. Gibson: They are sent in advance.

Earl Russell: And who collects the papers?

Mr. Gibson: That I am not prepared to say. One of the suggestions we have had is that they ought to be allowed to make their papers up, put them in an envelope and seal them themselves.

Mr. Micklem: Who conducts the oral examination?

Mr. Gibson: Both. When I was examined, I was examined in practical work by my own medical superintendent.

Earl Russell: I rather gather that Dr. Lomax's suggestion is that the papers are tampered with after they are written.

12,682. *Chairman*: This is rather an alarming suggestion. I do not think your evidence on this point, if I may say so, in contradistinction to your evidence on other matters is really of value to us. It relies solely on hearsay; we cannot act upon such evidence.—Will you ask Mr. Gibson the question if the papers are always handed in to the charge of the head attendants; if he is in the room when the examination is going on; if they are handed in to him in the names of the examinees, or in numbers only?

Chairman: I suppose Mr. Gibson can only speak of his own experience; but when you were examined, Mr. Gibson, were there a number of others being examined along with you?

Mr. Gibson: There were a number of others, and each candidate was too far separated from the others to allow of any cribbing, but there is no distinguishing feature on the papers, as far as I could see.

Chairman: When you had written your paper did you hand it to the presiding examiner?

Mr. Gibson: Yes. What happened to them afterwards I cannot say.

Earl Russell: They were not collected by an attendant?

Mr. Gibson: No.

Chairman: Did you write on the paper your own name?

Mr. Gibson: No.

Chairman: How was the paper identified by your number?

Mr. Gibson: It may have been numbered. I do not remember writing anything.

12,683. *Chairman*: I do not know that this is really very profitable. I rather gather that so far as your own personal experience is concerned, Dr. Lomax, you have found the attendants with whom you have come in contact to be very excellent people and well fitted for their work?—No, I have not stated that. I have stated that at the time I was at Prestwich there were a number of attendants whom I thought were good at their work, but there were certainly a very large number whom I should have said were not.

12,684. I thought that you were going to pay them rather a higher tribute, because I was very much struck with a passage on page 189 of your book: "I should like to put it on record that, in my experience, the character and behaviour of the male attendants with whom I had to do, for I had little experience of the female attendants, especially of the head attendants and ward charges, left, on the

25 February, 1925.]

Dr. MONTAGU LOMAX, M.R.C.S.

[Continued.]

whole, a distinctly favourable impression on my mind."—Yes, they did.

12,685. "They had their faults, of course, and I have not hesitated to mention such of these as, in my opinion, militated against their efficiency. But these seemed to me to be much more due to the defects of the system which they had to administer and under which they were trained, and to the monotony and dreariness of their life, with its many repulsive sights and sounds, than to any deficiency of kindness and good nature. Callous and indifferent a few of them were, while want of tact and sympathy were not infrequently met with, but I met none who were deliberately cruel or inhuman. One must speak, of course, with a certain amount of reserve in these matters, for no attendant would show actual animosity or unkindness before a medical officer, and it is the rarest occurrence for any patient to complain of an attendant." I gather your examination was of those with whom you came in contact yourself, that they were none of them cruel persons, and that they all made a favourable impression on your mind?—The charge attendants in my ward certainly did, and the head attendants, two of them at least, did, but there were a number of other attendants who did not. I am speaking guardedly there. I am very anxious not to traduce a body of men, or women either, who do such very valuable and arduous work, and who have so little encouragement from the authorities to do it well. I am very anxious not to say anything disparaging to that class of attendant.

12,686. But after all we need not flinch from the matter, and I am sure Mr. Gibson would not either. If you take any large profession you will inevitably find within it a certain number of persons who fall short of their duty?—Certainly.

12,687. The really desirable thing to achieve is to see that there are proper means taken to deal with these cases. All professions have disciplinary methods for dealing with cases. Similarly, one would wish that machinery should exist whereby undesirable attendants—because there must be such where you have such a large number of men and women engaged—can be eliminated, and the patients protected against them. Now, it is just there that one comes on to the topic of ill-treatment under the existing system without it coming to the cognisance of the proper authorities, and so being stopped by the dismissal or the warning of the attendant. That seems to be a very vital matter?—Very vital.

12,688. On that, in your experience, did you actually encounter under your own eyes any case of real ill-treatment?—By an attendant?

12,689. Yes.—No, I did not see any case, and a doctor never does; he is the last person in the world who would.

12,690. Surely not, because we have had cases in which the doctor has reported the ill-treatment himself?—It has been accidentally found out. What I mean to say is, the doctor is the last man who hears or sees anything of it. I suspected it in a few instances, but I did not see anything actually happen.

12,691. But if the doctor who is in charge of the case (I am talking of the medical officer as distinct from the medical superintendent) is hoodwinked in the matter of cruelty, that is to say, does not see it himself, how are you to get at the truth of the case?—I wish you could tell me, Sir. The difficulty is enormous, because if ill-treatment is going on he will only see the results of it, which may be explained in all sorts of ways which are not true.

12,692. *Earl Russell*: But which easily might be true?—In cases they might be true and might not. As a rule he hardly sees anything of it; he hardly sees the results of it. I mean, if it is very serious, if the patient is seriously injured, he is bound to know of it then, and he enquires into the cause of it, and he may be told all sorts of things—that the patient was resistive and had to be forcibly restrained, or had been fighting with some other

case or that he had fallen down and injured himself. All sorts of explanations are given, and, as a rule, if the doctor asks the patient about it, the patient is very chary of saying anything at all. I am afraid I must say that he is too cowed in a number of instances to explain how it happened. In some instances perhaps he is not sufficiently intelligent, and you have got to take the attendant's word. Well, I saw, as I have said, no case in which an attendant was ever ill-treating a patient openly. I have suspected it on certain occasions, but for a doctor, as I say, it is very hard to find out what is going on. He does not see the patients stripped except when they are ill, or except the attendant asks him to see someone.

12,693. But he would see him stripped if he has any suspicions?—He would, of course; he would have him stripped.

12,694. *Mr. Micklem*: Did any patient ever complain to you, Dr. Lomax, of ill-treatment?—Hardly any.

12,695. Not one?—I would not say not one. I should think probably two or three may have done.

12,696. *Chairman*: Just tell us about those two or three. What did you do about them?—I would say "Where," and he would say perhaps "My arm has been hurt." Then I would ask the attendant how it happened. "Oh," he would say, "Well, he was rather violent, and we had to forcibly remove him to a cell."

12,697. Did you believe the attendant?—I did then, I must say.

12,698. Was there any reason to disbelieve him?—Well, at that time I had not any idea of the amount of ill-treatment which since then has reached my ears.

12,699. Mind you, we must not allow our views to be unduly coloured. When you speak of the evidence which has reached you since, do you speak of complaints that have been made to you by ex-patients after they have left institutions?—Yes.

12,700. You will agree with me that the assessment of the value of that evidence is one of the most difficult things?—No, Sir, I may not agree with you. I know that it is hard to assess, but when you have had a large experience of patients and can give your own estimate of the value of their evidence, you form your own conclusions. I do not think it is so hard as you think.

12,701. Take the case you have given us. You tell us you have had large experience. Three patients complained to you that they had been ill-treated.—I say two or three; I cannot remember the number. I asked them where and when and how and tried to find out.

12,702. You were in the best and most favourable position to discover because you were on the spot; you had the patients there and could get the patients' own statements, away from any attendants?—I could have done, but there was not anything sufficiently serious then to occupy my attention. I cannot remember really more than one or two instances in which a patient may have said to me, "My arm has been hurt," or something of that sort. I practically never saw any evidence while I was there of ill-treatment, barring these few things that happened, which I could easily account for by struggles of some kind.

12,703. I will tell you why I am pressing this a little, because I think it is very vital. You say in your treatise that you were in an asylum with regard to which you had to make very severe criticisms, and therefore we may assume it was not one of the best administered in your view; and yet in that institution during the whole period you were there, you say that you encountered no case yourself of ill-treatment, and that although you had one or two complaints from patients they related to relatively trivial matters?—That is so.

12,704. That evidence, drawn from an experience of by no means one of the best—in fact, I think you would probably say one of the worst—institutions in this country seems to me personally to be of very great countervailing value, as contrasted with evidence gathered by you from

25 February, 1925.]

Dr. MONTAGU LOMAX, M.R.C.S.

[Continued.]

complaints and interviews of persons who have left institutions afterwards, when their stories were no longer susceptible of immediate verification as they were while you were in the institution. You see my point?—Quite, I see your point entirely. It has occurred to me over and over again. I did not at that time suspect anything happening, yet I do now. I had not the evidence before me. I may say this that a doctor never gets evidence of that kind. It is of course the rarest thing for a patient ever to complain to a doctor of ill-treatment.

12,705. That strikes me as very odd. I should have thought if I were suffering in that way the first thing I would do would be to say, "Doctor, I have been horribly ill-treated." Why does he not?—Because of what may happen after when the doctor is gone. The patient is absolutely in the hands of the attendants, and he is afraid to say anything. He knows that if he reports them his chances of discharge are very remote.

12,706. This is a most dreadful allegation (it may be true) against attendants, that first of all they are cruel, although you have not seen any instances of it yourself, and that when they are taken to task for it by the proper authority, what they do is to persist in their attacks upon the patients?—That is the danger.

12,707. But does it occur?—I am only speaking now as the spokesman of patients who have come to me; I am speaking for people who cannot speak for themselves, hundreds and thousands of them; I mean all over the world; I mean you find it reported from every asylum in the world, and they have not a chance of getting their cases stated. I am merely giving experiences which they have related to me, and which I pass on at the value which you choose to put on them. I cannot possibly prove these things, but I have got patients to produce who can give you first-hand evidence of it.

12,708. But you may take it that I think personally, and I am sure my colleagues also are quite satisfied, that cases of cruelty, possibly cases of gross cruelty, do occur; we need not carry that matter further. It does not assist one to know how many there are and that sort of thing; but these things must occur, just as you will have railway accidents on the best administered railways. The problem that interests us most is how is that kind of thing to be stopped, or to be diminished as far as possible. Your outlook seems to me a little pessimistic. You tell us that the medical superintendent is an Olympian, a remote person, who does not see anything of it at all. The actual medical officer in charge of the case is either undiscerning or is kept in ignorance of what is going on. Now, we have got it reduced down to this, that it is the attendant who is cruel, and the patient who is the sufferer. How are we to get at the facts of such instances, and how are we to stop their occurrence? You see you must, after all, recognise they would have to be investigated by somebody. You say the attendant will come, and like every other person, I apprehend, will defend himself, possibly truly and possibly untruly. The patient will give his version, although you say the patients will not give statements?—When they are out of the asylum they will.

12,709. Afterwards? — Yes, they will not in the asylum. What impressed me, what converted me into a lunacy reformer, apart from a critic of administration, was this fact, this undeniable fact to my mind, of ill-treatment going on under the surface. It was the volume, the amount, the character and congruity of it, the consistency of it, from hundreds of sources that compelled me to believe in its existence.

12,710. *Earl Russell*: That is just the question I want to put. You do not tell us what value you yourself attach in the way of credence to these complaints of cruelty?—I attach the greatest value to them. It took me two years to convince myself, and in the two years I became an absolutely convinced man.

12,711. *Chairman*: That is a generality. Take 1,000 cases coming before you of complaints of ill-treatment. Investigating them with such means as were at your disposal and assessing as well as you could the evidence (because I know the difficulty of it), how many of those cases did you think were well founded?—I think in every case the patient was stating the truth about the facts that had occurred. I did not see any reason why he should not. He had left the asylum; his charges were specific. They dealt with names and dates and persons. There is no reason why he should be lying. The only other thing that he could be doing was that he was lying or else that he was deluded. The assertions of ill-treatment are not of the nature of insane delusions of any sort or kind. These specific assertions are made by people who have left the asylum perhaps for years, and have been following sane lives, and have been occupied and employed, and treated as sane by everybody all round them, and yet they make them as firmly and consistently now as they did then.

12,712. Do you believe them all?—By no means all, but I believe the greater majority of them are true.

12,713. What is your criterion for distinguishing between those that are true and those that are not true? What is the dividing line?—I do not know that there is a dividing line. I should say that certain things were possibly exaggerated—I mean to say the trivial things I should not regard as of any importance; they might possibly be a little exaggerated; but when it got to cases of broken limbs and patients were not only ill-treated but were practically killed, there is not much dividing line there. I mean to say they were either true or not true.

12,714. *Earl Russell*: Broken limbs would be recorded in the case book at the time?—They ought to be.

12,715. There would be that much corroboration?—Yes.

12,716. *Mr. Snell*: Could we ask you whether this allegation of cruelty extends to the female side, and in what proportion in relation to the whole?—Certainly it does.

12,717. *Chairman*: Female nurses as well? — Yes. If you ask the patients you would hardly find the case of a patient, who has been in an asylum for any length of time, who will not have numberless cases to tell you of cruelty that has either been witnessed or inflicted upon themselves.

12,718. Of course you know people who have to deal with evidence, even the evidence of perfectly sane people, very often find that statements of fact which a layman inexperienced in dealing with evidence would regard as absolute proof are entirely fallacious?—Quite.

12,719. The human mind is so constituted that it very often persuades itself of things—I am speaking of the sane mind. I have known many instances of people sincerely believing things that are absolutely untrue.

12,720. *Sir David Drummond*: Did you take any steps to verify these cases?—Certainly I did.

12,721. What were the steps you took to verify them?—The step I took was to go and see the patients themselves.

12,722. You heard the statements from the patients, but what steps did you take to corroborate the statements?—How could one take any steps?

12,723. But you took none?—No, I did not take any. What we hoped for in the enquiry was that steps would be taken to corroborate the statements at the enquiry.

Earl Russell: How are they to be corroborated?

12,724. *Chairman*: We are not in a very much better position that you are. Perhaps you are in a better position, because you can see these people and talk to them informally without the circumstance of an enquiry. You simply transfer the task to us of evaluating their evidence, and I do not know that we can do it any better than you?—The only way in which it could be evaluated would be to take specific

25 February, 1925.]

Dr. MONTAGU LOMAX, M.R.C.S.

[Continued.]

instances, with dates and persons, and have up all the parties to the case and examine them judicially.

12,725. *Earl Russell*: Short of an admission by one of the parties incriminated, should we get any corroboration?—I think you could in some instances.

12,726. *Chairman*: You see we are not a court of law?—I know.

12,727. I will tell you how I look at it. I would say if you have had a large number of instances of complaints of ill-treatment, and have examined them as far as you could, that is to say, tested them with such means as were at your disposal, you are entitled, I think, to draw from that an inference. I would not draw quite so large an inference as you draw, if I may say so, but I would draw an inference that the convergence of testimony from these different sources and of different value does demonstrate that in point of fact a considerable amount of ill-treatment does go on in asylums at the hands of undesirable attendants, which does not come to light. Now that is the real thing that one is concerned with. I should think probably that many of the cases if explored would turn out to be exaggerated. On the other hand, some of the cases might be found to be absolutely accurate. I do not know. But the fact that a large number of complaints have been made converging to one result seems to me to demonstrate that this thing does occur. That is the point that one is concerned with. It is the possibility of its occurrence. I do not see that we are very much advanced by taking even a dozen or twenty cases, because, suppose on those cases we found ten proved and ten disproved, we are not much forwarder, are we? We have merely reached exactly the point which you have put to us to-day that the possibilities of cases occurring has been demonstrated?—I am asking you not only to hear ex-patients but to hear ex-attendants.

12,728. That is for Mr. Gibson to say, of course. *Mr. Walter Stewart*: We have four on our list of ex-attendants. (*Witness*): I have more than four on mine, people who are actually prepared to come forward and testify; they have not been patients at all.

12,729. *Chairman*: Again may I put this: what will they demonstrate beyond this, that the present system permits a possibility of such things?—It would show what you want to demonstrate is, that these things not only possibly exist but do exist.

12,730. I accept it.—Then you want to get the public to express an opinion too. Publicity is the only way by which these things can be stopped. It is by no reports of yours or by anybody else's that these things will be stopped, it is by pressure of public opinion, is it not?

12,731. *Earl Russell*: I think perhaps what Dr. Lomax feels is that it will not be brought home to our minds at secondhand so well as it would at first hand?—I have got patients who are here now who will tell you of the most ghastly things that they have not only seen, but which have been done upon themselves. All you can do is to see what sort of people they are, and whether they are to be believed. You cannot do more except you can call the witnesses to each act and cross-examine them as you would in a court of law. What we want to get in the public mind is that these things do exist and exist beneath the surface, and they exist unsuspected by the public, and until the public expresses itself in a note of indignation and even horror that these things can happen to poor, helpless, unfortunate people, they will go on existing. It is publicity that will stop all this sort of thing; I do not know anything else that will, except you get patients to bring a case to a court of law. I brought a case before you some time ago in which the evidence was extremely strong, and that case I am asking you to judicially examine. I do not know what view you took of it and what suggestion you are prepared to make about it, but I should regard that as a test case. There are scores of others of the same kind which could be brought.

Mr. Micklem: Which case was that?

12,732. *Chairman*: That was a case about a post mortem examination. That relates itself to another matter where your proposal is that all deaths of patients in asylums should come before the Coroner?—They all have to; all deaths of patients in asylums have to come before the Coroner. What I asked for was this: I said that the certificate of death has to be accompanied by a statement from the superintendent as to the cause of death; as to whether there were any marks of injury on the body; or as to whether there were any suspicious circumstances connected with the death; and it depended upon that accompanying statement whether the Coroner held an inquest. The case I gave you in detail was a case surrounded with every suspicious circumstance there could be, and yet there was no inquest held and no post mortem.

12,733. *Earl Russell*: There should be an inquest?—The object of the section of the Act is to give the Coroner information which will enable him to call an inquest if he suspects foul play. Everything depends upon the accompanying statement being a statement which will arouse his suspicions.

12,734. *Chairman*: And in that particular case the statement which was handed in did not arouse any suspicion in the Coroner's mind; but, again, that seems to me to be a case in which the medical superintendent might have failed in his duty?—I am afraid so.

12,735. How are you going to see that medical superintendents do not fail in their duty?—Well, Sir, if that case, as it did, resulted in the death of the patient in five days; if that case resulted in such a horrible occurrence as that, then I think a great deal ought to be done to the medical superintendent if it was owing to any neglect of duty. I do not say it was. The case was reported to him.

12,736. *Earl Russell*: Do you suggest that the Coroner should always hold an inquest, and not merely have the cases reported?—I should suggest that the medical superintendent should be so heavily weighted with legal responsibility as to make an absolutely accurate statement imperative; I have no doubt it is accurate in a sense, but I mean a complete and full statement to the Coroner, so that he might be able to form his opinion on it. The case which I refer to obviously had not aroused any suspicion in the Coroner's mind at all.

12,737. That depends both on the capacity of and suspicions of the Coroner?—Yes.

12,738. *Chairman*: The case was very fully investigated?—Was it?

12,739. Yes, I have all the papers before me.—Whom by?

12,740. And reported on to the Board of Control.—And reported by the attendant.

12,741. The report comes through the medical superintendent who was asked to report on it?—And yet the attendant who reported the case asked to be called at the inquiry, and was not called.

12,742. I do not want to go into his circumstances, but you know he was in the hands of the police at the time?—Oh, dear, no!

12,743. Is not that the person?—This was three years ago.

Mr. Walter Stewart: That was afterwards, Sir.

Witness: It was three years ago; he has been out of work ever since, and, unfortunately, he got into the hands of the police in the last few weeks; but the inquiry took place three years ago.

12,744. *Chairman*: Whenever you get into particular questions of fact with regard to any individual person, you inevitably come against highly controversial matters in which people give evidence against each other, and every fact is controverted. With regard to this particular attendant, he was dismissed (at least this is the allegation) from the asylum service for suspected theft. Most of us in a court of law do not pay very much attention to a person who comes and makes allegations in those circum-

25 February, 1925.]

Dr. MONTAGU LOMAX, M.R.C.S.

[Continued.]

stances. That is the difficulty. Whenever you come up against that particular case, you get into these side issues which disguise the matter one is really wanting to get at?—Quite, but there is a great deal more in it if you read my statement carefully. When we come again to read the statement I made to you, perhaps it may be read without the names being given.

12,745. Quite. I personally read it all, and I read the whole of the facts of the case, and I just felt once more, as I have felt so often in these matters, that the presentation of a case of that sort with the controversial elements in it makes it very very difficult, unless one were to thrash the whole thing out in the presence of a jury, and even then you would only get a result which would please some people and

(After a short adjournment):

12,748. *Chairman*: Dr. Lomax, before we resume the thread of your evidence, my colleagues and I have been impressed with a suggestion you have made, and we would rather like to see one or two of the ex-patients and one or two of the ex-attendants to whom you have alluded. It occurs to us that this can most readily be arranged, if you would be kind enough yourself, who know these people, to take perhaps three or four of each kind, three or four ex-patients whom you might select yourself, and three or four ex-attendants, and send their names in to me, with just a short *résumé* of what they will say, and where they have been; and then I think we should see some of them and have their story from them just as you did, so that we may be in the same position as you were in, and be able to judge for ourselves of what they have to say. We shall select from those whom you send in one or two whom we would like to hear. I think that is probably the most useful way of doing it, because, as you know, if we get into cross-examination we lose the real personal effect of it; so we should like to put ourselves in the same position as you have been in by asking some of them to come and see us, by asking them to tell us their experiences as they told them to you.—Will you communicate with them when you have their names and addresses?

12,749. If you could give us perhaps three, or four at the most, of each type, I shall read the statements, and from among those we shall select two or three probably altogether and invite them to come and see us. We will send the invitation, if they will come; some of them may not like to come.—They will come all right.

12,750. And we shall put ourselves just in the position you were in of hearing them tell us their story. I think that would be quite a useful thing for us to do?—I may say I have got in my bag here the *précis* of evidence of 10 or 12 or more which I can select, or let you have before I leave the room.

12,751. If you like I will read the whole 10 or 12 myself?—Then you can have them.

12,752. Naturally one has had to read a great many statements, far more statements than we can possibly deal with in evidence, but they are all useful as showing points of view?—Quite.

12,753. I think that method is probably the best that we could adopt to serve your purpose and our purpose?—Yes.

12,754. Now let us pass on. We have discussed the question of ill-treatment. There is just one comment I should like to make. You have spoken of hundreds, nay thousands, of cases of ill-treatment which have come under your cognisance?—No; I said I had had letters relating to them.

12,755. You have had letters relating to hundreds, nay thousands, of cases?—Between me and the Society for Lunacy Reform.

12,756. I really am concerned to see, and I am sure you are also, that the idea should not go forth that it is your evidence that hundreds and thousands of patients are being ill-treated, because you can

displease others. You do not get much further.—If we can bring evidence from eye witnesses and outside witnesses independently of these attendants' evidence at all——

12,746. And then the institution will bring all its witnesses also, no doubt to the contrary effect?—That is a case in which, of course, they will.

12,747. And we shall be occupied for days in considering which of the two sets of people is telling the truth, and at the end it will only be a judgment by us that we think one way or the other, and we will not be quite sure?—It is a case to my mind that ought not to be tried here; it ought to be tried in a court of law.

Chairman: That is exactly what we feel; you could not have put it better.

imagine what an unhappy effect that would have upon many homes; and we all recognise how much is being done in many institutions to the satisfaction both of the patients and of their relatives. It would be very unfortunate if people were deterred from taking advantage of the existing system, such as it is, by the idea that they were sending their relatives to necessary and inevitable ill-treatment. I am sure you do not want to convey that impression.—Certainly not.

12,757. One knows, of course, that in many instances recovered patients have been most grateful for the attention and care they have had, and one would not wish that people should be deterred from going to institutions; indeed, one of the things we want to do is to try and make resort to these institutions less resented?—Quite.

12,758. And it is not the way to do it to give everybody the impression that they are going to inevitable ill-treatment, of course?—Quite.

12,759. One point you refer to in connection of ill-treatment is the subject of prosecution. I have not quite ascertained the bearing of that?—When cases of ill-treatment are reported to the superintendents and the asylum committees, they apparently are the only people who are concerned with the question of prosecution. In every report of the Board of Control there are a certain number of prosecutions. These prosecutions are either at the instance of the visiting committee, or of the Board of Control. What I should like to suggest is that it should not be an optional thing with the asylum committee to ask for prosecutions, but a compulsory thing that when they get evidence of serious ill-treatment of a patient by an attendant they should be obliged to put it into the hands of the police, or a magistrate—that they should not have the option of selecting the cases which they think ought to go.

12,760. *Earl Russell*: Do you suggest they should prosecute when they are quite sure they will not get a conviction?—I do not know, Sir.

12,761. That is a question, you know, that every prosecuting authority always has to consider, not only whether they believe an offence has been committed, but whether they can persuade the magistrates of it?—Yes. I think the onus ought to be put upon the judicial authority.

Earl Russell: But you realise if they had a great many prosecutions which failed it would rather bring it into discredit.

12,762. *Chairman*: I see that last year in the 10th Report of the Board of Control one or two prosecutions were undertaken, and they appear to have been undertaken under the order of the Commissioners, so that the Commissioners initiate the proceedings?—They do; not in all instances, but they do often.

12,763. What is your suggestion? With whom do you say the initiative should lie?—I mean it should not be optional whether the cases are prosecuted or not; I think they all ought to be.

12,764. That is a very difficult proposition. I have been a public prosecutor myself, and there are

25 February, 1925.]

Dr. MONTAGU LOMAX, M.R.C.S.

[Continued.]

good many cases which come up in which you have to use your discretion whether you will prosecute or not.

Mr. Walter Stewart: Would you put a question to the witness as to whether it would not satisfy him, if the papers were laid before the Public Prosecutor, to leave it to his discretion?

12,765. *Chairman:* That is a different matter. I think you are hardly doing your own proposition justice in the way you have put it.—I am ignorant of the law in this department.

12,766. *Mr. Stewart* suggests that your object might be met if the papers relating to any case which is thought to be a case suitable for prosecution were placed before the Public Prosecutor, leaving it to him to take action or not, as the case might be. Would that meet your view?—It would, I think, yes.

Mr. Micklem: You might get less prosecutions that way than if you left it to the Board of Control.

Earl Russell: You almost certainly would. The Public Prosecutor is very reluctant to prosecute unless he is quite sure of a conviction. The Board of Control might think it well to prosecute as an example.

12,767. *Chairman:* It is enough for you if you express to us your view that, in the matter of prosecution, some method should be devised whereby cases that ought to be prosecuted are not hushed up. That is really the point?—Yes.

12,768. The devising of the method of preventing that is a matter for legal investigation?—Quite.

12,769. Now, the next topic you discuss is the question of safeguards against improper detention. I am going to suggest to you that that was a topic which *Mr. Parker* dealt with most fully, and unless you have any additional suggestions, I do not think we need delay long over it. I think we are really fully apprised as to the risks of illegal detention at present. You may take it that we are fully aware of the problems arising in that matter, and I think we have had really almost as much help as we can get. We wish to avoid reiteration, but if you have any views in addition which you think would help us, I do not want to stop your giving them.—No, I do not think I have anything to add, except to say that it would be most important in my view that the Board of Control or some responsible authority should define what they mean when they state that patients are legally but unnecessarily detained in asylums, owing to the inability or unwillingness of their friends to look after them.

12,770. Yes, I was struck with that passage. If I may suggest to you the meaning of it; this is not the Board of Control's explanation, as far as I know, it is my own interpretation of it, and it is really this: that there are many persons who are certified and certifiable persons, properly certified persons, but who are really quite harmless—that is to say, they do not do harm to themselves or to others—and could quite safely be discharged from an asylum, provided there were some place to send them where they could be properly looked after; and the suggestion is that these people are not being illegally detained but unnecessarily detained. Now there is a great difference. I could imagine there must be many people in asylums whom it is not necessary to detain in an asylum but whom it is perfectly legal to detain in an asylum—you follow my point?—Quite.

12,771. Many of these people, if there were some place to send them to, could with advantage to everybody be discharged from the asylum because they were being unnecessarily though legally detained—that is really your point?—Yes, it is.

12,772. The difficulty always is to get the appropriate relatives or the proper institution to send them to?—Yes.

12,773. You will have our assent at once to this view that no person who has recovered, no person, that is to say, who is at any particular moment

of time no longer a certifiable patient, can legally be detained a moment. You may take that as being with us elementary.—Yes.

12,774. But there are many cases which are being legally detained which might quite well be released, if there were some place else to send them to, and they need not occupy the asylum accommodation?—Quite.

12,775. That seems to me to depend very much on the accommodation available to them, or the relatives or some association being willing to take care of them. That is the real difficulty there.—It can be solved to a large extent by a system of boarding out which exists in Scotland and in Belgium at Ghent.

12,776. That is certainly an attractive solution.—It is one of the solutions; and again, as I say, if they are retained in the asylum they should be retained as uncertified, and if they are employed in work they should be paid as workers, if they can be useful in the asylum; and the stigma of insanity, of certification, such as it is, should be removed from them; they might possibly remain on and work as some of the ward maids do.

12,777. *Earl Russell:* Have you considered the trade union question involved? If they are paid at all they must be paid the full trade union rate of wages.—I have not considered it.

Earl Russell: It means a difficulty.

12,778. *Chairman:* Of course if a patient has recovered and works, he ought not to be there as a certified patient at all; he ought to be there as an employee. On the other hand, if the patient is still a properly certifiable patient, and is in the asylum, it seems to me that this labour is not any more than an adequate recognition of the fact that he is being supported at the public expense, because of his inability to be an ordinary citizen?—That all depends upon whether he is certifiable or not, and who is going to be the judge of that—the superintendent or the asylum committee—who find the patient's work extremely useful? Are they going to allow that to bias their views of the certifiability of the patient?

12,779. *Earl Russell:* Do you seriously suggest that patients are kept in asylums if sane because their work is valuable?—I do. It all depends upon what you mean by "sane."

12,780. Who are not certifiably insane?—Yes, I do.

12,781. *Chairman:* Again have you met such cases?—Yes, I have got one in my mind now.

12,782. *Earl Russell:* In an asylum or out of it?—Out of it.

—*Earl Russell:* Then he is not an instance now, is he?

12,783. *Chairman:* Take your own experience in Prestwich Asylum. You saw the people there, and there were a number of them engaged in laundry work and other work. Do you say you saw people round about you there who were not certifiable persons, but who nevertheless were being detained illegally under certification—that is really the point? Did you see such persons?—I did see two or three whom I considered, and I believe half the people in the asylum considered, were perfectly sane.

12,784. Perfectly sane?—Quite sane, and uncertifiable in any sense.

12,785. What steps did you take about these people?—I brought them up over and over again.

12,786. And what was the result?—Nil.

12,787. *Earl Russell:* Do you mean you recommended them to the Medical Superintendent?—Yes, I have got the notes of them now. I do not mean to say that they had not been brought up before, but I mean to say this, that as soon as my book came out two of them were almost immediately discharged.

12,788. You left the asylum two years before your book came out?—Yes.

12,789. Did you write to the Board of Control that these sane people were being detained there?—No, I did not, because I was writing the book at the

25 February, 1925.]

DR. MONTAGU LOMAX, M.R.C.S.

[Continued.]

time, and these people whom I considered sane I thought I would bring into my book.

12,790. But you surely did not keep these people there two years, in order to put them in your book?—No, the book was being written. At the time I deferred it; I was hoping to hear that they had come up and had been discharged. I did not know they had not been. It was only after the book came out that I wrote to a friend and asked him about these people, and he told me two or three of these had been discharged.

12,791. But still if you felt so strongly the injustice of their detention, I do not understand why you did not write to the Board of Control, as soon as you were a free agent, to say that these same people were being kept there?—Well, it was my view of their sanity; it was not the Superintendent's view.

12,792. Do you mean to tell us now you are less sure that they were sane?—No.

12,793. *Chairman*: I shall assume, of course, that your medical opinion that this particular patient was sane was sincerely entertained by you?—Certainly it was.

12,794. But I am afraid I must equally assume that the opinion expressed by the Medical Superintendent, differing from yours, was equally sincerely entertained?—Quite.

12,795. Does not that occur very often in the diagnosis of disease, in fact it is proverbial that doctors differ even as conspicuously as lawyers differ?—Quite.

12,796. In that state of matters, assuming that there is no improper motive entering into the decision, one or other opinion must prevail?—Quite.

12,797. Why should (I do not want to put it in the least offensively) your opinion have prevailed with regard to the question of this man's sanity or insanity rather than the Medical Superintendent's opinion?—I think his opinion would prevail because obviously he had the power, I had not.

12,798. But of course you had more means of knowing about the patient than he had?—I ought not to have had.

12,799. *Earl Russell*: I still do not understand how you reconcile it with your conscience to leave these people there for two years, if you thought they were sane?—I do not think I expected to leave them there for more than a few months.

12,800. Why a minute, why a week?—It was not my job after I had left surely? *

12,801. *Chairman*: There is one case you give us at page 175 of your book which has rather puzzled me, I frankly confess; you give it as a case of a man who had been in the asylum for nearly a year when you took office, and he was beginning to get tired of it. "I watched him carefully and soon had little doubt of his sanity." Then he did some things. Then I am rather surprised to find this sentence: "As a punishment I kept him back another two months and gave him my reasons." Then the paragraph concludes: "However, he was not insane, and I shortly procured his discharge." Surely you do not want us to infer from that that the man was sane, and yet as a punishment you kept him back for two months?—May I see the passage?

12,802. Yes—(*Handing book to the witness*)—it is on page 175. It is one of the few passages in your book that really puzzled me, I confess. I am sure there must be some explanation of it?—Yes. That case was a case in which the man was obviously malingering, and got into the asylum to escape the clutches of the law, if I remember right.

12,803. It rather looks like a case of malingering?—There were two or three when I was there, men who

preferred to come into the asylum rather than go to jail, and one man whom I succeeded in discharging was reconvicted and put back into jail.

12,804. But if this fellow was sane and a malingerer, I do not quite see how you could continue to keep him in the asylum and, least of all, how you could keep him in the asylum as a punishment?—I did not keep him; the man was obviously kept.

12,805. The passage reads, you know, "As a punishment I kept him back another two months and gave him my reasons."?—Because he tried to take me in. He had been trying to cheat me, and I told him that I would not send him up as soon as I otherwise should have done. I cannot remember the case for the moment.

12,806. To be quite frank the thing that really rather shocked me was that he should, as a punishment, have his name kept back from consideration for discharge for two months. That is what rather perplexed me?—I am afraid that is done over and over again.

12,807. *Earl Russell*: But what shocks us is that you should do it after all you have said?—Yes. I ought not to have put it in that way perhaps, but it is obvious that I did.

12,808. *Chairman*: That honestly rather shocked me, if I may say so. It really is not of great moment, Dr. Lomax?—It is to me.

12,809. I mean you can understand on reading that, that one was naturally a little puzzled—at least I was a little puzzled?—Quite.

12,810. Of course, the really important question we are at the moment considering is that no insane person should be detained a moment longer than is necessary to secure his recovery?—Quite.

12,811. On the question of preventing persons being so detained, I understand you have no additional precautions to suggest other than those we have already heard on behalf of the Society?—No. I was not here so I do not know what proposals the Society made; I only read the report of them in "The Times." I do not quite see that I have any other suggestions to make.

12,812. Of course, in putting these questions to you I have rather assumed that you have been familiar with Mr. Parker's *précis* and the case that was put before us?—I have seen it, but I am sorry to say I have been ill; I have been in bed for some time, and I have not been able to recall all I have read. But I suggested that the asylums board should have a day on which to hear appeals.

12,813. That is very important?—That struck me as one means.

12,814. I think that is additional to what we have had already.

12,815. *Earl Russell*: I think you mention in your book, or in your *précis*, a discharge committee of the medical superintendent and of others?—Yes.

12,816. *Chairman*: Then I think we may pass from that. Now I should like to have your views on a matter we are very interested in, and that is the question of the incipient case, Dr. Lomax?—Yes. My view favours the preliminary detention order which was suggested by the British Medical Association, and which I think is one of the most important things that has been suggested yet. I state here that as part of the feature of admitting patients into asylums there should be a preliminary detention order which lasts only three days in the first case; perhaps I might be allowed to read this?

12,817. By all means.—It has to do with incipient cases, voluntary boarders and mental observation hospitals, hospital clinics, observation wards in infirmaries, and so on, and the treatment of incipient insanity; it is all connected.

12,818. If you give us your considered opinion as you have put it in writing it will be the most convenient way to get it down.—The whole object of any alteration in the law regarding certification concerns the necessity of greater publicity, and less secrecy in the procedure, and much greater security

Note.—The witness has since expressed the desire to supplement this answer as follows:—"I took the best step that seemed open to me. I wrote to the Senior Medical Officer and asked him to do what he could for the patients' discharge. Later he wrote to me that three of those mentioned had been discharged, including one of those spoken of to-day, and that the other shortly would be. That seemed to me a better course of action than writing to the Board of Control who would only have referred the matter back to the Superintendent."

25 February, 1925.]

Dr. MONTAGU LOMAX, M.R.C.S.

[Continued.]

of the rights of the patient. Under the present law it seems to me that people can be far too easily put away in asylums by designing relatives, and far too easily kept there, and that far too autocratic powers are put in the hands of the medical profession as regards their admission to and detention in asylums. The responsibility of depriving a citizen of his liberty should be shared far more equally among the medical profession and the civic and legal authorities. In the following remarks as regards the legal and medical procedure of certification it will be observed that I personally am more in agreement with the, in my view, admirable statement of the British Medical Association, though I suggest a few additions to and modifications of this statement, than with the very able but rather more cumbrous and costly, and, as it seems to me, less practical suggestions of the Society for Lunacy Reform. I now make the following tentative suggestions, my reasons for doing so being that most of my other suggestions for administrative reform are based upon them. These suggestions refer to changes in and additions to the existing law, *i.e.*, they supplement but do not abolish most of the other legal provisions at present existing. The object of these suggestions is the unification and simplification of the present procedure as regards certification. My proposal then is as follows: There shall be a single medical certificate called a preliminary detention certificate required in all cases of suspected insanity, before any patient, by whatever means or order of admission, is admitted into any institution for mental patients.

12,819. *Earl Russell*: Would you not rather call it a preliminary detention order?—The detention order comes afterwards when the magistrate signs it.

12,820. I thought the certificate was the one you wanted to avoid?—Yes, but you want to certify the patient as detainable and not as insane.

12,821. Would it not be better to call it an order?—I did in the first place, a preliminary order. This preliminary detention order or certificate shall contain clauses which gives the medical officer of the institution to which the patient is taken power of compulsory detention and control over such patient for three days. It shall be signed preferably by the patient's usual medical attendant, and may be supplemented, if so desired by the patient or his friends, by a second certificate (in which case each examination of the patient shall be separate, though afterwards in consultation if required). I think it is a great absurdity, if you will allow me to say so, that in cases of certifying anybody the doctors are required to give the certificates separately, and not after consultation with each other. The object, of course, is to avoid any medical collusion, but I think the patient ought to be given the benefit of the combined experiences of the doctors, one of whom may be much more able than the other; and as in the case of ordinary illness the patient is allowed to call in two or three men who consult together and not separately, so the presumed lunatic should be able to have the advantage of consultation of the two people who are signing him up, if they require it.

12,822. *Chairman*: In that do you voice the feelings of the Society, or is that your individual opinion?—That has not been raised at all, but I raise it on my own account. Then I say: in no case shall the medical man certifying be the medical officer of the institution to which the patient is taken, except in the case of pauper lunatics and lunatics found wandering, and then only in case of emergency. Within 72 hours of the patient's admission he shall be personally interviewed by the judicial authority, who shall then sign a preliminary detention order—or countersign the order signed by the doctor, or, if he thinks fit, discharge the patient, otherwise the preliminary detention order shall have effect for 28 days. The same medical and legal procedure shall be gone through in urgency orders and summary reception orders as in orders in petition, that is, there shall be only one medical certificate legally required for the

preliminary detention order. It is in that respect that I differ from the Medical Association's idea that in every case the two certificates are required. I think with a preliminary detention order before the patient is certified insane at all, only one doctor's order is required, but that after, in the 28 days, if it becomes necessary to certify the patient insane, and to send him to an asylum on a reception order, a second doctor's opinion should be then called in, and a second certificate required, and that that second certificate should, if possible, be signed by a mental expert, or a man holding a diploma in psychiatric medicine who could conveniently perhaps be asked to come from the nearest asylum: that the magistrate then, after these certificates have been signed, should sign the final reception order which consigns the patient to the asylum. I think that that fact would relieve the medical profession of a great responsibility incurred in signing the patient up, in the first place. He would know that he was only being signed up for a probationary period, and that in 28 days' time additional inquiry could then be held before the final reception order was made, at which the patient could be represented if he preferred, or his friends preferred, a kind of judicial inquiry in the institution in which the patient is; that is to say, that the patient's friends should have the opportunity of seeing the certificates and of seeing the reasons for the detention and the certification of the patient, and to make objection if they thought fit, that a sort of legal formula should be gone through at the time.

12,823. *Sir David Drummond*: Those would be obviously cases that are certifiable?—Obviously in 75 per cent. of the cases, I do not suppose any inquiry would be asked for at all.

12,824. Would there be any preliminary detention order in cases which are obviously certifiable?—I think so in every case. I think in every case it should be optional after the three days. The magistrate ought to come into the picture as soon as he can within three days; then, if he thinks the patient is certifiable he can ask for a second doctor to be brought in at once, provided he holds this sort of judicial inquiry before the patient is sent away into the asylum, at which his friends or himself can raise objections if they like. I do not mean to say for a moment that he shall put the certifying doctor in the box and have counsel to examine him and ask him the reasons for certifying the patient, which seems to me perfectly absurd. You have got to trust the doctor who is certifying, or the scheme of lunacy administration falls to the ground.

12,825. *Earl Russell*: You disagree with your friends of the Lunacy Reform Society there?—Absolutely, and on other points. I do not see how the patient can be aided by being legally represented at this inquiry except in the sense that he might have a lawyer there to put the case. He cannot examine the certifying specialist and ask him his reasons. You have got to trust the specialist to know his job. When a patient is operated on in a hospital, his friends do not come in and see the surgeon and ask him to produce certificates that he is able to do the operation.

12,826. *Chairman*: That has been present to my mind, but you do not disregard this side, which I think is the justification of the view that the Lunacy Reform Society has been putting before us, that the treatment of this class of case involves an infringement of personal liberty?—Quite.

12,827. That is the whole difficulty of this class of case. The ordinary operation in a nursing home or general hospital does not involve any infringement of personal liberty, and perhaps, in justice to the view put before us by the Lunacy Reform Society, we ought to give weight to their insistence on the question of personal liberty being involved. True, you may answer that you are as jealous of personal liberty as they are, but you safeguard it best by reliance upon the medical man's probity?—No, I say it comes to that in the end.

25 February, 1925.]

Dr. MONTAGU LOMAX, M.R.C.S.

[Continued.]

12,828. In the end it must?—I deal with the questions which the Lunacy Reform Society raise afterwards in the case of the voluntary boarder and incipient insanity, but I say that when a magistrate has called upon a second opinion from a man, who should preferably be an expert, and a panel of whom should be kept in the province or area from which he can ask for them, and if the patients are given the option of calling at their own expense for some other man to consult with him, then you have done all you can to protect the liberty of the subject, because he will not be certified and finally sent away into an asylum without having the opportunity given to him or his friends of knowing why, and of being represented, if he likes, at the time by a lawyer, or anyone with legal knowledge.

12,829. May I just ask you about that question which I must say has puzzled me very much? I notice you have said that he should have an opportunity of knowing the contents of the certificates?—Yes.

12,830. There seems to be room for considerable difference of opinion on that subject. As a doctor, I think you will appreciate that you cannot always tell your patient what is wrong with him?—No, certainly not.

12,831. Let us take the case of a patient who exhibits the symptoms of general paralysis of the insane, but which are not quite determined, but where the doctor has felt it his duty to indicate among the symptoms, symptoms which any medical man would at once recognise as being at least indicative of that disease: I should imagine it would be a very dreadful thing to tell the patient, "We do not know whether you have general paralysis or not, but you have unfortunately symptoms of it which may or may not develop into this very dreadful disease." In ordinary practice you would not tell your patient a thing of that sort, would you?—No, but if the patient's liberty is involved as well as his health, it is on account of the liberty of the subject that the patient should be given much more information.

12,832. May I just put one of those curious balances that arise so often? I am not at all sure that his cure is not more important than his liberty. I do not know whether you would agree with that or not. Is the accent to be on the liberty, or is the accent to be on the cure?—I think, fundamentally, the principle involved chiefly is liberty.

12,833. More important than cure?—Yes. Of course if he is freed afterwards he is at liberty, but what I mean is this: that what the patient feels most is the liberty that is taken from him, it is that which he wants to safeguard the most, and if anything involving that seems to interfere with his chances of cure he would sooner have his liberty secured than his cure.

12,834. He might, but what one is concerned with rather is the public interest. I think that is a very difficult question, because one might, of course, by depressing a patient just defeat the object of cure?—You would not in a general paralysis case, because it progresses on to its inevitable end.

12,835. I am assuming it is a case where, in point of fact, the diagnosis might be wrong. Suppose, as has happened in cases, it has been incorrectly diagnosed; the patient is told that he has got one of the most fatal diseases. In point of fact, he has not got it, because even a doctor may make a wrong diagnosis. The unhappy person broods over the dreadful fate that has befallen him. That is certainly not the atmosphere for recovery from the disease, is it?—No, it is not, but I do not think you need tell the patient if you tell the patient's friends.

Mr. Walter Stewart: That is what I was going to ask you to put, Sir: whether there should not be an authorised representative to whom it could be told without the patient being told.

Chairman: The difficulty about the representative is that he must make some use of it when he gets it.

Sir David Drummond: He may make improper use of it.

Witness: Easily.

12,836. Chairman: That is a great difficulty?—It is.

12,837. I am sure you must have experienced in all forms of illness, but most especially in this form of illness, that people are sensitive, and properly sensitive, about unnecessary publicity?—Quite.

12,838. I am sure you must have found in your practice people who have had a mental illness, and who have completely recovered and do not want the subject talked about, advertised and known?—Certainly.

12,839. We do not even talk about our ordinary illnesses which we have had, though some people are rather bores about them, but we ought not to talk about them. In a case of that sort of mental illness, people who have been fortunate enough to recover prefer to let the matter pass into oblivion?—Certainly; but this inquiry would not be held in public; it would be simply an inquiry at which the patient and his friends can put their side of the case if they like, and then if the patient says, "I want to know the reasons for which I am certified," then I think in justice to him he must take the responsibility of how the knowledge will affect him.

12,840. Earl Russell: How can he take the responsibility, when *ex hypothesi* he has already an unbalanced mind? That is a bit rough on him, is it not?—Not if he says he prefers to know why he is certified.

12,841. But doctors do not let their patients do the things they want to do?—This man is not a normal person; it is his liberty that is involved as well as his health.

12,842. Chairman: I am not quite satisfied yet as to whether it is not your duty as a medical man to prefer the cure of your patient even to his liberty. I have not the least doubt you would have me held down in bed if I were a case of delirium following on pneumonia; you would have no compunction whatever in depriving me of my liberty, because you would be thinking of my cure all the time?—Yes, exactly.

12,843. Now one other point on that same question of telling the patient. As you know, there is one paragraph in which the certificate contains facts reported by others—hearsay?—Yes.

12,844. Suppose one of the statements in that is a statement made by the man's wife about him, and he sees there (we shall assume him to be unbalanced) that his wife is being instrumental in having him detained, may you not produce very great unhappiness in such cases?—I think you may; I think you often do.

12,845. I am always as concerned as you are with the patient's point of view throughout. I have been throughout the sittings of this Commission keeping my eye on that aspect, as you exhort us to do in your memorandum, and one is so concerned to see that the very safeguards we suggest may not themselves rebound upon the head of the very person we want to benefit. I can imagine one might create untold unhappiness if the patient were told who the person was who had made certain allegations about him?—I do not think he need be told all, but if he asks for the doctor who has done so, I think the doctor might tell him the reason why he had come to the conclusion he was of unsound mind. He need not show him the certificate.

12,846. You are making it very difficult, you know. Again it is at the discretion of the medical man. I can understand the view of the Society.

Mr. Walter Stewart: No spouse should be allowed to be a petitioner, so that that difficulty would be removed.

Earl Russell: Not in the least. Facts stated by the wife might perfectly well be stated by the wife, whether she was the petitioner or not.

Chairman: Or if it were a brother or sister the same trouble might arise.

25 February, 1925.]

Dr. MONTAGU LOMAX, M.R.C.S.

[Continued.]

Witness: The difficulty is this: hundreds of patients tell you, "I have not the least idea what grounds they had for putting me in. I want to know. If I had known I might have been able to give some explanation." Some of these grounds are most doubtful. A patient can never get hold of the certificate and know what grounds he has been detained on, or certified on, until he is discharged years afterwards.

12,847. That might be of importance if he were being illegally detained; but just follow me for a moment. We shall assume that doctors of competence, such as you describe, have considered the case and have said "This person ought to be certified; we say so on our professional responsibility." The patient is then taken to an institution. What good will it do that patient in the institution to be told the precise nature of his mental disability, and the precise allegations on which he had been certified? He would then proceed to occupy himself with trying to controvert them rather than to occupy himself with his cure. What good would that do to him?—Not a bit, until the question of the judicial enquiry had been raised, and it might not be raised at all. I am presuming the patient has been certified, that the expert has been called in, the second opinion has been called in and has certified the patient on certain grounds, and that the patient's friends are then informed, and they say "Well, may we see the reasons for which the patient is certified," and the patient may say "May I see the reasons?"

12,848. It is just there I am having my difficulty?—I know, but it is not that he would be brooding over it all the time until he was certified; I say if there was a judicial enquiry at all, there ought to be some means by which the patient should know, supposing he thinks he is improperly detained and certified, the grounds upon which the opinion of the doctor has been formed. That strikes me as just and reasonable.

12,849. *Sir David Drummond:* Do you for a moment think that the patient, if informed, could argue in such a way as to convince anybody that he was wrongfully certified?—I do not think so for a moment, and I think in 99 cases out of 100 he would only prove his unfitness more by argument; but it seems right to give him an opportunity which hitherto has been denied him.

Sir David Drummond: What is the advantage of it?

12,850. *Chairman:* That is just my difficulty, I do not quite see the advantage. We are taking a case where there has been a proper certification before a magistrate, and with a medical examination preceding it. The man is therefore of unbalanced mind; that is *ex hypothesi*. He is properly being detained in the institution. You suggest it would be of advantage to him then to know the grounds on which he had been certified?—Only if he asks, and in 75 per cent. of cases he might not ask.

12,851. Suppose he asks and says "Be good enough to send me these"—we are assuming he is a person who is insane: would the provision of that information to an insane person be really of any value? Might it not just set his mind brooding upon these things?—I think it would satisfy his mind much more than to be in doubt. I think he might not think he was justly certified, but still he would know what it was he was certified for. At present what is harassing a number of minds of these people in asylums is "What on earth have I been put in for?"

12,852. *Earl Russell:* That is true, but does not the medical superintendent without showing them the certificates, or quoting the certificates, tell them when he thinks they are fit to hear, what the idea is that is troubling them and try to cure them of it?—I think he does often, but in a number of cases I do not think the patient knows at all. He could know, of course, if he asks.

12,853. But is it not part of your way to test his cure, to try him with any delusions he has had or to tell him of his trouble?—Yes, certainly.

12,854. How will you help your insane patient by giving him an actual copy of the thing?—I should not give him a copy of the thing.

12,855. Who is going to bowdlerise or expurgate it?—I only suggest that at the enquiry that is held at the time, if he asks the reasons they should be told him. I do not know that it would be wise, but it might be an opportune thing for the man's own peace of mind to know. It might.

12,856. Then I want to know if he is not to be told all the reasons, that is to say if he is not to have what we call in law a disclosure, who is to make the selection, and how is it to be made? You do not get any further if he does not have the whole thing?—I do not think it would be wise to tell him all, certainly not.

Earl Russell: I am glad you agree about that.

12,857. *Chairman:* Well, Dr. Lomax, we understand your alternative programme of certification which you propose, and which you suggest in preference to the programme which we have heard from the Society?—The only alteration is that I think for the preliminary detention certificate there need be only one medical opinion.

12,858. *Sir David Drummond:* It seems to me that the proposal you suggest makes no provision for the patient possibly being taken in the early stages to another place than an asylum—a general hospital?—Yes, but that is only the reception order. With the preliminary detention order I say that the patient must be taken to a mental observation home, or a mental observation ward in an infirmary. That is an essential part of the whole reform: that before a patient of any kind shall be sent to any asylum he shall have the 28 days in a half-way house, a mental observation home. The whole thing depends upon that.

12,859. *Chairman:* We have heard a great deal of evidence from all quarters with remarkable unanimity in favour of what they venture to call the provisional period, which is to intervene between the case first being observed and its ultimate destination in an asylum. I really think upon that you are pushing an open door. I mean on that matter you have universal assent. One question on it, though, is worth asking you, I think. What would be most desirable as it seems to me would be if these observation places could be separate institutions?—Quite.

12,860. But I see quite a practical difficulty about that?—So do I.

12,861. Because you would only have persons in there who were, so to speak, in a clearing house, and it would be very difficult to set up special institutions of that sort. Do you favour the association of these observation or provisional places, with general hospitals or with existing mental institutions?—I think it would be much more convenient if they were in existing mental institutions. The advantages, of course, are obvious, that the patients are often much better treated in hospitals than in asylums. Their mental illness is often due to causes which are physical causes, and could be best treated in a hospital; also, it brings the patients into contact with students who would be able to take advantage of learning about insanity. All these sorts of things are in favour of the institution being part of the hospital clinic. But against it is the fact that the hospitals as a rule are in large towns, and in the most insanitary parts of large towns, and the patients in the early stages of insanity do not require the surroundings of the slum—for instance, Guy's Hospital, or the London Hospital. What you want is country air if you can get it, and fresh air, good food, and surroundings; you want something that will help the patient to recover, much more easily than he would in a hospital.

12,862. Then if we were able to recommend that asylums should not be so large as they have been tending to grow and that what I may call compendiously the villa system should be substituted, would you contemplate that included among the villas

25 February, 1925.]

Dr. MONTAGU LOMAX, M.R.C.S.

[Continued.]

there would be one which would be recognised as an observation place in which the patients would be provisionally detained?—Quite.

12,863. They might never pass into the asylum proper, that is to say, into the region of certification at all, because they might recover?—Quite.

12,864. On the other hand they would there be seen and studied, and the subject of study by the skilled staff of the asylum?—Yes.

12,865. And if any special treatment were required it would be available in the asylum?—Quite.

12,866. Now you also contemplate, I take it from your evidence, that these persons under observation would require to be under some qualified legal restraint during that period?—That is so; I think that is essential. I think that the early incipient cases (and I am sure all alienists would agree with me) often require more control than the later ones. It has been proved to me over and over again in my own experience; and that is where I do not agree with the Society for Lunacy Reform (and the Association also, I think, have the same view in mind) who wish to make the voluntary boarders persons capable of leaving at 72 hours' notice. I maintain that the voluntary boarder, if he goes as a voluntary boarder into a mental observation hospital, ought to sign a paper by which he undertakes to give the authorities of the observation hospital the right to medical detention and control for the 28 days if required, and if he is to be controlled the same formalities have to be gone through as if the patient had been removed against his will into an observation hospital. It is most important that the doctors should have the power of controlling the voluntary patient if he shows symptoms, as he often does, of sudden insanity.

12,867. That was present to our mind, and I ventured to put one or two questions to Mr. Parker upon it. Now I think that on the general question of the importance of dealing with incipient cases we are all in agreement, and we need not labour that further. At the other end, the process of recovery, I am sure you have studied that stage also. It has puzzled me a good deal. No man can say at what precise moment the patient has passed from the zone of insanity back to the zone of sanity. It is not a mathematical line, of course?—No.

12,868. I think many medical superintendents must have been anxious as to their duty at that stage?—Certainly.

12,869. They must have felt "This patient is no longer certifiable; I could not certify this patient *de novo*"?—That is so.

12,870. On the other hand, they might say "Although the patient has ceased to be a certifiable patient the process of cure is not complete. This patient would be very much the better for another month or two months in the shelter of this Institution, and then convalescence would be complete, and he could be discharged." What is one to do about that case? It is a very puzzling case?—I think the mental observation hospitals ought also to use the wards as "half-way houses out" as well as "half-way houses in."

12,871. Might one at both ends of the history of the patient have this twilight stage—that is to say, you might have observation at one end and observation at the other. Then the patient might be encouraged towards recovery by a relaxation of the legal restraint, and put under the less rigid legal restraint which he was under during the first 28 days of his detention; that might be held out to him as an encouragement, and then he might be moved back to the probation ward, and he would then be studied with a view to his discharge?—Quite, and it would enormously assist his recovery to know that he was in a "half-way house." If you gave him increased privilege of parole, if you employed him on work without being supervised, if you gradually showed him that he was being restored to his own personal control, all that would help him enormously.

12,872. I do not know whether you have seen the Institution at Ewell. I have recently visited it and I was very much struck with almost exactly the programme that you have described. It is for non-certified patients, of course. The patient enters at one villa and proceeds from villa to villa with increasing liberty, until he reaches the last one before discharge, and there he is practically a free person, and the patient is entitled to go into the grounds and into the town, increasing degrees of liberty being given. Of course, unfortunately some fall by the way and have to be certified, but those on the upgrade are taken stage by stage from villa to villa with the maximum of freedom until the discharge?—That is excellent, because to send a patient out into the world, straight away from an asylum, is a thing which is very dangerous to him. He may be undetainable, but he may get into bad habits at once.

12,873. Then I would like to have a few minutes with you on the administrative side. I rather take it from your book, and from the notes you have been good enough to give us, that you think that the Board of Control as the central body should have greatly increased powers given to it?—A reformed Board, I agree.

12,874. Accompanied, I understand, with much larger executive powers?—I think so. If you have a Board at all it ought to have much more powers of control. I think one of the reasons why the Board's inspections are often so ineffectual is that they cannot do more than suggest. If the asylum people say, "No, we will not," then the Board cannot say anything else.

12,875. Then you wish some sanction to attach to their recommendations?—Yes.

12,876. On that subject we have had evidence from the members of the Board of Control, and they are the first to tell us that the work which is imposed upon them, upon their relatively small staff, is very severe, and it must be, of course, especially as they have to be 'en voyage' through the country for such a large part of the year. The idea has been mooted that it might be an advantage to have district Commissioners throughout the country and a central body, to which these district Commissioners would report, and which would have executive powers in the way of giving directions throughout the country. How does that strike you?—I have got a whole chapter on that explaining exactly the same thing. I think it would be a great advantage to have local Commissioners or Boards of Control, if the country were divided up into areas or provinces, and for these people then to have the duties of inspecting the asylums in that area and reporting to the central Board in London. I think that would simplify to a large extent the work of the Board as it exists now: economise it too, and it would create a feeling of 'esprit de corps' in the provinces themselves. I mean to say if you have a local Board of Control with a local office and secretariat in the capital town of a county and they had all the asylums in their area to inspect—

12,877. *Earl Russell*: That surely is adding a good deal to the expense if you do nothing more than inspection—if you put a local office and a secretary there?—They would have to have a secretary of some kind.

12,878. Not if the papers were sent to the central office where the filing is now done?—You think not?

Earl Russell: I do not quite see what the point of it would be.

12,879. *Chairman*: If you have a district Commissioner with an area given to him in which he should reside, and with large visiting powers and powers of supervision, I do not see that we need hamper him really with a great deal of office staff and accommodation?—Would you have only one? Would you have a legal, or a medical, or both.

12,880. I do not know really. I should have thought a medical man would be the better man there. The legal man is more wanted, if I may say so, to see that the law is complied with when questions of

25 February, 1925.]

Dr. MONTAGU LOMAX, M.R.C.S.

[Continued.]

difficulty come up. You see this would not be certification we would be dealing with here?—No.

12,881. This is the administration of asylums?—Quite.

12,882. I quite agree to the importance of the legal element in certification, and in any question of illegal detention, but that would probably be a matter for the central office on report?—Yes.

12,883. What we are anxious to see is whether by having a responsible local official who would be in touch with the asylums, hear the gossip, in short, of the district, and get to know all about the place, you would be providing a valuable safeguard. It would to some extent lighten the immense labours of the Board of Control?—I think it would.

12,884. It would be a sieve through which the local material would pass in the first instance?—You mean that each of these local Commissioners should have to inspect and report?

12,885. I think so. I think these district Commissioners on the spot would be able to make a much more thorough investigation than the Commissioner who comes down for a couple of days from London?—You would have to have more than one. An enormous amount of work would be connected with drawing up his report.

12,886. *Earl Russell*: That depends entirely on the size of your districts?—Yes.

12,887. *Chairman*: If he were a whole-time official with a district of reasonable size under his charge he could do a good deal of inspection; that would be his main job, you see?—Quite, and he would be able to come and go in a much more unexpected way.

12,888. Yes, there would not be the pomp and circumstance of the visit of the Commissioners?—No.

12,889. *Earl Russell*: Nor would he have to put up at a hotel on the way where his presence would be known?—Quite.

12,890. *Chairman*: I think that it is a practical suggestion which is well worth following up?—I am sure it is; it is practically the same as the one I have suggested here, only I have two instead of one.

12,891. One has always to keep an eye on expense in these matters?—Obviously, yes.

12,892. And I think for the local man a medical man is better for that job than a legal man would be?—Yes.

12,893. *Earl Russell*: Can you show us any real help it would be to add a legal man to the medical man in this local inspection?—No, I do not think I can.

12,894. *Chairman*: I really cannot think of any. It might happen that a case of illegal detention came up where a patient said "I would rather have a talk with a lawyer than a doctor." I can imagine that case being put; but if it were a serious case of doubt it could be referred by the doctor to the central Board, where there would be legal advice. However, that is a detail in your scheme?—Yes.

12,895. Now, I think, Dr. Lomax, we might dwell for a little on the question of private asylums. The only comment I would venture to make on any observations you have on that topic is, that you have not personally had experience of these institutions?—Only as seeing people in them. I have gone to see some patients in them.

12,896. Have you visited some of these private asylums yourself?—Oh yes.

12,897. Have you visited many different types of institutions?—Yes, I have visited small ones and large ones. I mean I have gone there as an alienist to see the patients there.

12,898. *Earl Russell*: About how many?—I do not think I have been to more than about six.

12,899. *Chairman*: You must have been to a certain number. I think you have visited Ticehurst professionally?—Yes.

12,900. And Moorcroft?—Yes.

12,901. I would like to ask you this general question. Having seen a number of these institutions, as far as your experience goes, are they well conducted or not?—All the private asylums I have seen I should say were quite well conducted. I have not the least doubt in my own mind that private asylums in

England are conducted as well as they are in any part of the world, but I have a fundamental objection to the principal of private asylums at all being owned by private individuals. I do not object to the principle of private asylums which was mentioned yesterday—the case of the rich man who wants to go to a place where he can be surrounded by his comforts and luxuries. I think it ought to exist, but I do not think it ought to be under private proprietorship. I think they ought to be bought up by the local authority or the State, if they are going to nationalise all asylums, and the owners ought to be compensated; and the officers of those asylums ought to be appointed either by the local authority or the State. I am not alone in thinking this. A number of doctors have thought the same. A very eminent alienist 50 years ago, Dr. Bucknill, wrote a book which it would well be worth the while for the Commission to study on the subject, in which the question was discussed. He was a very eminent alienist indeed. He was the Lord Chancellor's Visitor; he was the President of the Medico-Psychological Society, and so on, and so on, and he was most emphatic on the subject in his book. It is the principle of the financial motive that is involved which we want to dissociate from the care of the insane altogether, if we can. I do not think it ought to be to anybody's profit to treat insanity of that type.

12,902. Yes, but will you permit me just to take it by stages for a moment. No doubt the observations of Dr. Bucknill were most valuable, but you say they were made 50 years ago. Since his period we have had the code of 1890, which at least tried to introduce many safeguards in the very context of licensed houses; whether they have been effectual or not I am not here to say, but let me just follow it by stages. You say that so far as you have seen licensed houses yourself professionally, their conduct at least seemed to you satisfactory?—Quite.

12,903. That is an important step. Do not let us minimise that, because it is useful for us to know that you can give that commendation to them. Those that you have seen appeared to you to be well conducted?—Yes.

12,904. And were they full?—Yes, all full.

12,905. The point that occurs to me at that stage is this: Do they not fill a want?—I am sure they do.

12,906. And would you not really deprive people of a facility or a convenience which they want, by converting those licensed houses into State Institutions? Is it not the very idea of their being private places that is their attraction to certain classes of the community?—Quite.

12,907. *Earl Russell*: It is a new idea that the funds of the State should be used to provide luxuries for the rich?—The rich provide them for themselves.

12,908. They are doing so apparently?—All I mean to say is that the rich pay, and the private proprietor of the asylum makes the profit.

12,909. *Chairman*: Think of this for a moment. If you were able to show to us that these places in private hands were being badly managed and that they were also places in which patients were being wronged in this sense, that they were being detained when they should not be detained for the motive of making gain out of their infirmities, you would make a strong indictment of the whole system, but are you able to make such a case?—From personal experience, no, but from the experience of attendants of many years' standing in private asylums I should say "Yes," and also from what has been told me by a doctor himself who owned a private asylum and gave it up, because he was unable to reconcile his conscience with certain events which took place. I have not any experience myself at all. I make no imputation whatever upon the owner of any private asylum in the kingdom. I have no evidence to go upon that they take unfair advantage of patients except what has been given to me from outside. I have no personal experience whatever. It is the principle of private proprietorship in what really comes to be the bodies and souls of unhappy people.

12,910. Of course it needs no demonstration, that

25 February, 1925.]

Dr. MONTAGU LOMAX, M.R.C.S.

[Continued.]

there is an interest to detain a person who is paying you 20 or 30 guineas a week?—Quite.

12,911. One may say, of course, equally that there is an interest in the medical profession to keep on attending a wealthy patient; rather more visits are charged perhaps than are necessary. I have even heard it said of my own profession, that there is a tendency to foment a litigation with a wealthy client, but I do not know that it has been established that on that account either the medical profession or the legal profession should be nationalised to remove them from the possible temptation?—No, I do not think so either, but again it is the question of the liberty of the subject largely involved.

12,912. Let me follow that up. If all these institutions are full, then there would be the less motive for these owners of licensed houses to detain persons, just as we know that a doctor in very large practice is anxious to get patients off his books as quickly as he can, or a lawyer with a large practice is probably the best man to go to, because instead of wanting to have you as a client he is regarding you as a nuisance. Now similarly with regard to institutions which have a waiting list, there is no particular motive there to detain one patient for the purpose of making gain out of him, if they are full up?—Not if they are of the same paying class.

12,913. And is there not this also, that an institution will have a much better reputation and be much more attractive if it has a remarkably good rate of discharge?—Yes.

12,914. So I should have thought. While there is of course the pecuniary motive which may be present, there is equally the other motive of establishing a reputation for a home where patients have better chances of recovery than anywhere else?—Certainly there is.

12,915. What is the result of that balancing of considerations; do you think it means this: the abolition of that class of premises?—No, I do not want to abolish them. I want to keep the asylums where the patients can have all the luxuries that they can afford, but what I do want is to remove the financial motive for detaining patients. Of course these places are not all full, I presume. The places I happen to have seen are fairly full, but I presume some are anxious to get more patients into them. It is the principle of private proprietorship that I feel is wrong.

12,916. The accommodation is steadily dwindling, while the population of this country is increasing at the present moment?—Yes.

12,917. Because certain licences are falling in?—Yes.

Earl Russell: I am told they are short already of necessary accommodation.

12,918. *Chairman*: Yes. (*To the witness*): You say that private institutions like private nursing homes are quite excellent, but you do not like private proprietorship. Are we not getting very near a contradiction in terms? You would like a private home publicly conducted. I am afraid a private home necessarily has the idea of private proprietorship?—Yes, if it is a private home it has, of course.

12,919. One knows, of course, a great many nursing homes which are very often run by a nurse who has had experience and has taken premises and then runs them, generally in connection with some doctor's practice?—Yes.

12,920. But I have a little difficulty in seeing exactly your idea. You say there is not to be private proprietorship of these homes and yet they are to be private homes. How are we to accommodate these ideas?—Well, I mean there is the country house in nice grounds, and the patient has the surroundings he is used to, the social surroundings he is used to, the comforts he is used to, and the privacy he is used to.

12,921. But who is to run it?—A doctor appointed either by the State or by the local authority; they will appoint the doctors to run the places at a certain salary and appoint the staffs, and so on.

12,922. *Earl Russell*: If they are State-owned, they will all be run by the Office of Works and have the same kind of garden and the same kind of roof?—I agree; but I am not proposing to nationalise all asylums right off.

12,923. I thought you said the State was to run them?—I said if they were to be nationalised.

12,924. Then who is to own them?—Could they not be bought up by the local authorities in the county?

12,925. There, again, you are asking a local authority to spend public money for providing private luxuries, which is quite a new idea to our administration?—If the patient is paying the cost of the luxuries, it does not make any odds who is asked to provide them.

12,926. *Chairman*: But it is not consistent with the idea of local government. You could hardly expect any authority to proceed to supply the premises for an institution which is to cater for one class of the community. The answer is: if these people are willing to support their institution, let them support it?—Yes.

Earl Russell: We have not got beyond parks, so far, and perhaps an extra swan, in the way of providing luxuries.

12,927. *Chairman*: If I may suggest it to you, I think that the provision of possibly even more stringent safeguards is the direction in which more satisfaction would be obtained. I sometimes think it might be better to have more of these institutions rather than fewer of them. I know that view is not entertained by everybody, but I can imagine that they play a rather useful part in the economy of the country?—I think they do, if they are properly inspected. That is the crux of all these asylums.

12,928. If they are properly inspected, then there does not seem to be much real reason for objecting to their being privately owned?—Do not you think that the private asylums, anyhow those that are owned by a board of shareholders, should publish the list of shareholders every year and an annual balance sheet?

Earl Russell: Why?

12,929. *Chairman*: As Lord Russell says, why? Why should this particular form of industry be selected for this publicity? I will assume it has been well reported upon by efficient inspectors; it has been well run and well conducted, and the patients are properly looked after and well-treated. If that be so, is not the proprietor of the place entitled to say: "I have done my duty; there is no complaint against this place. Why should I publish my income any more than the publican who conducts his public house next door"?—Again, it is the liberty of the subject which is involved. We get hundreds of very serious complaints from private asylums; and we know of instances. There was one the other day in the Harnett case; and, again, the case of Mr. H., who came before you the other day and whom I know well. If he had not escaped, he might easily have been there now, in the same way as Harnett might. Were those asylums properly inspected, if the only solution of the problem of a man's detention is that he should have the opportunity of escaping?

12,930. *Earl Russell*: How will publishing the balance sheet help that?—The balance sheet would not help that, of course; but what I meant was this: that one would have an idea of the profits made and the extent of the financial motive involved.

12,931. You mean you think you would see when his conscience was getting near the breaking point?—I do not know where the breaking point is, but I am told one of the largest licensed houses in the country to-day is paying its shareholders between 44 and 46 per cent.

12,932. There are plenty of industrial concerns doing that?—I know; but do you think that that sort of percentage ought to be made as profit out of patients who suffer from one of saddest infirmities?

Chairman: I am not sure that that is sound economically, because, as we know, some of the indus-

25 February, 1925.]

Dr. MONTAGU LOMAX, M.R.C.S.

[Continued.]

tries, the best conducted, are among the most profitable and they pay very large dividends. You may dislike large dividends in principle; that I can quite understand; but the mere fact that an undertaking pays large dividends does not necessarily mean that it is an undesirable undertaking.

12,933. *Earl Russell*: If you are conducting the thing properly, what right have you to object to the return?—If you are.

12,934. *Chairman*: It would rather suggest to me that every doctor who is making more than £5,000 or £6,000 a year ought to publish his accounts, lest it be suggested that he is making too much money out of his patients. It does lend itself to a *reductio ad absurdum*?—It does.

12,935. *Earl Russell*: I understood that you have information from attendants who have been for years in these places?—Yes.

12,936. What length of service have the attendants had in any one place?—I have the case of an attendant with 21 years' service.

12,937. 21 years in the same private asylum?—It was not a private asylum in that case; it was a registered hospital for paying patients of a good class.

Earl Russell: You mean it did not make private profit?

Chairman: It cannot, you know.

Witness: But there are others connected with private asylums as well.

12,938. *Earl Russell*. I thought you said this attendant told you what went on in these licensed houses?—He did.

12,939. How did he know if he had not been there?—I am speaking now of a second one we had.

12,940. How long had he been in a licensed house?—I think he had been there three or four years.

12,941. Have you known other attendants who have been for a long time in licensed houses?—I have got the proofs of two or three, I think.

12,942. I am asking you this because of what the witness said yesterday. The witness said yesterday that they never stayed for more than three months?—I think that that is the case perhaps in some instances, but the proofs of men I have here show that it was evidently much longer than that.

12,943. *Chairman*: Will that be one of the cases you are going to hand us?—Yes.

12,944. Now we have explored the question of the private institution. I see that you, like so many other witnesses who have favoured us with their views, are strongly in favour of the elimination of the pauperisation element?—Yes, I am.

12,945. That is, to some extent, linked up with the Poor Law institutions. There is a practical difficulty there. Where are we to put the unhappy patient?—There is a difficulty; the practical difficulty is great; I mean to say, 60 per cent. of the patients who come into asylums go through the Poor Law infirmary.

12,946. I wish you would give us your view as to how we are to eliminate the pauper element from the whole administration of the Lunacy Law, if it can be done?—The only way I can see is this. We cannot build mental observation hospitals *ad libitum*; if the Builders' Union will not build houses, they will not build asylums. We have got to take the asylum infirmaries and hospitals we have got and make the best of them. The infirmary wards, I think, are the worst feature of the asylum system, because not only is the patient often very imperfectly treated, scurvily treated at times, but he is pauperised as well, and all that happens before he is certified; often he is sent there and pauperised straight away. I do not know how you are to get rid of the infirmary wards until you have got mental observation hospitals which will take all classes of patients. Until then you have got to use the infirmary wards; but I should prefer them to be in separate buildings away from the workhouse altogether, if it were possible. I do not see why a patient should be pauperised, even a poor man, simply because he has become insane. He has got to be sent somewhere; he may be an

urgent case. He is taken, in the first place, to the police station, and then is sent straight on to the infirmary, and I do not know anywhere else you can send him to, except you have these observation hospitals built, and it will take a long time to build them. Unless you empty an asylum of all its inmates and turn it into an observation hospital, pure and simple, for all classes.

12,947. That would only be possible in a large centre of population?—That is all.

12,948. *Earl Russell*: You can only do that where you have three or four asylums to play with?—Quite so.

12,949. *Chairman*: However, you subscribe to the view that as far as possible the element of pauperisation should be dissociated from insanity?—Certainly, as far as it can be.

12,950. Now there is one matter which affects the medical profession and which I see you allude to in your communication to us, which is rather a serious matter. I see you state, "It is no secret that many medical men are refusing in the absence of these safeguards" (that is, safeguards of their professional position) "to certify to insanity at all." Do you find that, in consequence of the legal risks which medical men run, there is a reluctance to certify?—I do.

12,951. Of course, if medical men are deterred by those risks from certifying, is there not a danger that the whole machinery of the Lunacy Law will break down?—Absolutely; but then, if you have the mental observation system, the man who certifies, in the first place, does not run a risk at all. He certifies merely that the person is detainable.

12,952. *Mr. Micklem*: Why does he not run exactly the same risk as the doctor does to-day, except that it is for a limited time, so to speak?—He does not certify the patient insane; he certifies the patient detainable.

12,953. Suppose the patient alleges afterwards that he was not detainable?—Then the magistrate comes in in three days' time, and backs up the doctor or not. He has then to write the order for the detention for 28 days.

Earl Russell: He will still be shot at.

Mr. Micklem: The position is just the same.

Earl Russell: It is only that the measure of damages may be a little different if it is three days instead of 12 years.

Witness: How are you to avoid it?

Mr. Walter Stewart: This is the real point, I suggest: would you put it to witness, Sir? If it is a true judicial proceeding, there is absolute privilege for the medical man.

12,954. *Chairman*: I am afraid Dr. Lomax does not suggest that; that is not his case to us at all. What I want to get is this: I see the value of the observation period, and you may say that a doctor takes much less responsibility when he says, "This man may be detained for 28 days"; but I am afraid he puts once more his professional opinion in peril, because an action would lie against him equally for that detention as would lie against him for a certificate of insanity; the damages might be less?—That is so.

12,955. *Mr. Micklem*: In the case you refer to, Dr. Bond, I think, detained the patient for six hours, and he was held liable for £25,000 damages?—Yes, but then Dr. Bond was exceeding his powers.

12,956. *Chairman*: I think they linked up the whole of the periods. But whatever be the view, even suppose the judicial element entered into it, as Mr. Stewart suggests, there might still have to be a certain amount of detention preceding that judicial investigation. Even so, I mean the most ideal system that could be devised would always involve a certain interference with the liberty of the subject. I think what has been suggested there is that you must take your chance of that; but one is anxious to see that the doctor who has sincerely tried to do his duty, not only as a doctor, but as a citizen carrying out the law, should not be deterred by the idea that he is exposing

25 February, 1925.]

Dr. MONTAGU LOMAX, M.R.C.S.

[Continued.]

himself to unknown legal terrors and, possibly, to ruin?—Certainly not.

12,957. That is an intolerable state of affairs?—Absolutely.

Mrs. Mathew: Would notification cover these cases, as is the case with notifiable diseases?

12,958. *Chairman:* Again, notification is not a ground of action. Detention is a ground of action always. It is the actual detaining of a person against his will, which is an interference with his liberty, which results in damages. Of course, the doctor knows, when he grants the certificate, that he ought to do it with every sense of responsibility; but if he does it sincerely and honestly, even though mistakenly, he ought to be protected?—He is now, is he not?

12,959. He has to protect himself in a court of law, and you know what that means. Now an ordinary witness giving testimony in a court of law is protected absolutely?—And you think the evidence on the doctor's certificate ought to have the same privilege?

12,960. It is just a question whether that is not giving it too high a privilege, because too high a privilege might have, as its correlative, carelessness?—Quite.

12,961. However, you have not any particular suggestion to make on that topic?—I have not, except that after the Harnett case I believe a number of doctors suggested that Lloyd's should be approached and liability should be underwritten.

12,962. That is not a proper remedy. I mean, we should not have the medical profession put in that position?—Certainly not.

Chairman: Those are all the questions I have to put to you, Dr. Lomax. I can assure you that we are very much indebted to you for your evidence. My colleagues may now wish to put some further questions to you.

12,963. *Mr. Micklem:* Dr. Lomax, I only wish to put one question to you. I have been very much impressed with a good deal of your evidence, and I think it will be of considerable value to us, but there is one part of it I am troubled about still, and that is your evidence as to ill-treatment. You very frankly told us that although you have had considerable experience in two hospitals, you have never yourself seen any instance of it, and that on only one or two occasions has it been brought to your notice by patients?—Yes.

12,964. Now during the last three or four years at least this question of ill-treatment has been pressed very hard, I think, partly by yourself and certainly by the many Reform Societies and others?—Yes.

12,965. And statements have gone about and have been issued publicly as to this question of ill-treatment?—Yes.

12,966. So that in every mental hospital in this country the medical men must have been on the lookout for it very carefully, must they not?—We hope so, yes.

12,967. I mean, if it was brought to their attention—you know what your profession is, and you know the very high standard it attains—they would take every means in their power to ascertain if in their particular hospital such a thing did exist?—Certainly; if the reports were brought to their attention.

12,968. Do you think we can get any corroboration from the medical men at all of the statements that you have been making?—No, I do not know that you can, because when I was an asylum doctor myself, I should not have been able to corroborate any of it.

12,969. But if when you were in the asylum you had the knowledge which you suggest you have got now?—I had not got the knowledge of ill-treatment that I have got now.

12,970. If you had had that knowledge, you would have been very awake to the fact, and I put it to you that medical men throughout the country must have been taking that attitude for some time?—Yes, I think so.

12,971. Do you think we shall get any corroboration from them of the statements that you make?—No;

because I think that a great deal more care is being taken now.

12,972. That is to say, there is much less ill-treatment?—I cannot say, except that the patients and attendants who have come to me have not told me of things that have happened in recent years. The last bad case I heard was the one I gave you, in 1920; and I am perfectly convinced of this, that the attendants have been very much more careful, and doctors, too. I think it has been due a good deal to the public attention which has been paid to the subject. But I must explain—I want quite clearly to explain that my knowledge of these things has not been personal; it has been due to accumulation of evidence which has absolutely convinced me by its mass, its volume, its congruity, its character altogether. I have investigated it personally in a number of instances by examining patients who told me. I formed a very high opinion of their veracity, of their reliability, of their sanity. I have been told it by ex-attendants and ex-nurses as well. I am going to give you the proofs of two or three. The conviction has been borne into my mind irresistibly that a great deal of ill-treatment goes on which we never hear anything of.

12,973. Would you not say that it *did* go on, because you have told us that none of this evidence was recent?—No; I do not think that anything has reached me within the last three years.

12,974. *Miss Madeleine Symons:* Dr. Lomax, there is one point I should like to ask you about. You told us that you thought that this preliminary method of detention was necessary, perhaps particularly in early cases. Do you mean that you are contemplating that all the early cases should be dealt with, either in these observation hospitals or as voluntary boarders in existing hospitals? You are not advocating the establishment of clinics without certification, or are you advocating those as well?—Certainly I am. I advocate strongly the hospital clinics or the mental observation hospitals without certification in all these instances. I advocate very much the system of hospital clinics, if it can be done on the principle on which it is done in France. The clinic there is a sort of annexe to the hospital or asylum, and the patient is sent in there uncertified, and is not certified in the clinic at all. They are treated there as patients; they are treated in a variety of ways. I think it would be an admirable thing if we could do that in England. The difficulties are immense as regards hospitals, because in our large towns the hospitals have not got the facilities for having clinics; the hospitals can hardly support themselves as it is. If they are going to be asked to make large additions to their wards, I do not think they could do it.

12,975. There are a few now, are there not?—Yes.

12,976. You are not suggesting that this preliminary method of detention should apply to them, are you? Are you suggesting that they should be voluntary?—They are voluntary, but I think that every voluntary boarder who goes into a hospital clinic must sign a paper of some kind, by which he gives the people in his clinic the power of controlling him, if it is required, because an early case often requires control much more than a later case. These hospital clinics would practically be half-way asylums; they would have to be under some control or other; they would have to be inspected and reported upon. I do not see who is to inspect and report upon them except the Board of Control or some body of that kind. You cannot treat the patients in these hospital clinics like the patients of an ordinary type who can come and go as they like, except they go as out-patients only and not as in-patients; but when once a voluntary boarder has gone as an in-patient into a hospital clinic, I do not think that patient ought to have the power of leaving at any moment he likes by signing a paper, and then perhaps going outside the asylum and throwing himself under an omnibus or under a train. They are often people who need to be protected from themselves. I am speaking as an alienist here,

25 February, 1925.]

Dr. MONTAGU LOMAX, M.R.C.S.

[Continued.]

12,977. *Earl Russell*: Dr. Lomax, I have just come across this sentence in your *précis*; you were asked about part of it before. "I would impress upon the Commission that even the Board of Control admit that patients are often wrongly certified and unjustly detained." Do they admit that? You refer to the Report for 1922, and you say there are 22 cases who were not insane upon admission?—That is so.

12,978. That does not show they were wrongfully certified, does it?—No, because the Board of Control say it only means that they were not insane on being admitted; but it does not prove that they were wrongfully certified a day or two before. It leads to a very grave suspicion.

12,979. Nor does it prove that they are unjustly detained if they were found to be not insane on admission and set free. Do you mean that these 22 people who were found not insane upon admission were kept in the asylum?—Certainly.

12,980. How long for?—Probably for a month, until the discharging committee met again. They are kept in for that time, and I do not think the superintendent of an asylum has the power to refuse to accept them. If they come under certificates, he has to take them. All he can do is to refer them to the Board of Control, who send down and examine them and discharge them.

12,981. He can let them out on trial, of course?—I do not think he would as a matter of fact, for the first few weeks.

12,982. Why not—if they were not insane?—I think he would sooner wait till the first discharging day. He would not do anything at all until he had sent the papers up to the Board of Control to be overhauled. I think the law ought to be altered in that respect. I think the superintendent ought to have the power to refuse to accept a patient of that kind.

12,983. I am asking you about a power he has got under the law now. Do you say that when a patient is brought who is not insane the medical superintendent would not send him out on trial until the committee met?—I do.

12,984. A conscientious superintendent?—I do not think he has any option to refuse to take the man in.

12,985. He can take him in on the asylum books, but when he is sent out on trial he is still on the asylum books?—You mean sent out on trial the next day, or sent out for a few days in any case to see how he is going on? You cannot establish the sanity of a man straight away.

12,986. If he keeps him a few days, that means he is not sure he is not insane. I am taking you at your own stage, where you say he has found the patient is not insane. I ask you then, why should he keep him and not let him out on trial?—I suppose he would be able to, but he would have to send the certificates up to the Board of Control, and the Board of Control would have to say whether the patient is to be discharged.

Earl Russell: That does not prevent him letting the patient out on trial.

12,987. *Chairman*: He has to get at the visitors before he can let him out on trial?—I think not.

Chairman: I do not think he could really let him out on probation without the intervention of the visiting committee.

12,988. *Mrs. Mathew*: Dr. Lomax, some of the things you have been telling us you say are three years old. I would like to come to something a little more recent. What about the asylum food? Have you any recent knowledge of asylum food?—I have knowledge only of the Report of the Subcommittee on Dietaries, which made very startling recommendations as to improvements in the food required; that is all I know. Of course, I know from internal sources that the food has improved a lot in the course of the last few years, but the Report of the Cobb Committee stated that the food, the

thought, was quite good. As soon as they appointed the Departmental Committee, the report was diametrically opposed to that; they state that the food wants very serious improvement.

12,989. You have no later knowledge?—I have not, except that I hear every now and then from patients to thank me for having a kipper sometimes which they never had before. That is the only sort of personal knowledge I have.

12,990. And you would favour the light late supper?—Certainly.

12,991. And the later bedding?—Certainly. I think it is an awful mistake to go from half-past five to seven o'clock the next morning, considering what the quality of the last meal is; it is extremely poor in quality—bread and margarine, and weak tea; and they have not anything at all to eat till eight o'clock the next morning.

12,992. And that, again, is all a question of finance, is it not?—Purely.

12,993. *Sir David Drummond*: What view have you, Dr. Lomax, on the question of female attendants looking after male patients?—I think it is an excellent plan. Wherever it has been tried, it seems to have succeeded; that is to say, I have heard, in the Scotch system, of asylums in which a number of females are employed in the male wards, and the results have been excellent.

12,994. You would not object to it?—Not in the very least.

12,995. You know that we had strong evidence yesterday against it?—I know that some of the representatives of the Asylum Workers' Union do not approve of it; but it strikes me that it would be an excellent plan, especially in the hospital wards, to have female nurses for male wards. I do not see why it should not succeed in the asylums; it certainly succeeds in the hospitals.

12,996. I was very much struck with a statement in your book on page 102 with regard to the administration of croton oil. You state there that the effect in some cases is not only to scour out the bowels but to strip off the mucous membrane?—Yes.

12,997. Have you seen that yourself—I am speaking as a pathologist?—I do not wish to dispute the actual portion of the bowel which was stripped, but all I can say is that shreds of skin were frequently to be seen.

12,998. Mucous is often mistaken for mucous membrane—that is just the point?—Quite.

12,999. I notice that you advocate that larger sections of the asylum should be allocated to the hospital part?—Yes.

13,000. You are very much impressed with that?—Much impressed.

13,001. I thoroughly appreciate that, I must say. Just one more question. I think you have stated that certain people are wrongfully certified?—Yes.

13,002. Do you mean that they are absolutely sane, or that they are insane people who ought not to have been certified? It was not the best treatment to put them into an asylum. Do you mean they are actually sane people who are certified?—No. I think in a number of cases that certification does not prove insanity; that the facts related on the certificate do not prove certifiable insanity.

13,003. But you do not mean to say that they are actually sane people?—No, not actually sane. I do not think anybody is certified without some reason or other, often an inadequate one; but I am perfectly certain it is an honest certificate as far as the doctor who certifies is concerned. He may not be a very capable man, but he is doing the best he can.

13,004. It is his opinion?—Quite so; it is his opinion.

Chairman: Thank you very much for your attendance to-day, Dr. Lomax, and for the help you have given us.

(The Witness withdrew.)

(Adjourned to Tuesday, 10th March.)

5, OLD PALACE YARD,
WESTMINSTER, S.W.1

TWENTY-THIRD DAY.

Tuesday, 10th March, 1925.

MEMBERS PRESENT :

THE RT. HON. H. P. MACMILLAN, K.C. (*in the Chair*)

THE EARL RUSSELL.

SIR THOMAS HUTCHISON, BART.

SIR HUMPHRY ROLLESTON, BART., K.C.B., M.D.

SIR ERNEST HILEY, K.B.E.

MR. W. A. JOWITT, K.C.

MR. N. MICKLEM, K.C.

MR. H. SNELL, M.P.

MRS. C. J. MATHEW.

MISS MADELEINE SYMONS.

MR. P. BARTER (*Secretary*)

MR. W. FAIRLEY (*Assistant Secretary*)

Mr. Cremlyn: May I intervene just for one moment, Sir? I am asked to put this to you as Counsel for the National Society for Lunacy Reform. You recollect that a certain statement, a somewhat long statement, was sent in, and you took exception to a purple patch of it, and also to one or two other matters.

Chairman: I remember.

Mr. Cremlyn: I have just to ask you whether you consider that you could in any way make any use of that document, or attach it to the case, if it were considerably curtailed or cut down.

Chairman: To tell you the truth, I think it would be a pity to ask you to take the trouble to cut it down. Really what I was concerned with was this, that I did not want the public to get an idea that all institutions were open to those criticisms, which might produce a degree of alarm and unhappiness. That was affecting my mind. I thought that some of the statements in it were rather extreme if made public. But I have read it through myself, and I was proposing

to keep it by me until we come to prepare our report, because there are some drafting suggestions in it which may be useful; and therefore, although we did not mean to publish it, I do not think it will be lost sight of.

Mr. Cremlyn: If you please, Sir; that was what was in my mind. I thought that you did indicate that you would do something of that kind, and that the document would not be lost sight of. A kind of idea seems to have been created in some minds that it might be said you were giving a preferential treatment to the British Medical Association by publishing theirs and not publishing ours.

Chairman: Of course, the two documents are rather different in type. Your document would be quite useful to us for its practical suggestions, and I shall read it in that light; but I do not think it would be reasonable to ask you to recast it merely for a few passages which were really written from the advocate's point of view.

Mr. Cremlyn: If you please.

Alderman J. G. TAGGART, J.P., and Alderman Sir WILLIAM HODGSON, called and examined.

13,005. *Chairman:* This morning we are to have the advantage of evidence from the Mental Hospitals Association, who are represented by Alderman Taggart and Sir William Hodgson. I think that the latter also represents the County Councils Association. Perhaps the most convenient course would be to take Mr. Taggart's general evidence first, and then to take the more detailed evidence which Sir William Hodgson has to give us. First of all, would you tell us, Mr. Taggart, what is the Mental Hospitals Association; we like to know the constitution of the bodies who are before us?—In the first place, it is a body consisting of representatives of nearly the whole of the 98 asylums in the country.

13,006. A voluntary Association?—Yes, and at the present moment some 85 per cent. of the authorities are members of the Association.

13,007. Do they all appoint delegates to your Association?—They do; they appoint an executive that carries on the work from year to year. They meet in July of each year, and they appoint an executive to carry forward the work.

13,008. What is their function—what do they do?—Springing from that executive there are one or two things; there is the ordinary executive body of the

Association, and there is a Conciliation Committee consisting of ten of that executive body, who also meet a similar body of the National Asylum Workers' Union, which is the recognised organisation of the employees; and the Conciliation Board so constituted has been very effective in dealing with disputes during the last two or three years of the existence of the Association.

13,009. It acts really as a Whitley Council, I suppose?—In that sense, yes.

13,010. As a means of discussing and deciding questions arising between what one may call the employers' interests and the employees' interests in this matter—that is one important function?—Exactly.

13,011. Does the Association discharge other functions?—It takes a general interest in the management of institutions generally in so far as it allows a combination of the two; invariably the chairmen, or the leading members of these various asylum committees, meet to compare notes together, so that they can, and do, assist others in a variety of ways. We consider the advisory work of the Association to be very very important indeed.

13,012. Then the membership of the body, I take it, consists of representatives of different local authorities?—Quite.

10 March, 1925.] Alderman J. G. TAGGART, J.P., and Alderman Sir WILLIAM HODGSON. [Continued.]

13,013. They are not medical men, but are gentlemen engaged in local government?—They may be medical men, but they are simply the elected members on the visiting body in every case.

13,014. They might happen to be medical men, as Sir William is himself, or they might happen to be lawyers?—Quite.

13,015. But in their capacity as members of the Mental Hospitals Association they are really persons engaged in local government, in this aspect of it?—Quite.

13,016. Have you offices and a secretary and some organisation?—We have a permanent secretary, and a permanent office at the Guildhall in London.

13,017. And periodical meetings?—Of the executive, yes, at the Guildhall.

13,018. Do you publish reports?—Yes, which are sent to each of the authorities.

13,019. It would be rather interesting to have one or two of your reports?—We have several copies; I will hand them in. (*Handing in the same.*)

13,020. Then, coming to yourself, you are a past President of the Association, are you not?—I am.

13,021. And you are at present a representative of Liverpool on the Lancashire Asylums Board?—Yes.

13,022. On which, I think, you are at present the oldest member, having served since 1890?—Quite right, with one slight hiatus due to political misfortune.

13,023. That sounds as if you had stood for Parliament and had not gone in?—I have not gone that far yet.

13,024. You are Chairman of the Winwick Mental Hospital, which is one of the six mental hospitals under the Lancashire Asylums Board?—That is so.

13,025. You are an Alderman of the City of Liverpool and have been a Member of the City Council for the last 37 years; and you are a Justice of the Peace for the City of Liverpool?—Yes.

13,026. So that you have obviously had a large experience of local government and its association with the work of mental treatment?—I claim that.

13,027. I understood from the *précis* you have been kind enough to send us that you propose to confine your evidence to certain more general considerations resulting from your experience?—Yes.

13,028. And, in the first place, as a general ideal in any reforms I gather that you want to eliminate as far as possible the pauperisation element which at present enters into lunacy administration?—Quite; I feel very strongly upon that point.

13,029. Of course, you are alive to the fact no doubt that there are certain difficulties in entirely eliminating that element?—Yes.

13,030. I suppose one may take it that a considerable proportion of the patients are persons who would be paupers in any event?—Very slight.

13,031. Is that so?—I should imagine less than five per cent.

13,032. Then may we take it in your experience that the larger proportion of the patients have become in law paupers in consequence of their illness, rather than as being members of what one may call the pauper population from the beginning?—Yes, that, together with the procedure, makes them paupers.

13,033. Looking at it again broadly, if through the misfortune of mental illness a person has to be maintained in an asylum which is kept up out of public funds, at present such a person, being rate-aided, is treated as a pauper—is not that so?—Yes; he would be.

13,034. Then the ideal you place before us is this, that an ordinary citizen, who is not in any sense a pauper but who becomes afflicted with mental illness, should be in the same position as such a person becoming afflicted with any ordinary illness?—Typhoid, or smallpox, yes.

13,035. Who goes to a hospital, receives treatment, and returns to his life without having incurred any stigma of pauperisation?—Quite. May I indicate what is in my mind?

13,036. Please?—Liverpool, unfortunately, has 3,000 lunatic patients. Through the operation of the law, all of them are pauper patients.

13,037. Because they all reside and are treated in rate-aided institutions?—Yes, but for these rate-aided institutions there is one governing union. There are 27 unions in the whole of Lancashire, but in one particular Liverpool union, of the 3,000 patients I venture to say 2,800 of them are not at all paupers in any sense or shape. Although they receive rate aid, yet their friends do contribute directly to the poor rate, not only by way of paying rates, but they pay a contribution on top of that. It is the practice for the Poor Law authority to collect what they can from the relatives of the patient, and in many cases that I know the Poor Law authorities are able to get practically the whole 20s. in the pound that they pay for the maintenance of the patient.

13,038. But does such a patient not exchange his position into that of a private patient?—No.

13,039. I thought that if a person entered an asylum on the basis of a pauper, but the relatives contributed sufficient for his maintenance in the institution, the patient changed over from a pauper status to that of a private patient?—That is true. What I speak of is with regard to local authority patients that are sent to each of the six county asylums in Lancashire. The unions in question send them, and they are subject to a precept by the Lancashire Asylums Board—that is the authority. The friends of the patients who have to pay this money do not pay to the Asylums Board at all, but they pay to each of the 27 unions who themselves have to pay the money that is recovered from them by precept.

13,040. They are contributory to the central board?—Quite, if any money was paid to the central board over and above the pauper charge, then they would be transferred to the private side, if such exists, and there is one asylum only of the six where it does so exist.

13,041. That seems rather special to your district, because of the existence of the Board?—Yes.

13,042. In the ordinary case where guardians are chargeable for a pauper lunatic who is in an asylum, and the relatives come forward and pay for the patient, the patient has the status thereafter of a private patient?—I do not think so; that is not my experience.

Earl Russell: You must remember the pauper charge only covers maintenance, it is not the whole cost.

13,043. *Chairman:* Yes, but I thought we had some evidence that patients changed their status from paupers to private patients, if contributions are made by their relatives?—Unless there is a private side to the asylum, that cannot possibly be so. I am certain they have them in Cheshire.

13,044. It was not suggested that they were separated from the other patients, but they had a different status?—No, a different status entirely; we separate them, and they are treated privately; they have different treatment, a better class of society.

13,045. Now in what cases do you treat patients as private patients and give them those advantages in your asylums in Lancashire?—In the private accommodation in question the furniture is better, there is carpet on the floor as against the absence of it on the pauper side. The food is pretty much the same, it being good in each case. There are other comforts:—a smaller number, say, of five, six, or seven, in a small ward as against possibly ten in a similar ward on the pauper side.

13,046. Just to show you what we have in mind, we have had evidence from the London County Council, and they informed us that where patients who had begun as pauper patients paid 24s. 6d. per week, the patient was transferred to a private list and had that status, but did not receive any differential treatment; but that may be confined or course to the London County Council institutions and possibly some other local authorities?—I am afraid that is peculiar to London.

10 March, 1925.] Alderman J. G. TAGGART, J.P., and Alderman Sir WILLIAM HODGSON. [Continued.]

13,047. *Earl Russell*: I think Mr. Keene told us it was the law?—If we had a pauper patient in any of our Lancashire asylums whose friends came and relieved the Poor Law authority, we would willingly transfer the patient in question to a private side, and the patient would get different treatment; he would get, for instance, drives into the country.

13,048. *Chairman*: We have the patient who starts his asylum career as a pauper. What machinery have you for transferring him into the other category of a private patient? How does that happen with you?—We simply transfer him upon the request of the Poor Law authority. If the Poor Law authority do not pay, we transfer him to the other side, because the other authorities are paying instead. We simply transfer him from one building to another.

13,049. So far as your Board is concerned, it is indifferent to you whether you receive the payment from the Poor Law authorities, or from the patient's friends?—Quite.

13,050. But if the Poor Law authorities recover from the relatives, do they then apprise you of that fact, and do you then transfer the patient to private treatment?—No; we know nothing of the patient's conditions. We have no opportunity of knowing when the patient comes to us whether he is a millionaire or a miner.

13,051. Where do your private patients come to then?—Direct to the institution.

13,052. Then apparently the result of the way in which things are worked with you is this, that, once a pauper in your institutions, always a pauper?—With few exceptions, yes. We have known a few transferable.

13,053. I should have thought a more satisfactory method would be that if the Poor Law authority contributory to your Board received payment for a particular patient, that should be notified to you, and that patient should then have the status of a private patient rather than that of a pauper patient, because he was maintaining himself in your institution?—We think that may be so in many cases. Our present charge is 19s. 10d. to the Poor Law union for the maintenance of our patients. It does not include the rental charge, which may be 5s. per head per week. The standing charge, of course, is borne by the County Council authority, who are the owners of the building, but the permanent charge being 19s. 10d., that is all that the union are asked to pay us, and all we demand from them. If they collected the whole amount—we have no evidence of anything of the kind; I cannot conceive them collecting the whole of the money, because the person's friends who would be able to pay the union 19s. 10d. would surely stretch a point when they know they can be put on the private side for 24s.

13,054. If a patient comes to you direct as a private patient what is the charge for it?—We charge 24s.

13,055. So that the difference seems to be 4s. 2d.?—Yes. Of course that does vary, you know.

13,056. Naturally, but does that difference represent what you may call the standing charges, or does it represent the cost of the additional comforts that you give to the private patient?—In the one case the County Council authority pays the standing charge, the rental charge, so to speak; but when the private patient is sent to us he pays no part of the rental charges.

13,057. So that the 4s. 2d. evidently represents the difference in the standard of the comfort of the private patient?—Practically.

Mrs. Mathew: Is 24s. the full charge for maintenance?

13,058. *Chairman*: No, it does not include standing charges?—There are 24s. and 32s., and even £2 odd. We get voluntary offers from people in better positions in our asylums to secure exceptional treatment, and in one asylum we have to provide for that, a suite of rooms or a special attendant upon one patient, for two or three guineas a week.

13,059. Then 24s. is the minimum which entitles one to the status of a private patient in your institution?—Yes.

13,060. *Mr. Snell*: Does that include all the overhead charges?—No, not the standing charges.

13,061. *Chairman*: They are paid out of the county rate?—Yes. Some private patients pay as high as two and three guineas.

13,062. Now I would like to examine with you a statement you made just now, which was very interesting, namely, that out of your 3,000 patients you are of opinion that, roughly, as many as 2,800, not being paupers before, become paupers in consequence of their affliction?—Quite, and through the procedure.

13,063. Under the present legal system?—Yes.

13,064. Now one must bear in mind the difference between the case of the ordinary citizen who has an illness, and who goes to a general hospital, and the mentally affected in this respect, that unfortunately many of the mental cases are cases which are irrecoverable. The ordinary patient goes into a general hospital and remains there generally for a period of weeks, and is then restored to health and to society; whereas a considerable proportion of the inmates of institutions for the insane unhappily have to remain there for long periods and some even for life?—Yes.

13,065. Now there is that difference, is there not?—There is.

13,066. It is rather a striking difference is course?—But I do not see the ill effect of it.

13,067. It means that the cost of these cases that are permanent must necessarily be very much heavier, because it is far more prolonged than it is in the case of a relatively short treatment for a passing disease or ailment?—Does it matter whether it is an asylum, or hospital, if the rate pays?

13,068. Is it your idea that while the rates should pay for the treatment of the mentally afflicted, at the same time they should be removed out of the category of pauper patients?—I am rather quarrelling with the existing circumstances. Six people on the average go mentally wrong per week in Liverpool, and are so removed. There are potentially known to the medical fraternity in the town probably hundreds of cases who are not sufficiently advanced in mental illness to be certifiable at the moment. No provision is made. I do not want to animadvert upon the medical fraternity in the slightest degree, because I am a poor layman; but there is no opportunity given to the medical fraternity of segregating their particular patients who are in the incipient stages of insanity.

13,069. We are rather trespassing upon a topic I am going to ask you about later. For the moment, I am concerned with this aspect. We should all like, if practicable, to eliminate as far as possible the idea of pauperisation, but there are several points of difficulty in the idea; one is this, for instance, that many cases have to be dealt with at once and must be taken to some place for their own protection and for the protection of the public. At present there seems to be no place to which such persons can be taken other than to Poor Law institutions. The moment they get inside a Poor Law institution they receive Poor Law assistance, and then automatically there attaches to them the status of pauper by the mere operation of law. Then some of them pass out and recover, merely transitory cases, but for the time being they have been subject to the stigma. On the other hand, others pass into rate aided institutions where they may remain for indefinite periods supported by the rates. Have you thought out practically how you could dissociate the administration in both those aspects from this element of pauperisation?—Yes.

13,070. What practical ideas have occurred to you?—I think under the Public Health Act we ought to be able to take the incipient case of insanity which is not removable to the Poor Law institution in the first instance to a clinic attached to a general hospital. I can see no stigma attaching to that; that is maintained by the same public rate.

13,071. *Earl Russell*: The hospital maintained by the rate?—Yes, it is so in Liverpool—the Infectious Diseases Hospital I am speaking of.

10 March, 1925.] Alderman J. G. TAGGART, J.P., and Alderman Sir WILLIAM HODGSON. [Continued.]

Chairman: That is not a general hospital.

13,072. *Earl Russell:* You said a general hospital?—I beg your pardon, I meant a corporation hospital. I mean the ordinary public hospitals where we deal with tubercular cases; they are all on the rate.

13,073. *Chairman:* Your idea is that mental ailments should be dealt with as one of the classes of disease with which the public health authorities concern themselves?—Typhoid, tuberculosis, venereal disease and the like.

13,074. Yes, and that treatment should be devised rather on those lines?—Yes.

13,075. Take your clinic, the attendance at which, of course I agree, if such a clinic were established, would involve no pauperising element. That might be satisfactory enough for the initial stages, but suppose the patient is found to be certifiable and requires permanent treatment in an asylum, what is your suggestion at that stage?—Then you would have to revert to the present system, bad as it is; I see no alternative, but I am certain if the first step were taken a very large number of people, who are at the moment waiting to be worse before they can be treated for being better, would never go near an asylum.

13,076. We have heard some interesting evidence on that point. You might entirely obviate a large number of persons reaching the asylums at all?—Quite; that is our hope.

13,077. But under the present system, or any reformed system, you do not see any means of obviating the ultimate pauper status of permanent patients, or of patients who have to be relegated to an asylum in the long run?—No, except the abolition of the Poor Law, which has been suggested.

13,078. That is rather a big issue which we cannot go into, but the position is that a number of persons who are ill mentally perhaps only for a short time have, unfortunately, under the existing system, to incur this stigma of pauperisation, and you propose that that might be obviated by reforms in other directions?—There is no other stigma except the Poor Law stigma attaching to it.

13,079. Take a person who unfortunately becomes violent in the streets of your town and has to be dealt with at once, at the moment he is taken to a police station by a policeman; do you suggest that he would be taken to your clinic?—I think so, in the first instance, yes; I should use it as a sieve.

13,080. You would need to set up a new institution or associate an institution with some of the existing ones?—We could extend one of our many hospitals.

13,081. You would have a mental department there?—Yes.

13,082. Which would have the necessary means of restraining persons who were violent?—Of course, if they were very very violent—it is the question of degree in every case—that I should leave to the particular medical superintendent in charge of that particular clinic.

13,083. A very violent case might have to be sent to an asylum?—Clearly.

13,084. But you would wish to eliminate the stage of the Poor Law?—Yes, and to establish the treatment for the persons who were suffering and were ultimately going wrong, and could be treated to prevent them going wrong.

13,085. Have you in Liverpool at present special hospitals for infectious diseases?—We have.

13,086. Have you a clinic for tuberculosis?—Yes.

13,087. And a clinic for venereal diseases?—Yes, four.

13,088. Do they have in-patients as well as out-patients in this clinic?—No, all out-patients at the venereal disease clinic.

13,089. But for tuberculosis, all in-patients?—Partly in and partly out in one place, but mostly in-patients.

13,090. Have you separate premises provided for these patients?—Yes.

13,091. Do you contemplate that if a mental clinic were established to which incipient cases might resort and which might be treated as a clearing house, you

would have to provide different premises?—I think we could do it with our present premises in Liverpool, with a little extension perhaps.

13,092. You have mentioned six cases a week—a much larger number would come in if you had treatment for incipient cases?—I apprehend so, in the first instance.

13,093. And you think you would have accommodation for dealing with those cases?—I think so, and we have several houses attached to parks which were recently purchased; we have two or three large mansions on the outskirts of the city which could be admirably used in this way. I see no physical difficulty in the way whatever as far as the Corporation is concerned.

13,094. You would have a clinic established there to which patients who were in incipient stages might be brought for advice and diagnosis?—Yes.

13,095. You would also contemplate that in these premises there would be beds for those patients?—Both in and out patients, I hope, would be provided for.

13,096. That would be the kind of sieve, as you call it, through which the cases would pass, and the ultimate fate of those patients would be either to be restored to society, or to be passed on after study and observation through certification to the asylum?—Quite.

13,097. Probably of course Liverpool, like other progressive cities, has means of dealing with cases which might be difficult in less wealthy communities?—I daresay Lancashire as a whole could do the same.

13,098. *Earl Russell:* But Lancashire as a whole is a wealthy county?—It is one-ninth of the rateable value and one-eighth of the population, and Liverpool is one-twenty-sixth.

13,099. *Chairman:* You see we have to legislate also for rural districts where you cannot do this thing so perfectly?—Speaking again of Lancashire, there are 33 corporations who constitute the asylums authority under the Lancashire Asylums Board Act of 1890, this central authority consisting of 60 members, a quarter from the county, a quarter from Liverpool, a quarter from Manchester and Salford, and a quarter from Bury, Bolton and places of that description. There can be no doubt that the whole of the county and the whole of the boroughs in that county could fix upon a scheme. As regards the outlying places, like Macclesfield, or places just across the boundary in Derbyshire, or, if our friends in Cheshire wanted assistance, I see no reason why there might not be a combination of authorities in that way.

13,100. *Earl Russell:* Take a place like Wilts or Dorset?—They would be no worse off, even if we were doing well.

13,101. *Chairman:* If we have to suggest legislation to deal with the country at large, we have to look at the districts that are less well off than your district?—If you would give us permission—do not tread on our tail, let us go ahead. If Lancashire can beat London, so much the better for England.

13,102. What Manchester thinks to-day, we are told, London thinks to-morrow. But do you suggest that the provision of facilities of that sort might be made optional in the first instance, and would be taken advantage of by some of the larger authorities, and that that example might ultimately permeate the whole community?—Quite. We think in Lancashire we are sufficiently strong, if we had the power, to put it in practice, and we think that (all things considered) it would be a benefit. After all, it is no advantage to Lancashire to have a raving lunatic in Dorsetshire.

13,103. *Earl Russell:* But unfortunately it is no disadvantage, is it?—No.

13,104. *Chairman:* Of course, in a highly organised community you can have a very much better system with facilities of all sorts; but unfortunately people become insane throughout the whole of the country, and it is much more difficult to deal with cases, say, in a small rural area where there is nothing but a

10 March, 1925.] Alderman J. G. TAGGART, J.P., and Alderman Sir WILLIAM HODGSON. [Continued.

small Poor Law institution with a superintendent and a porter?—Does not that apply to any other disease as well, even in the smaller places?

13,105. That is quite true. Then would you suggest that, taking advantage of the increased transport facilities that exist nowadays, you might have in the larger counties some central institution to which the patients might be brought in the first place?—Quite. I think an arrangement of that kind could be made.

13,106. *Earl Russell*: Or even a group of counties, if they were poor and sparsely populated?—Yes. I see no reason why that should not obtain.

13,107. *Chairman*: These clinics which deal at present with other diseases are, of course, partly supported by grants?—Yes, some of them will be.

13,108. In fact there is a large grant?—You mean from the State?

13,109. Yes?—50 per cent.

13,110. I thought it was a 50-50 basis?—Yes.

13,111. And the other 50 per cent. is supplied by the local taxation?—Yes.

13,112. You would contemplate, I take it, that a grant would be made for the mental clinics as well?—I would hope so. We are complaining that the 4s. given to the union is quite inadequate now; it is a mere bagatelle. When the rate was 8s. per week for the maintenance of a pauper patient the 4s. was quite right; it was stereotyped in the Act of Parliament then; but now we are charging at the lowest 19s. 10d., the 4s. is out of all reason.

13,113. When one contemplates a fresh charge on public moneys one always looks to see whether there are any accompanying economies. Do you think that the institution of clinics of that sort might possibly decrease to some extent the asylum population and save the extension of buildings there?—I think so—I am sure of it in fact. I am sure a large number of people who are now going to asylums will never go there if we have the clinics we suggest.

13,114. I would very much like to have some statistics showing how many patients who enter asylums are discharged within a short time?—I can speak for Lancashire; the average is about 33 per cent. of the year's admissions who are out within the year. Eleven per cent. of the resident population are discharged, but 33 per cent. of the reception cases a year is about the average for the six asylums in Lancashire.

13,115. Let us take your whole asylum population. May we take it that of that whole population 11 per cent. in every year pass out?—Yes.

13,116. But that if we take the numbers admitted in any year, at the end of that year we will have found that one-third of them have passed out?—That is roughly correct.

13,117. Could we look at it even a little more closely? Of the one-third that are discharged within the year, are any of them discharged shortly after their admission?—Yes, many of them. Nearly all puerperal cases, cases that ought never to be sent, are discharged fairly reasonably early; they never stay longer than two or three months.

13,118. If you take the admissions, we will find there is a steady outflow as well of cases?—Quite.

13,119. And some of them are out as soon as two or three months after admission; others possibly nine months, and so on, but at the end of one year we find that one-third of the admissions in that year have been discharged?—Yes, I would hope so.

13,120. *Earl Russell*: Could you give us a table, drawn up in any way you think fit, to illustrate this point, as you seem to keep these statistics carefully in Lancashire?—The individual Committee send the reports, and I have first to digest them. I might have got the figures for them.

13,121. *Chairman*: You see how closely it bears on your suggestions; because if the position be this, that you find in your experience that quite a large number of patients only require temporary treatment and at present receive that treatment in asylums only through the medium of certification, your suggestion of the institution of a clinic where they might be dealt with in the first instance would obviously have this result,

that quite a considerable number would never reach certification and never reach the asylum. It would be very interesting to see how the figures work out, and how many people are resident only for a short period in the asylum, because these are the people who under your reform would possibly never reach the asylum?—You may take it that 11 per cent. of the population are discharged per year, and that 33 per cent. of the cases received in any one year are discharged—not all cured you know.

13,122. It is the latter figure which is the more interesting because the general discharge figures will include those who may have been there for years?—Quite.

13,123. But you might turn it over in your mind when you leave us to-day and see if you could get out any* figures which would give us an indication of the number of short term patients at your institution, say three months and six months, because these are people who might be dealt with through the medium of the clinic?—I will do that and let you have it.

13,124. We might just link up your evidence at that point with some evidence we got from Dr. Barham of Claybury, one of the London County Council institutions. He told us that of his discharges the greatest number were persons who had been in from three to eight months, showing, of course, that there is a considerable number of cases of short duration. These are the recoverable cases, and therefore one would expect they would provide the largest number of those who are discharged?—Quite.

13,125. And that chimes apparently with your experience?—Yes, that is pretty well my experience, and the class of patients must be similar as between Liverpool and London.

13,126. In dealing with infectious diseases you have compulsory powers of notification and removal?—Yes, of certain diseases, but I think that a magistrate's order would pretty well operate even in those that are not. I think it can be done; it would be difficult. I do not wish to suggest that we should compel people to visit our clinic for mental diseases. I only want the opportunity given to the medical fraternity to send their patients to a clinic, so that the patients who would not go near an asylum would go to the clinic.

13,127. *Earl Russell*: And on the medical evidence we have had you could have out-patients?—I hope there would be out-patients.

13,128. *Mr. Micklem*: You do not want to have them made notifiable?—No; I only want power given to the local authority to make that provision, in order to give the patient an opportunity of going to these places under the advice of the medical practitioner of the town.

13,129. *Chairman*: The out-patients department would present considerable difficulties in widespread areas. Country patients could hardly come in for daily attendance and observation?—No. You know the Irishman who would like to sell the Lakes of Killarney in a warm place!

13,130. *Earl Russell*: But often advice as to treatment and conduct at one visit would go a long way, and would keep the patient going for a month or two?—In some cases, yes.

13,131. *Sir Humphry Rolleston*: You have referred to the puerperal cases; and said that it is most desirable that no stigma should attach to a poor woman who was violently insane for a short time; so you would treat them in the clinics?—Yes.

13,132. How would you get over the obvious difficulty that you could not restrain them against their wishes?—I do not think they would be restrained against their wishes. If they knew that the asylum was the alternative they would willingly stay in the clinic.

Earl Russell: But they are not able to appreciate that.

* See Appendix XXIII.

10 March, 1925.] Alderman J. G. TAGGART, J.P., and Alderman Sir WILLIAM HODGSON. [Continued.]

13,133. *Sir Humphry Rolleston*: You mean you would restrain them?—I would advise the medical practitioner to send them there.

13,134. *Chairman*: We have had some evidence to this effect: that this provisional period which has commended itself to many reformers should be coupled with some power of detention, possibly less rigorous than the code which affects persons after certification; but that some power of detention would be required is obvious. Take the case of a person really quite mad and dangerous. He would reach this clinic as an in-patient and would obviously have to be restrained. You would need to have, as *Sir Humphry* points out, some power to deal with those persons, although not certified; you would have to adopt some form of provisional certification?—Clearly, a typhoid patient who is not under a certificate is at many times delirious and you do detain him. I suppose it is illegal detention up to a point. I do not know. No one grumbles at that. I should class the puerperal cases in the same category. My feeling is this: it is the greatest crime the country can commit to allow such a woman to go to a Poor Law asylum.

13,135. *Chairman*: Because it is simply a disease?—Yes.

13,136. *Earl Russell*: Do you suggest that these people should be detained and deprived of their liberty without the intervention of a justice or anybody representing the public? That would very much frighten people. They think they are very often wrongfully detained when a justice does come in?—Is not a fever patient equally detained without any magistrate's order?

13,137. *Chairman*: I think this is difficult, Mr. Taggart?—Yes, but I think we can always remove difficulties; that is why we are on this earth.

13,138. *Sir Humphry Rolleston*: Do you think you can educate the public up to your standard?—I am sure of it. The outcry that would be raised against the detention of a puerperal case would soon balance itself when people saw that the reverse was very, very sad. They want to see the other side of the picture to see how necessary it is to have detentive powers.

Earl Russell: You appreciate that the doctor who did this would be quite unprotected by law?

13,139. *Chairman*: And suppose his diagnosis of a case were wrong?—That is the case to-day in an asylum. We have heard of actions at law by people who are supposed to have been wrongly diagnosed and sent to asylums.

13,140. But they have been protected. I quite see your general point: that in the case of many illnesses a person may become hysterical and the nurse or doctor will restrain that person, and nobody seems to have created any difficulty about that, although in a sense it is interfering with the liberty of the subject. But we are now concerned with interference with the liberty of the subject in the case of persons who have been mentally afflicted. You propose to admit to the clinic persons who would be most unwilling to be treated, but who nevertheless, for their own good and for the good of the public, ought to be detained. Must you not have some safeguard against improper detention there?—Yes, but a certifiable case would always have to be certified, and if the poor woman in question were certified she would be certifiable anyhow, whether she was in a clinic or her own home.

13,141. But you want to avoid certification of a woman in that condition, who is merely passing through a phase and is ill for the time being, but the illness happens to have attacked the citadel of reason. That person is, after all, just a sick person, but (although a sick person) may require detention contrary to her own wishes?—Yes.

13,142. How are you to safeguard that state of matters? How are you to safeguard detention against the wishes of the patient?—I should protect the public by certification. At the present moment the medical officer of health is responsible for a patient of the fever class.

13,143. You mean there must be some modified form of order made in such a case?—Quite; that is all I want. I do not want certification at all if possible, but a modified form in the interest of the patient and the public, to enable the case to be restrained in some way.

13,144. We will assume you have a clinic. We will assume it is being attended by incipient patients who have gone there on the advice of their doctors and friends; they may be told what they have to do, what medicines they should take, and how they should regulate their lives, and so on. Then in addition to that we will assume that this is a clearing house for cases which are beyond the incipient stage, that patients are brought to you there. It is desirable that they should be under observation in order that they may pass through this sieve, as you put it. These are cases of persons who are at present certified right away?—No. They are kept in the Poor Law infirmary for a considerable period before certification follows.

13,145. They are seen within three days?—Yes, and they are generally detained up to 21 days.

13,146. That is taking advantage of the periods which the Act provides?—Yes.

13,147. Take your case, where they would be in a clinic: you would need to provide there for some form of order which might be made on one doctor's certificate?—Yes.

13,148. Entitling the head of the clinic to restrain and detain such patients for a period of observation?—Yes; there must be powers of detention. I would make the doctor in question the medical officer of the district. He would no doubt receive the advice of his colleagues, of course.

13,149. Just think again. Must you not introduce also some protection against the purely medical element. Must you not have some intervention by some representative of the public, such as a justice of the peace, before you can detain anybody, even provisionally?—I suppose for the sake of public sentiment, yes, but there is really nothing in the justice of the peace's signature to a document. I sign many of these things. I had better not say what I am thinking.

13,150. That is what we have heard, and what we have been alarmed at?—One does one's best, but what can one do? I would rather take the medical man, who is *au fait* with the subject, than call in a magistrate.

13,151. *Earl Russell*: But the intervention of the magistrate is not to decide whether the patient is insane or not. It is really to see that nothing is being done that is improper, or unjust, or irregular?—I have not the slightest doubt in every case that is so.

13,152. *Chairman*: And observe also that it has this value, that it enables representations to be made to you. Take the case of a patient whom you are seeing. Suppose a patient is brought to you with a medical certificate and all the documents are in order. Do you see the patient yourself?—Every time.

13,153. Suppose the patient said: "I want to speak to you, Mr. Taggart, about my case." You would give him an opportunity of doing so, would you not?—In every case, yes.

13,154. Suppose he was able to say to you "There is a mistake about my case. I did say something very foolish to the doctor. I would like to have my case more fully considered." Do not you see the safety valve that you provide in such a case?—I do not see much advantage in bringing the justice of the peace in then.

13,155. Surely?—It is supposed to be an additional safeguard, but I do not think it is of very much value.

13,156. Suppose the relatives came with the case, as they do sometimes, and said to you: "This certificate about our brother is all wrong; he is perfectly sane; he did something very stupid last night; he was drunk, or something, and he has been certified quite wrongly." Would you not take the matter up at once and see that he was not sent to an asylum?

10 March, 1925.] Alderman J. G. TAGGART, J.P., and Alderman Sir WILLIAM HODGSON. [Continued.]

—Quite, but I would rather take it to a doctor than to a magistrate.

13,157. *Earl Russell*: That is where the magistrate comes in: he can call in a doctor?—I have much more confidence in the doctor than in the magistrate.

13,158. Suppose, for instance, the doctor had not been quite honest about the matter. If you thought there was any reason to believe that, you would call in a second doctor?—That is the practice to-day.

Earl Russell: That is a protection to the patient.

13,159. *Chairman*: It assumes that the magistrate represents the law and represents this point of view, that neither the doctor, nor the relatives, nor anybody else, shall have the ultimate say as to whether a person is to be detained against his will or not. I quite understand in the majority of cases there is very little difficulty—the case is obvious. But if you are taking a case where there is really some doubt, or where there may be suspicious circumstances, where the relatives may have an interest to get their unhappy relation put away, surely the fact that the patient comes before an independent magistrate, to whom he has an opportunity of making his representations or to whom his relatives may have an opportunity of making representations against the doctor's certificate, provides a useful safeguard, does it not?—It clearly does, but he would be equally safe in anyone else's hands who is not interested.

13,160. *Earl Russell*: Are you not rather treating him as a justice who is trying any other case?—On the evidence before him, which is very short.

13,161. But as the Chairman has pointed out, you may have elements which may raise suspicions in your mind?—The magistrate can only take evidence as in the case of an ordinary trial. You must not turn him into a doctor.

13,162. *Chairman*: I do not suggest that for a moment. Take an actual case. He has before him first the patient, and secondly he has before him the medical certificate and certain documents. He can look through the documents in the first instance and see that they are in order. If the documents are unsatisfactory, if they do not disclose sufficient evidence to satisfy yourself, would you not look further?—I should refuse to sign, of course. Then I should take the evidence of the relatives as well, and I would weigh that. If the relatives did satisfy me that he or she ought not to be certified, I should, as a magistrate, give that evidence the value attaching to it.

13,163. And you would withhold your signature until you were satisfied. I think you are belittling the value of the magistrate, you know?—I think you are exalting him too much. I would rather have the public authority.

13,164. *Earl Russell*: But on the other hand the public have more confidence in an independent justice of the peace than in any public authority?—I should not say so. I happen to be one. I do not think they have much confidence in me.

13,165. *Chairman*: You are very modest. Of course, you may say that of any tribunal. But the public do insist, and I think rightly insist, that no persons shall be deprived of their liberty without the intervention of some representative of the public?—I agree.

13,166. *Mr. Snell*: Have you considered the possibility of a second doctor almost automatically agreeing with the decision of the first doctor?—In practice that is so. If there is any question whatever, on the furnishing of the documents to the Poor Law authority, which arises in consequence of the written statement in front of the Poor Law doctor, he can, and he invariably does, bring in an assistant to help him in his diagnosis and to justify it, and when you take his evidence you find that the two doctors have not consulted.

13,167. You have not seized my point, I am afraid?—I am sorry.

13,168. You prefer, apparently, the opinion of a second doctor to the independent judgment of a magistrate?—I do.

13,169. I am suggesting to you that there might be a possible danger in the second doctor, for professional loyalty or other reasons, agreeing with the first doctor's certificate.

13,170. *Chairman*: Merely saying "Ditto," is Mr. Snell's point.—There is the same danger with anyone who certifies as a magistrate.

13,171. Mr. Snell rather puts this: that a second doctor called in might, as he says, for professional reasons, not afford much additional safeguard, because he might be disposed merely to endorse his colleague's view and simply say "Ditto," but on the other hand it is proverbial that doctors differ?—Yes, but they are very clannish; and magistrates sometimes differ, too.

13,172. Are they clannish? I do not think that applies to magistrates, perhaps?—I will not answer that.

13,173. I think we have the general upshot of your idea. It is a spacious idea, and one which one would have difficulty in applying in detail, but your view is that we should have clinics, both in- and out-patient clinics, which would have the advantage of enabling incipient cases to be attracted and dealt with at the early stage?—Without certification.

13,174. It would operate also as a clearing house for cases, many of which would escape certification altogether, and would relieve the asylum population to some extent. You further suggest that the example of the infectious diseases hospitals or the venereal diseases clinics might be followed, and that the system might be aided by State funds as well as local funds?—I have a very broad view on the State contributions towards these things.

13,175. And you also advocate some qualified order being pronounced so as to enable these patients in your clinic to be detained if necessary against their wishes for that provisional period?—Quite.

13,176. But that order or certificate should be something short of the full certification which precedes the entry of a patient into an asylum?—That is exactly my idea.

Sir Humphry Rolleston: I am very anxious to know whether Mr. Taggart can give us any guidance as to how, if such a form of detention became common in the in-patients' departments of these clinics, the public generally, whose opinion one must respect, can be prevented from gradually regarding the in-patients' department as being an outlying wing of the asylum?

13,177. *Chairman*: Yes. Would this mental clinic not be liable to attract to itself the same stigma as the asylum itself? If it was known that so-and-so's brother had gone off to the indoor clinic and had stayed there, it would be tantamount to saying he had gone off his head?—That would be countered by the fact that it would be known that the brother of some one else had been there, and had come home. A great number would not go to the asylum. It will balance itself out in time.

13,178. Of course, no amount of legislation or reform will ever camouflage the fact that a person who has suffered from mental disturbance is in a more difficult position in after life than a person who has suffered from measles, let us say?—Quite.

13,179. Obviously you cannot eliminate that altogether?—You may patch the jug, but you will always see where the crack has been. Close the vase as you will, the scent of the rose will hang round it still.

13,180. But your aspiration is to try to assimilate as far as possible the treatment of mental illness to the other diseases?—Quite; that is my sole aim.

13,181. Now I will pass to the question of discharge. Under your system, how do you work the discharge provisions of the code?—Of course, under the Act each asylum committee has the power of discharge of itself, and they vary slightly in practice. We have the usual forms of discharge—relieved and not relieved, and so forth, and cases that can be sent to the workhouse. We have different kinds of persons who are to be discharged.

13,182. You have some views, I think, as to the present method of discharge—You may get on the

10 March, 1925.] Alderman J. G. TAGGART, J.P., and Alderman Sir WILLIAM HODGSON. [Continued.]

local committee a crank—perhaps I am one—of some kind, who thinks that certain patients who have been in the asylum for the last two, three or even ten years ought to be discharged. He converts a colleague to the same view. The committee consists of 27 members, yet any two of them, with the medical superintendent, can discharge a patient, and three without. Now if three cranks, in spite of the other 24 members of the committee, can release and do release and have released patients, I think that is very wrong, and rather stupid. We had a case quite recently at one of our asylums where three visiting members discharged ten patients, after consultation with, but in spite of the medical superintendent, and notwithstanding his diametrically opposed wish that they should be detained. I think of the ten patients discharged eight were almost immediately returned. But it is a weakness in the Act which allows any three to do it. The power of discharge should be in the custody of the committee, and theoretically it is, because it is only between one meeting and another when these visitors by twos and threes can and do discharge.

13,183. *Earl Russell*: But you do not object to their doing it with the concurrence of the medical superintendent?—No; it is in spite of it that I object to.

13,184. *Chairman*: It is really only in the case of the three visitors who may discharge at their own hand, whether the medical superintendent concurs or not. That is your objection?—Quite. I think the committee should rule in all cases. I am perfectly satisfied that the committee would never go against the advice of the medical superintendent. We meet monthly, at each asylum, and we discharge patients who are paraded before us for that month. There is an automatic discharge in that way. That receives the *prima facie* consent, of course, of the committee in question upon the recommendation of the doctor. There are doubtful cases brought before the committee, also, cases where the patient has not fully recovered, but has sufficiently recovered as not to be dangerous to himself or to others, and who might be sent to his home if the conditions are satisfactory. The committee then, and not the medical man, are the judges of the home comforts, and those are inquired into by bringing the patient's friends to the asylum and hearing the case, so the committee decide those discharges; but then as between that committee meeting and the next, I, as Chairman, and the deputy-chairman, go through the cases. The doctor says the patient has recovered, and he takes the responsibility from our shoulders. But where two or three men go into the asylum and discharge patients who ultimately would not have been discharged by the committee, that I think is a very wrong procedure.

13,185. One thing you have said rather struck me: that no visiting committee would discharge contrary to the views of the medical superintendent. That is just one of the points where we have got to be a little careful, because one of the complaints made is this, that the medical superintendent is apt to be too dominating in the fate of patients in asylums, that is to say, the visiting committee is apt to be complaisant to the views of the medical superintendent?—That is not my experience. Frequently we have done it in spite of the doctor.

13,186. That is very interesting. You say, in your experience you have very frequently, and, may I take it, justifiably, discharged patients, notwithstanding the opposition of the medical superintendent?—That opposition, of course, might not be violent; it might be less severe; he will offer no opinion. He will say: "As a medical man I cannot say this case has recovered, but you are discharging an unrecovered case. You, and not I, take the responsibility, having regard to what will happen in the future," and he throws that responsibility upon the committee.

13,187. Take the case you refer to of the ten patients discharged by the three members of the visiting committee, contrary to the views of the medi-

cal superintendent; that is evidently an extreme case?—It was.

13,188. And you say the persons were probably inexperienced?—They were old public men, but were new to the asylum committee work.

13,189. And they formed the impression that these people ought to be at large, and they were discharged contrary to the views of the medical superintendent. We are more concerned with the normal cases. Your suggestion that the independent outside authority (that is, the visiting committee), would not go against the medical superintendent's view seems rather to accentuate what we have heard, that the medical superintendent's power of control over the fate of the patients is what we may call the dominant factor. Probably it may be right that it should be so?—I do not think so, in practice. He has only the power to express that opinion to a very disinterested body of gentlemen coming from all parts of the country, and who have no axe to grind in taking his advice or refusing it.

13,190. But he is dealing with gentlemen who are laymen in this matter and are considering a case of illness upon which they really cannot have an expert opinion at all?—Yes, but is not the majority of a committee always safe?

13,191. I do not think so?—Perhaps not. I am a politician, and I say no.

13,192. I do not think the opinion of a majority of laymen is worth the opinion of an expert upon a matter where expert opinion is necessary?—Is it not more reliable than a minority of laymen?

13,193. *Earl Russell*: Do you mean more than this: if he said, "I tell you gentlemen that patient is actively suicidal" the committee as a whole would not discharge him?—Clearly. When it becomes a matter of opinion, that the patient is neither dangerous to himself nor to others, and when it is a question of home surroundings and the probability of his return, that is entirely a matter outside the medical jurisdiction.

13,194. *Chairman*: Your observation rather led me to this, that you were representing the view of the medical superintendent's almost uncontrolled disposal of the fate of the patients, because the visiting committee would not go against his wishes. Have I understood you, or have I put it too high?—I hope the committee is intelligent in every case. The case book is produced, the whole of the status of the patient to that moment is before the committee, the committee hear the whole facts from the medical superintendent, and upon that evidence they decide.

13,195. Of course the medical superintendent's view must necessarily be of great consequence, because he is the person in charge of the patient?—Clearly; he is living with the patient; we are not.

13,196. Do you see the assistant doctors, who are more closely associated with the patients?—Always. We examine the books.

13,197. But do you see the assistant doctors themselves?—Very often; we parade the wards with them, as a rule.

13,198. Do you see the individual patient whose case is being discussed?—In every case.

13,199. Do you have a talk with him?—Yes; we bring them before the committee and examine them closely, and with their friends as well, with or without their being present.

13,200. Have you sometimes discharged cases on your own responsibility, that is to say, the responsibility of the visiting committee, although the medical superintendent was not able to say that he thought the case was safe for discharge?—I have had 37 years' experience and I have only known three cases of that kind.

13,201. But in the three cases you did it?—Yes.

13,202. What was the result of those cases?—Two went to America and I think the third one committed suicide; we were wrong.

13,203. It is not a very happy result?—I should be very chary to fight the medical superintendent in

10 March, 1925.] Alderman J. G. TAGGART, J.P., and Alderman Sir WILLIAM HODGSON. [Continued.]

any case. He can have no axe to grind in wishing the detention of a patient.

13,204. Is not your suggestion that the whole of the visiting committee should deal with the discharge of patients rather a cumbrous one, because you might have patients detained for some time, until you had a meeting of the committee?—That is always done. A patient does not recover in 24 minutes or 24 hours. The patient is very happy to stay awaiting the discharge day. Two or three of us go through with the medical superintendent, take the responsibility, and report to the committee what we have done; that is always adopted as a minute by the committee. We can put the patients on trial for a month and automatically discharge them while they are out; we do that frequently.

13,205. That is another section. But I am a little surprised at your suggestion that the right of discharge should be vested in the whole visiting committee as distinguished from the provision under the Act at present. How often does your visiting committee meet?—Every month.

13,206. You might have a patient waiting for three weeks to be discharged, although anxious to get back, and perfectly well?—The doctor in that case would be the authority who reports it. He would at once send for two visiting magistrates and discharge the patient.

13,207. *Earl Russell*: But he cannot, under your system?—I think if you would put it that way it would be all right. The committee would have it reported to them at the next meeting.

Chairman: That is the existing system.

13,208. *Mr. Jowitt*: Your point is that you want the whole committee, if they are differing from the doctor?—Yes. I think that power should be taken from the three members or from any minority.

13,209. *Chairman*: Then finally you have views on the question of persons suffering from senile decay. There is a considerable proportion of that sort of case in your asylums just now?—Yes.

13,210. Is it your view as the result of your experience of local administration that they ought not to be in an asylum?—I think when a person has been there 20 years he would be much happier in a workhouse than in the asylum; in fact they would go back now, but for the question of cost. We can feed them cheaper, because of the large number, than the unions themselves can feed them; certifiable, of course, all of them, still, not dangerous to themselves or to others, and not fit to go to their homes; they will be better off in a workhouse than in an asylum. That is an individual opinion. My Association have given me no lead in this matter whatever.

13,211. *Earl Russell*: The workhouse would still get a grant of 4s. if they went back?—No; that would cease.

13,212. *Chairman*: We are told that the asylums in this country are rapidly reaching a stage when their accommodation is about to be exhausted, and that may mean that large expenditure may have to be incurred in extension. If the senile cases were taken away from the existing asylums and restored to the Poor Law authorities, might you not get some relief in that way, and obviate some of the extension which is in prospect?—Years ago we used to have an asylum on the stocks every five years, and we reckoned that the rate of increase, which is about 300 a year over the previous year, in the years 1909, 1910 and 1911, would necessitate our building an asylum every five or six years. That was an alarming thing for Lancashire. But the senile cases which would be sent back to the workhouses would at the moment relieve us to the extent of one asylum. Our asylums contain the following beds: Lancaster 2,625; Rainhill 2,155; Prestwich 2,707; Whittingham 2,838—I think that is the largest in Europe; Winwick 2,100.

13,213. *Mr. Jowitt*: Of course, it would tend to congest the Poor Law institution beds. Are they short of space?—No; it is the opposite way.

13,214. *Chairman*: There are a lot of unoccupied beds in Poor Law institutions just now?—A very large number.

13,215. Is not that partly due to the Old Age Pension system?—Yes, partly, and also to the fact that we can keep them cheaper than they can keep themselves, and also because they get the 4s. grant.

13,216. But it is very undesirable that new accommodation should be provided at great cost for cases which can be accommodated in premises at present not fully occupied. Re-distribution is indicated?—Yes; but, mind you, the figures I quoted do not obtain to-day. There is a great diminution, though not in female insanity, and the number is much less now than it was before the war.

13,217. What is that due to, do you think?—I suppose on the male side it is due to the war—so many killed; the male population has suffered in consequence of that.

13,218. *Mr. Micklem*: Has not the Mental Deficiency Act affected it?—That is another aspect of the same question. The application of the 1913 Act has been the means. We have put one of our six asylums for the purpose of holding those people, Whalley Asylum, and we have 2,400 beds in it. In that asylum we are catering for the boy and girl who in the past were the cause of insanity. We are now removing a greater means of the spread of insanity than we have hitherto dealt with.

13,219. *Chairman*: That may also account for the diminution in the numbers?—I flatter myself that Lancashire is showing a very good example to England in that regard.

13,220. *Earl Russell*: You mean you are stopping the breeding?—Yes, we are confining the breeding. The "Silly-Billy" no longer roams the streets, and your "Silly Sally" who was out for trouble no longer roams the lanes and streets of the country.

13,221. *Chairman*: Are they taken to the mental deficiency home?—Yes. We have it more in hand in Lancashire.

13,222. That may have some effect in diminishing the propagation of insanity?—I have not the slightest doubt it has.

13,223. Have you in your own territory a considerable amount of unoccupied accommodation in the workhouses to which these senile cases could be sent?—Yes. Speaking for Liverpool, we could take back a matter of 800 or 900 of them if necessary.

13,224. Is there this aspect of it, too, that if the asylums were freed from those occupants, the doctors of the staff would be able to devote themselves more to the cases of true insanity which have some hope of recovery under treatment?—At the moment the doctors divide their patients into two classes. They get every consideration if nothing can be done for them; but the medical staff do concentrate upon the recent and acute cases, and that is where the good work is being done by the medical staff.

13,225. But at the same time, even those senile cases must occupy a certain amount of the medical staff's time?—Yes, but the layman with 10 or 12 years' experience is almost as good as a medical man with that particular type of patient.

13,226. We hear that these very large institutions containing 2,000 or 3,000 patients are not the best, because they are so large that the medical superintendent cannot keep an eye upon everybody. Why should he be keeping an eye upon one-third of the population of an institution, when nothing can be done for them? Would it not be much better to have institutions which were really devoted to the treatment of insanity, as apart from merely housing persons who cannot be treated at all?—In practice it is done. After all, a doctor has 300 patients; he classifies them.

13,227. But they are still under his charge if they are in an asylum, and he has to look after accommodation for them and arrange amusements, which may tend to distract him from attending to his real duty towards his patients?—Some of them do not require very much attention from him. The doctor need not

10 March, 1925.] Alderman J. G. TAGGART, J.P., and Alderman Sir WILLIAM HODGSON. [Continued.]

waste much time in organising a dance or in arranging for them to go to the picture show or to the cricket match. He does devote his time to those who require his medical care.

13,228. He certainly ought to?—I hope in every case he does.

Chairman: We are much obliged for your views, Mr. Taggart. I think we might pass now to Sir William Hodgson's evidence, unless any of my colleagues would like to ask you questions on the views you have developed.

13,229. *Mr. Micklem:* There is one question I want to put to you, Mr. Taggart, with reference to the discharge of patients from asylums. Do the Committee consider any cases except those which are brought forward by the medical superintendent with a view to their possible discharge?—Yes. The visiting committee have before them a list upon the discharge day—the meeting day; a list that the doctor supplies. Then in addition to that the committee, after discharging, will appoint, in our case, four visitors who must pay the cross-visit once or twice between that and the next meeting, and as we perambulate we receive from the individual patients, from their own lips, applications for discharge; we note and bring before the committee such a list in addition to the doctor's list; so that the visitors' recommendations are always received on the day of discharge, and, if the visitors recommend, the patient is brought there, with or without the doctor's consent, to be examined by the committee.

13,230. Then you really have a duplicate list?—Yes, and a third; an application list from the relatives or friends. We bring all those forward.

13,231. And the committee consider all those with equal care?—Yes.

13,232. *Earl Russell:* With regard to the increase of the grant, which you were speaking of, you suggest, as I understand, that it should be put up to something like 10s.—If it is of any value at all it ought to have some relative value. It was fixed at 4s. when the cost was 8s.; the cost is now 19s. 10d.

13,233. I do not want to go into the question of what services the national funds should contribute to, and what they should not, but assuming that this grant were increased, or even continued, would you associate the giving of it with any sort of control by the Board of Control?—I do not like the idea of the Board of Control, because it seems an absurdity that whereas we get 50-50 in the case of venereal disease—

13,234. *Sir Thomas Hutchison:* It is 75 per cent. in the case of venereal disease.—Thank you. But they do not give anything like that for the most important of all diseases.

13,235. *Earl Russell:* You know, for instance, that there is a grant towards the police from the central authority, and that that is coupled with a certain amount of control before the grant is given?—Yes.

13,236. The Board of Control, as you know, have the power to make any recommendations about these asylums, but they have no power to insist on their being carried out?—Yes, but one does not like to invite Governmental control. The one thing I do not want, and I am sure Lancashire does not want, is too much Governmental control.

13,237. That is usually the view of the local authorities. But supposing you find a case, as I have found, in which letter-boxes are not provided in the wards, and the Board of Control one year, and the next year, keep on drawing attention to it, and say they should be provided, do you still think it should remain a recommendation in the air; that they should have no power to withhold a portion of the grant until it is done?—I do not see very much value in the grant at all. The grant from the Imperial Exchequer comes from the same pockets as the rates.

13,238. I thought you told us that the grant ought to be increased?—I would increase it or abolish it; I do not care which; but if as a concomitant it brings in governmental control, I would rather not have it at all. I would rather have Lancashire Home Rule.

13,239. Lancashire, no doubt, is a well-managed place, but if you have backward places which are not

up to the standard, if you can only make recommendations and no attention is to be paid to them, how are you to bring them up to the standard?—That I do not know. I do not see how you can.

13,240. Do you think there is anything wrong in doing that partially by the control of the grant from the Imperial funds?—I think it would be wrong. The Board of Control may not always be right.

13,241. There are six asylums in this district you have been speaking of?—Six in the county of Lancashire, yes.

13,242. How many patients are there for each doctor, on the average?—About 300.

13,243. And how are your medical superintendents appointed—by seniority or rotation?—By the quarterly meeting of the Board.

13,244. Do you advertise a vacancy?—We advertise a vacancy in every case.

13,245. And get all the applications in?—Yes.

13,246. That is the way you start on the business; but will you tell me what is done in practice? Does it go by seniority, or do you appoint outside medical officers to be superintendents?—In practice it goes by seniority.

13,247. Would a man in the same asylum be promoted to be medical superintendent if there were a vacancy?—It has happened on two occasions only; but in most cases, no; it would be from a neighbouring asylum under the same Board.

13,248. But an outside man is practically never appointed?—He would be brought in as third or second and be moved upwards. We want new blood in if we can get it. As a matter of fact, we have only one Lancashire doctor in the six asylums; the others, naturally, are Scotsmen.

13,249. *Chairman:* Even in Lancashire?—Yes; we do not complain.

13,250. *Mr. Jowitt:* I want to ask you about these clinics. You contemplate two separate clinics, one for out- and one for in-patients; or would one building do for the two, do you think?—The one building would do for the two.

13,251. Then you contemplate that there must be some powers of compulsory detention?—Yes.

13,252. Have you considered this: the population that is going to your clinic is going to be a voluntary population, with no compulsion in going there?—That is so.

13,253. Do you think that the knowledge and fear that when once you enter the portals you may be detained may prevent these people from being ready to go?—I do not think so.

13,254. We have had that view put before us, and it rather struck me as being a possible result of a system by detention?—It would be the lesser of two evils if it were so. The man or woman who develops the idea that he or she is only taking the first step towards an asylum by going to a clinic is the one who is now graduating for the asylum proper.

13,255. Are you not, by having a system of compulsory control, rather supporting the view of those who say that the clinic is merely an offshoot of an asylum?—Yes; but you see a person who is on the verge now of certification has no opportunity of treatment; and has no opportunity of consulting with anyone who is an expert in psychiatry.

13,256. Treatment and consultation: both those you could get without the power of detention. I am assuming you have got your clinic. At the present time, of course, you have not got a clinic at all?—No.

13,257. Assuming you start a clinic: I want to discuss with you the advisability of having or not having control. I point out to you that if you have your clinic, even without compulsory power of detention, you could give treatment and consultation?—Quite.

13,258. Why do you insist upon your compulsory powers of detention?—For the odd case; the case of the person who would not submit to treatment and who was clearly going wrong.

13,259. Then, for the sake of the odd case, you are really going to make what would be a purely voluntary

10 March, 1925.] Alderman J. G. TAGGART, J.P., and Alderman Sir WILLIAM HODGSON. [Continued.]

place into a possible sort of prison; that might be the public point of view?—It would not be so applied; we were thinking of the puerperal case at the moment; and there would be an enabling power to prevent a puerperal case having to go to an asylum.

13,260. I quite agree with you. Have you considered at all what your compulsory power of detention would be and how it would be exercised?—Pretty much in the same way as it is now. It must be a certificate of some kind to enable the public authority responsible for the clinic to detain the patient for a period.

13,261. It might be a certificate to the effect that for reasons of health such a person ought to be detained?—Yes, fixing a certain period.

13,262. And would you give the medical superintendent of your clinic power to detain for a very limited period of time, 24 hours, on his own responsibility, and for a longer period with the consent of the relatives?—Yes, I think so, with the consent of the relatives.

13,263. The mania in puerperal cases will generally last for about three weeks?—3 to 6 weeks, yes.

13,264. And, with the consent of the relatives, would you contemplate compulsory powers of detention, even without a magistrate being brought upon the scene?—That is a matter of machinery. That I do not think has much weight. The magistrate would do no harm. As a make-weight, yes.

13,265. *Mrs. Mathew*: I do not think I have anything to ask you, Mr. Taggart, except this: Would you give the medical superintendent power to discharge without the committee?—I would not give him the power; he has already the power of refusal. Some time ago one of the unions sent us a patient; upon arrival the doctor, in making the initial examination, discovered that the patient was not insane; he telephoned for me, and I went over. He said "What will you do?" I said: "Send him home at once."

13,266. He has that power?—Yes, he has that power now, I take it. Whether he has it or not, we refuse to take a person who is not certifiable. I think he can set his opinion against the certificate, as he certainly did in this case of admission. We can refuse a patient, and we have done so.

13,267. *Earl Russell*: You do not think it ought to be regarded as a case of instantaneous discharge?—At all events, his refusal to accept a patient was rather checking the stigma of certification.

13,268. *Mrs. Mathew*: That was not quite what I meant. What I meant was, after treatment and observation should he have the power to discharge?—No, I do not think he ought; it might be open to abuse. I would rather vest the power of discharge in the public authority than in the officer appointed.

13,269. *Chairman*: I think he must receive a patient who is addressed to him with a certificate; he must receive him in the institution. After that the patient becomes an inmate and he gets into the machine, and he can only be discharged through the provisions of the Act; but, of course, if the medical superintendent is satisfied that he is really quite a sane person, he will see that the proper machinery is put into operation as early as possible for his discharge?—In that particular case the man came in the ordinary way, and as soon as the doctor saw he was not insane, he sent for me, and I discharged him; I took the responsibility. I reported the matter, and there the matter ended. *Mrs. Mathew* asked me if a patient had been under treatment for a month or thereabouts, would I leave that in the hands of the doctor. I say no; I think the committee should in every case act.

13,270. *Miss Madeleine Symons*: In the six asylums in Lancashire have they all got a private side?—No.

13,271. How many of them have?—One of them has a private side; that is Lancaster Asylum, which is 170 years old; it is on the borders of Morecambe Bay, in a magnificent situation, and we have there provided a handsome villa for patients, with 106 beds.

13,272. That is the one, is it, that you told us provided accommodation sometimes in the shape of suites of rooms?—Yes.

13,273. I was interested in that, because certain witnesses, who were of opinion that the present licensed houses ought to go, suggested that the private accommodation, even private accommodation of an expensive kind could be provided by the public authority?—So it is. All the public authorities are willing so to provide it, and some do. We have done it very extensively. In addition to that, we could provide special accommodation at the other five places.

13,274. Do you reckon in those cases simply to make a charge that covers the cost, or do you reckon, where patients are able and willing to pay, to make something towards the cost of other patients. What is the arrangement on which you base your charges?—Of course, we have nothing to do with bearing the cost of the pauper case.

13,275. No; but I meant in these private cases, do you fix your charge simply to cover the cost of what the people get; or do you reckon to make anything out of it?—Yes; we make a very good profit out of it, which goes to the relief of the rates. We had a relative of a Lord Chief Justice for a long time as a patient, who contributed five guineas a week; obviously we made a profit out of that; he had a suite of rooms which might have been occupied by three or four persons, but at all events it did not cost us £5 to keep him. We made a decent profit; we were sorry he died.

13,276. *Earl Russell*: Does it go to the relief of the County rate, or do you credit the maintenance rate?—It goes to the maintenance rate. A portion could go to the new buildings too; we could claim that.

13,277. *Chairman*: Is five guineas the maximum charge?—No. We fix these scales now. We say: "You can have a scale of 24s.," 19s. 10d. being the rate. We have scales of 24s., or 35s., or 2 guineas. That is in three different classes of situation, aspect, light and the garden. Over and above that, someone suggests that they would like something superior, and very exceptional patients are treated for five guineas.

13,278. Have you ever had a case in which the magistrate has declined to accept the evidence of insanity put before him by the medical certificate?—I have known such cases.

13,279. What happened in such a case?—The magistrate in question refused to sign, and the patient was taken back to the workhouse for further observation.

13,280. And what was the ultimate fate of that patient?—Eventually he was so sent. The magistrate (perhaps right at that moment) was wrong. Eventually the patient came to the asylum three weeks afterwards.

13,281. In deciding whether a person should be discharged or not, is the same standard applied in judging of his condition as is applied in judging of his condition for certification?—I think so. In the discharge of a patient who is cured, no question arises; it is an automatic matter; but in the discharge of a patient who is really not cured, then it is a question of degree as to the home surroundings he is going to, and of the discrimination of the committee who discharge him; they will weigh that, just as the magistrate has weighed the matter in the first instance.

13,282. There is the discharge of the patient who has recovered: that person ought to be discharged if he is no longer certifiable?—That is automatic.

13,283. On the other hand, there are cases which are relieved and which might be discharged to the care of friends or relatives?—Or the workhouse.

13,284. And in all these matters does your committee pass judgment?—Yes; we send them out month after month on probation.

13,285. Now, Sir William, perhaps you might take up the running. You, like Mr. Taggart, represent the Mental Hospitals Association?—Yes.

10 March, 1925.] Alderman J. G. TAGGART, J.P., and Alderman Sir WILLIAM HODGSON. [Continued

13,286. And are you a Member of the Executive Committee of the Mental Hospitals Association, as well as Vice Chairman?—I am.

13,287. I think you have also been Chairman of the County Asylum at Chester for many years?—For many years.

13,288. And you are an Alderman and Chairman of the Cheshire County Council?—Yes.

13,289. You are before us this morning also as a member of the Executive and other Committees of the County Councils Association?—Yes.

13,290. Have you been a member of the latter Association since its formation over 30 years ago?—Yes, ever since it began.

13,291. Have you also been associated with a Municipal Corporation?—Yes.

13,292. You have been Mayor of the Borough of Crewe; you are a County and Borough Magistrate, and you are Chairman of the Cheshire Joint Sanatorium Board, and in your private or professional capacity you are a doctor?—That is true.

13,293. We have heard of the work of the Mental Hospitals Association, but perhaps before we go into your evidence you might tell us about the County Councils Association and its interest in this matter. What is that body?—That body is an Association of representatives of all the County Councils in England and Wales, not Scotland, and they act through an Executive Committee. Each Council nominates four on the Executive Committee, one of those is put on the Education Committee of the Council; another one is put on the Highways Committee and the Public Health Committee. They are distributed among various Committees. The Executive Committee meets monthly except in the holiday season, and, of course, they have a great deal to do with either opposing Bills or promoting them. Sometimes we have introduced Bills in the House of Lords that have come down to the Commons as approved Bills.

13,294. May I take it in general terms that they concern themselves with all kinds of local government affecting the County Councils?—Yes.

13,295. In all its various branches?—Yes.

13,296. And they are regarded as the body representative of the County Councils' interests?—Yes, of the county authorities.

13,297. And of course, the county authorities have, among their various functions, the duty of concerning themselves with the treatment of the insane?—Yes, they provide the public asylums.

13,298. And that is one of the departments with which the County Councils Association is concerned?—It is.

13,299. Now, in the course of your own public work, Sir William, have you had a considerable experience of the working of the Lunacy laws of this country?—Yes.

13,300. And have you been in contact with the various Departments of State which deal with this matter?—I have.

13,301. Including the Board of Control?—I have had a number of interviews and disputes with them.

13,302. Now taking the matters in order, I think, first of all, you agree with Mr. Taggart, that it is desirable to eliminate, as far as one can, the association of mental treatment from the pauper system, the Poor Law system?—I think it wants removing entirely.

13,303. But do you recognise that so long as we have the Poor Law as at present, the best that one can achieve is a mitigation of the association?—Quite. You cannot get everything you want all at once.

13,304. I think that you, like others, take exception to the use of the word "asylum," because of its association?—Yes, we think it is very unfortunate, and it certainly has created a great deal of heart-burning among people whose relatives may have to go there.

13,305. The trouble is, whatever name you may select may ultimately attract equal disfavour?—People do not object to the idea of a hospital. If they got to know that an asylum was a mental hospital

in the same way that other specialised hospitals are being run for special complaints, I do not think they would feel the same about their relatives going there.

13,306. There is no doubt something in the psychological effect of a name?—There is more than a little.

13,307. Do you think that if the title were changed, and, if one may call it so, the atmosphere surrounding the matter were changed, people would be less reluctant to take advantage of existing institutions?—Precisely. It is a good thing for the people who are working in the hospital as well to know that they are working in a hospital and that they must have a hospital atmosphere. These are sick people having definite complaints which must be treated.

13,308. And you find in your experience that people are deterred from resorting to the existing institutions because of their associations?—I have known some people.

13,309. I have no doubt that in mental disease, as in all kinds of disease, it is desirable that cases should be taken at the earliest moment?—Yes, very desirable.

13,310. Prevention is better than cure?—Prevention is always better than cure.

13,311. Do you think that in some cases patients have been deterred from going to the asylum, until the disease has become so advanced that it was not susceptible of treatment so effectually as it would have been if they had been taken earlier?—Yes, I think so.

13,312. On this topic generally may we take it you are in agreement with the views which Mr. Taggart has expressed, that is to say, the institution of clinics generally?—Yes; generally I am in favour of all that Mr. Taggart has said. There are one or two points of distinction which may come up perhaps as we go on.

13,313. But the scheme which was obviously in Mr. Taggart's mind has your approval?—Quite. It should be pointed out that you cannot get a scheme like that operating in sparsely populated districts and counties in the same way that you can in large urban aggregations of people. Lancashire has less difficulty than some other places. I do not think the difficulty would be quite as much as many people imagine. For instance, in Cheshire we are on the borders of both Manchester and Liverpool. There is an arterial railway communication running from both places right through Cheshire. It is not difficult to get about Cheshire from either Manchester or Liverpool where the large hospitals occur, where there are medical schools, where they have psychological sides to their tuition. I do not think it would be difficult to make a scheme with either Manchester or Liverpool, or both. We have two large hospitals. We could have a hospital clinic which could be used by the Universities of Manchester and Liverpool. I do not think we should find it so difficult. In some other counties where the population is more minutely scattered it would be difficult. It is not a remedy that could be generally applied; it is not a convenience that could be applied all over the country, but the point the Association has in bringing it forward is this: let us get as much provision as we can for the assistance of the treatment of a disease which has been neglected far too long. It is mainly to get the maximum provision of convenience in treatment.

13,314. Then, if empowering legislation were enacted, that would enable the more progressive parts of the country to take advantage of it and their example would no doubt tend to spread?—Quite. There are many useful Bills which have been passed with enabling powers; different authorities take them up one after another till often useful powers become general. It is an enabling power which could be usefully applied in this direction.

13,315. At the present time there are no such powers as you have with regard to infectious diseases and tuberculosis, and so on, for establishing clinics?—We have no power, and we have no power of voluntary reception either.

13,316. And you would like to possess some powers, and you are sure you would exercise them in Lan-

10 March, 1925.] Alderman J. G. TAGGART, J.P., and Alderman Sir WILLIAM HODGSON. [Continued.]

cashire?—I am sure they would be exercised in Lancashire and Cheshire. I can give you cases which I have in mind, but I do not know that it is necessary. We had an Irish curate who used to come over every now and then from Ireland to our asylum. Our superintendent erroneously took him once or twice until he found he had no power. He used to feel the mental tremor coming on and he used to come over. We had to stop that, because it was illegal. There are a lot of people like that who are on the border line, full of mental difficulty, neurotic, they get attacks of acute neurasthenia, and they are sufficiently intelligent to know that they may perhaps go over the line, and they like to get safe.

13,317. Shelter and treatment?—Shelter and treatment.

13,318. Therefore you advocate the admission of such persons as voluntary patients?—As voluntary patients without certification, yes.

13,319. *Mr. Snell*: With power of detention?—I do not like the power of detention except as an enabling power for odd cases.

13,320. *Chairman*: Of course, if I may diverge into this question of the voluntary patient, there is a difficulty that the voluntary patient may at any moment become a menace to himself and the public?—Quite, he may.

13,321. And it may be necessary to detain him involuntarily for a time?—It might be necessary that there should be some enabling power for a short period.

13,322. The Mental Treatment Bill contemplates that the voluntary patient may be detained against his will for 72 hours?—Yes.

13,323. But, at any rate, whatever be the period, there must be a time during which his voluntary residence may become involuntary detention in his own interest?—Yes.

13,324. That time to be utilised in communicating with relatives and getting medical men on the case?—Yes.

13,325. Now, first of all, on the subject of the medical staff of asylums, which naturally interests you professionally as well as administratively, have you any view as to the qualifications which should be possessed by medical superintendents?—Yes, I have. I think every medical superintendent, who is the chief medical officer in a mental hospital, should have medico-psychological, technical qualifications, to show that he has passed a definite strict examination in mental disease. Every medical man has gone through some study and examination of mental disease; but they want something more than the ordinary study. Usually their mental qualifications simply merge in their general medical qualification. I do not think that superintendents should be appointed to large asylums or mental hospitals without they have special technical medico-psychological qualifications. I think the Board of Control quite rightly has the same idea. It has not been possible to get many men of that type; of course, there are a limited number of men who possess those qualifications, and are appointed. It is getting less difficult now, but it has been very difficult.

13,326. Would this supply of especially qualified men be increased, if greater facilities were given to the subordinate members of the medical staff to study and to pass these examinations?—Yes; that is what we want to inspire. We have had some young people who have come to our asylums, both young men and young women, who have not shown very much desire to develop on those special lines; but, as a rule, they are keen, and they are more keen now than they used to be; but there should be the inspiration of the necessity for development among the junior medical staff, and an interchange of the medical staffs in various asylums would be exceedingly useful. We have sometimes sent a medical officer to another asylum and paid his salary just the same, and supplied a locum tenens in his place. I think if a sort of rota of interchange were to be undertaken by a central controlling committee (the Board of Control,

for instance, could do it), much more useful work than sometimes might be done, and I think it would be generally taken up.

13,327. You think there should be a more or less organised medical service dealing with mental institutions?—Yes, an interchange of service, but that all their service at each place should be counted as continuous service for the purposes of pension. That, by the way, should be applied to the medical superintendent—I think it is very important.

13,328. Is a man apt to get in a rut if he is too long in one place?—They do get in a rut. I have seen more than one superintendent get absolutely mentally stale and get quite into a rut, and committees have been very glad if they could make a change. No one can live in an asylum for many years without being influenced. We have had superintendents who have committed suicide without any apparent cause or anything indicating a suicidal tendency. It is almost impossible to say what influences are brought to bear on the medical staff by their work; and there is a nervous influence in the mentality of the medical service of asylums which is detrimental to the mentality of those who are in it. What I want to see, and what many of us want to see, is that for this special service, the oversight of the asylum, the chief medical officer should be a young and up-to-date man, who should not stay there too long. He should have a shorter period of service, and should retire on an early substantial pension so as to ensure change. I do not think anybody can live with lunatics, and we have 1,500 at the asylum I have had in charge, for many years—I do not think anyone can live among 1,500 lunatics without getting stale. Every now and again we say to our superintendent: "Get away for two or three weeks," and he comes back freshened and better. People are apt to forget that there is a penalty attached to the service of those who are suffering in this way. If they go wrong it is not to be wondered at. What we are finding, however, is this, that if they have a laboratory, and they can get the hobby of research work in that laboratory, well equipped and up-to-date, it is astonishing how they brighten up. The fact is that they get a side interest in their work. We have just been making the malaria experiment at our asylum. The superintendent is a good man and has to go away occasionally for a week or two to get freshened up. He has one set of rooms fitted up for the malaria treatment of general paralytics. We lined the place with special gauze to keep the mosquito within the premises. We obtained our mosquitoes and produced malaria in the patient; we cured the malaria by the treatment, and we also cured the general paralysis, and two patients have gone out of the asylum cured. It is wonderful how the encouragement to branch out into research work like that will freshen them up. The point is this: we want the best men to take the central official oversight of the asylum. The younger staff should be interchanged in some regularised system of rota whereby they will come across different ideas at different places with different practices.

13,329. Now in that connection have you any views on the definition of the duties of medical superintendents, because if you are going to have highly qualified specialists such as you desire, surely it is unsuitable that they should spend their time in checking stores and filling up forms, and diverting their minds from the medical aspect of their work to merely administrative duties?—I quite agree.

13,330. Have you any practical suggestion to make upon it?—Yes, I have. The suggestion I want to make is this, that the administrative business should be taken away entirely from the medical side, that the medical staff should confine their minds entirely to their medical work, and be relieved of the business, the commercial side; for instance, there is a great deal of farming in some places—we have a big farm. I remember one superintendent—he is dead now—who took such an interest in it that he became a farmer, and a very good farmer, but he ceased to be of much use as a medical superintendent, and the work was

10 March, 1925.] Alderman J. G. TAGGART, J.P., and Alderman Sir WILLIAM HODGSON. [Continued.]

generally done by the junior staff without taking his advice on medical questions.

13,331. Of course that is quite wrong, because the medical superintendent is responsible for the medical treatment of all the patients under him?—It is quite a wrong thing. The business and commercial side should be separated from the medical side, to relieve the pressure on the medical man.

Earl Russell: The medical superintendents themselves will not say that as a rule.

13,332. *Chairman:* No. It is a very practical difficulty. The head of the institution says "Well, I am no doubt a medical man, and medicine ought to be my province;" but the medical treatment of insane people is unlike the medical treatment of other people; it involves conduct, premises, and all those other things which an ordinary doctor is relieved of in a general hospital. He has to consider the lives of these people, and the regimen of their lives is actually part of the therapeutic treatment; and if he loses control of the establishment by delegating it to somebody else he may find that the establishment no longer chimes with his idea of an institution which will have beneficial results on its inmates?—I think, as a rule, medical minds are conservative—that is, they do not like alterations. The medical mind in an asylum does not like to give up positions of control and responsibility. I have met some medical superintendents who have those views. I have met others who have said "If I could get rid of all these blessed commercial details in this place I would be thankful; I have no time to think about my people." They are not all alike. Many men who have private pursuits find recreative occupation in public work, so it may be useful to medical men in asylums, but I have turned that over a good deal, and I have come to the conclusion very seriously that it would be a wise thing if the major portion, if not all, of the administrative business of the asylum were in the hands of some other person than the medical superintendent. I hope this will not be taken to have any reference to the asylums with which I am connected, because it might be misunderstood. It is a general view I am giving.

13,333. But how would you work it out—would you do it by regulations?—I think there should be a general administrative superintendent who should have control. For instance, the clerk of the asylum has a lot of clerks under him; we have a dozen or more in the asylum. In Lancashire I do not know how many they have, they have multiplied them there; but the administrative superintendent should have general charge over all the catering of the institution, the farms, and all the works in which they are engaged other than the treatment of patients.

13,334. Would you give the medical superintendent any control over that person—would he be subordinate to him?—That is a very difficult question.

13,335. I know, but it is one we may have to solve?—I know, of course, of its many-sided issues. As a rule, I think, the officers ought to be separate, and they should be both responsible to the committee. If the medical superintendent had any grievance against the "commercial" superintendent (we have not a name for it, but you know what I mean) the committee would settle it equitably whenever it was brought forward. I do not think I have known difficulties in large hospitals. It is the rule.

13,336. I was going to put it to you. One knows that in many large general hospitals there is a superintendent (sometimes he is a medical man), but his province is the general administration of the establishment, and he does not interfere in the least with the medical treatment of the patients?—He has nothing to do with them.

13,337. Is that the kind of model you have in your mind?—I want to see all the business removed from the medical man. I have seen so many overwhelmed with the details of petty business that they are absorbed with those, and their minds are taken off their patients.

13,338. Or if they are not overwhelmed with the detail work, they may be attracted to some of the other departments to the prejudice of their true work?—Yes. We made an uncommonly good farmer, and we lost a medical superintendent who retired very late in life on a good pension.

13,339. Then in order to get a supply of suitable men you are in favour, I take it, of the junior staff being encouraged to engage in post graduate work, getting leave for that purpose, and moving about among the different institutions to get diversified experience?—I think it is very important; it should be taken up seriously.

13,340. In your own experience of asylum administration, are you satisfied that there exists sufficient means for bringing to your knowledge anything that may be going wrong in the institutions?—"Sufficient" is a very difficult word. I do not think any system is sufficient to bring every information of every detail that goes wrong in a big place, but there is provision for such reporting of difficulties which I think answers very well indeed. It is not very often that a thing goes wrong. You must not forget that this is a business dependent upon the human element which is not always perfect. There is an occasional lapse of duty on the part of an attendant, or other official, which has to be dealt with, because it is the human imperfection that we have to meet; but it is the exception and not the rule. For instance, I do not know whether this is the right place for me to go on to what has been said about attendants not treating patients satisfactorily. We have known two or three cases in which we were satisfied when we investigated them, that the attendants were to blame. We have not known many cases. We always investigate every complaint, whether we hear it directly or indirectly, either from outside or inside the place. We always investigate a complaint, and as a rule the complaints are not well founded; but I do not think a counsel of perfection could be used in connection with these great places where we have people who, up till now, have not been too well educated for their job, and have not had, perhaps, the necessary sympathy which comes with the greater knowledge of it. We have a better class of young men and young women now.

13,341. Of course, everybody with common sense recognises that you cannot depend upon the human element, and you cannot get perfect medical superintendents, or even, if you please, perfect Royal Commissions. But what we are very concerned about is this, that there should be adequate means of bringing to a responsible authority's notice any instances where there has been a breakdown. If anything goes wrong on a railway system there is a Board of Trade Inquiry into it; and, similarly, where there is a breakdown in any institution one wants to know that the responsible authorities are apprised of it, and that there are means of so apprising them?—I am much obliged to you for giving me an opportunity of replying to that. We have such an administrative machinery that we do get information of anything that is going wrong. If we do get the information, and I think we do get it almost invariably, we certainly take great pains to investigate it and to put matters right.

13,342. Let me put this to you: the patient is in the hands of attendants primarily: suppose we have an attendant who is not a desirable person—such there must be among a large body. Is there not a risk of the patient being illtreated, or at least not well treated, and of that not coming to the cognisance of the authority, just for the reason that the patient has not any means of telling, or it may be that he is afraid of doing so, in view of the consequences that may be visited upon him by the attendant? One is so anxious to see that there should be a contact possible between the patient and the authority, and not the interposition of a barrier between the two. It is there that personally I am very much concerned to see there should not be any screen or barrier interposed. What do you say with regard to that?—With regard to our sources of information of

10 March, 1925.] Alderman J. G. TAGGART, J.P., and Alderman Sir WILLIAM HODGSON. [Continued.]

how things are going on, first of all we get a lot from the patients themselves, the patients are very quick to report anything; if they see an attendant strike a patient it would be reported directly by half a dozen different patients; it is impossible to keep it back. The attendants also tell of one another; if they are working with someone that they feel they cannot work with, because they have not the right spirit, they will communicate with the superintendent and let him know.

13,343. Then do you find there is not such a reluctance to communicate with the visiting committee?—No, the visiting committee regularly gets the expressions of patients as to their grievances, and they are very numerous, and are always listened to; and if there is any definite grievance we have it investigated, as to whether or not there is anything in it.

13,344. I am sure that as regards the disposal of complaints you do your best; what I am rather more concerned with is to see whether every justifiable complaint reaches you?—Well, I think the vast majority of them do.

13,345. Of course, if you say you have a great number of them coming in, that must show that the channel of communication is pretty open?—It is always open. We are always there to listen to complaints. Anyone who knows anything of asylums knows, of course, that it is the natural thing for the patients when they go there to imagine all sorts of grievances, but when they get better these all go. It is the best test when you get a person who has really been violent and bad and difficult to manage; and, when he is going out cured we say "Now have you been well treated, have you any complaint to make against anybody in the asylum? This will make no difference to your going out, but if you have any grievance let us know, if you have been inconvenienced, or hurt in any way." That is the sort of thing said to every patient on discharge, and, as a rule, in 99 cases out of 100 they say "Oh, we have been very well treated." A man might say "I know I was difficult to manage at first, but I have got all right now, and everybody is kind," and so on.

13,346. Do some of them ever draw your attention to things which have gone wrong in their own case? Yes.

13,347. They do sometimes?—Yes, sometimes.

13,348. As they are leaving?—Yes, we have one or two complaints.

13,349. Has that deterred you from discharging?—In one case I had, on investigation we found that the complaint was justifiable, and we followed it up with the patient after he left the asylum and held an inquiry, and had the whole thing gone into, and we dealt out justice to those concerned.

13,350. *Mr. Snell*: Would a restored patient's memory be satisfactory as to what happened when he was sick?—It depends; it is very difficult to account for the memory of some people when they are not responsible.

13,351. *Chairman*: But he would not be likely to forget if he had had ill treatment?—When they are getting better as a rule they realise it. When they are very violent as a rule they know nothing and do not remember very much. They get told what they did for instance. Some men would be going about knocking about everything, carrying knives about ready to stick into everybody, and even committee men have to be careful in going round asylums. We have had some killed and maimed by patients. There are some patients in asylums who are always threatening to murder the superintendent if they can get a chance, and committee men have to tolerate that sort of thing. I have been threatened by I do not know how many patients who would have murdered me if they could have got me quietly, because they thought I was responsible for keeping them. You cannot prevent people having these impressions.

13,352. I could imagine that a great many of the persons who are in asylums, although they may be suffering from a particular delusion, and therefore

quite proper persons to detain, may, on matters not relating to that delusion, be able to give you quite satisfactory evidence?—Quite. We have some cases where they are only deluded on one chain of ideas.

13,353. Take a person of that sort who, outside the particular sphere of his delusion, is more or less normal, what that person tells about the conditions in the asylum will be quite reliable, will it not?—Quite, and we get comments all the while from patients. We are on conversational terms with them all.

13,354. Yes, but I think it is desirable to remove the impression that what a patient says in an asylum about what is happening in the asylum is necessarily unreliable. It all depends upon the kind of patient you are dealing with, and the state of the patient?—Quite; it is often reliable.

13,355. Provided that it is not a thing permeated or tainted with his particular delusion?—Precisely.

13,356. Have you found you often get quite reliable accounts of what was going on in your institutions from patients who were actually certified patients in your institutions?—Yes; I can give you an instance of a telepathic delusion of a patient. Her husband was in South Africa. She swore that she could get regular communications through her eyes from her husband in South Africa. She was there in the asylum for a few months, and then we thought in talking her case over she seemed fairly sensible about everything else, and that she might be allowed out. Her delusion was not worth much. We allowed her out. She had not been out a month before she began visiting the police superintendent and threatening to commit suicide because she was getting messages through her eyes from the superintendent of the asylum, and she had to be sent back.

13,357. It may well be that a delusion may so permeate a person's life as to render them very properly detainable, but it does not follow that because a person is under a delusion on one subject, he may not be able to give quite reliable information on other matters?—What I meant was she was perfectly sensible and reliable except on her delusion. It was only when her delusion led her into violence that she had to be taken care of.

(After a short adjournment.)

13,358. *Chairman*: I think, Sir William, in view of the fact that you have expressed your general agreement with Mr. Taggart on the evidence he has given to-day, it would be useful if we were to turn now to matters which he has not dealt with, and upon which you have views to communicate to us, particularly with regard to incipient cases on which, I think, you can supplement a good deal what Mr. Taggart has said. Of course, having your own professional knowledge, it comes in supplement of his administrative experience. I see that you make observations on the Mental Treatment Bill?—Yes.

13,359. On the subject of the Bill generally do you approve the principle of it?—Yes. We asked for that Bill by resolutions of our Mental Hospitals Association, and we consider that for a long time the necessity for such a Bill has been evident. We are struck with the fact that we might have been relieved of a number of cases that came in very badly affected who would probably, with a little gentler treatment in the early stages, have avoided the acute development.

13,360. So you want to fill up a gap in the existing system which you think should be supplied by some such scheme as the Mental Treatment Bill provides?—Quite, but unfortunately that Bill was very much enlarged. The Board of Control, when they introduced it, also introduced a number of things that we did not ask for, and we opposed that Bill very seriously; and shall continue to oppose, so long as it contains what we consider to be so objectionable that we do not want it at all, until we get a Bill relieved of those matters that we have such strong objection to.

10 March, 1925.] Alderman J. G. TAGGART, J.P., and Alderman Sir WILLIAM HODGSON. [Continued.]

13,361. One may have to be a little more accommodating; sometimes one has to give away a little bit of what one wants oneself in order to attain an object, but I admire your resolution. However, on the general question, which is the first matter of principle in the Bill, I understand, you are in agreement; but as to some of the machinery, and some of the methods provided, you are in disagreement?—Yes.

13,362. I have the last edition of the Bill before me, and I understand the first point to which you take exception is the constitution of the visiting committees, and particularly of the provisions for co-option?—Yes. Both the Mental Hospitals Association and the County Councils Association entertain very strong objection to that clause, not that they object to women—they do not object to women being on these committees, but they say they should be representative women who come to represent elected bodies, who are the only bodies who constitute these asylum committees.

Earl Russell: I wish you would take sub-section (1) and sub-section (2) separately, because they are two separate proposals.

13,363. *Chairman:* If you take the first sub-section, it empowers the local authority to appoint as members of a visiting committee persons who are not members of a council, but subject to a very restricted limitation in number. May I just put to you a suggestion, and that is this: that you may well have persons who would be interested in the welfare of the mentally afflicted and who might devote both time and work to the subject, but who might find the rest of the work of a local representative distasteful—I mean the election, and all the rest of it. Such a person might nevertheless be an exceedingly useful assistant in that one particular branch?—Might I say that is always the argument used for co-option. I have had a good deal of experience of the co-option on public bodies, and I cannot say that I think it has been entirely of a satisfactory character.

13,364. What was wrong—I would like to know the practical point?—We find that some of the co-opted members, very enthusiastic and desirable people in promoting the interests of particular lines, are men who do not consider the question of cost sometimes at all. The most expensive members on our education committees, as a rule, are the co-opted members, because they are not responsible to anybody who has to pay.

13,365. But there is no authority to spend money; they can only recommend?—But they have authority to spend money on these committees. On the education committee their votes count as much as the votes of councillors and other people who represent bodies.

13,366. But the visiting committee itself does not spend the money, does it?—Oh yes; it is absolutely autonomous.

13,367. I thought it was under the control of the authority?—No, it is absolutely autonomous—that is the serious part of it.

13,368. They could not build buildings?—Oh yes; it is absolutely autonomous. We simply issue a precept on the overseers and the guardians for what money we want, and they have to pay.

13,369. *Earl Russell:* But surely you are wrong about capital expenditure?—If the county council approves, all the work is handed over to these visiting committees, and, as those who have had anything to do with the details of building know, it is often the extras which make all the difference.

13,370. *Chairman:* I can well understand the undesirability of having persons who have a voice in expenditure, but yet who are not subject to the electorate in any way. That is certainly objectionable?—That is the principal objection. The County Councils Association is very strong indeed about it. They have passed resolutions.

13,371. *Earl Russell:* Why do you say they can incur capital expenditure? Look at Section 238 of the Lunacy Act of 1890?—That is the obligation to provide asylums.

13,372. If you couple that with Section 240 you will see the local authority is defined.

13,373. *Chairman:* But we must also look at Section 254. Apparently there is a considerable degree of freedom in dealing with plans and estimates, and so on?—I have been in two large extensions at my own asylum, one costing about £100,000, and the other over £100,000. I know the County Council had nothing to do with the initial sanction.

13,374. Take sub-section (3) of Section 254: "A Visiting Committee shall report to the local authority or local authorities by whom they were elected, all plans, estimates, and contracts agreed upon, and also the amount to be paid by each local authority, and such plans, estimates, and contracts shall be subject to the approval of the local authority, to whom they are to be reported, except where the amount to be expended does not exceed an amount previously fixed by the local authority." If that is so, does it not mean that any contract for expenditure of money upon buildings, or any other matter, is to have the approval of the local authority?—That is in the capital expenditure. I think that is quite right; but in the maintenance charges they have absolute power.

13,375. *Earl Russell:* Maintenance, I agree; you can give them plum pudding every day if you like?—Yes, champagne if you wish; but when the county council has sanctioned the plans it is simply a question of course of the introduction of detailed extras. My experience has been that buildings cost an enormous sum for details and extras in excess of what is originally sanctioned, and the local authority has very little influence really in upsetting the resolutions of these autonomous committees.

13,376. They have complete power?—I have never known them to be overridden.

13,377. *Chairman:* Perhaps that was because they were reasonable?—The principle I might say of this objection is that we insist on the representative character of the present committees representing the rate-payers, the people who provide the money; they are either members of county councils or borough councils; they are the people who ought to have the right to say what money shall be provided and in the maintenance charges to the unions they are absolutely autonomous; they can fix whatever they like. We get some interested people who will come on, and will say: "We must have this, that and the other," and they can be very lavish in their expenditure. And do you know, Sir, it is very difficult to resist a sympathetic appeal made on behalf of suffering humanity on any committee. It is quite possible to be lavish and extravagant unreasonably. I have sometimes heard an appeal made on different bodies which I should say is a sympathetic appeal creditable to the heart of the individual who makes it, but not considerate to those people who have to pay the costs. It might be modified in consequence, and it is very difficult to resist, and it is the same experience that different councils have had in these matters which have caused them to pass unanimous resolutions, because these resolutions were all unanimous, they were not by majorities.

13,378. It is the irresponsibility of the co-opted members that you fear?—That is it. If they came on as members of committees we should be delighted. On my committee we have two very admirable women, and I should be very sorry to lose them.

13,379. *Earl Russell:* How do you find that this works in practice with education committees. Do you find the same objections that you are raising there?—Sometimes we do. That is a criticism which comes to us very freely from boards of guardians, who are the very people who criticise our expenditure in these asylums. The boards of guardians are always passing resolutions protesting against the extravagance of the county council, especially upon matters of education, and they say the co-opted members are the most extravagant of the lot. I am passing it on for what it is worth.

10 March, 1925.] Alderman J. G. TAGGART, J.P., and Alderman Sir WILLIAM HODGSON. [Continued.]

13,380. *Chairman*: But has not the principle of co-option already found a place in this chapter of legislation, because under the Mental Deficiency Act provision is made for co-opted members?—Yes.

13,381. Then a further provision is made whereby the visiting committee for the purposes of the Lunacy Acts may be the same body as acts under the Mental Deficiency Act, so that in that way you may get actually a body under the Lunacy Act which contains co-opted members. Is not that so?—Yes, it is so; all the same we set forward the objection as much as we can. I am here as the mouthpiece of the two Associations to say this.

13,382. *Earl Russell*: Are you not forgetting also that this is a permissive power?—I have already said that in my *précis*. We recognise it is an enabling power; in the case of women it is compulsory.

13,382A. *Miss Madeleine Symons*: But you would not suggest that two women would be able to persuade the council?—I have seen two women who could persuade any council of men.

13,383. *Chairman*: I am sure we all think that the presence of women on the administrative bodies of these institutions is very desirable, among other things, because of the fact that there are more women mentally affected than men; and also because of their greater knowledge of household concerns, which makes them perhaps better critics of the administration of the institutions. How are you going to get women on, because there are practically very few women on local authorities?—We do not find any difficulty. On most of the local authorities in my district women are coming on in an elected capacity.

13,384. On your own visiting committee have you women?—Yes, we have two who come from the Borough of Birkenhead. We are in partnership with the Boroughs of Birkenhead and Wallasey; two of them come on from Birkenhead, and there is another one who goes on to the other asylum who is a member of the County Council.

13,385. So you have not had the difficulty of having to go outside your area for co-opted women?—No, because they come in appointed by the representative authorities who have the power to appoint.

13,386. I do not think that is so everywhere, you know, Sir William. I mean there are some places where there are no women on the visiting committee?—Well, you know, Sir, I am voicing an objection which is the product of what experience we have in these matters on various bodies where it has been done, and many of my colleagues on the County Councils Association come across it in many ways; and I was rather staggered by the amount of opposition which came from them; it was very keen indeed. I do not say that we in Cheshire have had any difficulty. My wife was a member of the Board of Guardians for 15 years before she died, and I know all about the difficulties they have. I am not against women coming on; it is simply that I am here to say that both these Associations which represent County Councils and Borough Councils say, "by all means come on, but come on in a representative capacity."

13,387. So your general objection is, as I take it, this, that you object to the principle of co-option, because it introduces into the governing body persons who have not the same responsibility as elected members. That is your general objection?—Yes.

13,388. And that so far as it is necessary or desirable to have women on the governing bodies, you think that in course of time they can be obtained from the elected representatives without the necessity of having the power to co-opt them?—They are coming on rapidly. Women have come to stay in these matters; we must recognise it. I do not think there is any difficulty.

13,389. *Earl Russell*: Do not you think if you had more active and more inquisitive co-opted members on the visiting committee, some of the criticisms which have been passed on Prestwich asylum might have been averted?—Prestwich asylum—I do not think it

is quite fair to ask me about that, as I have had nothing to do with it. I know their difficulties; but my colleague here I daresay will be quite ready for it; but there was a lady on that committee, so Mr. Taggart tells me.

13,390. Yes, but I said active co-opted members?—I think she lost her seat because she was so active.

13,391. *Mr. Snell*: I cannot understand, Sir William, what objection there is to any person being co-opted who knows the subject, who is earnest and able and diligent, just because she does not wish to go through the strain of a contested election?—There again I hope I make it clear that I do not object to anybody on committees who may have particular knowledge, but my experience is that it is well to bring out people who have some sympathetic touch with those who provide all the money. I think that a father has a right to know how the expenditure is going in the house. I think these local bodies have a right to control expenditure, and if they say (I am voicing their sentiments) that their experience is that these sort of people are not representative, have no care about money, and are not the best people to appoint, it does not mean more than that.

13,392. *Earl Russell*: Your objection would not be met by an amendment in the Bill that they should not have any vote on financial questions?—Yes, it would. We suggested that from the County Councils Association, and the Board of Control turned it down.

13,393. But the Board of Control has not the last word?—No. We intended to fight it in the House, but it did not go further.

13,394. *Chairman*: Now may we turn to Clause 2 which is designed to extend the powers of visiting committees. Again, I think here you have a criticism to make of the Bill, in so far as it subjects to the approval of the Board of Control certain matters which in your view should be dealt with by the local authority without such supervision?—Yes. Take the beginning of Clause 2; "Subject to the approval of the Board of Control the visiting committee shall," then follow various clauses. Sub-clause (5): "undertake research in relation to mental disorder," and so on. We object to the Board of Control saying that they shall have the control of our research work. I was on a deputation that waited on the Board of Control some time ago to ask them to move the Home Office, which then had the Board of Control, to give a grant towards research work; and urged that it should be given and schemes approved, so that the money should not be frittered away. Public money so granted might fairly be claimed to be under an approved scheme, but this is different. In my asylum—and our asylum is a similar case to many asylums in this country—they spend large sums of money in fitting up up-to-date laboratories for research work; they have specially appointed officers in those laboratories capable of doing the finest work; they can make their own vaccines and sera, and everything, and their bacteriological work is everything that can be desired. Now we say, do not try to muzzle or to smother the impetus, the expressions of desire for getting on with discovering something; we say it is not needed. We say that that is not the way to deal with the research people. Research people have a peculiar type of mind. It is not the average mind, it is a discovering mind, the inventive mind; it is the mind of the pioneer thinker who prepares the way in a new direction, which has not been thought of before, and that is what research work is bound to be.

13,395. Yes, but I think the purpose of requiring the approval of the Board of Control, which would no doubt not be withheld in any reasonable case is rather this—it is to prevent duplication. For example, suppose two visiting committees in adjoining areas were both setting up laboratories, or pathological laboratories, for some particular line of investigation, when one would have been quite enough; you may have a considerable amount of expenditure by local authorities which is really superfluous. You may not want more than one or two centres for a

10 March, 1925.] Alderman J. G. TAGGART, J.P., and Alderman Sir WILLIAM HODGSON. [Continued.]

specialised study of some particular branch of mental disease. You know the rivalry which arises amongst local bodies, and each one wants to do it better than the other. That is healthy up to a point, but it is very expensive?—Is it not up to this point, that there is only one who may be a discoverer and you do not know where he will be? I am in favour of team work under proper circumstances; I am not in favour of preventing the individual investigation of any competent committee acting through its well appointed experts.

13,396. But do you think the Board of Control would resist that, when one finds in their Report, which I have read, that they are all for encouraging research?—Why should they have this power, they do not pay the money—we provide the money. Why should they ask for power to control it?

13,397. They do not ask for power to control it. They ask that this step should be taken, that if research work is being undertaken and money is being spent upon it, it is desirable that their approval should be invoked, which has several advantages. It has the advantage, first of all, that they know what is going on; it has also the advantage that they might make suggestions that certain bodies might join together to have a laboratory for some particular purpose. It may have disadvantages, but I can also see that it has some advantages; I do not think it is all one way?—We think it has so many disadvantages that it is mischievous in the extreme. They do not do anything to provide these laboratories, we provide them ourselves; we have the right officials to work them, and we are quite alive and informed enough to work in team work wherever we think it is desirable. I do not believe in restricting the liberty of research; it is a great mistake.

13,398. *Earl Russell*: You said, "We are providing the money, and why should we not be allowed to spend it"; you, the local authority, are not providing the money, it is the ratepayers who are providing the money?—I meant the ratepayers.

13,399. If Parliament grants you here a new power to tax the ratepayer, why should not Parliament attach to that power any precautions it thinks proper?—Is it a new power?

13,400. If it is not a new power it does not require to be given?—It is a power we have and use.

13,401. They say here, subject to that, you shall have the power?—It is a crippling of the local authority's liberty.

13,402. Have you this power now?—Yes, we have it now, and use it, and we say we have no right to be restrained, we say "Hands off, we are quite capable of managing our own business, and this is our business."

13,403. Parliament may think the public may require protection?—If Parliament thinks we want preventing they will say so.

13,404. *Chairman*: What is the power under which at present you can make contributions to the expense of anybody engaged in research into mental disorder?—Simply that we are doing it.

13,405. That is not a very complete answer?—Nobody can prevent us; it is part of the equipment of the hospital.

13,406. You see the Board of Control, so far as I have read their Reports, seems to me to be urging upon many visiting committees the desirability of engaging in and encouraging research?—On their lines; they want to settle the lines. They want to say "You do cancer here; you do tumours that are non-malignant there; you examine for dysentery in your place." That is not the way to do it.

13,407. *Earl Russell*: If that is what they mean, I should be inclined to agree with you, but do you think it is what they mean?—It is what they mean.

13,408. *Sir Humphry Rolleston*: In point of fact have the Board of Control taken any action that seems to be capricious?—No, because they have not had the power. That clause has more opposition to it than any other clause in the Bill.

13,409. There is the advantage of having the advice of the Board of Control as to the correlation of what work is to be done?—I do not think there is, because we can correlate it as much as we like with the asylums who are doing the work. This is like a bolt from the blue. Why should we be interfered with? When our Mental Hospitals Association was discussing the question of asking for State grants, it was also found that the Association was not in favour of having any State grants if it meant more control by the Board of Control. I am giving the views, the decisions of the Association, and if we had offered to us larger grants with more grip on our liberty of action we would say "Take your grants, we would be better without them."

13,410. *Chairman*: Of course, we are the recipients of very many diverging views round this table. There is another view that has been put before us by some reformers that what is wanted is that the Board of Control should have larger powers, including powers to see that things are done by local authorities who are remiss?—We have acted under the Board of Control for many years. I have known them for over 30 years, and I have had a good deal of experience in dealing with the Board of Control, and with all other Government Departments, as you may imagine. My experience is that the Board of Control are wrong as often as they are right. I can give you illustrations to show you our difficulties. I will give you one, if I may, not to be too verbose, but I shall be very glad to give it; for instance, we had our plans for the last extension of the asylum; we had in those plans the provision of an operating theatre. Those plans were held up for I do not know how long; we could not get any definite information from the Board of Control as to what was their precise objection. They did not understand anything about that operating theatre. There were several other things, but that was the principal one. I went up to see the Board of Control, and I saw one of the senior members, who is also a medical man, and he said "We cannot understand what you want an operating theatre for." "What," I said, "we have 1,400 patients in that asylum; we are constantly wanting operations of a serious character; we often get acute abdomens, appendicitis is a common occurrence." He said "Why do not you take one of these small wards next to the dormitories?" I said: "That dormitory is a very septic place. If you ask me, I should say it would save time if you wrote your death certificate before you did your operation, if you are going to operate in a room like that." We had no further trouble. They passed the plans, and we have got our operating theatre. Every day we have operations of a serious and intricate character.

13,411. That is a very good illustration, and, of course, we all recognise that there may be objections often to central control, delay, and so on, and also a divergence of view; but your theory would carry you a long way, it would carry you the length of this, that local authorities should not be brought under the control of any central body. I hold no brief for the central body, but I merely have to consider the position, and we know that conflicts between central bodies and local bodies are not unknown; in fact, they are pretty frequent?—If local government is to degenerate into a sham, and to be simply a ventilation of public opinion, the sooner local authorities are disbanded the better.

13,412. *Sir Humphry Rolleston*: There is a question with regard to the research work. It is conceivable—not, of course, in Cheshire, but in some places—that the medical officers attached to an asylum might have a tendency to investigate some point on which they were, so to speak, obsessed, which it was well known to the rest of the profession was a barren problem, or did not offer any prospects of advantage from its research. Would it not, in a case like that, be advisable that a central authority who took a broad view, and would not in any way want to limit the liberty of people, as a rule, should be able to point out that this was a problem which had already been investigated,

10 March, 1925.] Alderman J. G. TAGGART, J.P., and Alderman Sir WILLIAM HODGSON. [Continued.]

and it was not any good doing it again?—My experience is that team work regulated by central control is not successful work. I will give you our most recent experience of that, if I may, it is just hinted at in my *précis*. We have had foot-and-mouth disease in Cheshire; I have had something to do with all the councils which have been working under difficulties with the policy of the Ministry of Agriculture, and they have been slaughtering fifty thousand head of cattle, and have been spending millions of money on a policy of which we do not approve, but what is worse, they stopped us from investigation. We had Professor Beatty, who was working with us. I do not think there is a finer research bacteriologist than Professor Beatty, of the Liverpool University, in the country, and he had gone further than anyone had ever gone up to that point, and he had found that he had got what did produce foot and mouth disease in other animals, and was then going on to consider his preparation of other material for prophylactic work for the prevention of foot and mouth disease; and he was suddenly stopped and not allowed to go on any farm where there was foot and mouth disease, because he might carry infection round. That is our experience of team work. I think that team work in the Ministry of Agriculture has some alliance with another department. That is team work, and I say you cannot pick out your discoverers.

13,413. *Chairman*: That is elementary, but that, of course, would just go this length, that we should scrap the Ministry of Agriculture as well. It might be very desirable to scrap all the Government Departments, but it is not the way things are governed in this country. The system is, there is a hierarchy under which there would be delegated powers to local authorities coupled with a power of control in a central body. You may find that system irksome, and in some cases it no doubt embarrasses the activities of local authorities, but it is the system under which we have to live just now. What one is concerned with is, that there should not be undue interference; but a certain amount of co-ordination has been of value?—We welcome advice as much as you like, but we say the tendency now is that we are too much governed, and we want a little more liberty and not less.

13,414. *Earl Russell*: Would it meet your views in this sub-section (5) if it were worded—I cannot think of the words at the moment, but if it were so worded simply to give the Board of Control power to approve or not to approve of the expenditure of money on research, and then not enable them in that way to prescribe the method of research?—No, we want our liberty as we have it. We think the most precious thing we have got is to have the right of research work in our own laboratories with our own inspection, acting under the inspiration which our people could give.

13,415. You are sure you have it now?—Yes. I can give you some instances of very fine work done in our laboratory. We have the power now, I am satisfied.

13,416. *Chairman*: Let us examine that more clearly. First of all, the Board of Control's policy, as we know from their reports, and the evidence they have given us, is to encourage research as much as possible. Taking it that their policy is to encourage research, I have a little difficulty in seeing what the objection is to their being also invoked as the persons who are to approve of what is being done. I can understand your objection if it was to be a dead hand which was to stop all research work?—Do you not think it does stop us?

13,417. It might stop you where you ought to be stopped?—Can you give me any good reason why we should be stopped?

13,418. Yes, I think you might be stopped in a case where, as Sir Humphry said, a medical superintendent, not knowing that similar research is being carried out in some other place, was trying to persuade the visiting committee to spend £5,000 on a laboratory to investigate something which had already

been investigated in another part of the country?—I do not know any illustration of that where it has been done.

13,419. Nor do I, but you asked me to figure one, and it seemed to me that might be a very good example?—We object very strongly indeed. We must press our objection here as we must press it elsewhere.

13,420. Believe me, I appreciate it is a perfectly sincere objection?—I am beginning from the circumference and working to the centre. We say what has the centre done for our research work? We have been living under them ever since we came into existence. I have been under them for 34 years, and they have done nothing for research.

13,421. *Chairman*: They have had no powers?—They have had all sorts of powers of an advisory character, and they have had powers to give us a lead in many ways.

13,422. Would you be in favour of the Board of Control being given powers to compel visiting committees to engage in research work where they are not doing it now?—I should be against that even.

13,423. And at the same time you are complaining that they have never encouraged it.

13,424. *Earl Russell*: They have had neither the money nor the power?—They have the money in that they have powers of sanction. We cannot get loans without we get their approval. They have the grip of the money in that respect.

13,425. *Chairman*: We have been told by many witnesses that the Board of Control has no power to do anything but advise, and that its advice need not be taken, and, consequently, when it advises something that is desirable the visiting committee may just snap its fingers at it?—May I point out where the power comes in? A local authority is going to put up a building; it has to spend so much money, capital expenditure; it has to raise that money; they cannot raise a farthing of it if they do not get the sanction of the Government Department. To begin with that gives them very great influence, and they can block a thing for ever so long if they think fit, as we have been blocked. I think we were 12 months before we could get proper answers from the Board of Control to our letters in our first extension.

13,426. Would it not be very improper for the Board of Control to block an extension of buildings in order to compel an authority to engage in research work?—I should say it was always improper to bring pressure of that sort to bear. You cannot compel local authorities after all in that way.

13,427. And you have just been complaining that in your 30 years' experience the Board of Control have brought no pressure to bear?—They have brought pressure to bear on research work; they have mentioned it once or twice.

13,428. *Earl Russell*: That is all they can do?—They can do a good deal more than that.

13,429. What?—They have got their team work; they have got the touch with the central research committee which acts under Government control and Government moneys.

13,430. *Chairman*: Do you approve of the Board of Control's existing powers being enlarged or diminished?—I think the existing powers of the Board of Control need no extra permission being given to them, to prevent us from doing work which we freely are able to do and to provide money for now.

13,431. I am afraid that does not answer my question. The Board of Control has certain powers at present—do you think those powers generally are too narrow, or do you think they are sufficiently wide?—Generally I think they are sufficient.

13,432. As they are?—As they are; I do not think they need any further control. We are against their having any further control. I have just told you that the Mental Hospitals Association's view is that if it means more control we will not have their money.

13,433. And equally that would apply to the Ministry of Health, if they became the controlling

10 March, 1925.] Alderman J. G. TAGGART, J.P., and Alderman Sir WILLIAM HODGSON. [Continued.]

body in place of the Board of Control?—You know, Sir, there are great complaints against the compulsory powers of the Ministry of Health. There is a growing desire for the expansion of freedom rather than for the restriction of freedom.

13,434. Are you in favour of the existing powers of the Board of Control being diminished?—I am not in favour of their being increased.

13,435. *Earl Russell*: What you are in favour of is Soviet rule—local committees?—No, I am not in favour of that.

13,436. *Chairman*: It is difficult to see exactly where you stand, because I could understand your saying that you disliked more interference; that is a perfectly legitimate point of view; and that there should be more trust of the local authorities, and less intervention; that is quite a recognisable policy. On the other hand I think you must accept the view that in the matter of the treatment of the insane this country has decided that there shall be some central supervisory authority. The question comes to be what type of function ought that central body to have? Should it be supervisory, advisory on the one hand, or should it have what we may call executive powers on the other? That is really the problem, I think?—Yes.

13,437. You would assent to the view that we cannot at this time of day scrap the central body?—Quite.

13,438. The question comes to be what is the most valuable part that central authority can play in the administration of the lunacy laws?—I say the more it is advisory, and the less it is executive the more it will do well; and I do not think any effort which they are making in this Bill (because it has been put in gratuitously) any effort to get further executive powers over local authorities—is going to do any good. It will only create greater resistance, greater dissatisfaction. And there is one thing I wanted to say about it, there is no body of people who know better the advantages of publicity than the Board of Control; when the Board of Control speaks everybody listens, they have got the ear of everybody. They have only got to publish what they want to get any grievance remedied, and readily remedied. My experience is that when the Board of Control come down through their inspectors, if they say anything to us about our administration which is good we are delighted; we do not discard good advice, we welcome it, but if they come and find fault with something which we are satisfied is right and they are wrong, then we should not like them to have executive power to compel us.

13,439. *Earl Russell*: Do you provide more verandahs in your asylum on their recommendation at once?—Yes, we are doing so; they are doing it in some workhouses in Chester, too. We had a recommendation the other day to provide more verandahs so as to get more sunlight and shelter. I want to say that these committees are committees of the people, they are people who are elected from popular constituencies. They have to give an account of their stewardships. My experience is that the interest that they take in their work is magnificent; I have been amazed at the amount of time which some of them will give and the money they will spend on it, too, in order to carry out their work. Then take farmers. Now the farmer grudges the spending of sixpence more than a Scotchman. The farmer amongst us is known as a very economical spender. They pay their own expenses. Some of us think, of course, that it is not quite fair that boroughs should be able to pay the expenses of their members, but still they do it, and it is because they are interested. The amount of time and interest they give to this work is, in the last extreme, praiseworthy. I have met with it so much, I am bound to say it, and I never knew any good thing brought before them that they did not hold up both hands for it.

13,440. I have fought one or two county council elections, and I cannot say I recollect asylum manage-

ment ever being mentioned much by the candidates?—They must have been very well satisfied with it.

13,441. But do you find it is a subject of discussion at the elections?—I have seen it raised in one or two of our county elections, but they are so satisfied with what they are getting that it was not raised at the last election at all.

13,442. *Chairman*: On the general question you know I have not the least doubt that in Lancashire, where you have evidently, as one would expect, a very lively interest in your local government, all may be well; you may have zealous people and good work done, but there are other parts of England besides Lancashire, and there are other local authorities who may not be so zealous; indeed we have heard of a number of things that have happened in other places which are very different from what you tell us. Now the kind of legislation we have to contemplate is not merely home rule legislation for Lancashire, but legislation for other people who may not be so efficient?—I hope you dissociate my county from Lancashire. I like Lancashire very much, but I am here to keep Cheshire up as much as I can.

13,443. I beg your pardon, I should have said there are other counties besides Cheshire and Lancashire. Of course, we know in London, for example, the problems are much easier to handle and require much less interference from above?—May I point out that that was the very reason why this Mental Hospitals Association was brought into existence, to provide advisory centres, confederal centres, where different committees could meet, discuss their problems, deal with all the difficulties, and, if necessary, with the Board of Control, advise one another generally in matters of procedure; and it was because we had done that that we have found it is exceedingly useful. We have had expressions of thankfulness from a number of committees for the help we have been able to give them, and I think that this is a way in which the development of liberty on lines of responsibility is to be encouraged rather than to be discouraged.

13,444. *Earl Russell*: Now if I find, as I did find, an asylum where the wards were very dismal and very badly furnished, and not properly heated, and where generally the whole administration was slack, what is to be done about that without a central authority to ginger them up. You may take it there is no active public opinion there?—But there has been a central authority to ginger them up all these years, and they have never done it.

13,445. But they have, I have read their reports; but they have no sort of power. Having done that the matter drops; nobody reads the reports except the superintendent and the visiting committee?—Well, we are gingering up all our authorities as far as we can, because there is no sympathy in the counsels of reasonable people with being behind what is necessary.

13,446. What would call attention to it would be if they had the power of withholding the grant?—We say we would rather have our liberty.

13,447. You would, but other people would not; how are you to deal with them?—Our Association says so. It is the combination of other authorities.

13,448. That is the one that Lord Clifford of Chudleigh used to represent in the House, is it not, and Lord Balfour before him?—Yes.

13,449. *Chairman*: But your objection, I gather, to the approval of the Board of Control being interposed affects only the fifth head of sub-clause (2)—is that right? On the other matter, I take it, you do not object to their approval being required?—Yes, we do; we object to the appointment of these new inspectors, such a lot of them, with all the powers of Commissioners.

13,450. But that is not under Clause 2. For the moment I was asking whether any of the other sub-clauses of Clause 2 are objectionable?—No.

13,451. Then when you come to Clause 3, which proposes a reduction of paid Commissioners and certain other matters, have you any comment there, Sir William?—Yes, the appointment of new inspectors;

10 March, 1925.] Alderman J. G. TAGGART, J.P., and Alderman Sir WILLIAM HODGSON. [Continued.]

these inspectors are to have the full powers of Commissioners.

13,452. *Earl Russell*: Which, as we have just observed, are nothing?—Not if they get this Bill through. This is going to alter the complexion of everything. We are going to be under a tyranny if we get this. We have already had some experience of their inefficiency in the prescription of books and records. The tendency of all these Government Departments is to ask for multiplication of records and new books of all sorts. I would not say that if I had not had some experience of it in several directions; but we say that these inspectors, if they are to have the same powers as the Commissioners (they are practically Commissioners at a lower salary), will be inferior men. They will not be men we would appoint at high salaries; they will not be the best type of men, because they will not get the right type of men. We say it is the multiplication table again in their own direction, and in their own Department. I hope I will not be offensive in being so candid; I have tried very hard to avoid any language which would be offensive; I have no desire to be offensive.

Earl Russell: No; but I do not quite understand now what the actual objection is.

13,453. *Chairman*: We have heard on all hands that the Board of Control is ineffectual; its visits are perfunctory, at all events, some say so, and it has no power; but you come and say there ought not to be more officials to inspect, and there ought not to be more regulations as to the inspections?—You can understand it is not pleasant to me to have to give utterance to these views.

13,454. We are welcoming your candid expression of opinion, but we have had equally expressive evidence that what the Board of Control wants is more control to inspect, and what is wrong now is that the asylums are not properly inspected.

13,455. *Earl Russell*: We do not mind the opinion a bit, we want to understand it?—I have seen these inspectors as they have come to asylums; I know their work. Suppose they come to my asylum, of which I have been Chairman for so many years: they will see 1,500 patients all in a day, quite possibly go on for two days. What can they see in two days with 1,500 patients?

13,456. *Chairman*: Therefore their inspection is ineffective?—Yes; I say it is worth nothing. When they go up to the laboratory and have got anything to suggest we are all agog at once. If they pick out any new case and suggest any treatment we should be delighted. They generally pick out things which are of very little value.

13,457. *Sir Humphry Rolleston*: In a nutshell, do you think the Board of Control should be dispensed with?—I do not quite know that I should, because I do not think I have said anything that calls for that. I do not like the term "control."

13,458. *Earl Russell*: You have not said anything which shows they are of any use?—I do not believe they are doing good effective work.

13,459. *Chairman*: If the Board of Control is doing no good effective work, why should it continue in existence?—I should not be sorry to see it scrapped—I am giving my Association's opinion; and if they are to have more control we would rather scrap their grants.

13,460. If they are to be scrapped, should anything be substituted for them?—Not a controlling body—an advisory body, yes. I think the committees which are appointed by the people, by popular vote, are in direct touch with the people; these people know the members of the committee, go and interview them, buttonhole them,—I say that is the best system of control after all.

13,461. Of course, there should be no Ministry of Health, either, on that view?—I venture to say this, that the *reductio ad absurdum* argument is hardly fair in this respect, because I am a local government man, and I have had to deal with a great many Government Departments; but my experience has been, and it is the view of a great many of our associational bodies, different sets of councils, that we are getting

far too much interference from central governing bodies, and that we could do better if we had less.

13,462. *Earl Russell*: That is just what the Chairman put to you?—I do not want to be pushed to the other extreme, to say there should be none of them. I think that there ought to be some central bodies collecting information on their own and diffusing it, but when it comes to controlling it, I think there is too much control already.

13,463. Do you object to the central control of education?—Very often. I have objected to a great many of their controlling powers. It just depends upon what they happen to be for the time being. I have been Chairman of the County Education Committee for a very long time, not now, but I have had reason to differ a great deal from the Board of Education.

13,464. Anyhow, you think public opinion and public election is quite sufficient safeguard for all these things?—I think it is the best safeguard in the ultimate resort.

13,465. *Chairman*: That is with regard to the matter of inspectors. Is there anything else in the Bill to which your Association takes exception?—Yes. May I point out that this is the way the Board of Control frame their Bill? In Clause 4 you will find an arrangement made by which these voluntary patients who are certified shall be certified wholly by certain sets of medical practitioners. We think that that is not the right way to do it, unless they assume that it is necessary for these medical men to have special information of a medico-psychological character, and that there are enough of them to act as certifying doctors.

13,466. Which clause have you in mind?—Clause 4, sub-section (4). It is carried out in the schedule; there is a schedule of certificates, part II.

13,467. *Earl Russell*: Sub-section (5) you mean, do not you—not sub-section (4)?—Sub-section (4). It begins: "A recommendation for the purposes of this section."

13,468. *Chairman*: It is sub-section (5)?—I have not got as late a copy as you have.

13,469. That explains it?—We say, to begin with, the only effect of that will be that there will be the selection, from either social or political causes, of several people in every area who shall be asked to be the certifiers. That it is not a technical qualification. If they were men with a technical qualification we should not say anything, but it does not presume that they will have greater knowledge than other practitioners, and it introduces a social and political means of patronage which is very undesirable. I know how it works. I have seen people selected in that way for appointments; sometimes social influences operate, sometimes political influences, and Party Whips are not free from blame in the way of appointing people.

13,470. This is not an objection to the Board of Control, because I see it may be either by the Board of Control or the local authority?—We object to either as a matter of principle.

13,471. What else do you object to in the Bill?—I do not think there is anything else to which I need refer. To the principal clauses of the Bill, apart from what I have alluded to, we give a whole-hearted approval. We say these are foreign to what we want. We say we want to be able to let these people come in voluntarily, and let them go out—that is what we ask for.

13,472. Might I put one point to you of some general interest. It has been said that the Board of Control suffers rather from being too centralised. Would you be in favour, or would you be against, any project for setting up district Boards of Control, that is to say, for having Commissioners to whom areas would be assigned, and who would operate within those areas instead of their all being in London?—It would be very much more convenient for the executive government if they did not control more. If they had greater powers of control I think it would be worse still, because they would be too exacting; but at the same time, if you grant the necessity for

10 March, 1925.] Alderman J. G. TAGGART, J.P., and Alderman Sir WILLIAM HODGSON. [Continued.]

having the functions of the Board of Control well exercised directly, and with some widespread influence, you must have district boards. London is impossible with these few Commissioners. I really ought to say this. I always felt they were in a hopeless position, that they could not do anything if they would; but I do not like the multiplication of men in any central Governmental position in London that will still have its controlling power all over the country and say, "You shall do this," and "You shall not do that," and so on. Now in any distribution of their powers, if it is right for them to have those powers, and right for them to be exercised in the way I have said, then they ought to be in districts.

13,473. But you see you have just said once or twice very emphatically that the Board of Control is in a hopeless position?—Yes.

13,474. It is part of our duty to consider whether it should be left in a hopeless position. That is one of the things we must consider. We are giving your evidence the most serious attention. You tell us that a body which is set up and paid at the present moment is ineffective and in a hopeless position. We must address ourselves to the problem of what it to be done about that body. Have you any constructive suggestions to make about it, as to what we should recommend, because it would not be proper for us to leave it in our report baldly that the Board of Control is in a hopeless position, and not make any proposal to remedy the position. What is your suggestion?—My suggestion is this: Commissioners having purely advisory functions, who would be able to visit every asylum in their districts at more frequent intervals, to confer with the officials and committees of the asylums; and they should go to the meetings of the committees. They shy from that a great deal. I think only once did I ever succeed in getting a Commissioner of the Board of Control to come to a committee meeting. They do not like to come to committees—I do not know why.

13,475. *Earl Russell*: Is it not partly pressure of time?—Very likely; but, at any rate, we have never been able to meet them in that way, and they do not see the committees. They come and write their report in a book and there is an end of it. That has, of course, no binding power except for what it is worth. I want more influence from those who have information. I do not want to have more control from the central government.

13,476. *Chairman*: There is just one other matter before we part which I would like a word with you upon, and that is the question of after-care, which is another matter you have studied, I know. Is it your proposal that there should be some organisation of that kind under the local authority?—I think that it is a very difficult question. I think whatever is done will have to be done by money being found from some public source other than exists at the present time, and I think it would be most difficult to carry out. Our experience has been this (we have tried this after-care business to a limited extent), that people when they have been in an asylum want to forget it, and (what is more) they want other people to forget it. They do not like to see visitors coming to them. It is not as easy to go into after-care in these cases as it is in cases of tuberculosis, or any other disease, and I think the after-care of people who have been in an asylum is a very difficult question. I do not know how it is going to be done unless it is with the provision of money which does not exist now. It can only be done, I think, through the quiet private nursing activities of people who can be interested in them locally.

13,477. Well, Sir William, I think apart from matters which Mr. Taggart dealt with, we have covered the special points which you wished to bring before us. I will ask my colleagues if they have any questions to put to you?—May I mention the matter of the question of the superintendent? The County Councils Association thinks that when anyone is appointed as a Commissioner, as an inspector under

the Board of Control, or anything like that, service under the Board of Control, if he has been a superintendent of an asylum, should be counted for continuous service for the purposes of pension. At the present time a man loses his pension if he leaves an asylum and goes to the Board of Control; the service is not continuous. We think that has been forgotten, and ought to be rectified as soon as possible. If you pick a smart, good, up-to-date young man from any of the asylums and make him a Commissioner, his service ought to be continuous in his new position, and rank eventually for pension, as though he had remained in the asylum service.

Chairman: We will note it.

13,478. *Mr. Micklem*: I want to ask you one of two questions about the nurses. You say something about them in your *précis*. In the asylums in Cheshire and Lancashire do many of the nurses take the Medico-Psychological certificate?—Yes, a good many of them.

13,479. You are interested in getting the nurses better educated than they have been up to now?—Yes. The Mental Hospitals Association appointed me with two others to meet the Medico-Psychological Association to draw up a new scheme.

13,480. Did you have something to do with drawing up the syllabus of the examination?—I had something to do with it; I will not say I was responsible. In this respect, we altered them first. They only had two examinations in the three years, and they suggested it should be spread over three years. We found they were wasting a lot of time between the first and the third examinations, and that it would be far better to have annual examinations and spread the work over three years instead of over two examinations at the first and third years.

13,481. Does it strike you that the syllabus covers a very wide ground, and is extremely difficult?—Yes, it is, but it is not too difficult.

13,482. Has it not the possible effect of preventing a large number of nurses from ever obtaining a certificate?—It does prevent some of them, but a large number get it. We have regular lectures given by the staff, and we have a fairly good attendance, and there is a strong incentive in it, that they get more money if they get certificates.

13,483. Does that apply in all the asylums in Lancashire and Cheshire?—I think so, and throughout the country now. Most of the decent suggestions in this new Departmental Nursing Report are things which we suggested long ago.

13,484. There has been a good deal of difference of opinion expressed by witnesses whom we have had before us with regard to the desirability of female nurses in the male wards. Would you tell us something about that?—We have tried it very fully in Chester; we are superseding the male nurse as much as ever we can. We only keep the male nurses where they are really needed, where we have ruffianly cases which could not be allowed to be near a woman; but whenever they are needing any nursing at all, we see they are nursed very much better by women. They have a finer influence. It is astonishing how well a woman can manage a man, if she has tact about her especially, and if he does not know it. It is when he knows, it is difficult. We find that with female nurses the men are more amenable, and there is always protection in numbers, and there is always plenty of help about. We have never had the slightest incident in our asylum in Chester that made us regret that we extended the sphere of women in these wards. In the sick wards they have absolute control.

13,485. And to a large extent in some of the other wards?—Yes.

13,486. Does that apply in Lancashire?—*Mr. Taggart*: I quite share that view; where we have tried it it has been a great success.

13,487. Of course you are aware that the Asylum Workers' Union took a view the other way?—I am quite aware of it.

13,488. We had the evidence of one particular nurse who said she had herself had experience during

10 March, 1925.] Alderman J. G. TAGGART, J.P., and Alderman Sir WILLIAM HODGSON. [Continued.]

three years, and spoke very strongly against it?—*Sir William Hodgson*: I wish you would come to see us at Cheshire. *Mr. Taggart*: Or Lancaster.

13,489. The north country is very advanced in these things?—We think we try to get what is best.

13,490. *Miss Madeleine Symons*: Do you happen to know how many of the hospitals who are members of your Association have approved that plan?—A good many; I do not know how many. We cannot tell the number.

13,491. Is there a general view in favour of it?—Yes. We have had it up at our meetings, and the general feeling is in favour of the female nurse being multiplied as much as possible. I know that the Asylum Workers' Union does not like it. I know why, but I have nothing to say about it.

13,492. *Earl Russell*: I just want to get this on the note about expenses. I understand the travelling expenses of attending an asylum can be paid by a county borough, and they can also be paid in the county of London, but not apparently by other county councils?—No county council can pay the expenses of its representatives on these asylum committees.

13,493. The London County Council can, but no other county council can?—No.

13,494. Of course you suggest that it would be reasonable that they should?—Yes.

13,495. *Sir Humphry Rolleston*: Sir William, you spoke about team work, and you thought it was a

bad thing rather, did you not?—No, I did not say that.

13,496. I thought you gave that impression?—No. I think team work is good in its place. I am against any restrictions on research.

13,497. But team work should expand the possibilities of research?—Team work will perhaps avoid the necessity of some individual work, but I think it is common human experience in the history of the past that we have found the great discoverer and pioneer, not by selection out of a team, but by individual prominence of great personal intelligence.

13,498. Has not a great deal of valuable work in neurology been done by team work?—Yes, but I do not think there is any reason why we should prevent personal work on it.

13,499. Oh no, but you would have no objection to team work?—I have no objection to team work—not a bit. I believe in team work, of course, properly carried out and selected, but my objection is that they want to stop the individual from working, and I say I do not want that power to be given to anybody; that we must not restrict the intelligence of the individual, and the opportunity for doing work. I would multiply team work in some cases as much as possible. It is being done.

Chairman: We are much obliged to you for your attendance here to-day, and for the assistance you have given us.

(The Witnesses withdrew.)

(Adjourned to to-morrow at 10.30 o'clock.)

5, OLD PALACE YARD,
WESTMINSTER, S.W.1.

TWENTY-FOURTH DAY.

Wednesday, 11th March, 1925.

MEMBERS PRESENT:

THE RT. HON. H. P. MACMILLAN, K.C. (*in the Chair*).

THE EARL RUSSELL.

SIR THOMAS HUTCHISON, BART.

SIR HUMPHRY ROLLESTON, BART., K.C.B., M.D.

SIR ERNEST HILEY, K.B.E.

MR. N. MICKLEM, K.C.

MR. H. SNELL, M.P.

MRS. C. J. MATHEW.

MISS MADELEINE SYMONS.

MR. P. BARTER (*Secretary*).

MR. W. FAIRLEY (*Assistant Secretary*).

Further evidence (on behalf of the British Medical Association) by Dr. R. LANGDON-DOWN, Dr. J. W. BONF. Dr. C. O. HAWTHORNE, Dr. E. W. G. MASTERMAN, Dr. CHRISTINE MURRELL, Sir JENNER VERRALL

13,500. *Chairman*: We are much obliged to you for attending again this morning. In the interval we have read over the notes of the evidence which you gave us on the last occasion when you were here, and my impression is confirmed that the greater part of your contribution has already been made to our deliberations; at the same time, one or two topics were either very lightly touched, or not touched at all. Now we should like you this morn-

ing to complete your evidence. There is one topic which I should like you to discuss shortly with us, and that is the position of the private licensed house. You deal with it in paragraph 54 of your memorandum, and I observe that "The Association is satisfied that there exists a desire in the community generally that many patients should be able to be treated otherwise than in public institutions, and should the existing veto on the setting up of

11 March, 1925.] Dr. R. LANGDON-DOWN, Dr. J. W. BONE, Dr. C. O. HAWTHORNE, [Continued.
Dr. E. W. G. MASTERMAN, Dr. CHRISTINE MURRELL, and Sir JENNER VERRALL.

new licensed houses or the extension of existing licensed houses result in the diminution or inadequacy of this provision it may be necessary to repeal that veto or to provide extended facilities for the treatment of patients in small numbers in private hands under proper safeguards. The opinion of practitioners in general practice in various parts of the country has been sought on this point, and the unanimously expressed opinion is in favour of the continuance of such provision, as meeting the wishes both of patients and of patients' friends." That I take to be the opinion of your Association?—(Dr. Langdon-Down): Yes.

13,501. The whole question of the licensed house seems to raise a question of policy which we must consider, of course. In 1890 the opinion of the legislature seemed to be on the whole rather adverse to that type of institution, because they placed an embargo upon the further extension of them, with the result that from that date onwards there has been, I take it, a diminishing amount of accommodation of that type, although at the same time the population has been increasing. I suppose the objection in principle to this type of institution is the possibility of conflict between interest and duty which may arise in the person in charge?—Yes. I think that is the basis of the *a priori*, the theoretical, opposition and objection; because, as far as I can understand, the actual reports of the conduct of these houses have not been adverse to them in the main—the reports, I mean, by the official inspectors. I am sorry that unfortunately Dr. Edwards, who has made this particular point his special study, is unable to be with us to-day to represent the matter; but, as we have said, we feel, after all, this is a question not of what doctors want so much as what patients want. So far as doctors go, it is granting a certain number of doctors a monopoly. We put before you what we believe to be the wishes of the patients of our members through the country for their convenience. It is really for the benefit of the patients, and the patients' friends, that we urge that this is a thing that is needed and wanted in the country.

13,502. I can well understand that a certain class of patient and the relatives of that class of patient may well prefer an institution that is not public in any sense of the term, but is more analogous to a nursing home, and is conducted on private lines, where facilities, and shall we say comforts, can be given on a different scale and in a different atmosphere?—Yes, partly that, but taking your original question as to the conflict of interest—

13,503. That is the crux of the matter?—Yes. I think that people who put forward that view overlook very important motives which in all forms of enterprise are very strong: the desire to do a good thing, and do it well, by a private individual; the desire for good reputation. As a matter of fact, the success and prosperity of an enterprise of this kind depend far more on a good reputation and good results than on cheeseparing management, I think.

13,504. There are obviously a number of elements in the problem; one quite appreciates that the proprietor, and, if he be a separate person, the superintendent of such an institution, may best prosper if he conducts his place well, and has a good record; but there does seem to be some anxiety in the public mind on the question of the profits made by the owners of such establishments out of this line of business. It is suggested (I am putting it in its broadest form) that persons in that unhappy state should not be exploited for the purpose of making large financial gains; and there is the usual suspicion that large profits are made and are not disclosed, and that this line of business is very profitable, with the consequent temptations?—I am afraid I am not in a position to give precise evidence in regard to the profits that may be made; but as to exploiting, that would involve the suggestion that people are retained when they should not be retained

for one thing, or that efforts are not made for their benefit which should be made. Dr. Edwards, I remember, gave us some figures. Unfortunately, as I say, relying on his being present, I have not got the actual figures before me, but he gave figures to show the recovery rates of private asylums, which compare quite favourably with the recovery rates in public institutions, and I think I am right in saying that he told us that of his fresh admissions only 19 per cent. remain and become chronic residents, in his own experience—I think that was the figure. I must not lay too much stress upon it, but Dr. Edwards will be available shortly no doubt; but it was a very striking figure. Then, as I understand it, these suggestions are in the main hypothetical, *a priori*, based upon general principles, and not on concrete facts. For instance, I notice that Dr. Lomax in his evidence made this suggestion, that private asylums were undesirable; but, as far as I gather, he did not produce concrete evidence in support of that statement. It was hypothetical, theoretical, and, as a matter of fact, in so far as he had objections to make in regard to treatment, and so on, they did not apply to occurrences in private asylums but in public asylums.

13,505. But to do Dr. Lomax justice, he said frankly he had not much knowledge of that type of institution; that his experience had been entirely in public asylums, and he entered a caveat against us laying too much stress upon his evidence with regard to private asylums?—Yes; I only saw the brief report in the Press.

13,506. Let me put this to you, because it is a very interesting topic. In the case of patients who are rate-aided and in public institutions there is really comparatively little motive for the retention of any patients at all beyond the time when they ought to be under care. The only suggestion put before us hitherto has been that sometimes a patient becomes so useful in the institution as a worker that the discharge of that patient may be delayed, because of his very utility, because practically, one may say, of his very sanity. But when you come to deal with the licensed house, I think it is with regard to that type of institution that possibly more public anxiety is aroused; because the inmates there are generally persons of some means, and in their case there may be a motive on the part of relatives interested in their estate to have them retained longer, and there may also be a motive in the owner of the establishment to continue their profitable occupation of his premises. There are two sides to it you see, and the danger of the wrongful detention of a patient seems possibly to be greater in the case of a licensed house, because of those two factors?—Yes, I must recognise that.

13,507. The relatives' interest is possibly adverse to that of the patient, and so also the pecuniary interest of the conductor of the establishment. These two factors are present, and present only in this type of institution, in contrast with the public or rate-aided institution, where the natural desire is to get rid of patients as quickly as possible. Now it is these two aspects of the case that give the public a little anxiety, I think; and you must take along with it, of course, this, that with the diminished accommodation, and the increased population of the country, probably very few of the licensed houses have to look far for their patients now; it is not a case of their having to try and get patients, it is rather a question of their trying to accommodate the people who want to get in. I take it that is the general experience of the profession now?—Surely then there is very little temptation to run any risk.

13,508. One wants to assemble the various aspects of the question?—That points to the fact that at all events the section of the public that uses these facilities has confidence.

13,509. Apart from the question of ill-treatment in such institutions, which is probably less likely than in rate-aided institutions, because the people have

11 March, 1925.] Dr. R. LANGDON-DOWN, Dr. J. W. BONE, Dr. C. O. HAWTHORNE, [Continued.
Dr. E. W. G. MASTERMAN, Dr. CHRISTINE MURRELL, and Sir JENNER VERRALL.

more means and better attention can be obtained for them, it is the element of possible wrongful detention that has caused some anxiety. I think behind the whole thing there is possibly this idea, too, that it is not desirable in the public interest that private profit should be made out of the afflictions of that section of the community. That is a large question, of course?—Yes, it is. My answer to your first question, I think, puts the other side of that.

13,510. Yes. Of course, if the public want this type of institution, and if this type of institution can be properly safeguarded against abuse, then it meets a want?—Quite; we are quite content with that statement.

13,511. We have had some suggestions that the accounts of such institutions should be made public in order that the profits obtained should be disclosed; have you any view about that?—We have not discussed it in the Committee at all.

13,512. Then it would not be fair to ask you to deal with that, but from the general point of view of policy, I take it that the professional feeling is that this class of institution meets a felt want and ought not to be discontinued?—That is our point.

13,513. And you would like us rather to direct our attention to the safeguarding of the conduct of these institutions on the hypothesis that they ought to be continued?—Yes. It seems to me that the present situation is quite illogical; either the things are really an abuse and ought to be suppressed, or they should not be limited in number arbitrarily on mere grounds of suspicion.

13,514. I see the logic of that certainly. If the thing is wrong, it should not exist at all, even in a limited quantity?—Quite so.

13,515. If, on the other hand, it is right to have such institutions, the supply should meet the demand?—Yes.

13,516. And then would come the question whether you can supply such institutions consistently with the public interest and with their proper conduct?—Yes, and we believe that the records are favourable to them. (*Sir Jenner Verrall*): It seems to me that those who oppose these private asylums are rather proving too much. We believe there is a demand from the public for these places. Those who oppose them can only oppose them because they thought that demand comes from interested people who were going to get rid of their relatives. Surely the onus of proof lies upon them. If this is at all a common complaint, this abuse of these institutions, it should be possible to get evidence in favour of that. It seems to me the proof is too large, it carries you too far.

13,517. I do not think we shall be entirely without evidence that abuses have occurred in licensed houses as well as in public institutions.—No doubt.

13,518. And that, of course, affects the general question of stiffening up the safeguards; but I appreciate the point, that if the public at large, which is composed both of potential patients and of their relatives, wish this kind of institution, there should be no general ground why that wish should not be met, provided it can be met consistently with the proper conduct of the institutions.—Except for a sentimental objection, and the fact that there is a feeling that there is a possibility of abuse in making money out of this disease, there is *a priori* no particular reason why money should not be made from them, as from any other ailment in a nursing home.

13,519. At present one knows that the nursing home is an institution that has come to stay in this country. To a very large extent now people who are ill and have to be operated upon go into a nursing home, because of the greater facilities and the better treatment they get there. The licensed house, I should have thought, in principle, is just a nursing home for mental cases, but one has always got to remember that in a nursing home one re-

mains a free agent—more or less a free agent—I am not going to say absolutely a free agent, but at any rate the atmosphere is different, because there is not just that legal ingredient. Throughout the whole of our study of this matter we have always come across this question of the interference with the liberty of the subject; and that aspect with its attendant risks is present in connection with the licensed house perhaps in a more pronounced degree than it is in other institutions, because of the pecuniary motives that exist; but your considered policy, I take it, is that if safeguards are adequately provided and possibly fresh safeguards, the type of institution is one that should be encouraged rather than discouraged.—(*Dr. Langdon-Down*). Certainly.

13,520. Of course, we must take this along with the other suggestions in your memorandum for institutions of a rather different type, for cases of mental disorder which have not reached certification or certifiability. What I was thinking of was this, that you would like to encourage persons to go to licensed houses as voluntary boarders, as they do at present in large numbers?—Yes.

13,521. Of course if the voluntary patient of the wealthier class wishes to go into an institution he will naturally select a licensed house in the ordinary case under the present régime?—Yes.

13,522. And you want to encourage it?—Yes.

13,523. With the existing accommodation, it would be very difficult to cater for any large number of voluntary patients of that type?—We quite realise that there might be an inadequacy of provision.

13,524. *Earl Russell*: There is no probability of this demand being met by anything like disinterested management for quasi-charitable purposes; it would not meet the demand?—I did not think so. The difficulty of raising funds for semi-charitable purposes to-day is much greater than it used to be. I think it is only right I should mention that the attitude of the legislature in 1890 was modified in 1913 when the Mental Deficiency Act was passed, in that it again recognised the wisdom of recognising and allowing for private and semi-charitable institutions. Indeed, a great deal of the work of the Mental Deficiency Act has been done by semi-charitable homes.

13,525. *Chairman*: That is what is called the approved house?—No; the approved house may be either a privately run home, or a semi-charitable home. The definition does not depend upon the type of management, you understand; but there are institutions under the Mental Deficiency Act which are run by committees originally supported by charitable donors, and also there are private certified houses comparable to the licensed house of the Lunacy Acts.

13,526. *Earl Russell*: I suppose it would hardly be possible in the case of a private licensed house run by one doctor himself to have anything at all resembling a visiting committee; it either could not function at all or it would interfere with his management?—Yes, I think so.

13,527. *Sir Humphry Rolleston*: With regard to your suggestion, to provide extended facilities for treatment, you limit those extended facilities in your *précis* really to small numbers of patients in private hands. Is it not desirable that Section 207 of the Act should be in some way altered, so that the existing institutions which have already got the facilities should be allowed to take a larger number?—Yes, the repeal of the veto should do that, and I think really we ought to substitute the word “and” for the word “or”.

13,528. *Earl Russell*: Which paragraph are you on?—This is paragraph 54. I think that would meet your point *Sir Humphry*.

13,529. *Sir Humphry Rolleston*: Do you think there would be any advantage in extending the existing institutions rather than setting up new ones?—Yes, I do; but we should not like it to be said that we are

11 March, 1925.] Dr. R. LANGDON-DOWN, Dr. J. W. BONE, Dr. C. O. HAWTHORNE, [Continued.
Dr. E. W. G. MASTERMAN, Dr. CHRISTINE MURRELL, and Sir JENNER VERRALL.

in any way trying to fortify this monopoly. We are not out to benefit specially the existing holders of licences.

13,530. Has that veto on the increase in number of licensed houses been relaxed in any instance?—No, I think not.

Chairman: I think the quantity is steadily diminishing; the numbers are always limited.

Sir Humphry Rolleston: They are limited by the Act. I did not know whether they had been in any way relaxed.

Earl Russell: I do not think the Board of Control have power to, have they?

13,531. *Chairman*: I think not. (*To the Witness*): Then do you think that institutions on the lines of what are called registered hospitals in the Act, that is to say, institutions wholly or partially philanthropic in character, would not meet the case? Is it because of the insufficiency of supply?—I do not think they would meet it.

13,532. You know in Bethlem, which is the typical hospital, voluntary patients are received, and that has great advantages, because the excess payments of the voluntary private patients go to the support of the institution, and there is a sort of mutual benefit derived from that. It is rather an attractive idea. It is also carried into the Mental Deficiency Act, as you know. Institutions are provided for, which are partially or wholly on philanthropic lines; but, following your analogy, I observe that in the Mental Deficiency Act, while such institutions for defectives are contemplated, supported wholly or partly by voluntary contributions, there is also a class of premises where defectives are received for private profit?—Yes.

13,533. I take your point. It is rather odd that in 1913 it should have been recognised that premises may be approved for the reception of defectives, although for private profit?—Yes.

13,534. Then it goes on to impose rigorous conditions. The Board have to approve the premises or house, and they may grant their approval subject to such conditions as to inspection, the making of reports, and otherwise as they may think fit. Then of course the approval may be withdrawn if there is dissatisfaction on the part of the Board. Do you think that that indicates on the part of Parliament some relaxation of the prejudice against the home run for private profit?—I should think that they were simply contemplating the needs of the particular case, and they recognised that to satisfy the needs it was necessary.

13,535. It is difficult to see why, if a private establishment is allowed for defectives, although run for private profit, without objection, there should be an objection to one for insane persons, unless it be this, that in the case of defectives there is not so much risk of unlawful detention, because the defective type of person of course is different?—Yes, that is so.

13,536. *Earl Russell*: As against that, defectives are not as likely to be able to complain, are they?—That is so.

13,537. *Chairman*: However, the practical upshot of your evidence is that this class of institution is required?—It is.

13,538. In your view it ought, indeed, to be encouraged, provided that there are adequate safeguards?—Yes.

13,539. Do you think that the demand for such institutions justifies their retention or encouragement, notwithstanding the special risks attendant upon them?—I think so. I think the public may be divided from this point of view into the public that has not got relatives, who require care and detention, and the public that has. The public that has not takes impersonal views, *a priori* views, but the public that is interested in individual patients asks for and wants these places. I am sure it is so among mental defectives, from my own knowledge; I believe it is so also in regard to the insane.

13,540. Of course, it has been chiefly with regard to licensed houses that cases of abuse have been made

public. I mean the class of case that comes up from time to time of complaint of ill-treatment or detention is generally one relating to a licensed house, is it not?—Yes; of course, financial opportunities encourage that, I suppose.

13,541. That may be because the persons who have been detained there have more means to assert themselves in the Law Courts than occupants of public asylums?—Yes, and I suppose they think there is more to be got.

13,542. That is another thing. You mean that a medical proprietor is a better person to shoot at in the Law Courts than a public authority?—Yes, and I do not think you can claim there is absolute immunity in the case of the public institutions.

13,543. No; far from it. In your previous evidence you indicated that the opinion of the profession was that the safeguards, by which I mean the formal safeguards in the code, were adequate; but have you any suggestions to make, as the counterpart of your proposal to remove the veto on the number of licensed houses, for the stricter supervision of them? It would be difficult for us to recommend the reversal of a policy unless we accompanied it with some additional safeguards.—We have not considered that, but the safeguards are very great, the very frequent visitation; for instance, the houses near London, I believe, are visited six times a year by the Board of Control.

Earl Russell: I think it is eight.

13,544. *Chairman*: Of course they are under the direct supervision of the Board of Control, unlike the provincial houses?—Yes.

13,545. I think one must not forget to link up this proposal of yours with your general proposal for the provisional order, because that again is related to this?—Yes; it is.

13,546. The provisional detention might eliminate a number of the cases which reached the licensed houses, and in that way diminish their transitory population to some extent?—Yes.

13,547. *Earl Russell*: Just to consider what precautions are possible, if you have a patient in a licensed house, although he is a rich man, he is not in command of money while he is there?—Yes. I might have pointed out that is an additional safeguard also in regard to the wealthy person.

13,548. Is it?—Because in addition to being under the safeguard of the Lunacy Act, if his property is administered by the Court, the Court supervises the application of his property, and there is appointed a committee of his estate and a committee of his person.

13,549. What was passing through my mind was this: supposing he wanted to see his solicitor, or a solicitor, and even supposing that the authorities raised no objection, the solicitor might rather wonder who was going to pay him, as the patient would not have command of money himself. I am assuming the man is there, and he says, "I have a complaint to make, and I will see my solicitor." I am assuming that the medical superintendent puts no obstacle in the way. Before the solicitor takes any steps, he would like to know where the money is coming from?—As a matter of fact the Lord Chancellor's Visitor is the person for the purpose in question.

13,550. He may not have the same confidence in him as the man he instructed himself?—That is the safeguard to meet that particular point.

13,551. I can see it would be a safeguard if a patient could send for his own solicitor and see him, but I do see that the solicitor might be unwilling to act if he did not see where the money was coming from?—I cannot conceive that a charge of that kind would be refused by the committee of the estate or objected to by the Master in Lunacy—a solicitor's charge, I mean. You are presuming again that there is a sort of conspiracy?

13,552. Of course I am, and I am presuming the action being taken is hostile to the committee?—Yes. The safeguards are in the appointment of the com-

11 March, 1925.] Dr. R. LANGDON-DOWN, Dr. J. W. BONE, Dr. C. O. HAWTHORNE, [Continued.
Dr. E. W. G. MASTERMAN, Dr. CHRISTINE MURRELL, and Sir JENNER VERRALL.

mittee, which you know is done carefully in a private Court.

13,553. But the lunatic is not effectively represented?—Such representation as is possible is provided for.

13,554. *Chairman*: It is true, is it not, that where a person of means has his estate administered in Chancery by a receiver or committee, the Chancery Visitor has a special duty?—Yes, he visits the patient personally.

13,555. He visits the patient for the purpose, among others, of seeing that the patient is getting the benefit of the expenditure. He is charged with that duty to see that the money which he administers is applied for the benefit of the patient. He is at least concerned to see that he is getting value for his money?—Yes.

13,556. It is a safeguard in this sense, that the patient is brought into contact there, not with a person who has mere general supervision, as the Commissioners from the Board of Control have, but with a person who is expressly charged with the individual case of that patient, and who therefore when he goes there goes to see his man and not the institution as a whole?—Exactly.

Earl Russell: On the other hand, you have the chance of one official being ready to be satisfied with the assurances of another official, if any complaint is made.

Chairman: Not if they belong to different departments.

13,557. *Earl Russell*: True?—And the individuals vary from time to time. The visitors that are sent up by the Lord Chancellor vary from year to year.

Mrs. Mathew: Mr. Chairman, are all patients in licensed houses presumed to be under the care of the Lord Chancellor?

Chairman: No. If they have any means, their means may be either in the hands of a committee, or they may be in the hands of a receiver, but of course there are some persons who have no means. Take a daughter in a home, who may come from quite a wealthy home; she may have no means of her own, and therefore she does not require her estate to be put in charge. That case may arise and does arise, no doubt. I do not know whether she would be visited in that case. I rather think not.

Earl Russell: Not by the Chancery visitor, I think.

Chairman: I rather think not.

Sir Humphry Rolleston: The Lord Chancellor does not control any lunatics except those so found by inquisition?

13,558. *Chairman*: Except that when a receiver is appointed now, the Chancery visitors have a jurisdiction. It is at least a topic we might consider, as to whether we could preserve or increase the contact between the patient in the licensed house and the independent authority outside, which of course is always a safeguard?—Yes. We are not at all opposed to increasing the safeguards if there is a lacuna anywhere.

13,559. Of course there is just this trouble, that we may run a risk of imposing so many safeguards that the time of the medical superintendent would be occupied entirely in filling up forms, and so on, instead of attending to his medical duties?—Yes.

13,560. That brings me to one of the other things upon which possibly you might give us the view of the Association, because it is a large professional question. We have had a considerable body of evidence to this effect: that the association of the medical superintendent's work as a doctor with the administrative work of an asylum is in some cases at least calculated to divert him from his proper medical work, and to make him much more a hotel manager, putting it in the baldest form, than a doctor concerned with the treatment and cure of his patients. Has the Association any view upon that subject, as to the desirability of a dissociation of those two functions?—I do not know that we have discussed

that. I might perhaps be permitted to make some observations about it.

13,561. If you put it personally, it will not bind the Association. Having you here, we should like your view upon that. Can you give us an unbiassed opinion?—I must say that I am associated with a private institution under the Mental Deficiency Act.

13,562. In what capacity?—As proprietor.

13,563. All the better; we will have the knowledge from the inside?—Yes, but I must not allow you to go away with a false impression on that point. My general view is that it is the whole life of the patient that is concerned in the treatment, and I can see there are difficulties in dividing the management of an institution under different heads. It seems to me that the supreme authority ought to be the medical superintendent, and he should be able to impose his will in every department of the life of the place.

13,564. Take the analogy for the moment of a nursing home. I suppose everybody nowadays has been in a nursing home at some time or other. A doctor conducts the home; very often the doctor himself runs it; he attends there and he sees the patients, but he certainly does not concern himself with the administration of the place in detail, beyond seeing that everything is going all right; he gets a good matron in, generally, and trusts her with the administration of the place. Of course, if complaints reached him that the patients were not getting proper diet, he would give a direction that that was to be put right, but the surgeon or physician who has a nursing home is not cumbered with much serving, like Martha, at all; he is free to attend to his patients from the medical aspect.

Sir Humphry Rolleston: I rather doubt whether there is the proprietary aspect you suggest.

13,565. *Chairman*: I may be importing barbarous notions from the North. I know of a certain number of eminent medical men in the North who have homes. However, the analogy would remain. The question is whether it is done by himself or done by some ex-nurse who has devoted herself to running a nursing home. The surgeon or physician does not concern himself with the régime of the place, beyond seeing that it is a comfortable place, and that proper food is given to the patients, and so on. He is not cumbered with the detailed work?—No in that instance he would not be; but then of course it makes a great difference whether you have a resident medical superintendent or a medical man living outside. I do not think you can very well compare the two positions.

13,566. The former is supervising the whole life of the place; and one has to remember this, too, that the day-to-day conduct of that institution is itself intimately associated with the treatment of the patients?—Exactly; that is my point.

13,567. *Earl Russell*: We had very strong evidence from Sir William Hodgson yesterday that the medical superintendent should do no administrative duties whatever.—Of course, if the place is big enough he should have departmental chiefs under him, but in my opinion he should be supreme.

13,568. *Chairman*: We had a case given us. We were told yesterday of a medical superintendent who became so attracted by the farm work that he developed into a most admirable farmer, but ceased to be an admirable doctor. Of course that is not right?—No. Presumably the medical work was deputed by him to capable subordinates.

13,569. Just there you touch the heart of it. Has he any right, in view of the very responsible functions that are put upon him, because he is the authority to discharge the patient, to have his attention so diverted from these matters to administrative matters, that he finds it necessary to depute the care of his patients to his subordinates, and only to receive reports from them?—No, I do not regard that as the ideal arrangement.

13,570. We have been told it is a matter of individual temperament. Some people are far more interested in the medical side of it and dislike the

11 March, 1925.] Dr. R. LANGDON-DOWN, Dr. J. W. BONE, Dr. C. O. HAWTHORNE, [Continued.
Dr. E. W. G. MASTERMAN, Dr. CHRISTINE MURRELL, and Sir JENNER VERRALL.

business affairs. Some minds, on the other hand, are much attracted by business, and go off on that side rather than on the other side. Some are able to delegate, and some cannot delegate. We know the different types of men?—Yes. I want to enter a caveat against co-ordinate authorities in the asylum.

13,571. *Earl Russell*: You do not want another independent head, as it were?—No.

13,572. *Chairman*: I think that would be awkward because you might have friction. It seems to be rather a matter of guiding medical superintendents in their duties by, say, statutory rules or regulations, and in that way directing their conduct of the institutions?—Yes.

13,573. That might be the way out?—Yes.

13,574. I mean that would give a certain guidance to persons who were inclined to diverge from their medical duties, and also to the medical man who is inclined to neglect the other side, if one were to suggest the laying down of administrative rules defining provinces?—Yes.

13,575. I am sure you will be in favour of this: that the medical superintendent should, so far as possible, be relieved of unimportant routine matters of administration?—Yes, I quite agree.

13,576. And again you will agree with me that the main thing is that he should have his mind concentrated upon the study of his patients?—The general welfare of his patients.

13,577. *Earl Russell*: To some extent you could do that by making the steward, or whatever you call your business person, the man who would be responsible for the accuracy of the accounts, and not the medical superintendent?—Yes.

13,578. *Chairman*: That is the thing, to get responsibility associated with duties, because at present if he has the responsibility he must, to some extent, investigate detail, but if he is relieved of detail he would say, "That is not my affair," if the visiting committee calls him in question?—Quite.

13,579. One does feel that, with the very responsible duties placed upon the medical superintendent, it is eminently desirable that his mind should be concentrated on his work with regard to his patients, and also upon the study of his subject; because the subject is a growing one, and I should imagine, in your profession, as in the practice of all professional men, the mere keeping up to date with the progress of knowledge, the reading of home and foreign and technical periodicals, the reading of new books that come out, and keeping abreast with the experimental work, must involve a great deal of study?—A great deal.

13,580. A man who is cumbered with all kinds of administrative detail cannot do that properly?—No.

13,581. May I take it then that you would be in favour of his being relieved, as far as it can be done consistently with the general welfare of the institution, of the detail of administration?—Yes.

13,582. You have been telling us personally of what you feel about it. I may say it commends itself very much to us. I wonder if your colleagues have any views on the same lines?—Perhaps Dr. Masterman has. (*Dr. Masterman*): I am a medical superintendent of a very large Poor Law hospital of 890 beds, and of course all the financial side is entirely out of my hands. All that side of it passes through the steward, who is nominally under me, but I have nothing to do with that side at all, and it would be quite impossible in my work to have to take that responsibility and at the same time attend to the medical needs of the patients.

13,583. Connected with your institutions, have you a farm or anything of that sort?—No.

13,584. That is a difficulty, of course?—Yes, and I do feel that I quite agree it is impossible for the medical superintendent not to have responsibility for both sides, the administrative side and the professional side, and it is quite as important that he should keep in touch with the professional side as with the administrative side.

13,585. More so, if I may say so?—Yes. In my work I personally discharge every patient, and I have to be responsible ultimately for all of them.

13,586. In your experience do you find that, notwithstanding the large number of cases under your charge, you have reasonable time for keeping abreast with the progress of your science?—Yes. Of course in my own particular case I am specially concerned with the surgical side, and I specialise in that. I think in the case of work like mine the medical superintendent must always specialise on a particular department, while keeping a general control over everything.

13,587. Of course your patients are not exclusively mental patients?—They are not mental patients. I had some hesitation about speaking at all, but I thought it might give some indication as to how it is possible to take the business side entirely out of the hands of the medical superintendent.

13,588. The problem has chiefly arisen, as it has been brought before us, in the case of these very large asylums which are a community of themselves. The head of that place is the mayor of the community, and he has to look after the whole administration of the place, which I should have thought would have been very distracting to him when he wanted to study the interesting cases under his charge and keep himself abreast with his profession?—There again, all the engineering and building side is deputed to a special official. I have no responsibility for that; it would be impossible for me to do that.

13,589. *Earl Russell*: But some superintendents do not depute it; they spend a great deal of their time over it?—Exactly. I am only saying that something on the lines of our work would be better.

13,590. *Chairman*: Suppose you are going to get a new operating theatre; surely you would be entitled to see the plans and say: "That is a bad aspect for that room; the light is not good," or the arrangement would be unsatisfactory; because that is where you are going to work?—Of course, I should have a voice in anything done in the building, but I should not be responsible for the detail. My advice would be sought, but nothing would be done without my putting forward my views.

13,591. *Earl Russell*: You mean you would not measure up the room, and so on?—Exactly.

13,592. *Mr. Snell*: Would you wish to have a veto on such a thing as the building of a verandah for open-air treatment, because that is really part of the doctor's work?—It depends upon what you mean by "veto."

13,593. Do you want to be consulted?—Certainly, in anything that could have a bearing on the patients' treatment, and that really covers everything connected with the structure of the place, too.

13,594. *Chairman*: I think we may leave that topic. Now one other matter which we did not discuss last time is the question of after-care, to which you allude in paragraph 48 of your memorandum on page 9. "It is urged that the principle of permitting after-care homes and convalescent homes at the seaside or elsewhere in connection with county and county borough mental hospitals should be recognised." That is only one chapter of the after-care problem but an important one.—(*Dr. Langdon-Down*): Yes.

13,595. Now on the question of after-care two views have been put before us; one is that it would be desirable to have associations, probably of a voluntary character, who would assist the discharged patient in getting back into ordinary life, assist him in finding occupation and generally smooth the transition from the stage of the patient to the stage of the citizen once more. The other view that has been put before us is that many patients having left the institution desire to close that episode in their lives for ever and would resent people, however well intentioned, busying themselves about their affairs and

11 March, 1925.] Dr. R. LANGDON-DOWN, Dr. J. W. BONE, Dr. C. O. HAWTHORNE, [Continued.
Dr. E. W. G. MASTERMAN, Dr. CHRISTINE MURRELL, and Sir JENNER VERRALL.

treating them as if they were still persons requiring supervision. What do you think of the balancing of those two classes of consideration from the patient's point of view?—If I might perhaps approach it indirectly, the sort of idea that was put before us in our discussions was that if there were more intimate touch on the medical side between the asylum period and the after period—and I am ready to admit in some cases it is already done,—but if it were more habitual that the asylum people should enter into the relation with the doctor of the patient at home, tell him fully about what had happened so that the advice on these matters should be more widely given by the private doctor afterwards, you would tend to solve these questions, because each individual case must be considered on its own merits. I think that is the way I should put it.

13,596. Of course in ordinary private practice what happens is this, that after you emerge from the nursing home and once more come into the hands of your own private doctor, he generally does get indications from the consultant in whose hands you have been as to what should be done, diet and care and manner of life that should be lived for a time and so on, and the thing works very well. But we are dealing with a section of the population whose life is not quite so highly organised as that; it is the poorer class population. When a patient leaves the institution, he has technically recovered but the moment of recovery is not a mathematical moment. He has ceased to be certifiable we must assume, but he is still a person who has had an experience in his life and who may have a certain shyness and difficulty in returning to normal existence, and encouragement and help might be of great value to some people?—Yes.

13,597. *Earl Russell*: In a country area you could only communicate with his panel doctor by letter?—Yes.

13,598. And that would not perhaps give him all the details you wish?—No, but there should be regular communication. That is an important beginning.

13,599. *Chairman*: I suppose we may take it that the great majority of patients discharged are patients who are on some panel?—I imagine so; I cannot speak with authority. Might I ask Dr. Murrell? (*Dr. Murrell*): I think, Sir, we have rather felt that the patient suffered from the lack of continuity, because when a patient goes into one of these institutions the doctor is, as a rule, although not always, asked to send in a report so that the medical superintendent of the institution does get a report of his patient, not in every case, but in a great many; whereas at present it is not the custom when he discharges that patient for him to communicate with the private doctor in these panel and other cases. One objection that was raised was that we might find it somewhat difficult to find out even who the doctor had been, so great had been the lack of continuity; and the proposal made by us was that as some member of the patient's family is usually mentioned in the certificate, the name of the private doctor could be obtained through that channel as a rule; but it is very important, because the patient going out is under a doctor who does not know anything of his illness at all.

13,600. Of course the history of the case is so important?—Yes, and he does not get it.

13,601. *Earl Russell*: Of course this is only the medical aspect of after-care, but there is also the rather important financial aspect.—(*Dr. Langdon-Down*): We understand that so far as it goes, the After-care Association is doing excellent work.

Chairman: It is a voluntary association, of course, and therefore has to do what it can with such funds as are at its disposal. It was rather suggested to us that some public money might be given for that purpose.

13,602. *Earl Russell*: Asylums have no means of making provision except by a rather colourable month's trial.—I might say that we rather contemplated that if there were new intermediate types of institutions, it should be step by step in and step by step out.

13,603. *Chairman*: That is a very valuable suggestion. I must say this idea has impressed us very much indeed, that the transition from being an inmate of an institution to the resumption of ordinary life must be an exceedingly difficult period in the individual's history, as important in the individual's history as anything else in his treatment; because a person taken from shelter and care and re-exposed once more to the stress of life may, and I suppose in experience often does, break down just for the want of some care, advice and assistance at that stage. I can imagine the panic that must overtake some minds in that state. At present no provision at all is made for that except by voluntary agency?—Practically not; and you see in that paragraph to which you drew our attention at the beginning of this discussion, we suggest that there should be now some public provision possible at all events.

13,604. *Earl Russell*: With regard to the very question of the month's trial, we are now urged that the patient should be discharged forthwith the moment he has recovered. Very often you are giving him his month's trial when legally you might discharge him. He has to be nominally still under certificate in order to get the money; you are presented with that difficult alternative?—Yes.

13,605. *Chairman*: Dr. Murrell's suggestion of keeping in touch with the doctor is only a phase of it, because no doubt it is desirable that the doctor who participated in the admission stage should also be associated with the discharge stage as an adviser and help; but that is only a phase of it; the philanthropy would require to extend a good deal further than that, because the best intentioned panel doctor in the world could only give some advice, but could not pursue the thing much further?—No, that is true; but it would help if we can get the idea that insanity is not too separate an episode in the patient's medical life, that it is part of his medical history and should be taken account of.

13,606. You see a certain conflict between the two ideas; you have on the one side the clinical idea, the doctor who is not the least interested in the law, but in his patient, and is quite unable to say at one moment he is certifiable and the next moment he is not. Then you have the public point of view which always expects the scientific man to be much more precise than he can possibly be, and would have the period of certifiability delimited fore and aft by precise boundaries, outside of which anything done to the patient in the way of detention is illegal. The doctor's retort is that you cannot deal with our business quite like that. There is an intermediate zone that has got to be provided for. It seems to me we are touching here the provision for that zone which intervenes between the ailment and complete recovery, and it is the patient's protection in that zone for which no provision is made at the moment in law.

13,607. *Mr. Micklem*: When a patient of some panel doctor goes into a hospital, does he not automatically go off the panel, and would he have a doctor when he came out?—(*Dr. Bone*): He does not go off the panel until the usual period.

13,608. That would be at the end of the half-year?—As a matter of fact it runs into nearly two years; certainly more than one year. I believe the longest period is a year and nine months in any circumstances. When he returns he would, if he started work, be immediately placed on the panel.

13,609. *Chairman*: But not necessarily the same panel doctor?—That would depend upon the patient's choice.

11 March, 1925.] Dr. R. LANGDON-DOWN, Dr. J. W. BONE, Dr. C. O. HAWTHORNE, [Continued.
Dr. E. W. G. MASTERMAN, Dr. CHRISTINE MURRELL, and Sir JENNER VERRALL.

13,610. *Mr. Micklem*: Is it a fact that during the period of his detention in the asylum payment would still be made to his old panel doctor?—He would remain on the doctor's panel until his arrears had accumulated to such an extent that he was taken off the panel. He would cease to be an employed person, but would still remain on the doctor's panel.

13,611. *Chairman*: You have a vested right?—The doctors do not get individual payment from the patient.

13,612. *Mr. Micklem*: They are paid according to the number of patients that appear on their panel?—Yes.

13,613. *Chairman*: In the memorandum, Dr Langdon-Down, you really only deal with one aspect of this matter, and that is these after-care homes and convalescent homes at the seaside or elsewhere. Of course, if such were provided in association with mental hospitals they would afford an excellent means of bridging the transition?—(*Dr. Langdon-Down*): Yes.

13,614. Would you contemplate that in these after-care homes the patients would be patients who had been discharged—I mean, would you use them as places where the probationary period still under certification would be spent, or do you contemplate they should be places where cases should go after discharge?—I should include that certainly.

13,615. *Sir Humphry Rolleston*: Do you think the Association would be inclined to support the idea that there should be some kind of social service connected with mental hospitals, a kind of outdoor visiting service, partly by nurses, but partly by visitors?—A sort of friendly flow of visitors.

13,616. Yes, but connected with, and almost part of the staff of the hospital, to follow the cases up; so that if they saw a person beginning to fail they would be able to give a hint to the doctor or send the case off to some clinic?—I certainly see no objection to that. The Association has not specifically considered it.

13,617. It would be an extension of the after-care?—I think it would.

Earl Russell: Of course it would be possible to give legal authority to asylum committees or boards of guardians to continue the payment, where the doctor recommended it, for a month or two months after discharge from certificate.

13,618. *Chairman*: Yes; it is the abruptness of the transition that strikes one as being a danger?—Of course it would have to be arranged subject to the approval of the patient, if the patient were in a condition to give an approval.

13,619. We are assuming now a recovered patient; he is rational again, but although rational he is debilitated and he might welcome or he might resent this interference?—Yes, assistance during convalescence; we think it should exist for many cases.

13,620. *Earl Russell*: If people want to avail themselves of it, it seems rather an important branch of public service?—Yes, I think so.

13,621. And also there should be some system whereby their welfare generally, their reinstatement to social life is assisted?—Yes. (*Dr. Murrell*): Would you very kindly safeguard the consent of the patient in that case, Sir?

13,622. *Chairman*: It would need to be, because many patients would resent exceedingly busy-bodies interfering with them, while others, of course, would welcome very much the assistance?—Yes, as long as they had the right to say they did not want a visitor, if they did not.

13,623. Just as at present the district visitor may have the door slammed in his face, so in this case?—It is quite possible they would not even want to slam the door in their faces; they might want them never to have called.

13,624. *Earl Russell*: They might not want the association of the asylum brought home?—Yes.

13,625. *Chairman*: That could be safeguarded possibly in this way, that when the patient is about to be discharged the visiting committee could say, "Do you feel quite fit for taking your place in the world again, or would you like to be put in touch with the After Care Association?" If the patient said, "I welcome that assistance, I have no proper home to go to, and if I could get some help of that sort it would be very good," he would be put in touch with the Association. On the other hand, if a patient said, "I want to shake the dust of this place off my feet, and I want not to think about this at all," such a more robust patient would be just left alone?—Quite. Of course, the medical value would be enormous as long as that aspect were safeguarded.

13,626. Now, there is only one other topic upon which I would like to ask you a question or two. It arises partly on what we heard yesterday. In connection with the treatment of uncertified patients, which is so important an aspect of the problem, we were discussing yesterday the possibility of assimilating the treatment of mental disease in its early stages to the present system of treatment of tuberculosis or venereal diseases by clinics. At present, I think these particular ailments are dealt with in special premises, and, in the case of tuberculosis, it is not merely out-patients but also in-patients who are dealt with?—(*Dr. Langdon-Down*): I believe so.

13,627. An establishment really dealing with that particular malady, which, of course, as we know, is grant aided?—Yes.

13,628. Do you think that similar clinics might be established for mental disorder—the same type of institution—a mental clinic?—Yes; we think that among the provisions which would be desirable that is one.

13,629. The idea being this, that the patients who were to be under observation for a time might be housed there, and that the place might operate as a clearing house?—Yes.

13,630. The ultimate destination of the patient being the asylum or freedom, as the case might be; but that some institution of that sort, where patients could be received initially, their cases considered and their destination settled, would be of value; and equally that it would be a place where out-patients could come for consultation?—Yes.

13,631. One is trying to think out what kind of institution would best meet your proposals. The theory is quite simple, but how to work it out is difficult. Is the clinic your ideal?—I think that where there are teaching hospitals, or in university cities, it is very desirable that all this class of work should be closely linked with the teaching hospital or the university, as the case may be. Partly, it would afford much better opportunity for research; it would afford opportunities for educational work for the young practitioner, and it would tend to avoid the dissociation of psychiatry from medicine in general. The objection to the purely psychiatric clinic is the severance of psychiatry from ordinary medicine, which is bound to be in the asylum, but should not be accentuated further than is necessary. At the same time, I recognise that there are places where there is no such thing as a teaching hospital and no university in the town where, for many purposes, a clearing house, a clinic, an out-patient clinic with in-patient accommodation, if possible, would be a great advantage. For one thing, it would be a great convenience to be able to send from the Courts dubious cases, young people who are charged with offences, to have their mental condition sized up by expert people.

13,632. The whole conception is most attractive, but I was thinking of the practical working of it out. Is this institution to deal with these incipient cases both as out-patients and as in-patients? It must, I think, take one of three possible forms. It must be a department of the existing asylum, or it must be a branch of the general hospital, which is the case

11 March, 1925.] Dr. R. LANGDON-DOWN, Dr. J. W. BONE, Dr. C. O. HAWTHORNE, [Continued.
Dr. E. W. G. MASTERMAN, Dr. CHRISTINE MURRELL, and Sir JENNER VERRALL.

you have been putting just now, or it must be a separate institution such as has been set up to deal with tuberculosis or venereal disease. Now I can imagine that the second of those proposals is, medically perhaps, the most attractive, but it would probably encounter much opposition from those who conduct these general hospitals, because it is a more difficult type of case, and the introduction of that class of case might be resented. It has been tried, of course, in some institutions, and there has been considerable trouble about it?—Yes; and yet I think the trend of medical opinion is towards having psychiatric departments now associated with, or in control of, or actually in the building of the general hospital.

13,633. That is not in supersession of the asylum properly so-called, because you would not contemplate that cases would be kept there indefinitely?—No.

13,634. *Mr. Micklem*: Nor would you contemplate that such cases should go there under the temporary orders that you suggest?—One at once enters upon very difficult questions then. Sir Jenner Verrall put the same question to me just before you did.

13,635. *Chairman*: I cannot see how you could conduct such a branch of a general hospital where you are going to have mental cases unless you have some powers of restraint.—No. I quite agree.

13,636. And that involves again licensing and visitation and the whole apparatus once more?—Yes.

13,637. That would be resented to a considerable extent, I imagine, by the managers of general hospitals?—Yes.

13,638. *Earl Russell*: And indeed, it turns it into a small lunatic hospital at once when you get all that?—I heard Professor Winkler describe the institution at Utrecht when he was in London in 1924. In Utrecht they have established in association with the university, a very elaborate neuro-psychiatric clinic; they have a department for neurology; a department for neurosis, psycho-neuroses, and quiet alienated cases; and another department for restless and, I suppose, noisy and difficult insane patients. It is in association with the university, as I explained, and I understand that the admission of these patients is entirely without certificate, they come voluntarily.

13,639. *Chairman*: And yet they are detained?—And yet they are detained.

13,640. *Earl Russell*: On the same principle as you would detain a person in a delirium, you mean?—Yes. Then there are cases in the ordinary other wards of the hospital. A surgical case, for instance, that comes in, with damage to the head and is unconscious, or damage of any kind and is unconscious, is primarily put with the necessary dressings into this neurological department; cases of alcoholic delirium and so on are dealt with in it; they have students, and laboratories, and libraries, and all the apparatus for treatment.

13,641. In what respect does that branch of the hospital at Utrecht differ from a general hospital?—For one thing it regards the nervous system as a whole; it is all part of one system, so that they deal with ordinary neurological cases in one department; that alone differentiates it very much.

13,642. I should have thought that that would be the ideal of the asylum also, to deal with the patient's being as a whole scientifically?—But in no asylum would you have a case of pure paralysis without any mental affection—

13,643. I see what you mean. Do you know how they reconcile the carrying on of this institution in Utrecht with the legal aspect. We do not know what their system of law is?—I am afraid that the things that are done in Utrecht might not perhaps meet with your approval or with the approval of the public here; but that it is done without abuse in a civilised country is worthy of consideration, I think.

13,644. *Mr. Micklem*: Do you know at all if it is a popular institution there?—It has been going on

for 20 years now, and Professor Winkler spoke in the highest terms of appreciation of the work that has been done and of the popularity of it, too; and also his own private patients took advantage of it.

13,645. *Chairman*: Did he deliver a lecture on the subject or make any communication to any of the learned societies?—Yes, he delivered a lecture before the Medico-Psychological Association, and it is in the April number of 1924, of the Journal of Mental Science.

13,646. I would like to read an account of that. I think the practical working out of this suggestion is one we will have to attend to, and one wants to get down to the business side of it?—I should like to say one other word. I was questioned after my last appearance before you as to the accuracy of one of my remarks, that there were no institutions in England at present for the treatment of mental ailments short of mental unsoundness; and I should like to correct that, because it was a hasty generalisation that went too far. There is, for instance, a hospital in the neighbourhood of Brighton at Hove, the Lady Chichester Hospital, which has been dealing with neurosis, and neuro-psychosis, short of insanity, with great success.

13,647. We are going to have evidence from that institution?—Yes. I do not want it to be supposed that I do not recognise the fact. Maudsley itself is another example, and other hospitals are initiating wards and clinics, and in Edinburgh, I understand, the same work is being initiated.

13,648. But the Chichester Hospital and Maudsley are, of course, specialised institutions; they are not in association with general hospitals?—Quite so; and, of course, in the case of some of the hospitals for nervous diseases in London, I understand that the great bulk of their out-patients are mild psycho-neurosis; at all events, a very large proportion of those who come as out-patients to a hospital for nervous diseases in London will be mild psycho-neurosis; the other cases are pure neurological cases, without any psychosis attached, but they get both. (*Dr. Masterman*): I would like just to remind you that the Maudsley Hospital is in very close association with King's College Hospital; it is an ideal association with King's College Hospital; it seems to me that that is an extraordinarily good type of thing to develop.

13,649. *Earl Russell*: You might almost say it is associated with a general hospital?—It is thoroughly associated with, but is not under the control of, the general hospital. The physicians and surgeons of King's College Hospital are in touch with cases at Maudsley, and I think that is a model of the method on which the thing should be done.

13,650. *Chairman*: Of course, once you give it a separate name and a separate local habitation, it tends to become an asylum in the popular acceptance of the term; whereas, if it is "Ward No. 30" of a general hospital, the hospital is the "Royal Infirmary," or whatever it may be, it has not got the special associations of the mental institution?—I think it has got a perfectly distinct standing among the poor from any asylum.

13,651. That is very interesting.—(*Dr. Langdon-Down*): Of course, if you contemplate the reception of restless and noisy patients, obviously the ordinary general hospital could not receive them into the wards as at present arranged. Some special arrangements would be necessary, probably separately from the institution.

13,652. And some special financial arrangement?—And some special financial arrangement, yes.

13,653. *Earl Russell*: In that case, of course, it could not act as a clearing house unless it was prepared to take all cases as they were brought in from the streets?—No; but of course even now I find that the general hospitals do get insane cases brought in from time to time, and they are put in isolation or under supervision for the night, and dealt with on the following day as may be found necessary.

11 March, 1925.] Dr. R. LANGDON-DOWN, Dr. J. W. BONE, Dr. C. O. HAWTHORNE, [Continued.
Dr. E. W. G. MASTERMAN, Dr. CHRISTINE MURRELL, and Sir JENNER VERRALL.

13,654. Have they anything in the nature of padded rooms, if wanted?—Yes, at the London Hospital I know there are padded rooms.

13,655. *Sir Humphry Rolleston*: Are you familiar with Phipps' Clinic at Baltimore, isolated from the hospital, but in very close conjunction with it, which works very well?—No, I am not. Of course, at the Maudsley Hospital they are prepared to receive restless, noisy patients in a certain department in conjunction with the mild psycho-neurosis in other departments.

13,656. *Chairman*: Then of the three ways in which provision might be made, namely, a branch of a public asylum, a branch or associated institution of a general hospital, or a separate clinic, you favour the intermediate idea, if possible?—Yes.

13,657. That it should be associated with a general hospital?—Yes.

13,658. But should not be a place of permanent detention, but a place only for giving attention to out-patients and treatment of mental cases which are under observation, with a view to their ultimate destination?—Yes. I should like to say that in these matters you are going perhaps rather further than our Committee went, and if I am expressing adherence it must be regarded as a personal view.

13,659. It is so important to think out these things practically.—I think I am carrying my members with me.

13,660. Well, so far as I am concerned, I think I have taken up all the topics left over from the last day. If there is anything you or any of your colleagues would like to add by way of supplement to your evidence we shall be most happy to have any suggestions you wish to make.—Thank you. I should like to make one addition. You will remember that you discussed with us the question of the justice and the certificates, and Lord Russell, I remember, said that a good many of the certificates which were signed under Section 16 are apt to be rather thin.

13,661. Yes, that was the expression.—It so happened that in looking up Section 16 I noticed that it is said (differently from in other places, I think) that the justice "shall examine the alleged lunatic." Now in the presence of the doctor he is called in, and he is told off to examine the lunatic. I think that is likely to lead to a misapprehension.

13,662. *Earl Russell*: I do not think it need be in the presence of the doctor?—It need not, but at all events he has to examine the lunatic. The doctor knows the justice is told off to examine the lunatic. I think that that tends to make the doctor feel that his responsibility is perhaps less than it would otherwise be; I think it tends to diminish the feeling of responsibility of the doctor, and I think it is asking the justice to do something which we really do not regard as his duty, the examination of the patient, if by examination is meant a medical diagnosis.

13,663. *Chairman*: If the word were "interview" it would be different?—Yes. We feel that the attitude of the Act is different there from what it is in other places, and it is different from our views of the matter.

13,664. *Earl Russell*: It is more the word you object to than the fact of his seeing the patient?—Yes.

13,665. *Chairman*: You want the justice to see the patient in every case; that is part of your recommendation?—Yes.

13,666. *Earl Russell*: The practice under Section 16 is not what is laid down in the section?—I understand that it often is a simultaneous examination.

13,667. Sometimes it is. Obviously the section contemplates, I think, that the people should be in touch?—(*Dr. Bone*): So far as my personal experience goes, it is always a simultaneous interview—doctor and justice.

13,668. It is very far from being universal?—I believe so.

13,669. It is only the word "examine" you object to?—(*Dr. Langdon-Down*): Yes, that is it.

13,670. *Chairman*: The programme of certification in these different cases and under these different sections varies?—Yes.

13,671. That is exceedingly confusing, and one would like, if possible, to devise a programme which would be precise for all cases, and which both the practitioner and the justice would have no difficulty in following. These differences are most undesirable, if they can be eliminated, and we shall consider, of course, the whole question of the programme of certification. I suppose we have your assent to this that, if possible, the thing to be aimed at is a simplification of the programme, particularly in the direction of making it uniform, or, as far as practicable, uniform in all cases, so as to avoid the technical aspect as much as possible?—Yes.

Mr. Micklem: It is not easy to see what other word you could substitute for "examine."

13,672. *Chairman*: Would "interview" not be satisfactory?—I think so. We are proposing that there shall be two doctors in any case.

Earl Russell: What is the word in the case of the private patient?—That is in an earlier section, "whether it is necessary for him personally to see and examine the alleged lunatic."

13,673. *Chairman*: The word "examine" is used in the case of the private patient as Lord Russell pointed out; the phrase there is "to see and examine," so that the word you object to is there also?—We object to it there, too, as overstating the type of duty.

13,674. *Mr. Micklem*: Is it not the duty of the justice to make up his own mind if he can independently of the medical certificate, that is to say, form an opinion with the certificate before him? You see under Section 16 the medical practitioner might be called in after the justice had seen the patient. Is it not the duty of the justice to make up his mind on all the evidence that he can get, first and most important, the certificate of the doctor, but second, his own examination of the patient if the patient is capable of being examined?—It is difficult to define the slight differences between us, but our idea is that the justice should be weighing the value of the evidence.

13,675. Yes, but is it not evidence if you have a witness before you, the patient before you, and you see him and you talk to him, and you find out from him as far as you can what his condition is. Is not that evidence?—You want to hear what evidence he gives. It is rather different from trying to ascertain his subjective state of mind.

Earl Russell: You see what the words are a few lines down: "If upon such examination or other proof the justice is satisfied that the alleged lunatic is a lunatic"; so apparently he is expected to satisfy himself both by the examination and by the proof that he is a lunatic.

13,676. *Mr. Micklem*: You do not wish to confine the evidence to the medical certificates?—No, certainly not; I regard it as evidence to hear anything that the patient may have to say.

13,677. *Chairman*: It is rather a bad bit of drafting in the eighth section where, if the patient has not been seen, a right to see a justice is given. All that is required there is to ascertain whether the patient has been personally seen by such judicial authority. He may have been seen but not examined. It is a drafting hiatus there?—Yes.

13,678. *Mr. Micklem*: But the whole point of the justice seeing the patient is to examine him if he is in a condition to be examined?—It depends upon what you mean by examining him, whether it is to be a judicial examination or a medical examination.

Earl Russell: You talk about examining a person as to his means; you do not do it by searching his pockets.

13,679. *Chairman*: Examination and cross-examination are, of course, the words used with regard to any enquiry?—*Dr. Hawthorne* would like, if he

11 March, 1925.] Dr. R. LANGDON-DOWN, Dr. J. W. BONE, Dr. C. O. HAWTHORNE, [Continued.
Dr. E. W. G. MASTERMAN, Dr. CHRISTINE MURRELL, and Sir JENNER VERRALL.

might, to say a few words on the question of the doctor as a witness. (*Dr. Hawthorne*): It is rather a limited remark that I wish to make, but it is with regard to what Dr. Langdon-Down has said regarding the suggestion put forward by the Association that the medical witness, in so far as he writes a certificate, should be treated as a witness, and should enjoy the immunities of the witness. If I remember rightly one of the members of the Commission on the last occasion suggested that an exact parallel existed between the lunacy certificate and, say, a case of a certificate of diphtheria, or small-pox; and that as the medical certifier could not avoid the responsibility, a full legal responsibility for the one, so he could not expect to do so for the other. What I wish to say to the Commission is that there are two respects, I think, in which these certificates differ the one from the other. In reference, we will say, to diphtheria or any other certifiable disease the doctor offers himself to the community as a person who is ready and willing and competent to deal with it. It may be said he does exactly the same in respect to lunacy, but I submit there is a difference. The doctor undertakes to certify a patient as a lunatic with reluctance. I think if you took the opinion of 99 per cent. of the medical profession, you would find that they would be only too glad if some means could be devised to relieve them from this responsibility; but unless they undertake it, of course, we should have personal and domestic catastrophes, and we should run the risk of having demented people running about our streets. The total amount which an individual doctor does in this direction is very small. A man may conduct a practice for 20 or 30 years and do very little of it. As far as the remuneration is concerned it is a very very slight matter to him, and the responsibility and unpleasantness are very great. Therefore I submit he is acting with reference to these lunacy certificates as a public servant, whereas in certifying other diseases he is pursuing the proper practice of his profession for the sake of a reasonable and suitable remuneration. Then the second difference between the two classes of certificates I may say is this: in the certificate of a certifiable disease the doctor expresses an opinion only; he does not state the facts upon which he founds the opinion; whereas in the lunacy certificate, though there is an opinion expressed, the facts upon which that opinion rest in the judgment of the doctor are there, and they are not only there but they are put to a judicial authority who has the right to challenge them, to investigate them, to act upon them, or to decline to act upon them; so that the certificate bears a different quality when it takes its final shape than does a certificate of a certifiable disease. Therefore, with great respect, I submit, when the Commission comes to express an opinion upon the point raised by the Association, it should be borne in mind that the analogy of what one may call the ordinary disease certificate to the lunacy certificate is not completely a sound one. That is the point I wish to make.

13,680. I have gathered that the Association advocate the view that the immunity of the certifying doctor in respect of the contents of his certificate should be as high as the immunity of a witness testifying in a court of law?—That is so.

13,681. And that the Association would not be content with the somewhat lesser protection suggested, namely, that any person who seeks to impugn a doctor's conduct in the matter of his certificate should have upon him the burden of proving that the doctor had acted negligently and in *mala fides*. You would not regard that protection as sufficient?—That protection exists at present.

13,682. Yes, but not, if I may say so, in a very satisfactory shape from the medical man's point of view, because the onus seems to be rather the other way, and the burden is put upon him of vindicating himself. It is curiously expressed in the Act, and

I would not like to give a legal opinion upon the matter, but it does not seem to be expressed in a satisfactory way from the profession's point of view just now. In the ordinary case if you want to challenge any person who professes an art, he holds himself out to the public as competent to perform the things in which he is skilled; that means he will give his honest work. If you can show that he has acted carelessly, or acted in bad faith, then he is exposed to an action like anybody else is. He must give honest work, and he must give work in good faith. I do see a difficulty in conceding to the medical profession in this one aspect of their work an absolute immunity. An absolute immunity goes a very long way, because a witness may say things in the witness box maliciously and yet is protected. Would you wish a doctor protected from statements made maliciously in his certificate? Suppose, taking advantage of his position, in giving his certificate he made a malicious attack upon somebody for some collateral reasons; it is a very high immunity you are asking.

13,683. *Earl Russell*: And a witness, after all, is not protected if he does not tell the truth?—We do not ask for any protection for false statements.

13,684. *Chairman*: No, but the kind of protection you are asking would entirely protect you from this, for example: suppose somebody were able to establish that a doctor gave a certificate when he was drunk, that he knew nothing about the case whatever, and wrote the thing down in a state of alcoholic excitement. Now, if legislative protection were given such as you desire, that doctor would be absolutely safe. I do not think the profession would want to protect a person who had acted in that way?—I think it is very difficult indeed to think of a medical practitioner being so intoxicated as to make these extremely wild statements, and yet be capable of constructing a certificate which would commend itself to the judgment of a judicial authority.

Earl Russell: But the certificate does not commend itself; it does not in the least follow.

13,685. *Mr. Micklem*: Suppose a case of gross negligence, a doctor signing the certificate but grossly negligent to ascertain the facts; you would not wish him to be protected there, would you?—I do not, of course, wish any man to be protected for wrongdoing, but we have got to consider the whole question, how it is affecting, for example, the minds of doctors at the present day, the responsibility which they feel, and which many of them are determined not to accept.

13,686. Would it not very largely be got over under your suggestion that there should be always two certificates?—Yes, I think it would.

13,687. It looks as though at the present time the onus of proving good faith and reasonable care is on the doctor. Suppose you were to shift the onus on to the complaining party; would not that assist you?—If I may say so, this point had to be very carefully considered, not only by my Committee, but by the representative meeting of the Association, and it happened to be my fate to state to the representative meeting what was the legal position. Now that statement was made in the presence of the solicitor to the Association, and he afterwards endorsed it as a correct statement of the law as it stood to-day, and the statement was to this effect: that if an action is commenced by a patient who has been certified against the doctor who has certified him, it is open to the doctor to go to the court and ask for that action to be suppressed. Then the onus is upon the doctor to show not only that he has acted in good faith, but that he has not done anything which could lead any person to suggest he has not acted in good faith. That is the responsibility placed upon the doctor. Therefore if there is the slightest technical flaw or especially a meticulous judge, if I may say so, he might very well say, "I do not say you have not acted in good faith, but

11 March, 1925.] Dr. R. LANGDON-DOWN, Dr. J. W. BONE, Dr. C. O. HAWTHORNE, [Continued.
Dr. E. W. G. MASTERMAN, Dr. CHRISTINE MURRELL, and Sir JENNER VERRALL.

there is something here which might lead a person to say you have not acted in good faith, and therefore the case must go forward." When the case goes forward, the person who impugns the responsibility has got to establish the proposition. The onus therefore at the trial as to whether the doctor had acted in good faith or not, is to-day upon the patient, or the plaintiff; but the onus is upon the doctor when he asks that the trial be suppressed or cut short.

13,688. *Chairman*: That may well be so. Of course the procedure in England or Wales differs from what it is in Scotland. The position in Scotland is perhaps more favourable, because a patient wishing to bring an action against a doctor would have to set out in consequential detail the charges which he made of negligence or want of good faith. The doctor would be entitled to have a legal discussion upon the record as it then stood, in order that these allegations might be examined on the basis whether, if they are proper, they would establish negligence? It is the old English demurrer, and consequently you do not have a trial at once. But here, I understand, the case would be sent to trial, and these legal questions would be discussed later. It is really a retention of the demurrer idea in the particular case of the doctor; but it is asking a great deal that we should put the certifying doctor in the position of a witness giving oral testimony in court so as to protect him absolutely, even although the plaintiff were able to prove that this particular doctor had been induced to make reckless statements about the patient by a fee from a relative anxious to have him put away. It seems to be a pretty strong thing to say that the protection should go that length, however recklessly and in however bad faith such statements were made?—It occurred to me that statements meriting the adjective you apply to them would come under the category of being erroneous statements. We do not ask the doctor to be free from any responsibility for statements of that order.

13,689. They would be perjured statements?—Yes.

13,690. However, it is a difficult problem, and we are obliged for your assistance in the matter.—(*Dr. Murrell*): Of course, this subject was very much discussed at our Committee, and it seems that directly we discuss it here again we get back to the idea of the doctor doing the certificate. It is the judicial authority who really certifies the patient. The judicial authority is obviously immune. He has worked on the expert advice of a medical man, and all we want is not at all to have the doctor in any way protected if he was acting in bad faith, but we do want this protection if he was acting to the best of his ability as an expert witness. But we felt this, that the doctor and the judicial authority are really jointly responsible for that certification.

13,691. Of course, even the judicial authority, I think, might be liable in damages?—Yes, but it is not the usual thing, is it? It is generally the doctor who comes into court, and it is not only whether the action is successful against him or not. Therefore, doctors feel that if they are really trying to say what is honest, they should be protected in that sense, as long as they are doing their best. If we have suggested to you something which would give too great a cover to the doctor when he was not acting to the best of his ability, then of course we would submit that some other method must be considered.

13,692. So long as he is doing his best, he will be protected, but, unfortunately, only protected in the long run after he has got through the worry of proceedings.—Yes; that is the difficulty.

13,693. On the other hand, if a person comes forward and says, "This man does not do his best," and offers to prove it to a court of justice, are you to close the mouth of that person altogether, and in consequence is the action to be dismissed?—But one's answer to that would be another question: If he were acting as an expert witness in court you would protect him in that way? If he were a handwriting expert, would he not be immune?

13,694. He would be absolutely immune for anything he said in the witness box.—This doctor who is giving this certificate appears as an expert.

13,695. *Earl Russell*: You would have the advantage when he gives evidence in court of his being cross-examined, whereas this certificate is final.—Would it be possible for the doctor to appear before the judicial authority and answer any questions that were required?

13,696. But you have not the means for cross-examination; that is the difficulty.—(*Dr. Langdon-Down*): We feel very strongly that if the judicial authority exercises all the powers given to him and considers the certificates carefully, there would not be any great risk in granting the immunity we suggest.

Chairman: I need scarcely say that we are exceedingly anxious that nothing in the existing state of the law should deter the medical profession from performing the very important duties laid upon them under the Act, and it is very undesirable that any profession should feel they are performing their work under the possible menace of actions, which may be quite unfounded but to repel which may involve an expenditure of a sum of money which may almost spell ruin to the practitioner, in addition to the publicity of the attack.

Earl Russell: And ruin his reputation?

13,697. *Chairman*: Yes.—I feel sure we can leave the matter in the hands of the Commission. We have put our case and it has been most sympathetically received.

Chairman: It is working it out into legislation that is so difficult to my mind, because we are anxious to give every encouragement to the profession to carry on their work without any such menace hanging over them. At the same time, one must preserve the right of action where action ought to be taken, because, after all, if a person comes into the court and says, "I have suffered a real wrong," there is nothing worse in a system of law than that that person should be driven from the seat of judgment and told "Right or wrong, you have no remedy in our law." That one wrong should remain unredressed because of legislation is, to my mind, always a very regrettable blot on our legal escutcheon?—(*Sir Jenner Verrall*): You were saying that damages might lie against the judicial authority making the order, but, as a matter of fact, that hardly ever occurs. The person really aimed at is the doctor, and does not it follow that the fact that it might occur has thrown an undue share of responsibility on the doctor? Might it not be possible to increase the capacity for inquiry of the judicial authority, so that, although it might not be equal to the criticism of a cross-examination in court, there might be a considerable protection. If the judicial authority was capable and felt the responsibility and necessity of going into the case and considering whether the doctor's certificate was genuine, he having to give the facts on sufficient grounds, would not that be sufficient protection?

13,698. It would go so far, but it would not go the whole length. We would still be dealing with an *ex parte* investigation, and unless you were to convert the whole thing into a court of law, which one would deprecate, it is difficult to attract to this particular function of the medical profession all the immunity given to a witness in an open court of law. You must take the risks of people misbehaving themselves, because the freedom is so important in the cause of justice. I have no doubt that witnesses abuse their immunity often in court, they do sometimes, one sees that, but it is better that they should abuse their immunity in certain cases than that the cause of justice should be impeded by people being frightened to give evidence. It is not quite the same in your capacity?—Except for this, that although we may be driven to putting before you our unfortunate experience of attacks made in connection with the matter, in the long run what we are honestly desirous of doing is to take away from our profession

11 March, 1925.] Dr. R. LANGDON-DOWN, Dr. J. W. BONE, Dr. C. O. HAWTHORNE, [Continued,
Dr. E. W. G. MASTERMAN, Dr. CHRISTINE MURRELL, and Sir JENNER VERRALL.

any excuse for refusing to do in the general interest what they are bound to do, and we are bound to state that there is a risk of that unless some increased protection is given beyond what the Act gives us at present.

13,699. *Earl Russell*: You cannot ask us to go so far as to protect an admitted wrongdoer?—Quite.

13,700. *Chairman*: And then as to the alleged wrongdoer who comes into court, is the allegation to be precluded from being proved?—That is a matter for the Commission. Are not those the extreme minority of cases? We think they are.

13,701. Of course they are? (*Dr. Murrell*): As Sir Jenner Verrall suggested, would it not be possible to increase the responsibility of the judicial authority? After all, two people are responsible for the certification in a sense. The feeling on the part of the medical profession is that they have to bear the brunt of the risk. If you cannot make their risk much less, cannot you associate the judicial authority more in that risk?

Mr. Micklem: Do two wrongs instead of one.

Chairman: You want two people in the dock instead of only one? If I may say so, it is not at all an easy problem from the legal point of view. The policy of it one sees perfectly. One wants to preserve the profession in comfort in discharging a very important part of their duty, and one can see that the work under this menace must often be very alarming.

13,702. *Earl Russell*: I can only tell you that I put this point to a very distinguished lawyer and said that the doctors obviously desired and wanted it for their protection, and he threw up his hands in horror, and said that it was contrary to the whole principle of English law.—(*Sir Jenner Verrall*): He would.

Earl Russell: Still our principles are founded on practice.

Chairman: And it is even the Roman law too. The whole doctrine of law is this, that a person who professes an art is responsible to the public for the proper exercise of that art, and to ask immunity in one department of your activity is a large order; but we understand where your minds are, and we will do our best.

13,703. *Mr. Micklem*: I think it would be an enormous protection to the doctors if there were two certificates?—(*Dr. Hawthorne*): The fact of two certificates would make it very unlikely indeed that any of the things put by the Chairman would happen.

13,704. *Miss Madeleine Symons*: I am afraid, Dr. Langdon-Down, it is troubling you to go back to another subject, but I was very much interested in what you said about the possibilities of using these clinics for young people in connection with cases from the court. I wonder whether you share the view which I have heard expressed, that there are a good many children who do not come under the definition of the Mental Deficiency Act who would benefit by advice and treatment, and who, if they got it at clinics of this kind, might not become part of the asylum population?—(*Dr. Langdon-Down*): Yes, I do agree with that. I think it is very important that a clear understanding of the children's minds should be obtained in these difficult and doubtful cases, whether possibly the whole trend of the children's upbringing is partly in fault and might be remedied.

13,705. And are there at present not many opportunities for them to go there?—There are not, no.

13,706. *Earl Russell*: I just want to ask you a general question as to any possible extension of the powers of the Board of Control. The only actual power they have now, I think, is a power to make regulations about returns, and the right to visit, but there are cases where it is desirable that backward asylums should be brought up a little. It is obvious you could not give a central authority power to compel a local authority to go in for capital expenditure, to build a new wing, or anything of the sort, but you might give them power to make regulations for certain things, for letter boxes,

or the training of nurses, or as to the administration or non-administration of drugs, perhaps. Do you think it desirable, generally, that the Board of Control should have any more power, or that they should remain entirely an advisory body as now? Which do you think on the whole would be for the benefit of asylum administration?—It is very difficult to say. I am not personally very anxious to see the central authority interfering with local and individual action except as an advisory and supervising body; but I must only speak for myself in that matter.

13,707. You must remember that, whereas some districts are progressive, there are other districts which are retrograde, and where things are not brought up to date in spite of repeated reports; but you still think it better to rely upon public opinion rather than on the actual legal power?—I think so, yes.

13,708. *Mr. Snell*: I would have liked to have continued the question of the private institutions, but time is getting on, and I will not, except to ask one question. I think you said that the public is divided on the matter, between those who have relatives who want treatment and those who have not; but is it not just possible that there are relatives who are interested in putting into a home and keeping there patients long after they have been restored to health?—I expect that is so.

13,709. You admit the possibility?—I admit the possibility. I only say there are numerous safeguards, and they are rightly there.

13,710. I thought your statement rather omitted to take note of that. There is just a question on the after care matter. Have you in mind any conditions under which public help could be extended to an ex-patient as a help towards his being reestablished as a self reliant citizen?—I think the first steps have already been indicated in our discussion this morning. I have no ready-made further suggestions.

13,711. What is the extent of the danger, in your opinion, of a relapse in the case of a patient who is without help, with a home possibly bankrupt, and having to face a hard world? Is there not some real strain put upon him which a thoroughly strong balanced mind can hardly bear?—Undoubtedly. The reason the patient broke down in the first instance is because his resisting power was unequal to the conditions with which he was faced of some kind or other.

13,712. Does not it seem a waste of all the money that has been spent upon him and of the medical care he has received when he is thrust back, without any provision being made for him, into the conditions which broke his health down?—We certainly hope the transition will be softened by the suggestions we have made.

13,713. Have you no figures as to the proportions of the relapses due to that?—No, but I would say that probably a patient in ordinary life gets worried about his affairs and gets an exaggerated and false impression of them. He goes away for a year, perhaps; he comes back and the things which worried him before will not at first be worries in the same sense.

13,714. He may not have any affairs after a year?—No.

13,715. *Mrs. Mathew*: I was rather alarmed at the statement that the provincial licensed houses are not directly under the Board of Control. Why is that?—Oh, they are under the Board of Control, but the visitation is different in their cases. The visitation is more largely local visitation.

Mrs. Mathew: They are not directly visited, I think.

13,716. *Chairman*: They are visited by the Commissioners, but not in the same way?—Not so frequently. They have a local visiting authority.

Earl Russell: Is it not rather a local visitor appointed by the local justices?

13,717. *Mrs. Mathew*: I think that makes it rather less direct. A local visitor is not exactly the

11 March, 1925.] Dr. R. LANGDON-DOWN, Dr. J. W. BONE, Dr. C. O. HAWTHORNE, [Continued.
Dr. E. W. G. MASTERMAN, Dr. CHRISTINE MURRELL, and Sir JENNER VERRALL.

principle, is it?—It is different certainly; I do not know whether it is more or less efficient.

13,718. *Earl Russell*: The local visitor has to be a medical man, has he not, the justices' visitor has to be a medical man?—I believe so.

13,719. *Chairman*: The justices visit themselves, by an appointed member, and along with a medical

practitioner?—Yes. I am sorry I am not sufficiently familiar with this particular aspect of the matter.

Chairman: It is all laid down in the Act. Then that concludes our meeting this morning, and we are much obliged to you for coming to us again and assisting us further.

(The Witnesses withdrew.)

(Adjourned to Saturday, 21st March, 1925.)

5, OLD PALACE YARD,
WESTMINSTER, S.W.1.

TWENTY-FIFTH DAY.

Saturday, 21st March, 1925.

MEMBERS PRESENT :

THE RT. HON. H. P. MACMILLAN, K.C. (*in the Chair*).

THE EARL RUSSELL.

SIR HUMPHRY ROLLESTON, BART., K.C.B., M.D.

SIR ERNEST HILEY, K.B.E.

SIR DAVID DRUMMOND, C.B.E., M.D.

MR. W. A. JOWITT, K.C.

MR. N. MICKLEM, K.C.

MR. H. SNELL, M.P.

MRS. C. J. MATHEW.

MR. P. BARTER (*Secretary*).

MR. W. FAIRLEY (*Assistant Secretary*).

EVIDENCE TAKEN IN PRIVATE.

Mrs. M. called, and examined.

13,720. *Chairman*: We are very much obliged to you for coming and seeing us. We have been discussing how we might best take your evidence. I think the most convenient course would be if you would just tell us in your own language the experiences you have had, and bring out any points you would like us to hear about. We are very interested indeed to know how the actual life of these institutions goes on from day to day and the experience of people who have been there; and as you were in B. for some time, it will help us very much if you tell us in your own way of your experiences there and any matter which you would like us to have in mind, when we are considering possible reforms that may have to be made. If I remember right you were in B.?—Yes.

13,721. For just under a year, from the 1st November, 1919, to the 18th October, 1920?—Yes. Might I speak about R. Infirmary first?

13,722. Perhaps we ought to get one or two little details about yourself.—I would sooner you questioned me on it; I might wander a bit.

13,723. We want to introduce you, as it were. You were born on the 9th September, 1889, so you are now 35?—I shall be 36 in September.

13,724. And you are by profession a teacher?—Yes.

13,725. You were on the permanent staff of the L. County Council for five years and you hold all the necessary certificates?—Yes.

13,726. Then in 1916 you married Mr. M., who is at present in the Royal Navy?—Yes.

13,727. And you had one child born on the 16th September, 1918?—Yes.

13,728. Do you remember the date when you went to R. Infirmary?—The 26th October, 1919.

13,729. That is a Poor Law institution?—Yes; I was there for six days. It was a very good place, the mental ward; I was very kindly treated. The food was very good and the nurses were very good. I have heard a lot of evidence about infirmaries and what happens in the infirmary ward, but there is one point that has never been brought out: that is, the mixing up of patients. You are left in the

21 March, 1925.]

Mrs. M.

[Continued.]

infirmary ward, the mental ward, just with a daily worker. She is paid weekly. She comes in in the morning and goes home at a certain time in the evening; a very ignorant girl the one at R. was, and she had charge of us all day long. The head nurse of the infirmary would just look in now and then, to see that everything was going on all right; but there was no one there who really watched you to see what your characteristics were. Now I am not disputing that I was quite in a fit state to go into an asylum, and if there had been voluntary places I would willingly have gone to a voluntary mental hospital, but I knew of no such place, though I was going about London trying to find someone who understood me. While I was in the mental ward another patient was brought in, and I got the credit of that woman's actions.

13,730. So I notice.—I was rightfully certified, and wrongfully, because I was actually put away on that woman's actions. The day I went into the mental ward they took away my wedding ring; that was on the 26th October.

13,731. What did they do that for?—I do not know, but that is the custom, because I got a solicitor to write to the R. Infirmary and ask when my wedding ring was taken away, and they said it was taken away on that day, according to custom. That was a great grievance with women in lunatic asylums, that they were not allowed to wear their wedding rings.

13,732. What was the idea, do you know—is it in case they might lose them?—In case you swallow them or in case a nurse was to rob you of them.

13,733. If your wedding ring was taken from you, was it kept and given back to you when you left?—Yes, it was sent with my clothing to my father.

13,734. As you have said very frankly, at this time you were suffering mentally?—Yes.

13,735. And you felt that you would have liked to go to some place where you could get rest and shelter?—Protection.

13,736. A very good word—protection until you could recover. You felt you were ill for the time being?—Yes.

13,737. And you felt the want of some place to which you could go and get such care and protection, which you would have quite willingly undergone voluntarily, without any certification?—I would. I went to two doctors in fact, one in I. and one in London. One gave me a white bottle and the other gave me a black bottle, but it did not have any effect.

13,738. Do you think that your illness really arose after the birth of your child?—Yes.

13,739. Up to that time you had had no symptoms?—I had never had a mental illness of any description.

13,740. But had you a difficult time when your child was born?—No; but I had breast abscesses afterwards.

13,741. And was it at that time that this feeling of unappiness came over you?—It was a racing of the brain; my brain was going very quickly.

13,742. You could not control it?—No. Instead of just doing one job at a time, I would start about five jobs and then get myself in a muddle.

13,743. You felt, therefore, in your own mind that there was something wrong, and that you must get some protection for the time being?—Yes.

13,744. There is also some record in your case that you wanted to do away with yourself?—Yes, continually.

13,745. Did you feel that you could not get on in the world, and that you were out of gear with the world?—When I started all these different jobs, I used to go out to get away from them, and I found I could only spend my day going out walking, and then I could not walk enough. I used to go on trams, the trams did not go quick enough. I went on trains, they did not go fast enough. I went on in such a worked-up state that I would stand in the middle of the road with my brain going round.

13,746. How long was it after your baby was born that you felt like this?—I had breast abscesses, six weeks; they were diagnosed after the baby was born.

13,747. *Sir David Drummond*: Your nervous trouble began six weeks afterwards?—No, the abscesses started then, and then I was ill three months with the abscesses. I was at my father's house, and then I went back to my own house at L., where I lived with my husband when he was at home; and as soon as I walked into the house I felt as though the walls were coming in on me, as though I was walking into a cave. I think that was the beginning of it.

13,748. *Chairman*: Was it about six weeks after your baby was born that the abscesses appeared?—Yes.

13,749. After your baby was born did you still feel all right?—I was quite normal mentally; I was being well looked after with the abscesses.

13,750. When would you say the breakdown mentally took place?—It came on gradually. I went back to my own home about the 6th January, and when I walked into the house I felt as though the whole of the room was coming down on my head.

13,751. *Earl Russell*: And that was the first time you felt odd?—Yes; I ran out of the house at once. As I walked into it, I ran out.

13,752. *Chairman*: It came on quite gradually. Your child had been born on the 16th September, 1918, but it was not until January that you really began to feel so badly upset, and meantime you had had these abscesses as well?—Yes.

13,753. *Mrs. Mathew*: Did you go back to work?—No, I gave up work on my marriage. I am not teaching now.

13,754. You have given that up also?—Yes, I gave it up.

13,755. *Chairman*: Now, having wished to get some place where you could go voluntarily, you found the only provision for such cases was to go to R.?—No, I did not find that out at all. I went to doctors and I was told there was a hospital in London for nervous diseases; but I did not feel it was a nervous disease. Then I went to the L. Hospital; I saw a very young doctor, and I did not have any confidence in him. Then I came to the conclusion that I was incurable; and I was living in my own house with a servant and the baby, and the baby was being left entirely to the nurse.

13,756. Was your husband at home at this time?—He was at sea. I had a feeling that the child was being neglected and if I was out of the way somebody would look after it, and I felt my husband's future would be ruined by having a wife like myself who could do nothing, so I decided I ought to die; but at the same time I did not want to die; I kept trying to kill myself, but I was stopped every time somehow or other, fortunately.

13,757. *Earl Russell*: Stopped by yourself?—I went to a railway to throw myself on the line, and there were a lot of little school boys waiting for their train and I could not do it in front of them. I made about five attempts. Nobody knew I was doing it, but I was anxious to get out of it, to give my husband and child a chance. Then in the end I put my head in a gas oven but it did not have any effect on me. Then I went home to father and I said "If you do not put me away, there will be a tragedy."

13,758. Your father was Mr. G. M.?—Yes.

13,759. Have you any other relatives?—I have a number of married brothers and sisters.

13,760. Do they live in London?—Yes.

13,761. When you were in this trouble did you see any of them?—Yes, I saw a lot of them; they all did their best for me.

13,762. You have brought us up to date with your story very clearly, if I may say so. How did you actually come to go to R.? You had been to one of the London Hospitals, and you were not satisfied with the advice you got there?—My father had been very

21 March, 1925.]

Mrs. M.

[Continued.]

worried about me, and when I told him about it, I said: "You must put me away or else there will be a tragedy," they were my words—he was a relieving officer and he knew what to do.

13,763. Then it was suggested that you should go to R.?—I knew he would act on my statement; he took me down to I. and sent for the local relieving officer.

13,764. So that really it was with your father's sanction that these steps were taken?—Yes.

13,765. Now R. was the place to which you were taken—I would rather like to know about this in detail. When you went there what was the first thing that happened to you. Who received you there?—The doctor was waiting for me.

13,766. Did he have a talk with you?—Yes. He was rather an old man and rather gruff, and he merely mumbled out a few questions, "Is your husband away at sea?" "Have you been worrying about him?" "Has the war upset you?"—things like that.

13,767. And how did you get on with him?—Quite nicely; I just answered everything he asked me.

13,768. What was done next?—I was given a bath and put to bed.

13,769. In what sort of place were you put to bed?—It was a very rough room, a very old room, and there was a bed in each corner.

13,770. How many patients would there be altogether?—There were four patients, with myself, one in each corner; there were four beds in the room.

13,771. And they were all occupied?—Yes. They were very old women; the one opposite me was quite blind and she used to ask the nurse what the time was; when the nurse said ten, she would say, "Is it 10 at night or 10 in the morning?" In the other corner there was the oldest inhabitant in R. She used to talk loudly all the time. In this corner (*describing*) there was a lady named Mrs. J. I will have something to say about her later on. They found out she had a broken shoulder bone when she was there.

13,772. When you saw the doctor, did he prepare a certificate about your condition at the time?—I do not know what he did. He simply asked me questions, and he wrote down answers, but I could not say what he wrote.

13,773. I have the certificate in front of me just now, and it corresponds very much, if I may say so, with what you have been saying yourself. Have you ever seen it?—Yes, I have seen it.

13,774. It is one of the documents you are entitled to get after you leave the asylum. The date of it is the 26th October, 1919, and it is signed by the doctor whom you have just mentioned. He says he observed himself that you were very depressed, and he adds: "and says; she is tired of it all; her husband is at sea; and she has no comfort in her married life and that yesterday she tried to kill herself by putting her head into the gas oven and turning on the taps." That is all exactly as you have told us yourself. Then it goes on to say that your father "states she is always talking of suicide, is delusional and says she has killed her child and nurse, attempted suicide by putting her head in gas oven." The only new thing there is that your father said that you were suffering from delusions, and thought you had killed your child.—That is not true. I do not like to mention this sort of thing, but there is a person in the family who when there is a little smoke sees a lot of fire; she had known for a long time that I had been ill, and she had made the most of it.

13,775. There are people who do that, you know, but had you said to anybody that you had killed your child?—I would like to explain it in my own way. She had been putting anonymous letters under the door, and my husband used to get up early to get these letters so that I should not see them. When I knew I was sort of past all hope, I felt I could never

really live in the outside world again. I thought she had been talking, and I would give her something to talk about, so I went round to the house and said "I have murdered Maggie and the baby, and," I said, "they look very beautiful;" and the first thing I saw on the certificate was that statement, so what I imagined would happen had happened.

13,776. Apart from this matter of the wedding ring you have told us about, or even this statement you have mentioned about murdering your child and the nurse, you appreciate that the condition of your mind at the time obviously made it necessary that you should be protected against yourself for the time being?—Absolutely, I recognised it.

13,777. As far as the incident of the ring is concerned, what you want to point out is this, that there was attributed to you an incident which really related to somebody else?—Yes, and I want to prevent anybody else having such incidents attributed to them. I was not wrongfully put away.

13,778. The incident of the ring was this, was it not, that this other patient had thrown her marriage ring into the fire?—Yes.

13,779. And then the story of throwing the ring into the fire was in some way attributed to you?—Yes.

13,780. And told, I take it, to the justice of the peace who signed the order in your case?—Yes.

13,781. What you want to point out is that an incident that may have happened in the case of one patient may, through a mistake, be attributed to another patient?—Yes.

13,782. It was not that you were not yourself in a proper state to be put under care, but rather you think there is a risk of an incident relating to one person being applied to another, which might of course be very unfortunate?—Yes.

13,783. Now we have got to the R. room, and the other patients there. Did you find the other patients disturbing?—Not till the 28th October when this Mrs. C. came in.

13,784. She is the lady of the marriage ring?—Yes.

13,785. As far as the three other patients were concerned, they did not disturb you?—They did not worry me at all.

13,786. You did not find it distressing to be with them?—It was rather interesting. The woman on the right side was a very badly discoloured woman; she was very, very ill, and she muttered a lot, and she rather frightened my visitors; I had some relatives come to see me, and they were terrified.

13,787. I should have thought if you were in that worried and distressed state which you have described, you might find it rather unhappy to be with other persons who muttered and talked, and so on?—Not then; I felt safe. I had been on my own for a very long time and very worried, and now I felt I was safe.

13,788. You had got shelter?—I had got shelter.

13,789. Who was looking after you,—merely this inexperienced girl, do you mean?—In R. there was merely this girl, a rather strong girl; she used to scrub the floors and look after the fires and serve out our dinners.

13,790. But was she placed in charge of this room?—Not really. She was in fact, but the one who was supposed to be in charge was the head nurse in the infirmary.

13,791. Did you see her?—She used to look in to see if we were all right.

13,792. Take the nurse who was actually in charge—was she a kind girl?—She was a kind girl; she was a rough class of girl, but she was quite all right; she never interfered with us.

13,793. Did she bring you your meals nicely, and look after your washing, and things of that sort?—Yes.

13,794. If you are in bed you have to have a bed wash and so on—were all these things done quite

21 March, 1925.]

Mrs. M.

[Continued.]

nicely?—Quite nicely; I have nothing to complain of at all

13,795. What about the doctor coming to see you?—Dr. F. saw me at the start.

13,796. While you were in this room did any doctor come to see you?—No, the justice of the peace came. The justice of the peace was a very nice old gentleman; he came into the room and sat down beside me; had a nice little talk with me; asked me how I got in there, and he got up and he refused to sign the certificate. He simply went out of the room saying, "No, no" and shaking his head.

13,797. He did not think you were in a state to be certified?—No.

13,798. What happened next?—I think the people there were rather puzzled what to do about it, and I really think if I had got up and demanded my clothes I could have got out; but I felt quite safe where I was and I did not bother.

13,799. I suppose in your talk with him you had told him of all your experiences and so on?—No. He did not take that attitude at all. I should hardly think he had seen the certificate. He simply talked to me about my life; he was placed exactly as my father was placed.

13,800. Did he know you had wanted to commit suicide?—He did not ask me anything at all about it, but I told him I got into a state of depression and worry.

13,801. *Earl Russell*: Is this Mr. P.?—Yes.

13,802. *Chairman*: You did not tell him you had tried to commit suicide, did you?—This is the way he talked to me. He said "Tell me all about it; how have you got yourself into this state?" I was the youngest of a large family; my mother was dead, and my father asked me not to marry until he died. The war was on, and I was afraid my sweetheart would get killed, so we got married, and my husband wanted a home of his own, he did not want to live with my father.

13,803. So you just talked about family relations?—Yes, and he sympathised with me, because he could see the position I was placed in. I looked after my husband while he was home on leave, and then I went home and looked after my father, so I was serving two masters.

13,804. Apparently, after his talk with you, he was not prepared to write any order in your case?—No.

13,805. But he ultimately did, you know.—Yes, I know he did, about four or five days afterwards, on the 1st November. He saw me on the 28th October.

13,806. And he did not see you again, did he?—No; but before his second visit, Dr. F. came again, and I want to tell you something about this, and I am afraid you will not believe it. I have told you he was rather an old man. When he came and he found that Mr. P. had not signed the certificate, he wagged his pen about, and then he said "What shall I do?" The Relieving Officer was there, so the Relieving Officer said "Sign it," so Dr. F. signed the certificate, and I thought within myself, that is a nice way to sign up a certificate.

13,807. It was the doctor who said "What shall I do?"—Yes. Before Dr. F. had come, the Relieving Officer had come into the room with the wedding ring, and he said "Why did you throw your wedding ring in the fire?" I said "I did not throw it in the fire," and the attendant came forward and she said "No, it was not you; that is the one that has gone to B."

13,808. The mistake was corrected?—It was corrected, but the Relieving Officer said "Oh, it is too late now."

13,809. I should not have thought, if I may say so, that a doctor would have much difficulty in signing a certificate on the facts (apart altogether from the ring) that you had been trying to commit suicide, and so on, and your state of mind as you have described it yourself, which you agree made you suitable for detention for the time being?—Well, what I say is this, that you have got to be convicted of some

crime before you can get into a lunatic asylum and have treatment.

13,810. Surely not; it is not a crime to be ill?—But you have to be convicted of wanting to take your life, let us say.

13,811. You are right to that extent, that it has got to be very clearly established that you are in a state which ought to lead to your protection; but you must not use the language about being convicted of a crime, because there is no more crime in being ill in your mind than there is in being ill in your body?—Supposing I went and knocked at a lunatic asylum door and said "I want to be taken in, I am mad"; they would not have taken me in.

13,812. They cannot, you see. That is one of the very things we are considering; whether, in your type of case, it would not be right that you should be able to go there and say "I want to come here"?—That is one of my points.

13,813. It is a very good point. For the moment, with regard to Dr. F. signing a certificate about your state as he did, you agree it was quite proper it should be signed, and I do not quite understand why he had any difficulty about it?—Only this: Why not have a straightforward business? Why have so many complications? Getting the blame of somebody else's wedding ring, and listening to a doctor taking advice from a relieving officer as to whether he should sign or not. Why could I not have said "Yes, I am mad, take me."

13,814. *Mr. Snell*: It was not your wedding ring that was lost?—No, it was not. We have had a letter from R. and they say that the day the wedding ring was handed over to the Relieving Officer was the same day that Mrs. C. was admitted.

13,815. *Chairman*: That is quite clear—I mean you need not elaborate it, it is quite obvious what must have occurred. But what does seem to me important is that before the doctor signed his certificate, and before the justice of the peace made his order, the attendant who knew what had really happened had come forward and said "This is a mistake"?—Yes.

13,816. Therefore that was not made the ground on which you were certified?—No, but things like that stick in your mind, and you see the injustice of it.

13,817. You rather point out that there is a risk of wrong things being attributed to wrong people than that any wrong was attributed to you?—Yes.

13,818. *Earl Russell*: The doctor did not put it in his certificate?—No.

13,819. *Chairman*: Then the doctor signed and the justice of the peace signed; then, as you know, that authorises a person to be kept under detention?—Yes.

13,820. Did you see the justice of the peace a second time?—Yes.

13,821. What sort of meeting had you with him this time?—He came into the room and shook his head at me, and he said "I have heard some very bad tales about you." He looked very sad and severe; he thought I had been "kidding" him I think before, so I tried to say something, and he picked up the pen and he signed the certificate and off I went.

13,822. The place to which you went was B., was it not?—Yes.

13,823. How long had you been altogether in R.?—Six days.

13,824. So far as the actual treatment in R. infirmary is concerned, I understand you have really nothing much to say against it?—A very good place.

13,825. It is interesting to hear that. How were you taken to B.?—In a taxi.

13,826. Who went with you in the taxi?—The Relieving Officer and the nurse.

13,827. Did you take your own belongings with you—what belongings of yours had you taken with you to R.?—All my own clothing, of course. I took nothing to B.; I went to R. with my father and the Relieving Officer.

21 March, 1925.]

Mrs. M.

[Continued.]

13,828. Did you take a bag with your things?—No.

13,829. Just what you stood up in?—No. They took me to B. in the workhouse clothing. They removed all my clothing and sent it back to my father.

13,830. In R. you were in bed at first. You must have got up?—They kept me in bed all the time.

13,831. But when you got up to go away?—I cannot remember whether they dressed me, or whether they put me in a dressing-gown. I think I must have been in a dressing gown, because they put a lot of blankets round me.

13,832. When you got to B., do you remember what you were dressed in then?—A dressing-gown—a green dressing-gown.

13,833. When you got to B. where did you go—who received you there?—A woman in black clothing and a frilly hat.

13,834. That sounds like a matron?—The head attendant.

13,835. She received you, did she?—Yes.

13,836. And what happened next?—They took me into an empty dormitory, and I had to get on the bed and they stripped me; then the doctor, Dr. D. S. examined me.

13,837. That is a lady doctor?—Yes.

13,838. Was it a thorough examination?—Yes.

13,839. All the usual things that one goes through in these circumstances?—Yes.

13,840. *Earl Russell*: This is a physical examination, not a mental one?—A physical one.

13,841. *Chairman*: Simply to look at the main organs of the body, and generally overhaul?—Yes.

13,842. Was that the first time you met Dr. D. S.?—Yes, the first time.

13,843. And after the general examination what happens next?—You are given a bath, and then put to bed in the middle dormitory. That is a large dormitory with about 12 beds in it and a number of patients sitting about in the dormitory.

13,844. How did that place strike you when you came in?—It was not so bad when I got in, because I got in about 3 o'clock in the afternoon; but when they started putting the patients to bed at night it was very, very terrifying. I was put in a bed right opposite the open door, and there was a patient who was very noisy, and the nurse was putting her to bed, and she was stamping down the ward, and screaming out, "Nurse, nurse, I cannot do it," but of course very loudly; and you could smell draughts. There was a general screaming and moaning and shrieking and noise, slamming of doors, and at last it died down; but by the time it had died down I was in a very excitable state, my brain was simply racing. I did not know what to do with myself to control myself, my brain was on fire, and I was full of energy, and I simply could not stop in bed, so while the nurse was out of the room I got on the bed and got two pillows and did a lot of dumb-bell exercises to get rid of some of the energy. I think I must have frightened some of the patients.

13,845. That is quite an important point. You had just come into this place, and you were in an abnormal state of mind, your brain was racing, and so on, and you found the association with those other cases distressing?—Yes, very exciting.

13,846. And alarming?—Yes.

13,847. How many of the other patients in this ward were of that type? Were there several of that type—violent patients?—Those in bed in the dormitory were mostly lying quietly in bed.

13,848. Did the disturbance come from those that were being put to bed?—Yes.

13,849. Was it putting them to bed that caused the row?—They move them from the side rooms into a padded cell, and to get them from one place to another causes trouble. When they slam the padded cell doors, they are very heavy, and there is a terrible clang as the door shuts.

13,850. Did the rooms open off the ward?—A dormitory opens on to the ward.

13,851. There is a day ward, I suppose?—No, in B. the ward is like a long street.

13,852. A corridor?—A long corridor, yes. In this ward there is a big sitting room just as you get into the corridor on the right hand side; opposite that there is a night dormitory, go straight on, and you pass little side rooms; further on still there is the door of this large dormitory; further on still are the padded cells.

13,853. How many of them were there?—There were three padded cells and about six side rooms; they all had bad cases in them.

13,854. When you were sleeping could you hear anybody who was shouting in any of the side rooms?—You could hear every sound that was in the ward.

13,855. Would you hear specially noises from the side rooms?—Yes, you could hear the noise from the side rooms, and you could hear the patients shouting when they were being given draughts.

13,856. And you found that very disturbing?—Very frightening.

13,857. Would you rather have been taken to some ward where there were no cases except quiet cases?—I would rather have been taken to a part where there were no people in uniform; the sight of these people in uniform frightened me very much, too. When you are in this fiery state the least little thing upsets you, and the white frilly bonnets of the nurses, the blue uniform and the white aprons, and these women walking about in dark dresses, the head attendants, give you a very terrifying feeling.

13,858. You think it was all so official?—Yes.

13,859. *Earl Russell*: More terrifying than seeing nurses in a hospital ward?—When you go into a hospital ward you are not in that state of mind, are you?

Earl Russell: True.

13,860. *Chairman*: That is rather a different question. In every institution, whether it is a school or an asylum or a hospital of any kind, a certain amount of officialism, I am afraid, is inevitable, is it not?—Yes.

13,861. And you must have, I suppose, for nurses some kind of costume?—Yes.

13,862. But it gave you the feeling of being in an institution?—Yes.

13,863. Some people resent that very much more than others; it is a matter of temperament to some extent, but you felt as if you had got into a place where you were in charge of officials?—Yes; I did not know what they were going to do to me.

13,864. So far as your own relations with these officials were concerned, the nurses and the various people in uniform, were they kind to you?—Quite kind; they did not interfere with me at all.

13,865. But you expect a little more than non-interference from nurses; you expect that they will help you or show you some of the kindness which most of us have experienced at the hands of nurses who take an interest in you in any way?—The only way to get on well with the nurses is to avoid them.

13,866. That is a very strong statement?—Not to be noticed by them, keep out of their way.

13,867. For instance, in the morning, did the nurse not ask you how you had slept?—Oh dear, no, they would not dream of such a thing.

13,868. Or if any medicine had been given you, did they not ask you how it had acted, or anything of that sort?—They did not mind in the least how it acted as long as you got it. If they had medicine to give, their one idea was to get it down your throat.

13,869. That is quite a serious matter, because you suggest that the attitude of the nurses was not sympathetic.—They found their amusement among themselves and they looked upon the patients as nuisances. I heard a charge nurse of the ward herself say that B. would not be so bad if it was not for the patients.

21 March, 1925.]

Mrs. M.

[Continued.]

13,870. Then you did not get from the nurses that kind of attention which in an ordinary hospital patients get from the nurses?—Oh dear no; they were far too young, far too inexperienced and untrained.

13,871. So your point is not that they were actively unkind to you, but rather that they did not take an interest in you?—They were not the type of women to deal effectively with mental people.

13,872. You are telling us so admirably about the whole thing, if I may say so, that one may ask you this general question: there are people of different classes, naturally, in these wards?—Yes.

13,873. I can understand that a lady like yourself, well educated, and so on, naturally looks at life a little differently from other people who have not had those advantages. Some people may miss the attention more than you were missing, other people would miss that less. It is very difficult to get an attendant who is able to appreciate the minds of all the different kinds of patients and sympathise with them in the way best suited to each case, is it not?—Well, I do not think that I am of the class that you mention. I was born and brought up in what I call the slums of London, and I have taught in the slums of London, and I know the type of poor class very well, and I have always got on very well with them; so I do not think I was a sort of aristocratic person demanding special attention.

13,874. I am not suggesting that, but it is quite obvious from our interview with you, if I may say so, that you are a woman of education and therefore of sensibilities which one does not find always in every person. I mean people vary so much. Do you think that you perhaps suffered more just because of your greater sensibility?—No, I had not been used to more. I was motherless, and at my father's home he had housekeepers, and these women were just ordinary women.

13,875. Then you evidently got the feeling when you went in there that you were not being cared for?—I was not in the hands of people who knew anything about mental treatment.

13,876. And you were just, if I may put it so, resident in the place?—Yes, and keeping out of danger as much as possible.

13,877. *Mr. Jowitt*: Did it strike you that there were too few nurses—that they really had not got time to go round?—There were about seven nurses in that receiving ward, but they were all very young, and most of them had only been there about three months, except, of course, the head nurses. They were all jolly girls, having games among themselves.

13,878. Not troubling much about the patients—that was your impression really?—Quite.

13,879. *Chairman*: Now apart from the attitude of the nurses, are there any other things that you noticed in this ward which were unpleasant?—Yes.

13,880. I wish you would tell us; please be quite frank about everything. You may say anything you wish. Just tell us anything which struck you as unpleasant in your surroundings?—The very first thing they gave me on the Sunday morning was a dose of salts. I never need such things so I threw it under the bed, but I did not do it when the nurse was looking and they did not know I had done it. Beside my bed there was a commode and it was used by all these bed patients and by the people sitting in the dormitory and that was very unpleasant, the smell was very unpleasant.

13,881. *Earl Russell*: Why was that? Was there not lavatory accommodation adjoining this ward?—A very long way from that dormitory. In order to get to the lavatories the patients would have to be walked through the ward, and they never did it, they simply let them use this commode.

13,882. *Chairman*: During the day?—All day long. What I felt was they could have made a proper lavatory with a pull chain.

13,883. It was a very unpleasant bed?—It was right by the side of my bed.

13,884. *Sir David Drummond*: Was it emptied frequently?—They never emptied it until it was quite full, brimming over, and then it was always a patient who had to empty it, not a nurse. To see it go out was enough, and I thought it was very bad to see it go through the ward with all the patients there.

13,885. *Chairman*: Did the patients in this ward never go to the ordinary lavatory?—No, they were always forced to use the commode.

13,886. *Earl Russell*: Was the commode frequently full, or half-full, when the doctor visited the ward?—The doctor only visited the ward after breakfast and late in the evening.

13,887. He never came at uncertain times?—No, never; he always came just at the regular times.

13,888. And when he came he found this empty?—I could not say. I only know it was so appalling a smell that I had to put my head under the clothes.

13,889. *Chairman*: That seems a most unpleasant thing, if I may so. Was there anything else that struck you as defective in the arrangements?—I thought it was very unpleasant for a patient to have to lie in bed and see nurses kneeling on other women, and forcing china cups in between their teeth and pouring stuff down their throats; it was very frightening.

13,890. Were there many patients being forcibly given medicine?—There was one in each corner; I do not remember any others; but the woman on my right, they used to feed with milk; they simply used to kneel on her and pour it down her throat.

13,891. Of course, forcible feeding under any circumstances is a very unpleasant thing?—Yes, but they might have put a screen round the bed while they were doing it.

13,892. You did not like to see that going on?—No.

13,893. That distressed you also?—Yes.

13,894. You said that the nurses knelt on the patients. What do you mean by that?—One nurse stood at the side, and the other got on the bed over the patient.

13,895. That is a little different from actually kneeling on the patient?—Of course, you could not tell exactly where they were.

13,896. The nurse got on to the bed?—But she was across the patient.

13,897. And what you objected to was seeing these patients forcibly fed in your presence?—Yes.

13,898. About this dose of salts which you got: do you know who had prescribed it for you?—I do not know at all.

13,899. Did the nurse say you were to take it?—The nurse brought it to me and said "Drink this," and then she went away.

13,900. *Mr. Jowitt*: Do they prescribe these aperient medicines without knowing how frequently the bowels have been acting?—I only know they give you a dose of medicine once a week, every Monday morning, without any inquiry at all, every patient.

13,901. *Mr. Snell*: Was this on a Monday morning?—No, this was a Sunday morning, the first morning I was there.

13,902. *Chairman*: Ordinary Epsom salts?—It was a white mixture.

13,903. How did you know it was an aperient?—I just tasted it and I thought it was salts.

13,904. And you were not having any?—I was afraid to take it. I do not habitually use such things.

13,905. If you did not know what it was, it might have been some medicine to quieten your brain. You did not ask the nurse what it was?—No; they just hand you a thing and off they go. She said "Drink this," and went away.

13,906. *Mr. Snell*: Were you in an excited state then?—Not to anyone seeing me. Nobody would have known.

13,907. But there may have been a sedative of some kind in this?—I had not given any trouble at all. When I came into the ward on the Saturday afternoon they sat me down beside a radiator until

21 March, 1925.]

Mrs. M.

[Continued.]

there was a bed vacant; then they put me to bed, and I had not given any trouble at all.

13,908. *Chairman*: But, as Mr. Snell says, it might quite well have been that this medicine that was being given to you might have been a sedative to help to quieten your brain; but you did not know what it was at all?—I had no idea, but I used to have it offered me regularly once a week afterwards.

13,909. *Earl Russell*: And did you take it afterwards?—I never took it.

13,910. And you were never detected?—I used to put it in my mouth, and then go down to the lavatory and let it go down the sink, or else I would throw it away.

13,911. *Chairman*: But where was the lavatory that you used to go to?—The lavatory and the bathroom were quite close together.

13,912. I thought that all the patients used this commode, and did not go to a lavatory?—The commode was for all those dormitory patients, the 12 in bed, and there were many who were sitting in the ward.

13,913. The lavatory was used by the other patients who were up?—Yes.

13,914. Did you go to this other lavatory sometimes?—Not while I was in bed in the dormitory.

13,915. I understand. Was there anything else apart from this commode and the medicine that distressed you?—While I was sitting in the dormitory on my arrival there was a woman named H.; she was in bed and had got most lovely hair falling all over her shoulders; and she was quite lost; and she was calling out for her husband and her child, and the nurses said "Just hark at that beast H.; let us put her in the pads," and they took her out of bed and put her in the padded cell, and put me in that bed. It was very distressing to have this poor woman calling out for her husband and her child, and then to hear her being dragged out and put away somewhere.

13,916. Was she disturbing all the other patients?—Of course she was, but the patients in the beds had only just been admitted, and they were bad, but they were not actively resenting it; they had all got their own little troubles.

13,917. *Mr. Snell*: You suggest that she was removed to this padded room without a doctor's order?—Yes, "Let us put this beast H. in the pads." You do not hear those terms in a general hospital, do you?

13,918. *Chairman*: No, I should hope not. Was this patient, Mrs. H., violent at the time?—No, she was merely sitting up in bed calling out, calling out the names of her husband and child, as though she was puzzled; as though she did not know where they were.

13,919. It would have been quite a good thing to have taken her away to some place by herself (I do not say the way they did it was right) rather than let her disturb the other patients?—I hardly think it was right to put me in a dormitory where I was seeing so much.

13,920. I understand that, but if you are to separate the patients, you must take the ones that are noisy and violent and put them away from the others, must you not?—Yes.

13,921. And this patient was distressing you by her presence?—No, because she was so beautiful, and she was calling out in such a very nice manner; she was not upsetting me; it was not like a maniacal one.

13,922. At the same time, it distressed you emotionally?—It was distressing the nurses more than the patients.

13,923. Is there anything else about the arrangements of the place that struck you as calling for attention?—No, nothing else.

13,924. One point we understand you wished to refer to, and that was the removal of any patients who had died. Was there anything unpleasant about that?—Of course, I did not notice that till I was up.

13,925. That did not occur at this time?—No. I was in bed on the Sunday. I think I had better tell you one thing: I was admitted there on the Saturday; on the Sunday afternoon I was taken to the doctor's dormitory or ward, I think it was a little room, to be examined by the medical superintendent. I want to say something that I am afraid might sound rude.

13,926. Please do not mince matters in the least. —This medical superintendent at the time he examined me was far more mentally ill than I was myself; a fortnight afterwards he had a stroke, and he was away for many months; he only returned in order to finish up his work and resign; and he died a year afterwards. I really think that the medical superintendents and the mental experts of the asylums ought to be examined now and then, just to see in what state they are.

13,927. Now the doctor who examined you was the medical superintendent?—Yes.

13,928. What sort of examination did he make? This is a mental examination to find out what your state of mind is?—I can only say this: he was in a very old brown overcoat; he kept his bowler hat on; he had a little short cigarette in his mouth, and he kept walking in and out of the room muttering "Telephone, telephone." What he said to me I do not know, and I kept thinking who on earth can this man be? He asked me a few questions when he could contain himself and sit down; and then he got up again and muttered "Telephone." Then I was sent back to the dormitory. I quite expect you to think it is my delusion; but the fact that he did have a stroke and that he died, I think, confirms my statement. I may say that they gave me another examination later on, as I think they felt that the first examination was not good enough.

13,929. Who conducted the second examination?—Dr. S.

13,930. I have got in front of me what the medical superintendent wrote that day—that was the 6th November, the day that you were examined by him?—I am afraid that is not quite correct. It was the 2nd November; it was the day after I was admitted.

13,931. *Earl Russell*: On a Sunday?—On a Sunday; but I was seen later on by Dr. S.

13,932. *Chairman*: The original order was made in your case on the 1st of November, and all I have in front of me is the official statement that is made by the medical superintendent of an examination made of you. The date may not perhaps be so very important, but this is what he says about you. He had seen you and examined you, and you showed marked emotional apathy. He also said that you said: "By marrying her husband has deprived her of living a useful life and placed her in a position in which she is unable to use her talent. Is quite content to stop here all her life if we will keep her employed. Admits frequently threatening suicide, but says it was merely an expression of her weariness of her life and that she did not intend to commit the act. She is in fair health and condition." That looks, you know, like a fairly accurate representation of the state of matters, does it not?—I can only say that I am not responsible for what they write down.

13,933. No; but is it not very much what you would have said if you had wanted to describe your own state then?—One of my complaints is that they lead you on to make statements; they take statements away from the context, they put them down on the paper, and you do not know what they have said. They simply sit in front of you writing; they never read it over and say, "I have said this about you. Is it correct?" I think it is unfair.

13,934. But you must remember that all patients are not like you. There are a great many who are quite incapable of taking any interest in their affairs. Your mental ailment was of a different kind, and it had not deprived you of your intelligence. There are a great many patients to whom it would be quite idle to read over any statement?—Quite.

21 March, 1925.]

Mrs. M.

[Continued.]

13,935. The difficulty is to know how far the particular patient you are dealing with is able to appreciate what you are saying?—Yes; but under no circumstances do they ever tell you what they are writing down about you—not even when you are well.

13,936. But one can imagine in some cases it might be unfortunate to tell a patient what the doctor had observed; it might be very upsetting?—Yes, but then it is so upsetting to be put into a lunatic asylum that why worry about little extra upsets?

13,937. *Earl Russell*: But you must remember that our own doctors when we are perfectly sane do not dream of telling us what they write in their case books about us?—No.

13,938. *Chairman*: It is a difficult thing, you know. You said that to be in any asylum is so bad that nothing can make it much worse?—No, you are ruined, are you not?

13,939. That is just the thing we want to try and prevent if we can. I do not know that we ought to tell every patient all that the doctor has said about them. However, you have told us your own experience. Then you remained in this ward for some time, I suppose, in bed?—No; I got up on the Monday. Dr. D. S. allowed me to get up on the Monday. That proves I am wrong. It was Dr. D. S. who examined me on the Sunday. She allowed me to get up on the Monday and go to the needle room; that is where all the best patients are; they do needlework.

13,940. *Earl Russell*: Still sleeping in this observation ward?—I was still in the middle dormitory.

13,941. *Chairman*: Were your nights or your sleep disturbed, when you slept there?—Very disturbed; you simply could not sleep, but at the same time it was very interesting.

13,942. Did you find when you were so upset that it was very distressing to be in a place of that kind with all the noise around you?—If I may speak, taking my whole stay in the asylum, I could speak generally. After I had been about four nights in that middle dormitory, I was removed to the end dormitory, where I was still under observation. There were eight of us in that room, and in that room the noise was simply terrible. I never had a night's sleep; there were patients in there making all sorts of noises, all sorts of swearing, moaning, groaning, having fits, having heart attacks. I used to be disturbed three times in a night sometimes.

13,943. *Earl Russell*: That was supposed to be an improved place?—Yes, it was in an improved place. One woman in the bed opposite to me had the most terrible epileptic fit that it was possible for anybody to have. Another time I was awakened up in the middle of the night and in another bed there was another patient saying "Oh dear, oh dear" in a strangled sort of voice, and I got out of bed and had a look at her. She looked so queer that I went and called the night nurse; the woman in bed was having a very bad heart attack. Another night another woman had another sort of fit. Then another night I was in bed fast asleep and I heard the night nurse call me by name, and I went out into the ward and she was struggling with a patient. She told me she had been struggling with this patient for an hour, and she hoped some of the relieving nurses would have come along and helped her, and she felt her strength gradually going. I helped her to get the patient back in bed. There was an old woman who slept in the bed beside me who was always singing to herself, singing hymns, but she could never lie down; she would sing and go off and fall sideways. I always had to watch in case she went on the floor. You never could get a night's rest in that dormitory at all.

13,944. *Chairman*: Was there a nurse attending to that dormitory at night?—No. There was a night nurse who sat opposite the middle dormitory by the fire, and she used to come round with a bull's eye lantern, I suppose, every hour. Then she would have someone come in and keep her company in the

middle of the night, and then the head night attendant used to come through the ward.

13,945. And does that disturbance at night apply to all the time you were there?—I was in that observation ward for 17½ weeks; I was in that dormitory for a considerable time; the last 4½ months I was in the asylum I helped them every night regularly; the night nurses used to give me a cup of tea every morning for helping them.

13,946. *Earl Russell*: Still in this bad dormitory?—In the bad dormitory for the last 4½ months I was there.

13,947. Was that because they had no better place to move you to, or why?—I think as my story goes on you will hear the reason why I was there.

13,948. *Chairman*: Now I think you might tell us about this incident of removing dead patients, which seems to have impressed you?—There was a large window. Every now and then you would hear a very terrifying whistle blown. When the nurse heard that whistle she had to go outside into the courtyard, walk down a little path and open a wooden door, and then some man, a male attendant, with male patients, would come through with a stretcher and the nurse would let them into the corridor; then the whistle would blow again, and that was the attendants going off with the corpse. The male patients would carry the stretcher on their shoulders. The corpse would be simply lightly covered over; sometimes there would be two on it, and you could see them wobbling; that was taking the bodies to the mortuary. This whistle made you all look; you simply went to the window and looked out. I used at first to bury my head in my hand, but I got quite used to it.

13,949. Did it happen often?—Almost every day. There were about 2,000 patients in that asylum, and I was there all through the winter.

13,950. *Mrs. Mathew*: How many nurses were there in the ward?—In that ward there were seven nurses.

13,951. *Chairman*: Of course, they would not all be on duty at the same time?—I think so; it was the receiving ward, and there were about 60 patients.

13,952. Now there is another matter you might tell us a little about. What about the bathing arrangements?—Of course they were very bad. We had to line up in a queue directly after dinner and have our bath, and the bath room would be crowded with people either drying themselves or waiting to get in and have their turn in the bath.

13,953. Was there a bath every day?—No, once a week.

13,954. All on the same day?—All in that ward. The old women, and the bed cases, were all bathed before breakfast, and the walking patients were bathed after two o'clock.

13,955. Were none of the bed patients bathed in the beds?—I never saw them.

13,956. Was the only all-over wash once a week?—Once a week, yes.

13,957. *Earl Russell*: How many would there be in this queue all together?—Directly dinner was over the charge nurse would call out: "Ladies for the bath," and we would all have to line up.

13,958. How many would that come to?—I suppose there would be 40.

13,959. *Mr. Jowitt*: Is that a hip bath or a long bath?—A long bath; but I have heard there have been an extra number of baths added since.

13,960. *Chairman*: Was that at the other end of the ward?—You had to go straight on past the dormitory, past the padded cells, and then you turned into a little sort of room.

13,961. Was there any accommodation for undressing and dressing again?—None at all; you simply dropped your clothes in the ward—that is, the corridor.

13,962. *Earl Russell*: What did you go to the bath in?—Nothing.

21 March, 1925.]

Mrs. M.

[Continued.]

13,963. Not even a towel?—They allowed five towels for the whole of the 40. The first five would get a towel and be able to put it round them, and the rest would have to go on as they were. Some of the patients used to get an old nightdress and put it round them.

13,964. Do you mean you were all stark naked in the file?—A lot would undo their clothing and wait until the last moment, drop it off and then make a run for it.

13,965. *Chairman*: Was any order preserved? With two baths and 40 or 50 people waiting for them, I should think it is rather a difficult thing to manage.—And a very tiny bathroom, too; it was a big crush.

13,966. *Sir David Drummond*: Did they use the same water?—No, they always emptied it and gave each patient fresh water. There were two nurses in charge.

13,967. *Earl Russell*: Did the women object to going about in this way?—The women did not think about it.

13,968. Why—because they did not mind?—You had to do what you were told, and if you made a fuss then you had a paraldehyde draught—you were not so well.

13,969. You had to sink your modesty at the risk of a black draught?—Yes.

13,970. *Mr. Snell*: Is your memory right, do you think, about the same towels being used for patients who had infectious diseases?—I have had a talk with the charge nurse of that ward and she agrees with me on the matter.

13,971. That is to say, you feel your memory is quite right on that point?—I feel that when I say there was no clothing, we all wore the same clothing and all that sort of thing—

13,972. I am talking about towels?—I think I am quite correct, because I discussed it with the charge nurse, and she agreed.

13,973. *Earl Russell*: Apart from dirt, you said there were only five towels, and by the time they had been used over and over again I suppose they would be wet?—They call them bath sheets; it is just the size of an ordinary bath towel; it was not made of fluffy material; it was more like sheeting. I always tried to be one of the first five so that I had a dry towel. If you were not one of the first five you had a very wet towel to dry yourself with; in fact, you could not get dry.

13,974. *Chairman*: Just to turn aside from that for a moment, what clothes had you at this time?—No clothing except what the asylum provided.

13,975. What sort of clothing was that?—The clothing was very good; it was very warm, but you could not wear it without looking a lunatic. For instance, on the first Sunday I was allowed to go to church I had thick heavy boots, pale blue stockings, a very thick stuff dress, a shawl such as you see in the side streets of London, and a straw hat; and they sent me back because I had got no ribbon round my hat; they would not let me go to church.

13,976. You suggest that it makes you look rather a figure of fun?—Yes.

13,977. *Mrs. Mathew*: How about your hair?—You were never allowed hairpins, so it made it very difficult. You had to do your hair up in two plaits and fix it across your head; plait one plait into the other.

13,978. Was that the rule?—Yes; no hairpins were allowed at all.

13,979. What about hair brushes?—I never saw such a thing. I did see one, but then you would not dream of using one brush that was used by 40 other patients.

13,980. So you used none at all?—No. I had a comb of my own.

13,981. *Sir Ernest Hiley*: Did you never have a hair brush all the time you were there?—Never, all the time I was there.

13,982. *Mr. Micklem*: Were you what is called a private patient?—My husband paid whatever they

asked him. He has told me that he was charged a guinea each time the doctor looked at me, and he had to pay £5 for the taxi that took me to B., but I am still a pauper lunatic.

13,983. Was he paying so much a week?—So much a month.

13,984. *Earl Russell*: He had to pay for your being taken to the asylum?—He had to pay £5 for the taxi that took me to the asylum.

13,985. *Mr. Micklem*: And then he had to pay every month so much?—Yes. It started at a reasonable figure, and then went up.

13,986. *Chairman*: Had you a toothbrush?—Not till I asked for one.

13,987. Did you get one then?—I got one then, yes.

13,988. On the question of clothes, the clothes evidently were not a uniform—very far from being a uniform?—Why?

13,989. Because they were mixed garments of all kinds. I mean there was not one regular uniform for all the patients?—No.

13,990. They were miscellaneous clothes?—Yes.

13,991. Did you just take your chance of what you got?—When you went to bed at night you had to take your clothes off, fold them up in a heap, and leave them outside the dormitory door. Your underclothing went to wash once a week, and you were simply dealt out underclothing.

13,992. *Earl Russell*: Outside your dormitory door; you mean you never left them near your bed?—No.

13,993. You undressed at your bed, took the whole lot out, and put them at the door?—You laid them in a pile at the bottom of the bed, and the nurse took them out for you in some cases; if not, you took them out yourself.

13,994. *Chairman*: Are you quite sure you got your own clothes back in the morning?—Yes, otherwise the patients would have made a big fuss.

13,995. The description of the costume you have given us strikes me as very odd. Why should they provide pale blue stockings?—Yes, that is just it.

13,996. Did you ever ask for any of the small comforts to which no doubt you are accustomed—I mean tooth-powder or anything for the toilet?—No, I never asked for anything. You were glad if you were allowed to live, let alone anything of that sort.

13,997. Did you feel that you must not ask for things, and so on?—Oh, yes.

13,998. That was the impression you got from the atmosphere of the place?—I got the impression that the quieter you kept, the better.

13,999. *Earl Russell*: What about pocket handkerchiefs?—I never saw any.

14,000. What did you do if you wanted to blow your nose?—For one thing, they never got colds there; I never had a cold the whole time I was there.

14,001. Even if you had not a cold, you sometimes have to blow your nose. You say there were no pocket handkerchiefs?—I never heard of a handkerchief; I do not ever remember such a thing.

14,002. *Sir Ernest Hiley*: The whole twelve months you were there you never had a handkerchief?—I cannot remember one. You never had a pocket unless you made one yourself and tied it on; there were no pockets in your dress.

14,003. *Chairman*: Had you no little personal treasures that you kept to yourself?—No, they never allowed you to keep anything. If you had any parcels or any food it had to be put in the storeroom, and then it was often taken by other people. There were only two little shelves where patients could put their belongings, and the charge nurse used to go and clear those out and burn all the things; and the patients used to grumble about it very terribly.

14,004. Supposing you had had something sent to you by your husband; suppose he had sent you a cake or some fruit, had you no place where you could keep it?—Nowhere at all.

14,005. You would have had to give it to the nurse?—Yes.

21 March, 1925.]

Mrs. M.

[Continued.]

14,006. If you did, would she keep it for you and see that you got it?—She would put it on the shelf, and the nurses' pet would help herself to it.

14,007. Who was the "nurses' pet"?—She was a patient, and she was a very strong girl; she used to help the nurses. She was not very much liked by the nurse in charge, but the other nurses used, to like her very much, because she was so strong and powerful and could help them; she was only a young girl about 16, and a very fat girl; she used to have all the powers of a nurse. If she saw a patient with anything she wanted, she would simply swoop down on the patient and snatch it away. I have often gone past the store-room door and have seen her helping herself there. Whenever I had a parcel I used to share it out at once so that she could not get it.

14,008. Would not it have been an advantage if you had had some little place beside your bed where you could keep things?—There ought to be some lockers, I think, in the ward, and each patient allowed a locker with a little key, where she could keep her own little treasures.

14,009. *Earl Russell*: We have heard of an asylum where they have cupboards with glass doors in the wards.—That would only be in a very good ward, because glass attracts some people and they break it.

14,010. *Chairman*: And even then I suppose if some patients had a key they might try to swallow it?—They might; but you would not give a locker to a patient like that.

14,011. A great deal depends upon the state of the patients. I was in an institution some time ago where they told me that some of the patients were so trusted that the staff did not even open their parcels. That all depends upon their experience of the patient. In your case, for example, would it have been a comfort to you if you had had some place in which you could have kept your personal things?—Yes, such as letters; all my husband's letters were flung in the fire one day; I very much resented that.

14,012. *Earl Russell*: And you must remember that there are other patients who might steal things from patients who had lockers?—Yes.

14,013. *Sir David Drummond*: You were not compelled to wash in the bath, were you?—You had to step into the bath, and the nurse soaped your head and rubbed your head, and then she poured the bath water over your head, and then you got out.

14,014. *Earl Russell*: Did you not take a piece of soap in your hands?—She did not give much time for that; she just washed your head.

14,015. *Mr. Snell*: It was a case of walking in and walking out?—Yes.

14,016. *Chairman*: When you came out, if you were lucky you got a dry towel; if not, a wet one; and you say those towels were used by all the patients?—Yes.

14,017. *Mr. Jowitt*: What was the morning wash like?—That was very bad, too; there were about four little wash bowls. There was certainly hot and cold water, and you just sluiced your face.

14,018. That was in the same place where the bath was?—Yes.

14,019. *Chairman*: Did you get soap then?—No.

14,020. *Mr. Jowitt*: Did you have your clothes on as a rule when you went there?—You just washed your face and hands, and you could not do that very thoroughly, because there were so many patients waiting to be washed.

14,021. *Earl Russell*: You could not even wash your neck, if you had your clothes on?—No; you had all your clothes on.

14,022. *Chairman*: Were some of the patients who were sharing these bathing arrangements with you suffering from disease?—Yes.

14,023. Could you see that yourself?—Yes; a woman named M. and another named W.

14,024. Were they suffering from unpleasant diseases?—They were.

14,025. Could you see it?—I did not see those two, because in that ward I was always one of the last

to be bathed. I only saw a patient with it when I was in the infirmary ward, and I was taken out of bed to be bathed, and the patient who had that disease was in the bath and was shrivelling with being exposed; then I saw all the black spots on her body with red inflammation round them.

14,026. With regard to the towels that were used, can you tell us whether the towel that was used to dry that patient was used for other patients?—I could not tell you anything about it.

14,027. *Earl Russell*: Did they allow you sanitary towels when required?—No, never.

14,028. *Chairman*: Did you have to take a bath at these times just as at other times?—Yes. I may say that I believe there were some sanitary towels in the ward, but they were never given out to the patients, and I really never knew about them till I was just going home.

14,029. Did you ever ask for them?—I was told they were not there when I first got there; you could not have them at all; the point being, I suppose, that some patients would have strangled themselves with them. Every night before you went to bed they used to take away your hair tape, garters, and false teeth, and then the nurse used to call out for glass eyes and wooden legs; that was her humour. They used to take those things away because, I suppose, at some time somebody had done something.

14,030. It is a difficulty really, because some of the patients would require very strict supervision; others could be trusted more?—Yes.

14,031. *Earl Russell*: False teeth are very dangerous things, even to sane people?—Yes.

14,032. *Chairman*: I should really infer, from what you have been telling us, that there should be more classification amongst the patients, and those who, like yourself and others in the same condition, could have been trusted up to a point should have had more consideration. The strict measures you have spoken of may be very necessary in some cases?—Yes.

14,033. What you are saying rather indicates that there should be more individual consideration of the case, more study of the case, and classification of the case?—Yes.

14,034. And that the privileges and rights and so on should be graded to meet the different cases?—Yes.

14,035. *Mr. Micklem*: When you were in this observation ward during all these weeks, were you examined at all by a doctor?—I was seen by Dr. D. S. on the Sunday. Then according to that, I must have been seen the following Sunday by the medical superintendent. My husband was away at sea when I was put away, and he got leave and he came home. He went and saw the relieving officer, but the relieving officer told him it was no good going to B., as they would not allow him to see me, but I think he communicated with B., and as a result Dr. S. was put to examine me. But this is what I rather object to—I had been working in the needle room all the morning; someone put their hand on my shoulder and beckoned me into a room where there was a tall man in grey. They do not tell you who it is or what is wanted. They simply begin talking to you, and then you are sent out, and you do not know any more, why it is or what has happened. This doctor asked me questions really about my husband.

14,036. Was that the only time you were examined?—I did not see anyone else.

14,037. Did not the doctors visit the observation ward every day?—Yes, morning and evening.

14,038. On those occasions when they came in the morning and evening would not you speak to them, or would not they speak to you?—No; they would simply walk along with the head nurse, talking to her.

14,039. You do not mean that they just came into the ward and passed through it, do you?—That is all they did. If they happened to pass a patient

21 March, 1925.]

Mrs. M.

[Continued.]

quite near they would say "Good morning" to her, but if you were out of the way they did not run after you.

14,040. *Chairman*: Did the doctors not take any special notice of a patient unless the nurse drew attention to her?—They only took special notice of bed cases.

14,041. I suppose if the nurse had said, "This patient had a seizure in the night" the doctor would pay attention to that case; he relied on the nurse?—Yes.

14,042. And such a case would, I suppose, be attended to by the doctor?—Yes, I suppose so.

14,043. But if nothing happened, and just the ordinary routine was going on, he merely said "Good morning"?—Simply "Good morning"; but he did not take the trouble to find out if he was saying "Good morning" to everybody.

14,044. *Earl Russell*: Were there many bed sores among the women patients?—No, they are very well looked after.

14,045. *Chairman*: Did you say you were examined by a Dr. S.?—Yes.

14,046. How long was that after you were there?—I should say about three weeks after.

14,047. We find a good many notes about your case?—Yes, by Dr. D. S. at first.

14,048. These notes must have been made after seeing you, so that Dr. D. S. must from time to time have had a talk with you?—That is right. I think you are seen by her in a room each month until the third month.

14,049. There are quite a number of notes about your case at short intervals during this time, obviously from observation of you?—Yes.

14,050. Now you had quite a lot of visits, I notice?—Yes.

14,051. Have you any complaint to make about the visits, the admission of your relatives or friends?—Yes; my father used to be kept waiting.

14,052. I see you really had a tremendous lot of visits. You had 73 visits paid to you by your friends and relatives, and 13 people came to you at different times?—Yes. I have got a brother; he is my youngest brother; he is married; he was very much upset when I was put into B., and he fought very hard for me to get me out all the time I was in there. If he had been allowed to do it at first, he would have been my worst enemy; but eventually he really saved me from lifelong imprisonment in B.

14,053. But the fact that you had so many visits as 73 in less than a year suggests to me that your friends and relatives could come and see you pretty freely?—This brother of mine organised the visits; he knew all my own friends and relatives, and he used to write to them and say, "Now will you go on such and such a Sunday?" He booked them all up, so I was never left a week without a visitor; and he arranged that every one of them wrote to me on a certain day of the week, so that on every day of the week I had letters.

14,054. So that you were kept very well in touch with the outside world?—By this brother, yes.

14,055. I do not think you can really complain that you were being shut out from the world so far as your friends and relatives were concerned?—This is the point; when those people had visited me, and I wrote thanking them for their visit, or if I wrote to my friends at all, the letters were interfered with; they were either totally suppressed or else they were sent to my father. My father had just retired; he was at H., so the letters used to be sent from B. to my father's London address, they would be forwarded to H., and then sent on. That caused great delay. Then my father wrote and complained about it. He said he did not want the letters sent to him. I have Dr. D. S.'s reply to that. Then she used to send the letters to my husband, half to my husband and half to my father.

One letter I wrote in B. to Wapping went to Constantinople, then it went to London, then it went to H., and then at last reached my friend in Wapping.

14,056. What sort of letters were you writing at this time?—After I had been in the asylum for 17½ weeks my brain had quite righted itself. I knew I had control of my brain and was quite all right. I felt if only I could go away to the seaside for a couple of months I would be completely recovered. So when I made a request to Dr. D. S. and said, "I now feel quite better, and would like to go home," she merely looked at me. I waited a little while, and did not hear anything. So I wrote a letter and asked why I was being detained. I again said I felt quite well, and should like to go home. No notice was taken of that letter. I did not know what to do to occupy myself, but I had thought a lot about the asylum. I wrote a letter to my brother, and I said that that week there had been ten fresh cases brought in, and nine of them were returned cases. I said, "There are patients in this asylum who have been here 10, 20, 30 or 40 years. Does not it seem a pity to keep them so long in one place? Would it not be better to send them to another asylum after five years? Perhaps the change would be beneficial." I wrote that letter thinking it was a letter of helpful criticism, and that Dr. D. S. would send for me and ask me for my views on the subject. Instead of that, I was sent to a refractory ward. I told my brother when he came and saw me. He complained to Dr. D. S. The next morning she came to the refractory ward and said, "How dare you tell your brother you have been placed in a refractory ward? It is the best ward in the building. It has plaster walls." I said, "What about the plaster walls? We are not allowed to make a cup of tea in this ward; we are not allowed to go out of the ward. We have got the worst courtyard; and look at the patients around me." She simply said, "You are a liar," and walked on.

14,057. Did you not get on very well with Dr. D. S.?—Up to that moment I had got on quite well with her, but it was the letter of criticism: instead of taking it in a generous spirit and wanting to know about it, she took it in the wrong way.

14,058. Was that the first time you had been sent to the refractory ward?—The first time. I had been in the receiving ward.

14,059. Had you complained to your father, brother, or husband of the treatment you had been getting in any way?—Not up to then.

14,060. Do you remember when this was?—About the end of February, 1920.

14,061. That is rather interesting, because we have here a letter from your father to Dr. D. S. written at that time. You do not mind my referring to it?—Certainly not.

14,062. He says, "Letter for Lieutenant M."—that is your husband—"received with thanks. You were very good to stop its transmission, because I am sure he would have been very much upset at its contents." What does that mean?—I can tell you what that means. I knew I had recovered. When I was put into B. Asylum I felt it was the end of my life as it had been run. We had married, and had been very, very happy. Then this trouble had come, and when I got into the asylum my husband would never have dreamt of taking any word of mine. He would always have gone to the doctors to have asked the doctors their opinion of me. He believes in constituted authority. He would not have dreamt of questioning me about the place. If I had said anything, he would have looked upon it as a delusion. I got very angry with him, because I knew I was better, and I had asked him to take me out. I do not know whether he had been to see me, but I had asked him to take me out, and he said, "You are quite all right. You are going on all right." I could never get an answer, and I

21 March, 1925.]

Mrs. M.

[Continued.]

got rather angry. I thought that when I came out he would have his own opinions of me; he would never believe that I was sane. I wrote to the Admiralty—I would not do such a thing now—and I said I was going to separate from my husband, and I wanted them to make him make me an allowance.

14,063. Your father was probably very wise not to send that on?—Quite; I am very glad he did not.

14,064. *Earl Russell*: Were you on good terms with your husband before you went in?—Quite.

14,065. And are you since you came out?—Absolutely.

14,066. *Chairman*: It is only fair to say this. In this letter to Dr. D. S. your father goes on, “Mrs. M. speaks very highly of your care.” Had you been telling your father that Dr. D. S. had shown care and devotion to your needs?—I had had no complaint whatever to make about Dr. D. S. up to then.

14,067. Your father is writing to Dr. D. S., and it rather suggests that you had been saying to your father, when he had been visiting you, that Dr. D. S. had been giving you great care and devotion?—Yes, but you will see another letter farther on.

14,068. At this stage this was true, was it?—I think he would write that sort of thing to anybody. For instance, when I was a school teacher he would go up and see the headmistress and say, “She is very fond of you.”

14,069. He was a bit of a diplomatist, perhaps, was he?—Yes.

14,070. But you know your brother also writes?—Which brother?

14,071. A.?—Yes.

14,072. Is he the brother who organised the visits?—Yes.

14,073. This brother writes also to Dr. D. S.: “Dear Madam, My sister, Mrs. M., speaks so highly of you that I feel I must write and thank you for all the kindness you have shown to her whilst under your care; it takes a great load off me to know that you take such an interest in her, and I do hope that the time will soon come when you will recommend her discharge.” There is your brother writing to Dr. D. S. saying that you have been speaking highly of the kindness shown to you?—I think that was diplomacy as well.

Mr. Snell: Were these letters before this incident?

14,074. *Chairman*: I think they were. This was in February. (*To the witness*): One must of course hold the balance, as you can understand, in this investigation?—Yes.

14,075. It looks to me rather, both from your father's and brother's letters at this time, that you had been actually complimenting Dr. D. S. on her care for you?—Yes.

14,076. That letter is rather different from what you have been suggesting, namely, that you had been neglected—I mean neglected by the doctor?—You ought to have my father and brother here and ask them exactly what I have said.

14,077. That is a fair observation, if I may say so. This is all we have in front of us?—I say that she behaved like one lady to another up to that time.

14,078. But you want more than that. Did she behave as a doctor to a patient—which is another relationship altogether?—Or as a mental expert to an insane person?

14,079. If you please?—I can only say she walked through the ward, and she was civil. She had got these Girl Guides, which I thought was a very good movement, and she had me to drill the Girl Guides; she let me be one of them, really. She asked me to give them a lecture on the Union Jack, so that they could get some little badge which they get—the “Tenderfoot,” it is called. I had helped her with these Girl Guides a lot; I had nothing whatever to complain about. If I had been allowed to go home when I asked, I should have no more to complain about than any woman who goes into a general hospital, and who, although she may have a minor illness herself, has to see a lot of very dreadful cases.

14,080. That is very fairly put. Now let us pick up the story in February. You had written these criticisms, and you say that Dr. D. S. did not like her place being criticised?—No; she had been there so long.

14,081. Was there no other reason at all why you were sent to this refractory ward?—I had put criticisms into a lot of letters, about the bathing and so on, and I generally put these criticisms into the form of a poem.

14,082. *Mrs. Mathew*: Do you remember when you were sent to this refractory ward—at what date?—No; I can only say it was about the 24th February; I should think.

14,083. *Mr. Micklem*: I suppose your brother did not keep the letter? You have not got the letter that you wrote then, have you?—It never got out of the asylum then.

14,084. *Chairman*: There are quite a number of people, you know, who think that poets ought to be punished?—Yes.

14,085. *Mr. Micklem*: How do you know that the letter did not get out of the asylum?—Because my brother kept every letter from me, and he has not got that one.

14,086. *Chairman*: You do not happen to have any letter that you wrote at this time, do you?—I have crowds of letters that I wrote when I was in the asylum; my brother kept them all, and when I got out of the asylum I asked him for them.

14,087. Have you any here?—Yes, I have a lot here.

14,088. Have you any written about this time—in February?—I will see if I can find them.

14,089. *Mr. Jowitt*: These were sent by you to your brother?—Yes, these got out, but they went a round-about way; they were often three weeks before they reached my father.

14,090. *Mrs. Mathew*: Did they open your letters to your father?—Yes, and those to my husband as well. You had to write your letter, put it in an envelope, leave the envelope open, and then the charge nurse came and sat amongst you and then she simply undid all the letters and read them all through. Any letters with criticisms in them she put on one side, and gave to the doctor, and the doctor interviewed you about them.

14,091. *Earl Russell*: She read them there and then, did she?—Then and there in front of all the patients.

14,092. Did she ever make complaints to you about what had been said in the letters?—No; only one letter in which I criticised the bathing; I saw her taking it round to all the other nurses and showing it to them, and I heard one nurse say to her, “So you have sealed it up?” and she said, “Yes, I have sealed it up and sent it.” Here are some of the letters I wrote at the time—(*handing in the same*).

14,093. *Chairman*: I am rather interested in this. You wrote your letters, they were read by the nurses, and then those which contained any criticism or complaint were put on one side and handed to the doctor?—You had to appear before the doctor the next morning, and she criticised it.

14,094. That is rather important, because it shows that if any patient is making a complaint it is brought to the notice of the doctor, and that is desirable, of course?—Is it? Not for the patient! The head attendant said to me, “What good do you think you are doing by making all these complaints? Every one you make puts you back months.”

14,095. That of course depends upon whether the complaints are truthful or not. I could imagine a person making all kinds of complaints which had no foundation at all, which would be an indication that that person's mind was distraught?—The food was very, very bad; there was no delusion about the food. The soup consisted of warm water. There was bully beef on Monday, and the suet pudding they gave you was so hard you could not get your teeth in it. Their meat was boiled in water; you rarely ever

21 March, 1925.]

Mrs. M.

[Continued.]

got a cut from the joint, and then it was so cold and so hard you could neither cut it nor bite it. On one occasion I sewed my Sunday dinner to a piece of paper, put the potato peelings in an envelope, and sent it home.

14,096. *Earl Russell*: Did it get home?—I was interviewed by the doctor.

14,097. *Sir David Drummond*: Was your general health good all the time you were there?—My physical health was quite good.

14,098. You never suffered from colds?—No.

14,099. You never had sore throats?—They said I did on one occasion.

14,100. Do you mean you had not?—I do not know exactly what was supposed to be the matter with me at the time, but we will come to that later.

14,101. *Chairman*: You seem to have increased in weight?—Yes. I was very much run down when I got into the asylum.

14,102. You made a considerable gain during this time?—What about the parcels and the visitors?

14,103. They may have helped. You said that you had written a letter criticising the methods and saying that patients should be removed to other institutions from time to time?—Yes, I think those were the main things.

14,104. What was the nature of the ward you were moved into—the refractory ward?—The women patients were human tigresses; that is all you could call them. They were very strong women physically. They were kind-hearted, very generous, but at the same time they were wild; they had been shut up for many years, nearly all of them. It was really an unusual thing for anybody to be sent to M.8 ward. They were not insane. I can say now that nine out of every ten of those women ought to have been in their own homes, but they were women whose own friends and relatives had neglected them, and that had made them very, very vicious. They were women who had got spirit, and they would not be crushed. There was one nurse in charge of them, and she got on with them very well, but if she was away and there was some other nurse on, that nurse had a very bad time of it, because she told them to do the work and they refused to do it. They were also very insulting to Dr. D. S. I am afraid she rather enjoyed their insults, because she had power to detain them there.

14,105. *Earl Russell*: When you speak of human tigresses, they are not the sort of people one would wish to let loose upon the world at large?—You cannot keep adult human beings in confinement. You cannot take adult animals and put them in any zoo and expect them to thrive. They will knock themselves against the bars. You cannot take human beings and shut them up like that. They are put to bed every night at seven.

14,106. When you say they are tigresses, it is due to their indignation at being shut up?—Yes. Every privilege that it was possible to give a patient was stopped. You were never allowed to make a cup of tea in that ward, and that is a great privilege when you live on asylum tea.

14,107. *Mrs. Mathew*: You got your tea in parcels, I suppose?—Yes.

14,108. *Chairman*: You would require to get a teapot and cup for yourself?—I never had my own teapot, but somebody used to lend me one; some people had teapots and no tea.

14,109. *Mr. Mickle*: When you had these visitors seeing you, where did they see you?—On the whole, down in the visiting hall, and I was usually searched before I was allowed to go down there.

14,110. Were you taken down by one of the nurses?—Yes.

14,111. Would you see your visitors quietly and privately?—Quite all right—except when we come to later on.

14,112. *Chairman*: By this time, in February, you felt you had regained your control and you wanted to get back to the world again?—I did.

14,113-14. You were seeing, about this time, relatives of yours—seeing your brother and your father and your friends, and so on. Did you tell them that you were now feeling much better?—Yes, I told them all; but that is the trouble. Once I was a lunatic they would never believe me, except my one brother, but the more I complained to my father the more he thought I was suffering from delusions. He had been taking people himself to county asylums for many years, and to private asylums, as a relieving officer. He would believe anything of a private asylum, but he thought county asylums were the best places on earth. He had simply taken patients to the entrance hall of the asylum, and thought he knew all that went on in the wards; and I really think he felt his dignity insulted when I complained about the things that went on in the ward. He said, "Do not you think I know about these places?"

14,115. You think he had the official mind, if I may so put it?—He had the official mind.

14,116. Your brother took a different view about it?—He believed me.

14,117. And your friends and relatives, seeing you, would have a chance of judging of your state, and I suppose you had quite sensible talks with them?—Yes.

14,118. Did they then proceed to make any effort to get you restored to them?—I do not know what efforts my father, my husband, and my eldest brother made at all, because they did not confide in me, but I know my brother A. continually wrote; he simply made himself a nuisance to them.

14,119. *Earl Russell*: You say they did not confide in you. You have been out some time now. Have you not asked your husband about what efforts he did make?—My husband has asked me to let it be a sealed book; he will not let me speak about it.

14,120. *Chairman*: Your brother A. was doing his best to get you out?—Yes.

14,121. In consequence of the letters he wrote, were you not interviewed by the medical superintendent or anybody?—He was away ill.

14,122. Then the doctor in charge?—Dr. S., never. He used to come through the wards on a Sunday morning while the medical superintendent was ill, but he was a very fine-looking, tall man, and you would not have gone up and spoken to him. He simply walked through.

14,123. But in your case you were obviously recovering, and your relatives—your brother, was drawing the attention of the authorities of this place to the fact that you were a case that ought to be considered for discharge. Do you mean to say that no step was taken by any person in that institution to have you examined, in view of that representation that had been made?—I feel that any effort my brother A. made was of no avail, because my father was the petitioner.

14,124. Your father really had taken you there?—Yes.

14,125. And there were cross-purposes in the family: one saying "She ought to be there" and the other saying "She ought not to be there"?—Quite.

14,126. The two views cancelled each other in the minds of the doctors, I suppose?—Yes.

14,127. But in point of fact you were not specially examined in consequence of your brother's representations?—No.

14,128. Now were you taken to this refractory ward entirely in consequence of your writing a letter of complaint? Can you not think of anything else that brought it about?—I know of nothing else that could have caused it, but it happened the very day the doctor got the letter.

14,129. How long were you there?—I was only there about 2½ weeks.

14,130. What did you do while you were there; did any incidents happen?—No. There was nothing whatever to do, but the ward was in a very dirty state because these women refused to do work. They said if they could work there they could work in their

21 March, 1925.]

Mrs. M.

[Continued.]

own homes. I am rather fond of housework. I cleaned up the bath taps and polished the floors. I was so afraid of the women I was amongst, that I was glad to do something so that I did not have to look at them.

14,131. Where did you sleep?—There was a dormitory there, and there was absolutely no light in it; it was February, and it was pitch dark when we went to bed. We had to undress in the corridor and put our clothes in a pile on a chair, and then walk quite naked into the bedroom, get our nightdresses, and then get into bed; it was pitch dark, and very, very cold. There were seven other women in that ward. There was one woman swearing terribly; there was a woman talking to herself; and after we were locked in, with no nurse, a woman kept getting out of bed and I could hear her in the darkness pushing her bed across the floor. That was very terrifying. My hair went white that night. I have a white patch on my hair. When my brother came to see me, he said "Whatever is the matter with your hair"?"

14,132. Do you mean to say the place was locked up at night with these violent patients in it and no nurse in charge?—No nurse in charge. They came round during the night—two of them. They shut the door, and it bolted on the outside. I always wondered what would happen if a fire occurred.

14,133. Or if one of the patients had started assaulting another, what would have happened?—I leave it to your imagination. There was one woman taken ill in the middle of the night, she had to use the chamber, and the stench was simply awful, and of course it was never removed till the morning.

14,134. Do the nurses not come round at intervals?—They would not interfere with a thing like that. They have to get over their ground; they could not stop to do anything of that sort.

14,135. *Earl Russell*: Was there no bell for ringing for a nurse if one were wanted?—I do not know of any, and I did not know of any at the time.

14,136. *Chairman*: Perhaps you may be a little wrong in your dates, because the record we have shows that you were removed to this refractory ward on the 25th March?—That is a later one; there is another refractory ward. I do not think Dr. D. S. recognised this ward as a refractory ward.

14,137. You have described it as that?—But it was a refractory ward, all the same. She always declared it was not a refractory ward.

14,138. It is only fair just to tell you this from the other point of view. On the 23rd March there is an entry about you that you were noisy, singing, calling out, and very defiant?—That is later on, Sir.

14,139. Later than February?—Yes, later than that.

14,140. On the 23rd March you were very defiant, and announced you were going to break every rule possible. Do you remember that?—We are in the M.8 ward now. That is the refractory ward that Dr. D. S. says is not a refractory ward. I was there 2½ weeks. I continued writing letters of criticism because I felt that her attitude towards me was a very unjust one, and the fact that she resented the criticisms did not mean that the criticisms were wrong; it meant she was wrong. I continued writing these letters. After 2½ weeks I was removed to the infirmary ward, and was put in a side room of it at the end of the infirmary ward. I do not know why I was put in there, but I thought at the time they imagined I was going to have some infectious complaint, because the nurse was told that no patient was to go near me, I was not to speak to any patient, I was not to be allowed to write, and was only to have a book to read, so I thought I was going to be ill.

14,141. How long were you in this infirmary ward?—I was in that ward, I suppose, for another two weeks.

14,142. We have got into March by this time?—Yes.

14,143. What happened in March? Because it seems that in March your conduct was violent?—In

connection with that infirmary ward I am going to tell you something that is rather startling. A woman in October of 1919 had been lying asleep on the floor of the padded cell. She had been given a draught. This is the woman I said I was going to tell you about who was in the corner bed when I was in R. Infirmary. She was taken to the infirmary ward, she was given a draught, and she fell asleep, and while she was lying asleep on the floor of the padded cell, rats came in and ate her face. The report of the inquest is in the "E. Chronicle" for February 6th. She did not die till three months afterwards. While I was in my little side room in the infirmary ward I heard rats creeping around the wainscoting. My eldest brother had been to see me, and had brought me a lot of food, which I suppose had attracted them. I told the nurse I could hear rats. Later on, when she put the bull's-eye lantern on, of course one could not hear them, but when it was dark I heard them. I felt I did not want to stop there and have my face eaten; so I picked up my mattress, went out of the side room, put it across the corridor, and went to sleep there. The nurse in charge came along and ordered me back into the room. I said I was comfortable where I was; the doctor was sent for, and I was taken back to the receiving ward. I have had to compress all that in my *précis*. Dr. D. S. was very annoyed with me, and with another thing as well. She had ordered me not to write—

14,144. Did you explain to the doctor that you were taking your bed out into the corridor because you were annoyed by the rats?—Of course I told her; I told the nurse; everybody knew why I did it.

14,145. Were the rats not annoying the other patients, as well as you?—They were very bad patients; they were dying patients in the infirmary; nobody was ever put into the infirmary ward unless they were on the point of death.

14,146. I should not imagine it was desirable for people on the point of death to hear rats, either?—They would not be likely to complain.

14,147. Did you go back into the ward?—No; they took me to the receiving ward and put me in a side room. The asylum was very full up. There was a patient there named C. She was a clergyman's sister and a doctor's cousin, and very much fancied herself. She thought she always had this side room because her people paid so much money for her. They took her out of that side room to put me in it. I still thought I was going to have an infectious complaint. The nurse was told that no patients were to go near me or to speak to me. This patient came into the room the next day, and she found me in her bed, and ordered me out of it. I said: "I do not want your bed; you can have it," so she got into bed with me with her clothes and boots on. She was a maniacal woman; sometimes she was very nice and sometimes she was the other way. The charge nurse came in and was much annoyed, got hold of her, flung her out of it, made her yell, said something to me, and then went away again. I do not know what the cause of it was, but I heard I was going to be sent to M.5. That is the worst ward in the building. I was sent to M.5 on the 23rd March.

14,148. What was the difference between it and the other ward?—That was the ward where there were ever so many padded cells, and the patients were the worst patients in the county. They were terrible; they shrieked, they swore, and they moaned. Just before I got there, the nurse told me two of the patients had gone into the scullery and had completely cleared the dresser of every bit of china. The food I had to eat out of a pewter cup and a pewter plate.

14,149. Do you think it may be true that before you were taken to this M.5. ward you had been noisy and singing and calling out?—Quite true, and I will tell you why. I knew M.5 was the ward that was only spoken about in whispers. You heard the most terrible tales of what went on in M.5. Do you think

21 March, 1925.]

Mrs. M.

[Continued.]

I wanted to go to a ward like that? When I knew I was going to be sent to such a place I thought: "I will do something to be worthy of it." I thought: "If I am going to be hanged, I might as well be hanged for a sheep as a lamb." So I thought of all these songs that had been coming into my head and sang them at the top of my voice.

14,150. Do you remember whether you wrote a letter in blood to your husband at that time?—Yes, I did. While I was in the infirmary ward they refused to allow me to write. They took away all my note paper, pencils, and everything else. So just to show them that if a person really sets her mind to do a thing she can do it, I wrote a letter in blood with the end of my tooth brush.

14,151. Now tell us what happened in the refractory ward?—I was placed in the inside room again. First of all, when I got to the refractory ward there was a little short nurse. I was taken down there with my hair hanging down my back, and I was in a dressing gown. She clutched hold of it and swung it off. As she swung it off she said: "This is the finishing off school. You come in here on your feet, and you go out on a stretcher." She said: "You are going to sit on the form all the afternoon." She dressed me up, although I had been in bed without any clothes for a considerable time. She took me down to the dormitory, and I cannot imagine anywhere out of hell a worse place. She sat me down on a chair right in front of an open door. I said: "Do you know I have been in bed for a fortnight?" She said: "Them's my orders." Just behind me there was this woman C., who had been in R. She kept getting up, catching hold of her chair, and slamming it down. I thought it was coming on my head. We were both sitting near a radiator, which had a padlock and a chain on it. She got hold of that and rattled it. Over in the other corner there was the most awful creature I have ever seen in my life. She was a living skeleton. All the bed-clothes had come off her, and you could see every bone in her body. The charge nurse said: "Go and fetch her medicine." They covered her up, and the nurses poured the draught down her throat. Then a little nurse covered the poor creature completely over with a quilt and all the bed-clothes, and held them down. She twisted it into a knot and held it down, and I could see the poor thing struggling under the clothes, and gradually she went down and down, and I suppose she went off into a deep sleep. There were patients calling out, shouting, and moaning. There I stopped.

14,152. Had it not occurred to you that if you were feeling more controlled at this time, and wanted to get out, it was a very bad way to go about it, to shout and sing and say you would break all the rules?—I never said such a thing. I never made a threat all the time I was in there.

14,153. *Mr. Snell*: But you did break the rules?—I acted. I did not threaten.

14,154. *Chairman*: But do not you think it was a very unwise way to go about things?—But I was in for it, was I not? I was going to M.5.

14,155. I do not know that it was the wisest thing to do?—It was not wise, but I was absolutely at their mercy.

14,156. *Mr. Micklem*: I want to ask you one question about M.8. Have you not forgotten? Was not M.8. a little improvement upon the original observation ward?—After you got used to it, it was an improvement, because they were all patients of one kind. When you were in the receiving ward you had the very bad padded cell cases, while in M.8. there was not a single padded cell case. They were women who had downed tools and refused to work; women who had complained about anything were all in there. Later on I was put in F.4, which was supposed to be the best ward in the building, but in that ward they were women whose temperaments I did not like at all. I did get on very well with the M.8. people, and I would have preferred to have stayed with them for ever.

14,157. Many of the M.8. people you thought were not insane at all?—I am certain of it. I have got one of them in my own home at the present moment.

14,158. *Sir David Drummond*: I should like to know if you had any experience of dentists visiting this institution?—Dr. S. was the dentist. Dr. S. took out teeth.

14,159. *Chairman*: There was no regular dentist?—No.

14,160. Was there any dentist's chair?—No; just an ordinary chair. I had a tooth out.

14,161. No dentists coming from outside?—No.

14,162. What happened to you in the refractory ward, in M.5?—They had been disinfecting this end cell, and when evening came I was taken in there and put into bed. I fitted exactly into a shape that was in the mattress. Some woman had evidently been lying on that mattress for months and months, and had worn a complete grave in it, and I just fitted into it; I was rather afraid a dead body had been in there, and that I was going to be another one.

14,163. What did you do?—Actually the woman had had scabies, and that is why they were disinfecting the cell. There I was for 25 days. I was not allowed to write a single letter. When letters came to me, a nurse brought them to me, waited while I read them, and took them away, and when I had a visitor the nurse sat at the door and listened. They allowed me a book to read, and that was all. I was never taken out, except to be bathed once a week. Then I said to Dr. D. S.: "I do not agree I am so ill that I have to stop in bed. I want other advice." She said, "I am the mental expert for the women." There came a day when I felt "I cannot stay here any longer." 25 days is a long time. I wanted a change. Every night and morning there was the smell of these draughts coming under the door, nearly choking me, and the noise night and morning was simply awful, when they were giving the patients the draughts. I thought to myself: "What shall I do? If I tell my brother, they will take no notice of any letter he sends. I had better act for myself." One day I asked every official who came into the room, the nurse, the head attendant, the charge nurse, Dr. D. S., the matron, the head night attendant and the ordinary night attendant; I said: "I want to see the acting medical superintendent," and the last two—they were two fat, jolly old girls—gave the door a slam and they said: "You will see the medical superintendent!" I knew it was absolutely useless to ask any of the officials, because no official would dare to tell the medical superintendent I wanted to see him. There was no medical superintendent at the time. Dr. S. was acting medical superintendent. There I was, locked in for the night, and it looked as though I was going to be locked in for ever. Then I took the mattress and everything off the bed and turned the bed up on end, and I pushed it into the corner between the door and the window. The window was shuttered. I got on the top of the mattress and flung the loop round the bedstead and hoisted myself up to the top of the bedstead, in my nightdress, and I stood there. There is a little ventilator over the door, and I put my fingers through there. Before I called out for the nurse, I thought: "They are sure to pull me down by my nightdress," so I took the nightdress off and tied it round my neck by the sleeves, so I was covered up. Somebody tried to pull me down by the nightdress. They gave a good old tug, and away it went. I held on to the ventilator and I called out "Nurse, nurse." The night nurse came to the door and she opened the door and said, "Oh my God!" she fell back. She called for some other people, and five of them came in. They stood there and tried to persuade me to come down. They said: "Come down. You shall see the acting medical superintendent." I said, "I have rung that bell all day, and I have asked you to let me see the medical superintendent." I said, "You have not told him, so I am going to stop here till he comes." I think they fetched every nurse in the

21 March, 1925.]

Mrs. M.

[Continued.]

asylum. They fetched Dr. D. S., Dr. J., and a young man who was there learning; he was the only man there; there was a whole crowd of them begging of me to come down, but I stood up there and I thought I would convert the lot of them. I kept on telling them why I was in the asylum and how long I had been in the asylum. I said, "If I had been taken to prison for attempted suicide I should only have been detained for a month at most."

14,164. Did you say all this while you were holding on to the ventilator?—I was standing on the bed. I had a platform, really, but it was pitch dark.

14,165. *Mr. Snell*: During the 25 days you were in bed there, were you being treated for any physical illness; were they giving you medicine?—I think I had a tonic; I cannot be sure whether the tonic came then or after.

14,166. *Sir Ernest Hiley*: Did you never see Dr. S. all that time?—I never saw Dr. S. all the time; only Dr. D. S. night and morning.

14,167. *Chairman*: How did the scene end?—They fetched the kitchen table, and five of them got on the kitchen table, but their heads were only up to my feet and they could not do anything. Then Dr. D. S. was calling out "Fetch the firemen." But the young doctor got hold of the bed and gave it a good shake, and I nearly fell off the top of the bed. I was flung off the top of the bed and left swinging. Then they were calling out: "Catch her; catch her." I said: "I will surrender to Dr. D. S.; she is my enemy." I was thrown into her arms. I was put in the padded cell. They put a nurse at the door, and every two hours they changed her. The next morning the order came through to put me in the dormitory. The padded cell was right opposite the dormitory, and a nurse had to stand at the door watching me.

14,168. What happened next?—I was in this dormitory, and it was very interesting to be in that dormitory, because there were so many peculiar cases there. There was a woman on my left who never stopped talking; she did not want an audience. One of her remarks was: "Beauty is only skin deep, but my ugliness goes to the bone." I had never heard that before. There was a woman on the other side, and she was making all sorts of extraordinary noises; she could not speak—

14,169. I think we may take it that there were odd cases there. How long were you in that place?—I was in there, I think, about four days. Now I must tell you this. My brother came to see me. The morning that I was put in the dormitory, Dr. S. came to see me.

14,170. You did see the acting medical superintendent at last?—Yes, he came after this scene. He asked me everything, and I was in a very excited condition, because it does not do you any good to go climbing bedsteads. I was very very angry at the treatment I was receiving. I did not think it was fair. You ought to be able to make a request and have that request granted, not to be continually refused. I simply raved at Dr. S.

14,171. After the four days there, where did you go next?—I was visited on the Sunday while I was in that dormitory, but my visitors were never allowed to come into the dormitory; they were taken into a quiet ward. I was got up and dressed, and taken into that ward. My brother and his wife sat on a little sofa, and the nurse squeezed herself in between them; she had a note-book and pencil in her hand. I was put in a chair right opposite facing the three of them.

14,172. *Earl Russell*: Was it usual for other patients to have a nurse with them when they saw visitors?—No; it was most unusual. She had a note-book and pencil, and she told me she had to report everything I said to the charge nurse.

14,173. *Chairman*: What happened next?—Right opposite this room was a padded cell, and in that padded cell was a girl—R. P. She had been turned out of her bed so that I could have it. She was in the

padded cell, and she used to come to the dormitory door, saying: "They said they wanted the bed for a worse patient than I am. She is not worse than I am"—and she would not go back into the padded cell. The nurse gave her a paraldehyde draught, and she was better for a while. She gave her another, and you could hear the struggling. When night came she began screaming, and she screamed for three days and three nights, and never left off. It was the most awful screaming you ever heard in your life. Dr. S. came to see me every day while I was in the dormitory, and I asked him to listen to the screaming. I said: "Is it part of my cure to lie here and listen to that noise?" He simply took no notice. He said: "You are not so well this morning." Dr. D. S. came in, and I said: "Put the girl in another ward, or put me in the padded cell, and let her have my bed." But they never took any notice at all. After three days and three nights of it I simply could not stand it any longer. I said: "I cannot stand that noise; it is driving me crazy." I said: "Do do something. Get the girl away into another ward, or get me away." No notice was taken. When the night nurse came on duty, she said it was nothing to do with me. So I simply went to the commode; took the top off it; it was broken in two halves; each half was like a hatchet; and I smashed four windows.

14,174. And?—And I was removed and put in a special cell, with a little glass panel; I was put on a mattress on the floor; there were mice holes all round the floor; the room simply stunk of stale cheese and mice; and the shutter was kept shut all day and all night. The frame of the bed was put into the room during the day, but it was removed during the night, and I slept on the floor.

14,175. *Earl Russell*: On a mattress?—On a mattress.

14,176. *Chairman*: I think your father came to see you there?—Yes; and he was kept waiting. They put a chair beside the bed for the visitor and a chair at the door for the nurse to sit down. I knew a visitor was coming. I could hear them running the bad ones away; two nurses would take a patient, and then run her off. My father complained that he was kept waiting. Before he was allowed in, they opened the shutter; they tidied me up and made everything look nice; but I think I must have begun to look rather bad, because he took no notice of what I said. I told him to write and complain to Dr. S., and when he got home he did do so.

14,177. I see that something was done immediately after that?—Yes.

14,178. *Earl Russell*: All this time you never wrote to the Commissioners?—I never knew about the Commissioners. Later on I did hear a rumour that there were Commissioners, and I wrote to Dr. E. and asked for the address of the Commissioners.

14,179. *Mr. Micklem*: There was no notice up in the ward about the Commissioners?—Not a word; nobody ever knew a word about the Commissioners.

14,180. *Chairman*: Your father was now convinced that something should be done. He wrote to the acting medical superintendent, and did that bring about immediately a better state of affairs?—Absolutely. Dr. D. S. came into the room, and said something to the nurse, and they brought along a wheel chair and wheeled me all through the corridors to the verandah, and it was very nice indeed.

14,181. *Mr. Snell*: You were weak at this time, were you?—I daresay I could have walked, but they never gave me an opportunity to do so.

14,182. *Earl Russell*: What aged woman was Dr. D. S.?—It is difficult to say. She had been there 25 years.

14,183. *Chairman*: You were taken to the verandah, and that was much nicer?—Lovely.

14,184. *Earl Russell*: I think you were kept in the infirmary ward?—Dr. S. visited me when I arrived there, and he wrote a very untrue letter, which I have in my possession, to my father. In my opinion he should have told my father the truth about what

21 March, 1925.]

Mrs. M.

[Continued.]

had happened. Instead of that, he put all the blame on me, and did not blame his colleague, Dr. D. S.

14,185. *Chairman*: Have you got that letter?—Yes. I think it was simply medical etiquette would not allow him to blame his colleague.

14,186. *Mr. Mathew*: Do I understand that there were no letter boxes in the ward?—No letter box at all. This is the letter (*handing in the same*).

14,187. *Chairman*: After that stage, things got better, and you were ultimately discharged?—No. I was sent to a very good ward; but I did not want to stop even in the best ward of a lunatic asylum; so I wrote a letter to the Committee; and Dr. D. S. brought me back the envelope that I had sent the letter in, and said: "What good do you think you are doing yourself by writing these letters?" "Well," I said, "it ought to do me some good," and a long argument followed. I was sent back to the verandah again, and put into bed; I was kept in bed for a fortnight, and by that time my brother had written to Dr. E., and Dr. E. answered the letter, which I have got. Dr. E. sent for me and had a very long interview with me. He asked me questions in front of Dr. D. S., and I named the different nurses. It he had really wanted an honest enquiry into it, he could simply have sent for those nurses and found whether what I was saying was true or not. He never sent for a single nurse. He listened to all I said, and at the end of it he said: "Mrs. M., is that all you have got to complain of?" I said: "Yes." He said: "Let bygones be bygones." Then off he went; that was the end of it. Then after that I was simply at Dr. D. S.'s mercy. I was sent away from the verandah; I was sent back to the observation ward. I never had a moment's peace. I had patients hanging on to me all day long; and I was twice murderously assaulted before breakfast by bad patients. It was enough to drive anybody raving mad to be there.

14,188. I think you were there for about four months?—Yes.

14,189. How did you ultimately get discharged?—I had been continually writing letters to the Com-

mittee, but never had an acknowledgment. Then one day Dr. E., who had been newly appointed, came to the ward with two gentlemen; I did not know who they were. I, of course, ran up to them and I spoke to one of them. I said to Dr. E. first of all, "Can I speak to this gentleman?" and he said "Yes." This gentleman happened to be Mr. F. I told him all about my case, and he said he would look into it. I gave him my brother's address, and he said he would find out if my story was true. I waited another six weeks, and then my brother wrote and said: "No gentleman has been to our house." As a result of the letter I wrote to the Chairman of the Committee, I obtained my release; I have it here.

14,190. There are other matters to which you refer in your *précis*, but I think we have got from you a very detailed account of your stay in this institution. I do not think we should detain you longer, because this afternoon we shall be having more evidence from other people. I think you have given us a pretty full outline of your case, have you not?—Yes.

14,191. Then I think we shall not detain you any longer. We can only thank you for coming and assisting us; it has been interesting to listen to your story.—I should like to say that within the last 8 months I have been doing a lot of work among other patients in other asylums, and I have visited 9 different lunatic asylums, and I have got most interesting cases in each of those asylums. These patients are always asking me to do something for them, and I have told them that, if possible, I will tell you about them. I should like you to give me an opportunity of putting their cases before you.

14,192. I am afraid we cannot go into those individual cases, because our duty is rather a larger one; but we are always quite pleased to read accounts of cases which are illustrative of the general problem. If you have got anything of that sort that you would like to send us afterwards, I will look at anything you send; but we cannot, of course, extend your oral evidence any further.—Thank you.

(The Witness withdrew.)

(After a short adjournment.)

Mr. P. called and examined.

14,193. *Chairman*: We have asked you to come here this afternoon, Mr. P., to tell us a little about your experiences, and we may perhaps get a few facts from you generally first of all. I think you are an engineer?—That is so.

14,194. And you are now 56 years of age?—That is right.

14,195. And you were for a number of years with the old South Western Railway, in charge of hydraulic machinery?—That is so.

14,196. And then for a time you were with the S. Borough Council, also in charge of the same type of machinery?—That is so.

14,197. I think for many years you have interested yourself in political matters, and were active in connection with your trade?—Yes.

14,198. We will just take, as a start, the plain facts of the situation. You were, I think, in C. Mental Hospital for 13 years nearly, from the 10th July, 1910, to the 12th April, 1923?—That is correct.

14,199. You were discharged in April, 1923, "Recovered"?—That is right.

14,200. I think the most useful thing that you could do, would be yourself to suggest the points which you would like us to know in your own experiences. Just tell us the things that you experienced during those years which you would like us to hear about?—May I gather from that that you wish simply to deal with my experience in the asylum, or my opinion as to the procedure in connection with lunacy certification?

14,201. One would like first of all to hear about your own experience and we would be very glad to have any hints or suggestions arising out of that experience, the points where you think things want improving. Just tell us, first of all, the experiences and then the lessons that may be drawn from those experiences?—In the first place, if we begin at the commencement, I may say that my own case I suppose is typical of a great many others. I was in a very bad state of mental breakdown, and was not told where I was likely to finish up. Of course, you understand I was paid for by the rates, simply what they call a pauper lunatic; and the relieving officer came with two rough men to the house where I was living, and they did not tell me of course that they had anything to do with my mental state; they simply put up a pretext of getting me away by telling me that there was a breakdown with my plant, and that the borough engineer had sent for me. I did not think there was much likelihood of that taking place, but, at any rate, I said I did not feel disposed to go. They then seized me and dragged me down the stairs. At the time I was disabled through an accident, my shoulder was dislocated, and, as a matter of fact, I was taken away without a coat on, simply in my shirt sleeves.

14,202. Where were you living?—At C.; I was the householder.

14,203. Were you alone?—No, my wife was there.

14,204. And your family also?—I have no family.

21 March, 1925.]

Mr. P.

[Continued.]

14,205. You said you had a bad mental breakdown; do you remember any of your symptoms at that time?—I remember everything.

14,206. What was the nature of the mental breakdown?—In the first place, I may tell you, I have rather burnt the candle at both ends; I tried to do too much. I was working during the day time and occupied the whole of my evenings in social and political work. I was assisting Mr. S. for the County Council election. That was in the March and I broke down in April. For years I had thought I could do with very little sleep; I used to do with four or five hours of a night for 15 or 16 years. I was always warned that I should have a breakdown, but I took no notice of it. Finally insomnia set in, and that was the first trouble with me; I could not sleep at all. I began then to worry about anything, work, finance, and everything connected with my whole mind, and from that I got worse and worse, and finally I went to the surveyor whom I was under and told him I should have to give the job up. He persuaded me to take a holiday, in fact, I do not mind saying now candidly that he paid for a trip to B.—he thought it would do me good. As a matter of fact, my experience made me worse; I got no sleep the whole of the time I was there; I came back worse. I tried to recommence work, had this accident, and finished up in St. Thomas's Hospital. I may say that there was some iota of truth in what were put down as delusions. I had the idea that I should never work again, for the reason that my spine was fractured, and this right shoulder dislocated; as a matter of fact, it is dislocated at the present day. If you gave me £1,000 I could not put that hand round on the left side; still I manage to do my work. At that time I had the idea that I should never work again, and I told the medical man that I never should work, I thought. From that I began to worry. I could not sleep; I was restless; and I know I generally upset the home; and I suppose the wife got in touch with the relieving officer, and they took me to the infirmary.

14,207. Looking back on it all now, you might tell me this—do you mean you were a proper person to be taken to an asylum then, or do you not?—Under the existing law, perhaps I was; but not under what I should consider proper conditions. Under the present conditions in all probability there was no other alternative but to take me there. The specialist came down and he expressly wished my wife to send me to a private home, but my financial position would not allow it.

14,208. Would you have been willing to go to a place voluntarily, if it had been possible, for a time?—Undoubtedly I should, because I knew I was a nuisance at home.

14,209. The ordinary public mental hospital cannot take voluntary borders?—No.

14,210. You have told us how it came about that you were removed by the relieving officer—will you just pick up the story at that point?—Yes. On my way, of course, I remember everything that took place, I knew I was not going towards my work, and I made a remark to that effect; then I was told I was going to see another doctor. I was taken to St. J. infirmary. There I spent two days amidst the most horrible surroundings, for the simple reason there was noise and filth of all descriptions, and I may say I had not an hour's sleep the two nights I was there. On the Saturday, without any information or anything, I was taken to a room. I know now,—I did not think at the time it was,—but undoubtedly it was before the Chairman of the Board of Guardians, a justice of the peace, and I was asked two or three questions there, quite preliminary questions, from a brief which he had in front of him. I was not told even then where I was going to, but in the afternoon I was rigged out in an old guy's suit, it was not fit for a scarecrow, and taken straight away in the conveyance. I did not know where I was going; I knew I was going towards C., because

I knew the tramways and so forth; and I finished up in C. Asylum.

14,211. You had seen the doctor—did the doctor discuss the case with you at all?—At the infirmary?

14,212. Yes, the doctor who certified?—One or two simple questions. There I told him the same as I have told you; I made a statement to him, and that was included in the note of my case, that I thought I never should work again. I know I also had what you call delusions, that there would be a great deal of trouble if I did not get back to my job. There, again, if I had been allowed to explain the position, they would have seen there was some ground for even those ideas.

14,213. They may have been exaggerated ideas?—Undoubtedly. My job with the Borough Council was a rather peculiar one. I do not know, but I suppose you are acquainted with the fact that the Board of Trade do not allow steam boilers to be under arches over which trains travel, but for a great number of years that Borough Council has had the opportunity of having steam boilers underneath the arches over which railway lines run.

14,214. I do not know that we should really go into the details of this matter; it is enough that you tell us this, that you had some apprehensions in your mind as to what would happen if you were away from your job?—That wants a little amplification. I do not want it to be thought I was absolutely silly in my ideas, but the point was this, that I had with me an unskilled man, a stoker, and I knew that the man was carrying on my work, and in the event of his being negligent and not keeping water to its proper level in the boiler, there may have been a boiler explosion; I was worrying about that. There is a reasonable thought that, with unskilled labour taking the place of skilled labour, it may possibly cause a lot of trouble. You understand what the position would be if the arch was blown up when a train was passing—what a disaster there would be.

14,215. I quite understand that. What you are really telling us is that the facts on which you were certified had some basis?—Yes.

14,216. The doctor said in his certificate that he saw you were irresponsible and apathetic, "not caring what happens to him. He tells me also that although feeling physically well he has given up work because he has taken a violent dislike to it. Further tells me that this will bring him into serious trouble with his employers, that his absence will cost them millions and bring about a terrible disaster that will affect the whole country. He fails to realise the absurdity of his statements and conduct." That is all we are told about you?—Exactly.

14,217. You say you were anxious and worried about what would happen when you were not at your work?—Exactly.

14,218. Had you also put it in this exaggerated form?—Undoubtedly I did.

14,219. Therefore your view is this, that while you had some occasion for being worried, you were really upset at this time; and under the then existing system there was no alternative but to send you to a mental hospital, and you accepted that position?—Exactly.

14,220. Will you tell us about your experiences at C.? What things struck you in the life there which were unfortunate or distressing, which you would like to see improved?—In the first place, upon arriving there a patient goes into what they call the receiving ward. Take my own particular case, a person suffering from insomnia; you are simply put into the receiving ward with about 40 or 50 cases of all various descriptions; there is no classification from the commencement; whatever your trouble may be, you simply go *holus bolus* into one common dormitory to sleep at night time. In the first place, you understand the receiving ward and observation ward are never left night or day without attendants. The night dormitory is patrolled by the night attendant; every half-hour he has to go from one end of the dormitory to the other where there is a clock

21 March, 1925.]

Mr. P.

[Continued.]

arrangement in which he has specially to clock each time, and he has a lantern with him. You can understand what it must be to a man suffering from loss of sleep, without all the other disturbing influences. This was my first night's experience there. The night attendant, if he is a careful man, a judicious man, will take pains to make his round as quiet as possible; on the other hand, if you have a man who is naturally careless he will blunder round, he does not care whether he knocks against your bed or disturbs you in other ways, and he will flash his light right on the top of you. In addition to that, as I say, there are various cases you are mixed up with, epileptics, noisy cases, quarrelsome cases, people that have all kinds of delusions and shout out in their sleep, and even when they are awake, and so forth; so you realise how much chance there is for someone suffering from insomnia in a place of that description.

14,221. Did you find it very distressing?—I did indeed.

14,222. I suppose that would be mitigated to a considerable extent if you had a better classification of patients?—Exactly.

14,223. It means more accommodation, of course?—Not necessarily.

14,224. Do you think with the existing accommodation and better classification you could get an improvement?—Quite so, as I have had experience myself.

14,225. *Earl Russell*: Were you by any chance noisy yourself when you went in?—No.

14,226. *Chairman*: No one has ever suggested that Mr. P. was noisy?—I was simply going to say that (under what will come out perhaps later on) I had something like 11 years out of the 12½, roughly speaking, in one of these observation wards. I had no opportunity of going to any other ward. Then, at the finish, I went into another ward, what is called an open ward; there I improved wonderfully in the short time I was there, I knew the marked effect of it. There was no night man in the open ward; the door is locked on you, and there is no night watchman, and the light is turned down. In the observation ward the light is never turned down.

14,227. These open wards are the wards, I suppose, where the patients, who it has been found can be trusted, are allowed to sleep under normal conditions?—Not altogether normal conditions—nearly normal.

14,228. *Mr. Micklem*: Did you say you were 10 years in the observation ward?—I was.

14,229. *Mr. Snell*: Under observation the whole of the time?—Under observation night and day.

14,230. *Chairman*: Were you in the same dormitory?—Not exactly the same; I was moved twice, but I was always in the observation ward. My grave objection, of course, really to the present state of affairs is the power that is placed in the hands of junior medical men when it should rest in the hands of the superintendent. In my case I have proof that the doctor made a wrong diagnosis of my case, and for that I had to suffer.

14,231. *Sir David Drummond*: Were you supposed to be suicidal at all?—I understand by the papers I have seen since my discharge that I was put down as suicidal; but, as a matter of fact, I will ask you whether you think it is possible for me to be so, seeing that all suicidal cases are on what they call the red ticket, that is to say, if they go out for exercise into the court the attendant always goes with them. I was never treated like that, and therefore I do not see how I could be classed as suicidal, with the exception that I said many times, I said so to the first attendant, that I wished I was dead, and that I would much rather be dead than living under the circumstances under which I was living.

14,232. *Chairman*: I think we must get this accurate. There are two kinds of observation in an asylum: there is, first of all, what one may call the preliminary stage; that lasts for a certain time until the patients are allocated to a particular ward. When you say you were ten years in the observation ward

do you not rather mean this, that because of the diagnosis of your case you were kept for ten years under observation—which is rather a different thing?—You may put it that way.

14,233. The observation which you were subjected to for these 10 years was not for the purpose of diagnosing your case. It was observation thought to be necessary because of the character of your ailment?—I waive that point if you like, but the application of the term is exactly the same in all cases.

14,234. Of course, if a case really were a suicidal case, it would have to be kept under observation, though it was there for 20 or 30 years?—Not at all, Sir. In this open ward I knew of an entirely suicidal case who had a definite exhibition of his case round his throat. He was a hairdresser by trade, and although he did not enter the institution until some time after me, when I went into the open ward, I met him in the open ward, he had been there for some years. He was a suicidal case.

14,235. Had he not recovered by that time?—If he was recovered, why was he retained there?

14,236. He may have got over the suicidal stage.—His duty has been for years to cut the medical officers' hair and shave them, and also the patients, and yet he is not out at liberty; so I leave that to the Commission.

14,237. I think, if I may say so, the most important point you have made just now is this, that in a case like yours, a person suffering from worry and breakdown, it is very inadvisable that they should be subjected to noise and distraction in a ward with patients of a different type altogether. You would advocate, would you not, that there should be much more classification, and much more individual attention?—Exactly. That is not only applying to admission but right away through.

14,238. That is classification. What is the next point you would like to draw our attention to?—Certainly in connection with the dormitory life I should like to see a vast alteration in the cleansing arrangements.

14,239. We would like to hear about that. What are your experiences?—In the first place, I may tell you that in the ward I was in the normal figures were about 44 patients; during the war they went up on account of their being limited for space; that was on account of war hospitals being required for war patients, and drafting other patients into existing institutions; so that our numbers went up to 60. In the lavatory there were three basins for washing purposes, for the whole of the 44 or 45 or 60 patients; we had three roller towels. I may say these got very small after the war; before the war they were certainly a little larger than afterwards, but they were cut down. For the war time there used to be two or three hand towels laid out, but afterwards there were three roller towels. I leave it to anyone as to whether or not that is sufficient for a person who has any feeling of cleanliness or decency,—to think he has got to be the 45th patient to wipe on one of those towels, especially as patients get up in the middle of the night and use them for purposes for which they were not meant.

14,240. Did you find that some patients were suffering from diseases?—Yes.

14,241. Were they using the same towels as you were?—There was an order that they should be supplied with separate towels, but this was not adhered to. I know myself of patients having complained of having used the same towels as patients having scabies. There was one watercloset in the dormitory for these 45 patients.

14,242. A single closet?—One single closet. During the night following what they call a medicine day, you can just imagine what the position was like. Not only on the medicine days, but on days when there has been an epidemic of diarrhoea, I have seen those hand-basins simply reeking with filth; every chamber in the place has been brought out, they have been overflowing with filth, and the hand basins have been filled.

21 March, 1925.]

Mr. P.

[Continued.]

14,243. *Earl Russell*: Does nobody ever clean these things?—As a matter of fact, they cannot do so; the place where they wash is kept locked during the night time. The night attendant is there; he could, if he liked, have it altered; but he is simply human, and they try to make the job as easy as they can for themselves. But, as I say, in the day room there is more closet accommodation, but very little; there are two instead of one, but there is one always locked up for the use of the attendants. There are two closets for 45 men, and one kept solely for the use of about half a dozen attendants.

14,244. Was the night one always open; could the patients go there when they wished to during the night?—It was not locked; the door was locked in the dormitory.

14,245. What I was thinking of was this, whether the patient who wanted to use the closet at night could do so?—Certainly, if there was not an epidemic on. You can understand the position if a dozen men were rushing at one time.

14,246. In the day time there were two closets in the day ward?—Yes.

14,247. Were they locked?—No.

14,248. Could you go at any time if you wanted?—At C. you could; it is not so in all asylums.

14,249. At C. could any man wanting to use the closet use it at any time he wanted?—Yes.

14,250. Was there sufficient paper provided?—None whatever. There was nominally supposed to be some kept in the scullery. A patient was always there on duty for washing up, and sometimes he would have a stock of paper, and if patients liked to go in there and ask for it, they could get some there. There was paper supplied by the authority, but I am afraid it was commandeered for other purposes.

14,251. By whom?—By people who wanted to write notes, and so forth. The patients are taken up to draw their stores nominally in charge of an attendant; if they get a chance of getting this paper for scribbling purposes they will do it, and as a result the ordinary patients get none. If they had paper it was supplied by the good nature of the scullery man, who was a patient himself.

14,252. Then it is pretty obvious that it would have to be issued to the patients every time they wanted to go to the closet?—Is it not in our public lavatories in and about London?

14,253. *Chairman*: What about the baths?—In this particular ward that I was in for so long, what was known as C.1 Ward in C., there were two baths, and I was informed by the attendants that the time allowed for bathing 44 patients was 1½ hours. If you come to divide that time up for two baths, it does not allow half an hour for each patient. Nominally we were told 3 minutes was the recognised time for bathing.

14,254. Was the water changed between each patient?—It was supposed to be.

14,255. Do you know whether it was or not?—I know it was not oftentimes. It was in my own case, because I would not get into it otherwise; but many times I have seen four patients go into the same water.

14,256. What about the towels?—There was one towel for each individual.

14,257. So that was better?—That was better in that way.

14,258. Have you any complaint about the decency of the arrangements?—Of course there was no privacy at all, none whatever. If it was a bleak cold day, you were, first of all, turned into the open dormitory and told to strip. All the windows were thrown open for airing the dormitory; you had to undress there, throw your clothes on one of the beds before they were remade, and simply go from there and wait your turn. Of course that is applying to this particular ward. In the other one, what they call the general bathing room, that would be where two wards were bathing at the same time, there might be half a dozen baths there—of course there are more patients, and one or two

extra attendants. There is no privacy. As a matter of fact, I felt that very keenly myself. I have seen men who have been very badly ruptured, old men in a shocking state, having to unrobe in front of boys practically; it does not matter what age they are; all ages down to 16 and 17, and there is no privacy whatever.

14,259. Now on that point have you any suggestion to make. Would it not be desirable to have some kind of curtained cubicles or boxes in which the patients could undress privately and get into the bath?—Undoubtedly it would be far better, but there again the question of expense comes up.

14,260. It has been done for women, of course. Do you think men would appreciate the provision of some kind of arrangement such as I have spoken of?—I have not a shadow of doubt some of them would; I do not say everyone would; there is a kind of mixed company in those places.

14,261. It is more important to see that you get a reasonable time for a bath, and get a clean towel for it?—Exactly.

14,262. *Mr. Snell*: Did you feel the cold very much while waiting for a bath?—Personally I am of a hardy nature, but I am afraid many people did. The dormitory was supposed to be warmed during the night, but then of course the windows were thrown open for airing.

14,263. You have to stand undressed for some minutes waiting your turn?—Exactly.

14,264. *Chairman*: The next matter which you deal with is the subject of the parole system in asylums—that means giving a certain measure of graded liberty to the patients?—That is so. That was simply a matter that was introduced into C. within my last 18 months' experience there.

14,265. Was it an improvement there?—Undoubtedly, one of the finest improvements ever introduced into these institutions.

14,266. How was it worked?—The only way I can put it is that certain individuals were recommended on account of their good conduct by the charge attendant in the ward, who recommended them to the head attendant, and from that, of course, to the superintendent.

14,267. One may say the degree of liberty given was determined by the conduct of the patient roughly?—Exactly.

14,268. And the better behaved the patient was the greater the freedom given?—No, I would not say that.

14,269. Was not that the idea of it?—No; I mean the one who was exceptionally good, once he got his parole card, was on the same basis as the one who was only moderately good, or had some little favour shown him.

14,270. I have heard of institutions where you get more and more freedom according as your conduct merits it?—At the present moment I know that at W. they are granting paroles down in the village. That we never had in C.

14,271. At any rate, we may take it that the idea has your approval, the idea of giving a greater degree of liberty to cases that can benefit by it?—Exactly. May I say I consider that was one of the great things that brought about my improvement in health. We had something like 200 acres attached to the institution at C., and as a man brought up in the country, I can appreciate a thing of that sort. I could do anything I liked as long as I behaved myself properly.

14,272. And you think that the benefit of greater freedom showed itself in the improvement of your health?—Yes, undoubtedly.

14,273. Now what about the food which you got there?—Pre-war, or after-war?

14,274. The whole time. You were there pre-war, during the war, and post-war?—The position is so peculiar in that respect; it has varied so much.

14,275. Has it improved—that is what we would like to know?—If you ask me candidly why I think the

21 March, 1925.]

Mr. P.

[Continued.]

improvement was brought about, it was on the publication of Dr. Lomax's book. I have no hesitation in saying it followed immediately after that, and the improvement was so marked that it was impossible for anyone to draw any other conclusion than that the powers that be were influenced by that book; because it went practically from one issue to another; from being meagre, it went almost to the other extreme.

14,276. How would you say it was when you left; was it decent food?—It was decent food at that time, but it was going downhill again; the after effects had gone off a little. May I say it got so good at one time that the visiting guardians came round on one occasion—or whether it was the visiting committee I do not know—but I happened to be working in the dormitory just at the time when the tea was on the table, and one of the gentlemen made the remark: "Do these men always have such a good tea as this?" Of course the slices were not the same as you get in Lyons at the present time, wafers; but they were something like three-quarters of an inch thick and 8 or 12 inches long and about 4 inches wide, and there was a scraping of margarine on them. I should say this was after Dr. Lomax's book came out. Pre-war there was nothing but the plain slice; then after this alteration in the diet, we were provided for breakfast with porridge on three mornings a week in addition, and a little portion of meat; for tea there was not only this slice of bread and margarine, but also jam, marmalade, or honey, and cake, if you can describe it as cake. It was not 1s. 6d. a pound, but at the same time it was supposed to be cake.

14,277. You have advocated the introduction of the parole system. In your case, when you got your parole, I think you also got a good deal more interest and recreation in your life—games to play, and so on?—Yes. There was an improvement made in this respect. I know it is a point you have touched upon in this Commission, because I have followed the Commission's reports pretty fully, as regards the recreation at night time. Of course at one time when I went there first, and for many years afterwards, some patients were drafted off to bed at 7 o'clock, and all at 7.30, and you were there till 7 in the morning.

14,278. Do you think that was too soon to go to bed?—Too many hours in bed. After that an alteration was made, and that was a great improvement. There was the open ward kept open, and a number of patients were allowed to stay up for two hours beyond that, till half-past nine, and enjoy games and singing, and so forth.

14,279. It is satisfactory to know this from you, that during your fairly long time there, conditions seem to have been improving—on the upgrade?—Certainly towards the finish, but it took a long time before there was any improvement. I may say I had 10 years without any improvement, and I had perhaps 18 months or a little more with the improvements.

14,280. *Mrs. Mathew*: Had you any open air treatment?—None whatever.

14,281. Noverandah or anything at the time?—Only for consumptive cases in connection with the hospital; it was more like a cage because it was protected by a large wire blind, but there the patients lived and slept, practically speaking.

14,282. *Chairman*: Tell us about the work that went on in the institution.—I may say when I remained there for the last two years I did no work—I was simply out in the airing court—except little odd jobs in the dormitory. I did no outdoor work.

14,283. Were you fit for work, do you think?—I do not suppose I was. I was asked to go out, and I told them I did not think I was fit to go out. You must remember my insomnia was practically persistent and lasted for nearly 10 years. After two years I volunteered; I asked one of the head attendants if I might go out, and he jumped at it; he said, "Most decidedly." As a rule you have to wait a week or two, but they put me out as soon as I expressed a wish to go out.

14,284. What sort of work did they put you to?—I could have gone in the engineer's workshop.

14,285. You got the pick of work, did you?—Not exactly, but knowing I was a skilled engineer they would have been glad for me to have gone there; but I was not out for two ounces of tobacco a week when I felt that workmen were working for 2s. an hour outside. I objected on trade union principles. I absolutely refused to go and follow my own trade, and I never did. Carpenters will go in the carpenters' shop; cabinet makers and upholsterers, blacksmiths, tinsmiths—they all go and work in the workshops. I was simply out working on the land, and that I think was another reason why I brought about a cure for myself.

14,286. You think the open air and the work helped you?—We were on exceptionally heavy work, breaking down trees and banks and cultivation, and I think that extra laborious work induced sleep to come. Once the sleep came, my constipation got better; I was suffering from constipation; and the two things together removed the depression.

14,287. *Sir David Drummond*: During the 10 years you speak of, had you any desire to leave the institution?—No, practically not. I was asked on one occasion by one of the temporary medical men if I thought I could go out and make a fresh start. I had not reached that stage then, and I said I was afraid I had not sufficient confidence in myself.

14,288. *Chairman*: I think we may say in your case that under the existing law you really do not complain that you have been unlawfully detained because, as you have told us, you think under the existing law, you were probably quite rightly certified. Then you were in there for a long time and began to recover, and after you got a better grip of things you applied to get discharged?—That is not quite correct.

14,289. Give me the real facts?—In the first place, if I may broach on another topic, my one great complaint is that in all the institutions there is a lack of any curative treatment whatever. There is no curative treatment as regards mental trouble, from first to last. From the day I went into the institution to the day I came out there was not one iota of curative treatment offered to me. I cut my finger with a saw; I was immediately kept in and sent into the hospital and had it attended to, but as regards any curative treatment from first to last, not the slightest iota.

14,290. You mean for mental ailments?—For mental ailments.

14,291. What do you think should have been done in your case. Have you any idea?—Yes, very definite ideas.

14,292. What are they?—In the first place, I think, knowing what I was suffering from, there should have been an attempt made to help me to recover my sleep, treatment for insomnia and treatment for constipation. As a matter of fact, I went for years without having assistance in regard to constipation. Then I approached a deputy ex-superintendent, Dr. B., who was there on duty, and I told him I did not want purgatives; I wanted something that would act in a rational way. He put up a compound; there was a little laudanum in it and cascara.

14,293. *Sir David Drummond*: That is a purgative?—It may be a purgative, but it is not a purgative in the way they give you horse salts. I am quite willing to admit it must be a purgative, but I am speaking about violent purgatives, and cascara acts very mildly indeed; and I believe it is the only thing by which you can reduce the dose and not increase it. In my experience I may say I took some hogsheads of that.

14,294. *Chairman*: You think that your constipation and insomnia should have been specially dealt with?—Exactly.

14,295. Constipation, you suggest, was not a thing that could be properly dealt with by merely giving

21 March, 1925.]

Mr. P.

[Continued.]

you a dose of salts once a week,—I suppose you got that?—That is another objection—whether patients want them or not, they are given salts twice a week.

14,296. On the other hand, for your insomnia I cannot imagine anything better than good hard work in the open air, and that is really what you got?—That was on my own. It was not an attempt by the authorities with that intention. All they did it for was to get the work of the farm done, cheaper labour. That is their only alternative, to run the institution on as cheap lines as possible. I put it to the farm bailiff, what would be his position in running the farm in opposition to the house steward if he had no patients' labour. Where he could run a farm with perhaps a dozen men, he would want at least 30, and that reduces the cost of labour; and for that labour you were given a little screw of tobacco each day. You would get just the same amount of subsistence had you done no work whatever. The only inducement for going to work is a screw of tobacco amounting to two ounces a week, and you get a small portion of bread and cheese for your lunch.

14,297. Did it not occur to you that you might wish to give some work in return for your keep?—That is a matter of opinion; I suppose anyone would wish to do it.

14,298. I thought you said that you had been of the mind that you were not fit to go out, and that you must go on living there at the public expense. I should have thought you would have been rather anxious to recoup the expense you were causing?—As I say, I was an invalid for the first two years, but for just on ten years I worked continuously on the ground.

14,299. But you preferred to do work on the ground rather than do work which you were specifically skilled to do?—Certainly. One objected on the question of trade union principles.

14,300. Another thing is the amount of touch you can keep up with the outside world, when you are in an institution of this sort. I understand you do not think much of visiting committees?—I do not.

14,301. Do you remember seeing them come round?—Yes.

14,302. Did they come regularly?—Yes.

14,303. Did you ever have a chance of speaking to any of them?—I had a chance if I had cared to take it, but I did not care to take it for the simple reason that I knew it was a waste of time.

14,304. Were you wanting to get out at this time? When did you first begin to want to leave the place?—Two years before I did.

14,305. Then we may take it that down to 1921 you did not want to go out?—I was not particularly keen on going out.

14,306. You began to feel better and thought you should be out of the place—did you try and see the visiting committee then?—No, I did not. I wrote to the Board of Control.

14,307. Would that not have been a good idea, to buttonhole one of the Committee?—Shall I tell you what happened in my experience on one or two occasions?

14,308. Yes, that is what we want?—The poor law guardians come round occasionally and see they are not paying for dead men. I will now deal with the county council visiting committee. My experience is that if a patient wishes to approach the committee and happens to get in touch with them, the committee immediately turn to the superintendent, the senior doctor and said: "What about this case?" "Oh so-and-so, and so-and-so." "Very well, we will see into your case." But I may tell you what occurred once, when a man who is on the county council, I believe, at the present time, that is Mr. P. (he is a labour man) came round with the head attendant and the doctor; and a patient, who was an ex-policeman, wished particularly to see them, and he got up and made to go over to the committee man; immediately the inspector, or head attendant, pushed him back: Mr. P. immediately says "That man

wants to speak to me. You stand on one side." "Now," he said, "what is it you want?" and he told him he was willing to hear what his trouble was, and Mr. P. said "Very well, I will see about your case, but in the meantime your proper plan is to make an application in writing." That is what goes on with these people. Every obstacle is placed in front of you. As regards a private interview, there are no facilities whatever. That is the stereotyped thing: "Oh yes, we will see into your case," and nothing more is ever heard of it. I never knew of a case in my experience when anything came of it.

14,309. The board of guardians' duty, of course, is to see that they are no longer paying for patients who are no longer there?—They do not like paying for the dead ones; but, there again, the whole thing is an absolute farce.

14,310. They at least see they are not paying for dead people?—They do not even know that, for the simple reason that, if they care to do it, they can transfer patients from A. Ward to C. Ward, and then dodge them back to A. Ward.

14,311. Did you ever see one of the Lunacy Commissioners?—Yes.

14,312. Did you ever have a chat with them?—We always knew when they were coming a day before, if not two days.

14,313. The patients knew?—Certainly; I always knew it.

14,314. How did they know it?—Simply through the attendants: "You will not be out to-morrow, the Commissioners are coming." The whole thing is a farce.

14,315. Did you ever want to talk to any of the Commissioners yourself?—No. I saw that frequently done by the Commissioners. The most interest I ever saw taken was where a gentleman who was known at C., one of the recent additions to the Commissioners certainly took a great interest in the thing and wanted to see some of the patients, but nothing ever came of it.

14,316. But there must be many cases where nothing should come of it. We have all, I think, interviewed patients and heard their story, and you find that the patient is obviously very properly there, and nothing more can come of it in that state of matters?—I quite follow that; I quite agree with that. I am of the candid opinion that it is undoubtedly the worst cases that go up and see these individuals.

14,317. That is the great difficulty, how to know which are the cases which ought to be interviewed?—I quite follow that, and I quite agree, but undoubtedly that is my experience, at any rate, that the individuals who are the best qualified for discharge were those who felt it was absolutely hopeless to expect any benefit from these individuals.

14,318. You mentioned just now the Board of Control. You did not ask for an interview with the visiting committee, but you went straight to the Board of Control about it?—No, not exactly; I went through the proper channels, first of all.

14,319. What are the proper channels?—The proper channel, I take it, is you have, first of all, the ward doctor; then you have over him a senior doctor—that is in large institutions of about 3,000 patients; you have a senior doctor who comes under the superintendent. In the first place, I applied to the junior doctor.

14,320. With what result?—I got no result from him, who, unfortunately for me, was the senior doctor. The consequence was, having seen these two, I made a personal application to the superintendent, wrote him a full statement of my case, telling him exactly the whole procedure from the time I commenced till I finished up; and, as was his usual practice, the doctor came on the Sunday dinner time, just walked through the wards, and he passed me at the table, and when he had gone a little way beyond, he turned round and looked over his shoulder and said: "I have received your letter, and I can do

21 March, 1925.]

Mr. P.

[Continued.]

nothing for you at present." I simply stood up, and I said: "Thank you, Sir," and with that I found it was no use dilly-dallying with matters again, so I sat down and wrote to the Board of Control just a brief note. I kept a copy of the note I had sent to the superintendent; I quoted one or two Labour Members of Parliament who could speak as to my respectability, and so forth, and gave the reference which is required.

14,321. We have it in front of us. You wrote this letter on the 8th February, 1923, and you forward a copy of your recent letter to the medical superintendent?—I did, copy of testimonials, and a brief note of them. Within a week I was told I was for the superintendent's office.

14,322. You got an answer I am glad to see quicker than sometimes happens with some of us.—I was very pleased with them myself. I wrote and thanked them after I came out.

14,323. They got a report from the superintendent, and after that they pegged away at it for some time.—I do not know whether they did or not; I was never told that.

14,324. I can assure you the Board of Control did not leave the matter alone, because there is a series of communications here with the medical superintendent; and consequently you were ultimately discharged on the 12th April. I do not think it was very wise in the first letter you wrote to the Board of Control to put this in?—I know exactly what is coming.

14,325. I think it was perhaps a little unwise because they might not have taken it as a joke?—It did not seem to do much harm. It is perfectly true, is it not? That explains my position, if I may hand in this letter. (*Handing in a letter.*)

14,326. This was written after you came out?—After I came out.

14,327. Would you like me to read it out?—I do not mind.

(*The letter was read by the Chairman.*)

I had no reply to that.

14,328. Now what you were complaining of there was that the Insurance Company had a certificate about you which contained an incorrect diagnosis?—Yes. I think I have proved that up to the hilt; I do not think there is any query about that.

14,329. *Sir David Drummond*: Whose diagnosis was that?—Dr. M's. He was the senior doctor, and that was the doctor I applied to for discharge.

14,330. *Mr. Micklem*: Was this one of the asylum doctors?—Yes; I was under him for a number of years. As a matter of fact it was Dr. G. who moved me out of the observation ward.

14,331. *Chairman*: There is one question I should like to put to you about that certificate. Enquiries have been made of the Insurance Company to find out about this matter, and they have sent on a series of certificates signed by Dr. M. about you dated in 1915 and 1916, and none of them say anything about this unpleasant matter of general paralysis. I have the certificates signed by Dr. M. and they are different from this?—Yes, I can draw my own conclusion.

14,332. What is that?—It may be a serious one to you as a legal gentleman. I made trouble at the Company's Office over that, when it was shown to me, and I imagine it is possible that that other certificate was destroyed after I went and made a bother about it. I applied and the solicitor who took my statement knew nothing about this until 12 months afterwards.

14,333. *Mr. Micklem*: That is not the original.—I applied for it, but I was told as well that they could find no trace of it.

14,334. *Sir Ernest Hiley*: Did you see the certificate?—I saw it actually and took it down from memory, practically word for word, as it was. I did not apply for it; not for over a twelvemonth; it was only three months ago that I made any application for it.

14,335. *Chairman*: I do not see any reason for saying anything about general paralysis. As far as I can see, what the Company wanted to know was whether you were in an asylum and were fit to manage your affairs?—No, excuse me, that was not the point. At one time when my wife did not keep up the payments of the policy she went and enquired about it, and they told her she could have the bonuses commuted and paid for premiums, and they came and obtained my signature for that. I gave my signature for that when it was to their interest for keeping the premiums up. When I wanted to make the policy over to my wife she went and made a complaint and they said: No, it was for my life, and my life alone. The only thing I could do was to make it over to her. When I wanted to make it over to her they would not accept my signature. When I was told this at the office I asked why my signature could be taken when it was to the interest of the company to take it, and when it was to my interest to transfer the policy to my wife my signature could not be taken. The gentleman told me then "You were in such a serious state of health that we could not possibly accept your signature."

14,336. Let me put this to you. It is pretty obvious you have not general paralysis, but, on the other hand, doctors may make a mistake in diagnosis just as an engineer may make a mistake in a calculation, or I may make a mistake in law?—Exactly.

14,337. Are you sure that at this time you did not show symptoms which might quite reasonably have been interpreted to mean that you had general paralysis?—I do not think so. If so, can you explain the reason why they never treated me for the blood test? That was never done for me from first to last, the whole time I was there; I was inoculated for typhoid, but the blood test was never taken from me.

14,338. Now I am afraid our time is a little limited. You have given a most useful survey of various points. Have you anything else you specially desire to mention before us?—In the first place, I think that what is required before certification, especially in a case like my own, is, that there should be an intermediate stage. I mean to say, I was a cost of £600 or £700 to the ratepayers. With six months' treatment in a home of rest—

14,339. You need not go into that; other witnesses have indicated it. What one wants to get from you is what you have encountered yourself?—As regards the brutality of the attendants, that is another point. My one complaint is this, that even yesterday—it is not a question of past years, but even yesterday—the "Daily Chronicle" contained an advertisement for female nurses; and it is practically tantamount to this, that if you want a man to look after your pigs or poultry or your dogs, you want a man with previous experience. When you want anyone to look after your mental patients, no previous experience is required. Only yesterday in the "Chronicle" they are advertising for young girls from 16.

14,340. But they must learn the job at some time?—That is so, but I do not suppose you would care to go into a barber's shop and be shaved by the barber's boy. At any rate, my point is this, that you have there an advertisement for nurses. No previous experience is demanded; but if she can play the piano that is an inducement for which she should be appointed. She is 16 years of age. Do the Commission consider it right to put a girl of 16 in charge of women of all ages up to 80? As regards the men attendants, it is worse still. You do not require mental experience in an attendant. Neither in my opinion is it necessary to have prize fighters, men who have served in the Army, and to advertise the fact if they can play football, or play in the band; that is a very necessary adjunct, but it is not necessary to have any mental training whatever. There are good, bad and indifferent, as we all know. In my own experience I have met some very fine fellows amongst the attendants; on the other hand, I have met men I would not touch with a long stick. men

21 March, 1925.]

Mr. E.

[Continued.]

who are absolute brutes. I have seen cases of gross brutality by individuals who have come in in the morning the worse for drink, who have gone into the single rooms, when the patient has been not able perhaps to help himself and has made a mess. They have pulled the poor things right up in front of me, dashed them on the ground, and picked them up again, and kneed them in the stomach. That is the awful part of it; they do not mark the patients so that they can be found out; they have the practice of kneeling them. As I say, it is not only in the morning. I have even seen a night attendant, because a patient was snoring, do the same thing with him; he was a neurotic man himself, never fit for a night attendant, sleeping in the centre of the room, with a patient on each side of him. Those are the things I have seen myself. As I have said in my *précis*, I have seen another patient who was a deaf and dumb mute, he was not actually so by birth, but he had not spoken for many years. When that man was out in the fields, he was objectionable to the attendant, refractory in some slight way, and the attendant absolutely kneed him to such an extent that it was the nearest approach, in my experience, to speaking I had ever heard; he was more like a dumb animal in pain. That was simply through the brutality of the attendant.

14,341. What happened to that attendant?—As a matter of fact, he served a term of imprisonment for nearly killing two game-keepers after he got his discharge from the hospital. His wife got him discharged from there after he had had about 16 or 18 years' service, but then he went poaching, and he nearly killed two game-keepers there. For that he served a term of imprisonment. That is the type of man you have in your mental hospitals.

14,342. What do you think is the best way to prevent things of that sort?—I think the best way would be to have a better and more suitable class of attendants in the first place.

(The Witness withdrew.)

Mr. E. called and examined.

14,350. *Chairman*: We would like to have from you a little of your personal experiences in L., and perhaps we may get one or two facts about you first of all. I think you are 57 years old?—Yes.

14,351. And your experience was in L.?—Yes.

14,352. You were there from August 1921 till you were discharged in July 1924 "Relieved"?—Yes.

14,353. So you were there about three years?—Yes.

14,354. Now, as you can understand, we have not a great deal of time to go into all your history, and the most useful thing you could do would be to tell us anything in your experiences of L. which you think was wrong, and which you would like to put right. We want just the things that struck you as important things?—The thing that struck me through the whole of my career there and my detention are the utter lack of honesty of purpose.

14,355. What do you mean by that?—There was no object in detaining a man, no object at all. I asked the superintendent on one occasion—I said to him: "Is there any integrity in this institution?" He said: "Well, I should hope so." That was one thing. Then another thing I was told there was: "As long as you maintain there was nothing at all the matter with you when you came in, so long will you be detained here."

14,356. Do you think you should never have been there at all, or do you think you should have been out sooner?—I am perfectly sure there was never any foundation in the whole course of my life for my being sent to a lunatic asylum. I never had a moment's mental aberration in my life, asleep or awake.

14,357. There was a doctor who examined you, was there not?—Several.

14,358. Do you think they were all wrong in imagining you were mentally afflicted?—No, I am not going to say they were all wrong, but the principle of

14,343. Better supervision?—I do not see how you can supervise when it is a question of two attendants taking out a gang of men into the fields.

14,344. Whatever precautions you take, you cannot make all attendants perfect?—No, but you can improve the position very much.

14,345. Could such a person, assaulted as you have described, not complain effectively to the doctor?—I do not want to be humorous, but in that particular instance it would have been impossible.

14,346. But I was thinking of the other cases?—In the other cases the point is that, as a matter of fact, that night attendant must have been reported at some time or other for his brutality to patients, because after a number of years being the night attendant in charge of the dormitory, he was removed from that position and was put on just as a relieving man, going round relieving other attendants. He was not discharged then, but someone must have reported him.

14,347. *Mr. Micklem*: Were most of the attendants in your time humane and kind people?—As I have said previously, I have met some very fine individuals indeed, but they are a mixed party altogether. I will say that a very good proportion of them are very decent men indeed; but, unfortunately, there are quite a number who are otherwise.

14,348. *Chairman*: And in order to remedy that, it seems to me that you want to provide, if possible, a higher standard of attendant, and means of supervision and protection of the patient against brutality?—Exactly. Under present circumstances, unless some provision is made, there is no precaution taken to see that the patient is not ill-used still further, and then it is one constant recrimination between patient and attendant.

14,349. *Chairman*: We are much obliged to you for attending to-day and for what you have told us.

it was all wrong. There was one doctor there, Dr. S., and after I was detained there four months he recommended me for discharge. He said: "You have committed no crime; I do not see anything the matter with you"; but he said: "You have had a bad cold, you have been laid up. I should stay a little while longer if I were you." He said: "I will put your name forward for discharge." I said: "I do not want to stay one minute longer; I want to get out and take up the threads of my former life." After that, after a lapse of about 18 months, he simply denied that he had said so, and yet Dr. S. was very, very nice to me, a man I had every respect for. I cannot say so much for the others. There was a Dr. P. there; he was the one that received me into the institution. It was simply general routine that I went through, but after I was there about two years, I said in despair to him one day: "Is there any likelihood of my getting out of this institution?" and he turned round and said most seriously: "None whatever; you will simply have to wait for an earthquake." I reported that to the superintendent; I reported it to Mr. P. He was a sort of a general supreme head attendant there. I also wrote to the Board of Control, and I got no answer from them. He simply assured me there was no chance of my ever getting my freedom.

14,359. But you did get some letter from the Board of Control?—Just simply to say that the visiting committee would see me on the next occasion.

14,360. Then I see, after you had written complaining, the Board of Control wrote to the Superintendent of L. about you to find out what there was in the complaint?—I am not aware of it.

14,361. Of course you would not know of that. It is to show that the Board of Control took that amount

21 March, 1925.]

Mr. E.

[Continued.]

of interest in your case?—That is the first knowledge I have of it.

14,362. I find on the 23rd November, 1922, a letter from the Secretary of the Board of Control to the Superintendent of L. saying: "I am directed by the Commissioners of the Board of Control to send you the enclosed letter which they have received from —; and to request you, in returning it, to favour them with your observations on the part marked in blue; the Board will also be glad to know what opportunities he has recently had of seeing members of the visiting committee, and whether anything can be done to satisfy the patient on this point." You see they were looking after you?—Without my knowledge.

14,363. Now is it not the case that at this time you were giving some trouble in the institution?—I can explain that, if you came to details.

14,364. We have of course the certificates about you at the time, and some of the things they say about you are not just very complimentary?—I will be truthful, and I hope I am polite.

14,365. At this time they say your behaviour was hostile and aggressive, and you thought you were the victim of persecution, and you were saying you were what was known at that time as the T. murderer; do you remember that?—That is all to be explained away quite easily. It was like this: I was over in Czecho-Slovakia. I had a little trouble there, and I came back; and the first thing I got to be aware of was what was going on in the papers as to this T. murder. I took no notice whatever of it, but there were one or two coincidences (you know how coincidences will arise), and I made a casual joke about it. I said "I must be T." just casually, but there was nothing more than that in it.

14,366. Have you anything else that occurred during your experience which you would like to bring before us?—I asked the doctor one day when I was in the hospital ward "What are you going to do with me eventually?" He said "I am going to get rid of you," and after a moment's hesitation he went on a little further, and he turned round to me and said "You know what was the matter with you when you came in." I said "Yes, nothing at all; I have never had anything wrong with me; I have never had five minutes' aberration in the whole course of my life, asleep or awake." Of course I expected to get in trouble for saying that, and I apologised to him immediately afterwards. I said "I am sorry I spoke so candidly, but still I am of an open disposition and I cannot help saying candidly what I think."

14,367. How did you get out in the end?—My brother-in-law claimed me out, and he had a great deal of trouble to claim me out because there were such far-fetched reports about me given to him. The very last report given to him about me was that Dr. C. said that I was far too indecent a man to be allowed my liberty. I told Dr. C. I had become aware of what he said to my brother in law, and I said to Dr. C. "It is nothing more or less than a downright slander on your part. Surely, if you have a code of honour at all, it is your duty to your ownself to write and apologise for the slander you have committed to me about my brother-in-law." I said "You know perfectly well I am not indecent; you know perfectly well I am a well conducted man."

14,368. But your brother-in-law ultimately got the medical superintendent to discharge you?—Yes, he did.

14,369. And you were discharged "Relieved?"—Yes. My trouble was really—and this is the first time I have ever had such a thought, sitting before you—I believe the foundation of all my trouble there was my failure to go against my conscience. The head attendant said to me "So long as you maintain that there is nothing the matter with you, so long you will be kept here"; and the very next day I went to the Roman Catholic priest, I was very friendly with him, and I said "Would you, as a priest, allow me to go against my own conscience in order to obtain

my liberty?" and he said "No." I said "I only asked you as a matter of form," and I told him what had occurred the day previously.

14,370. Do you suggest that they would not let you out until you admitted you ought to have been in?—That is what the attendant said. The whole thing is that there was no honesty of purpose in the asylum whatever, because I was perfectly sane.

14,371. Then your complaint really is that you should never have been in the asylum at all?—Absolutely so.

14,372. *Sir David Drummond*: Do you mean that you never had any delusions at any time?—No, none whatever.

14,373. When you thought people were persecuting you, they were really persecuting you?—I never thought people persecuted me, not to use the word "persecution." The word "persecution" is the wrong word to use. I simply recognised one or two facts that had occurred as extraordinary coincidences, not persecution.

14,374. *Sir Humphry Rolleston*: May I ask what your occupation is now?—For a good many years I was a bookmaker's clerk over in Austria and Bohemia; that is how I came to be sent across to Prague, because I speak Czechish.

14,375. Is that your occupation at the present time?—Not at present, not what you may call an occupation, but I am in the Home down at B.; I am doing work there and getting my food and lodging free until something turns up.

14,376. You are in a home now?—Yes; I am very comfortable there.

14,377. *Chairman*: The aspect of the thing that interests us most is whether during the course of your experience in the asylum, apart from the fact that you say you should never have been there at all, there were any things of which you had to complain while you were there?—With regard to the treatment?

14,378. Treatment, or the conditions of life, or anything else, which you think you have good cause to complain of?—With regard to the food, nothing at all.

14,379. What about the attendants?—The attendants were all right with me with the exception of one occasion; I jibbed to take the weekly "black jack," because I found it did not agree with me; then I was maltreated.

14,380. That is the weekly medicine?—Yes.

14,381. How were you maltreated?—I was winded; I was got down on the ground, and three or four attendants kneeled on me and administered this weekly medicine, while I had no breath in my body at all. Then they pummelled me a little bit afterwards—a good deal.

14,382. Why did they do that?—Because I strongly objected to taking it.

14,383. And they made you take it?—Yes, they made me take it. Then another thing: sometimes they put a man in bed for one thing for a whole month. When a man is perfectly physically well they keep a man in bed for a whole month in a cell and deprive him of even the Bible to read, and that is a big punishment, to be kept in bed for that length of time.

14,384. Was that done to you ever?—Yes, it was done to me. Would you like me to use plain language?

14,385. Please?—I was lying on the grass in the exercise yard one afternoon, and there was an attendant there named H., who was eventually discharged for maltreating another patient. I was rather stout at the time and he said to me, "Come on mudguts; you are always the last." He called me that name and I resented it and I said to him—he was an ex-constable—"You have no right to call me names like that; you are exceeding your duty. You are no more fit for an asylum attendant than you apparently were for a policeman," and with that

21 March 1925.]

Mr. E.

[Continued.]

he pummelled me. Of course, I got the worst of it, and I was put to bed for a whole month.

14,386. Not because of the pummelling?—No, because of his accusation against me.

14,387. Is there any other incident you would like to tell us about?—There is a multiplicity of them.

14,388. But I mean is there anything serious that you think we should hear about, not just trifles, but anything serious?—The thing is, that what you as gentlemen on the Royal Commission should endeavour to get at is the spirit of the institution underlying the camouflage of it. The camouflage of it is beautiful, everything is all right. An outside gentleman, or even an outside Commission enquiring into this could never possibly get at the spirit of the place. The spirit of the place towards the sane man is almost like this: if you know you are well and say you are well, in consequence you are absolutely incurable.

14,389. How does anybody ever get out?—I do not know; it is a wonder to me. I consider myself very lucky in getting out.

14,390. How is this spirit to be improved? Have you any idea?—First of all, you have visits from the

guardians and then you have the visiting committee. When the guardians came down on one occasion, I said "What on earth can I say to you to convince you that I ought not to be here? I assured you the time before that I am simply a compulsory imposter on the rates, and I should not be detained here one minute and should never have been here at all." On another occasion the visiting committee came round and I then explained to them "I am sane." It seems to me the very fact of saying you are sane is almost a guarantee that you are insane, if you can follow what I mean.

14,391. I think we see the purport of your evidence. Unless any of my colleagues would like to ask you further questions, I do not propose to keep you longer. We are much indebted to you for coming to us to-day. —I hope the result of this Royal Commission will put things on an honest basis, because, so far as my limited intelligence goes, I can see a big scope for improvement in the asylums with regard to the detention of sane men there.

14,392. That is your special point I take it?—Well, I think it is a big point, do not you?

14,393. Very big indeed.

(The Witness withdrew.)

(Adjourned to Monday next at 10.30 o'clock.)

5, OLD PALACE YARD,
WESTMINSTER, S.W.1.

TWENTY-SIXTH DAY.

Monday, 23rd March, 1925.

MEMBERS PRESENT :

MR. N. MICKLEM, K.C. (*in the Chair*).

THE EARL RUSSELL.

SIR HUMPHRY ROLLESTON, BART., K.C.B., M.D.

SIR ERNEST HILEY, K.B.E.

SIR DAVID DRUMMOND, C.B.E., M.D.

MR. W. A. JOWITT, K.C.

MR. H. SNELL, M.P.

MRS. C. J. MATHEW.

MR. P. BARTER (*Secretary*).

MR. W. FAIRLEY (*Assistant Secretary*).

EVIDENCE TAKEN IN PRIVATE.

Miss C. called and examined.

14,394. *Deputy-Chairman*: You have already furnished us with some information. I understand you want to give further oral evidence to the Commission?—I suggested that I should really. I did not expect that I would be called, so I put most of it in writing.

14,395. I understand you have had experience both of a private institution and of a public institution?—Yes.

14,396. You were first, I think, at C., a licensed house?—Yes.

14,397. That was from August to November of 1918?—Yes.

14,398. And then subsequently in December of 1920 you went to the S. Mental Hospital?—Yes.

14,399. And you were there until June of 1921?—Oh, no—that was only five weeks at the most.

23 March, 1925.]

Miss C.

[Continued.]

14,400. You were out on trial after that time; you were not discharged?—No. I was living in my flat in London.

14,401. You were only a few weeks in the hospital?—I think it was five weeks, because Dr. S. could not get my people to get me out.

14,402. After you had been there some five weeks you were let out on trial and were living in your own flat?—I lived at B. for a month or so in a home with Mrs. R., and then after that Dr. S. allowed me further freedom which was to go to my flat, which was empty.

14,403. And ultimately you were discharged in June of 1921?—Yes.

14,404. You have formed from your experience some definite conclusion, have you not, as to the advantages of the public institutions over the private institutions?—The conclusion I have formed very definitely is that there should not be such a thing as a private institution; there should be no traffic in the sanity of people; that is absolutely definite.

14,405. But you appreciate, I suppose, that there is a considerable demand by many patients for these private houses?—I cannot see why they should not be put in public institutions, and by paying extra get extra luxuries or extra accommodation.

14,406. But do you mean you would like to see the public institutions so extended that private patients could get what they wanted there on paying for it?—Yes.

14,407. What is your objection to the private institution?—I consider that it is a traffic in the sanity of the public.

14,408. But observe, if it is a public institution the same thing would apply if you could pay what you liked?—No, because they would not be making profit. They would be paying for what they got.

14,409. The institution would be making profit; they could run the poorer part of the institution at the expense of the expensive part?—If they did what I did at S. I paid a little extra there for extra things I had.

14,410. At S. you had a room to yourself?—Yes, and I had extra food. Any extra food I got was paid for; and if by any chance my payment was helping the poorer people, why not?

14,411. Is yours just a theoretical objection to a private house?—No, it is just what I saw at C.

14,412. What did you see at C. which led you to think that it is a disadvantage to allow these licensed houses?—I think the tendency of everybody in the institution is to keep people instead of letting them go.

14,413. You mean where the doctor is making a considerable profit, then it is in his interest?—Naturally; the profit is going to the shareholders, and the more profit they make the better pleased they are with the doctor.

14,414. Did any instances come under your observation of persons being detained longer than they ought to have been there?—Yes. There was one lady whose name I regret I cannot tell you, who was in the room with me the last few months I was there; she had been five years there. As far as I could see she was the most calm and normal person I had ever met. Her story was that she was a rich woman of rather humble origin, who had married an army man above her in position. He had taken her money and she was being kept there while the money was used. Probably she had not the power to defend herself.

14,415. Was any other instance brought to your observation?—There was a lady there, Madame B., who subsequently got herself released.

14,416. You do not think that you yourself were detained at C. too long, do you?—Of course; but everyone does not think so.

14,417. That is a common view, you think?—I escaped because I thought so.

14,418. You were there only a comparatively short time?—I was there from August 23rd to November 13th, 1918. It seemed a lifetime.

14,419. Were you comfortable yourself while you were there?—No, very uncomfortable.

14,420. Had you anything to find fault with?—Yes, lots of things.

14,421. Would you just tell us what they are?—To begin with I was suffering terribly from sleeplessness, and I was put in a room with 12 people who were not in good health, who did various tricks, and I could not sleep at all; and the nurses talked all night, they came in and chatted and laughed all the night in the ward. The night watch went round every two hours and turned a bright lantern on to one; it was the most impossible treatment.

14,422. Were you in that room the whole of the time?—All except about a fortnight. It is called the observation ward, and under the title of observation they simply torture you at nights.

14,423. You were paying a comparatively low remuneration?—Four guineas a week. The food was terrible. Of course it was war time, and perhaps it is not fair for me to criticise the food because in war time it had to be so.

14,424. A good many of the patients would pay larger fees?—Those who had rooms. Madame B.'s husband was paying 7 guineas a week, and she only had a room to herself part of the time.

14,425. You will appreciate that it would be difficult to give a patient only paying four guineas a separate room?—Afterwards I was removed into a room with four people, which was much pleasanter; I need not have been all that time in that room, and the treatment was abominable.

14,426. When you say the treatment was abominable, would you tell us exactly what you mean, because we want to find out, if we can, exactly what goes on?—To begin with as to this room, the doctors should have realised that I probably wanted to sleep—that was what partly upset my nerves; and they should have tried to make me sleep instead of stopping sleep; I got rapidly worse with getting so little sleep.

14,427. Do you mean they should have given you a separate room, or given you some sedative?—No. I think they should have seen that the ward was quieter or put one with suitable people. There were lots of rooms.

14,428. How many people were there in the institution altogether?—I think there might have been up to 600; I cannot tell you. I was in what was called the convalescent ward.

14,429. You were in one of the villas?—The convalescent house; it is the house from which you go out.

14,430. Something detached from the main building?—Yes. We went to the main building every now and again for entertainments.

14,431. *Earl Russell*: You were in the convalescent ward?—Yes, always.

14,432. And even there you had these noisy patients, had you?—Terrible, there was one who talked all night, and one who had St. Vitus's Dance; she kept jumping up and down.

14,433. *Deputy-Chairman*: Were those patients, there all the time with you?—Yes, all the time.

14,434. *Mrs. Mathew*: Miss C., you used the term "observation ward": Were you in the observation ward?—This ward in the convalescent house is what is called the observation ward; there are also rooms where they have three or four people, and these are separate rooms.

14,435. *Deputy-Chairman*: Apart from this question of insomnia, had you anything else to complain of?—Yes. Of course it was war time. Perhaps I came on at a very bad time. They were not able to have fires in all the rooms. We only had a fire in the living room, and we all had to sit round this fire.

14,436. What rooms had you to be in, apart from the dormitory. A living room?—You are never allowed to sit in your bedroom; you are never allowed to be by yourself. You had the dining room which had a kind of lounge place off it. Then there was a

23 March, 1925.]

Miss C.

[Continued.]

long living room, and in the summer time there was a verandah in the garden.

14,437. Everything was very comfortable for you as far as the surroundings were concerned?—Yes. Perhaps if it had not been war time it would have been better. Of course then they were short of fires. We all had to be herded in one room, where if it was not war time you would be in two rooms.

14,438. To some extent you think the food was rather poor food?—Yes, it was very poor food.

14,439. At that time we were all suffering in the same way?—Of course I do not say anything about the food, because in war time it had to be so. We perhaps got as much as was given then; I think they were attentive to the food.

14,440. After you had been there for some few months you made your escape?—Yes, I got a letter. Would you care to know the circumstances, the way I made my escape?

14,441. You might tell us about that?—Unfortunately they treat lunatics as people who must not be told the truth, which to my mind is the greatest fallacy in the treatment, because Dr. S. acted quite differently. They dig pits for you; you do not know anything about it, you fall into these pits. Dr. E. was always telling me I was just going. Every time I asked him he said: "Perhaps next week, certainly very soon." I believed him implicitly. The nurses always told me so. I had not seen my papers, I had not the faintest idea what I was really there for. I was believing Dr. E., and suddenly I got a letter from my mother in which she said "Poor girl, I am sorry for you, but never mind, H. (that is my brother) will be home in May, and then we will see what can be done for you." This was the 13th November, and that was six months till May. Then I knew quite suddenly, it came to me, that I was being absolutely deceived. Then I distrusted everybody. I went and saw the sister and asked about some of the things she had been saying to me. I said "Were those things false?" and she said, "Of course those things were false, your reason should have told you they were false."

14,442. It may be in some cases inadvisable to let patients know?—No; if you are so insane, as that it does not matter. If one is sane, as I believe I was, it is much better to know the truth. Dr. S. at the S. Mental Hospital acted differently with me, and I was very different under his care.

14,443. Have you any complaint to make of the attendants or nurses while you were in the private home?—Yes, they were quite different from all the other nurses; it was quite a different atmosphere the whole place, even granting they were acting for the best.

14,444. It was different from the public hospital, you mean?—Quite.

14,445. In what respect did the atmosphere differ?—You got the idea while living in C. that you were there for the sake of the institution. You were there for life, and it did not matter whether you got better or not; a hopeless and helpless place.

14,446. *Earl Russell*: You will bear in mind that a very large number of patients are discharged from C. every year. The records show that, you know?—I am awfully surprised at it, really. The building only holds so many, and they have to make room for somebody else—that is what I should say it was.

14,447. *Deputy-Chairman*: I think you wish to make some observation about the escape clause?—I was getting rapidly worse under the treatment there; I was terrified of myself there. When I got this letter from my mother I did not know what to do to get away. In a way I am not going to blame Dr. E., because if I were sent there certified he had to accept me at that. He was in a difficult position.

14,448. While you were there had you any visitors?—Yes, and every friend of mine who came to see me was warned about me. I did not have many. One day a lady came and she was allowed to take me out,

but she was warned by the doctor how frightfully bad I was. It was very brave of her to take me out.

14,449. But you had visitors come to you?—Yes, I had visitors come to see me.

14,450. Had you any official visitors to see you?—Yes, I had visitors from the Board of Control—two of them.

14,451. Do you remember who you saw?—Yes. Is it necessary to mention names—because I consider they were perfectly useless.

14,452. *Earl Russell*: You might as well mention them.—One was Mr. Trevor, a very pleasant man, and the other was Miss Dendy, who was no good at all.

14,453. You had conversations with them?—Yes.

14,454. Was there any other official visitor?—When I got in first there was a justice of the peace who saw me, a little man came in one day just after I arrived. We people who go into an asylum do not know anything about the Lunacy Acts.

14,455. You do not quite appreciate who the persons are?—No, nothing is told you, you are absolutely at sea; you do not know who the people are.

14,456. This is the private asylum you are speaking of, is it?—Yes.

14,457. Could you tell us at an early stage what happened before you were taken there, if you remember? I should like to know exactly how you got there?—Long before I was put in that place doctors were called in to see me by L. the solicitor, and I maintain here that he could put anybody in an asylum provided they were not rich enough to protect themselves. Under the present safeguards you have no protection against a man like that, who wishes to put insanity on you.

14,458. The doctors had then seen you and you did not know they had signed your certificate?—No, I was taken from a prison.

14,459. *Deputy-Chairman*: There were certificates by M.C.?—M.C. was sent to my house by L., and he certified me on the spot, because he had already heard what L. had told him and also my family, and these stories were not true, and they were never investigated. Therefore M. C. accepted what L. had told him, and he certified me. His difficulty was that he could not get the other doctor to do it; my medical attendant refused to do it.

14,460. Then afterwards you went to H.?—Afterwards they took me to prison.

14,461. Then a magistrate was called in?—When I got to C. a magistrate came; I do not know what authority he had.

14,462. You escaped in November of 1918, and then I think you were certified again in December of 1920. Did you go to friends, or did you go home when you escaped?—I went to friends.

14,463. And stayed with them?—I meant really to go down to my sister, my petitioner, and ask her to remove me to B., because I knew I should always get worse at C. When I got to the station I remembered a friend that I thought would lend me some money, and I thought I would go and see her. When I went to see her and her husband, I told them about the escape clause, and that 14 days would free me if I could escape. They were willing to help me, though I could not stay in their house; but they gave me their support.

14,464. Then later on, in November, 1920, you went to the S. Mental Hospital?—Yes, I was taken to that hospital. That was because with the escape clause you are never quite free from surveillance. That had nothing to do with the original thing at all.

14,465. The certificates were very much alike, in both cases?—There was no reason for that. My offence in the second act had nothing whatever to do with the first. They simply used the fact that I had lost my temper to shut me up again. It was nothing whatever to do with the original cause; it was all put on me.

14,466. You found your treatment very much better in the S. Mental Hospital than it had been in C?—Yes, much better.

23 March, 1925.]

Miss C.

[Continued.]

14,467. You were there, I suppose, first in an observation ward?—Yes. I was only two days in it—two nights.

14,468. Had you the same experience in that ward that you had at C.?—Yes. That was a terrible ward, but everyone has to go through it.

14,469. I suppose there are a large number of patients in that place?—Yes; it is a terrible place.

14,470. Was it an admission ward?—I should think it is the admission ward. Every patient that is certified has to go through that, I should imagine.

14,471. Immediately after that, you were put in another ward, after two days?—Yes; No. 1 ward.

14,472. Was Dr. S. your medical superintendent there?—Yes.

14,473. And you found him exceedingly kind?—A very nice man, a very humane man.

14,474. One of the things that I think you found fault with in the private asylum was that you had no occupation?—No, there was nothing arranged for one. Some people make their occupations.

14,475. I suppose there are opportunities of reading and writing, and taking exercise, and so on?—Oh yes.

14,476. I notice that while you were at C., in one of the reports you were said to be cheerful and occupied most of your time?—I walked round the garden a good lot; you could not get out, so you walked round the garden, ran round it a great deal, too.

14,477. Inside the house how did you occupy yourself?—I talked with the other patients, and got worse, as far as I could see.

14,478. Now you say you were only in the public mental hospital for five weeks?—I think five; it may have been less even than that. I would have been out sooner, but Dr. S. found it difficult. The petitioner did not want to have me out. They were so imbued with what all the other doctors said; they would not take the responsibility.

14,479. The doctor wished you to stay at B.?—Yes; I was there for three weeks, I think.

14,480. And then you went to your own flat?—Yes. I stayed with a friend on the way to the flat.

14,481. Have you anything to find fault with in your treatment at the S. Mental Hospital?—Nothing, of course I had a room to myself; I was very lucky; Dr. S. thought I needed to be quiet, I think. They were very kind to me, indeed. Beyond that, I think the restrictions that you have to have in an asylum want remedying. I think there are lots of things that want remedying.

14,482. Will you just suggest what improvements you think could be made at the S. Mental Hospital?—To begin with, they send the patients off to bed far too early. I did not go so early; they were very kind and allowed me to play bridge, but the other side do go to bed frightfully early, about seven or half-past seven. Of course, the nurses are glad to be rid of them, naturally, but they are awfully long nights. They get up too early, too, far too early. It would be better to have more nurses and give the nurses shifts, as in factories.

14,483. We know that in many of the hospitals that system has been adopted?—Has it?

14,484. I do not know that it has been in this particular one?—I am glad to hear that.

14,485. *Earl Russell*: Would you consider this point on that: how do the hours at which they get up compare, as regards the average patient, with the hours at which they get up at home in their normal life? Are they not more or less the same?—If you are going to work you have to get up early, but if you are not going to work your days are very long.

14,486. I am only thinking whether they are not really carrying out the normal life of the average class of patient. What should you say to that?—I think perhaps you would, because most of them are drawn from the working class.

14,487. Of course we have often considered these hours, and to us they appear naturally rather odd hours?—Yes; it is the going to bed that seemed too early. I was in the convalescent ward in both places.

14,488. *Mr. Snell*: Would you say the going to bed early, or the getting up early is so objectionable?—It is going to bed so early.

14,489. *Earl Russell*: Could you tell us anything about the evening meal at the S. Mental Hospital. Did you get anything after tea or not?—Yes, we had supper.

14,490. About what time—about seven?—We had dinner, and then we had supper.

14,491. You were more fortunate than some places?—It was very plain food, but quite enough.

14,492. *Deputy-Chairman*: Did that apply to all the patients in the hospital—those who went to bed early?—I think perhaps we had our early dinner at one; then we had tea in the ward; we used to make ourselves tea in the ward; and then we had a sort of evening meal.

14,493. *Mr. Snell*: What time was it, do you think?—I think it was about seven.

14,494. Then they would go to bed immediately after?—Yes, the wards were cleared immediately after. One can understand the nurses being glad to get free.

14,495. *Deputy-Chairman*: Of course you were a private patient there?—Yes, I was a private patient there, but I was with all the other patients. The tea was made in the wards; that was where the work was all arranged. One lady would have charge of making tea, that would be her job, and I was polishing the wards; then another had laundry work, and so on. Then in the afternoon we sat all round, and got our cups of tea and a biscuit, or whatever it was.

14,496. For the ordinary patients in the hospital was there a further meal later on?—Yes, we all had a meal, I had fish or eggs, or something, because I was paying extra. There was a case of a girl who was frightfully poor; her brother was paying for her; she was an awfully nice girl, and she did not want her brother to have to pay a penny more than was necessary. She needed food, and Dr. S. gave her extra food because she required it. If we who pay extra are paying for that, all the better. That is why I think the more paying patients you have in public hospitals the better for other people.

14,497. Does that extra meal apply to all the patients?—Yes, we all got that evening meal. I cannot say what hour it was, but we had breakfast, dinner, and this evening meal. We had a cup of tea in the ward. It was generally bread and butter and cheese.

14,498. How did the efficiency of the nurses strike you at the S. Mental Hospital? Were they a good and effective set of nurses?—Yes. They were very businesslike; they attended to their job, and were very well superintended.

14,499. *Earl Russell*: Were they at all rough in their manner with the patients?—I did not find any like that. I was very lucky; I had a very nice nurse there. Of course, remember, I am only speaking of the convalescent ward; the people were more or less normal. I found them very nice and very efficient girls; they were young.

14,500. *Mrs. Mathew*: Were they better than the nurses at C. private asylum?—Much; very superior, I thought. Another thing is that in C. if you had a complaint, if you thought there was anything wrong, it is only listened to if the nurse allows it to be listened to, because they always take her word for it. On one occasion at C. I had to make a complaint about the bath; the doctor and his wife came and saw whether it was true or not, they did not accept it as a delusion. They came and saw that what I was saying was true.

14,501. *Deputy-Chairman*: In C?—No, this was at S. I stayed too short a time in my bath because it was all covered with the soapsuds of the people who

23 March, 1925.]

Miss C.

[Continued.]

had had the bath; it had not been properly rinsed out; I did not like it, so I jumped in and out, and the nurse complained that I had not taken a proper bath. When I gave the reason they appreciated the point, and they came around the next time there was a bath and saw that the bath was properly arranged for each person. Of course the nurse had been just a little careless.

14,502. Did you find that all the bathing and sanitary arrangements in the hospital were good?—Yes, very. Considering the way things were, it was very good. There is an awful lot, of course, to be remedied. You want a great deal more space for asylums.

14,503. Do you mean in the wards, or do you mean space outside?—Outside you want more space.

14,504. At the S. Hospital what grounds were there?—We had a very small paddock; not nearly so large a garden as at C. It was rather tiring walking round and round it.

14,505. Where is the S. Mental Hospital?—At D. 14,506. D. Heath, is that?—No, I do not think it is on the heath. It is frightfully flat and uninteresting.

14,507. And comparatively small grounds?—Yes, the different wards have their different paddocks, and it would be an advantage to have larger gardens, of course.

14,508. Mrs. Mathew: How many were there at the S. Hospital?—I imagine there were not so many as at C. I am not very accurate about figures. Another thing, the general dining room was quite cheerful; you went in there every day; the more convalescent patients from the men's side and the women's side all dined in this big room. We had music sometimes upstairs in the balcony.

14,509. Earl Russell: I gather from the report that you were always what was called a good patient; you were never put in the refractory ward, or anything of that sort; you were one of the good patients?—There was never anything wrong with me at all.

14,510. Deputy-Chairman: Now I think you want to tell the Commission some views that you have about the after care of patients?—Yes, I think it is a great pity that the patient should not be sent to someone she likes and chooses; amongst the friends the patient chooses there would surely be some they could approve of. It is a great pity to send you back to the people who put you in, which is generally what is done. The petitioner takes you out, and of course you are always very annoyed with the people who put you in.

14,511. You are rather in the hands of the petitioner there; you cannot get your discharge without the petitioner's consent?—I think if the doctor thinks it is right you should be discharged, it is not a question for the petitioner to choose where you are to go.

14,512. In some cases one can appreciate that is so, but in most cases one would expect patients to go back to their families?—Why should you go back? If the circumstances have sent you to an asylum, why should you return to them?

14,513. In the ordinary case one must assume the patient has been sent to the asylum by their relatives, because it was in the interest of the patient that he or she should go?—That is an absolute fallacy. You are sent by your relations and people because you are a nuisance to them. Why should you return to them if you are a nuisance to them? It is not for your good at all; it is for their good more often than yourself.

14,514. I suppose the patient coming out must go somewhere. Do you think it should be left to the medical superintendent to find a place for them?—Yes, Dr. S. found me a place. If he is interested in his patients, as a good doctor would be, he will consult with the patient, and find out between them what is going to be the best thing for the patient.

14,515. Now with reference to this after care question, you know we are rather interested in seeing what provision can be made for those who require

some further supervision, or who have no place to go to—an After-Care Association?—Yes.

14,516. You are not dealing with them, are you? Your point is that the patient should have an option of going where he or she pleases?—If it is a question of sending you back to your friends, or people who put you in, the petitioner, then the patient should have the choice of whether she will go there or not. If it is a question of sending you back to a home then, of course, that could be arranged by the medical superintendent.

14,517. Are you interested at all in the provision made in some places by the After-care Association?—I do not know of them.

14,518. Earl Russell: There are such things as convalescent homes at the seaside for patients who have been actually discharged and freed from certificate.—Are they free, though?

14,519. Oh, yes, perfectly free.—Not under surveillance?

14,520. I do not know about surveillance, but they are not under restraint.—If they are discharged they should be free.

14,521. Deputy-Chairman: Your point is this—if the patient does not want to go back to her relatives, the doctor should make some further provision for her?—Certainly. It argues itself, that the circumstances that have been responsible for putting you in are not the best to return to.

14,522. Another point you make I think is this, that you would like the certificate to be delayed as long as possible, and, if possible, not made at all?—Oh yes.

14,523. There, I think, you hold the view that almost everybody holds—that certification should be delayed till the last possible moment?—Yes, every means should be taken to avoid putting that on people, because it is very difficult to live apart from it afterwards.

14,524. We have had a great deal of evidence about that from other witnesses, and I do not know that I need really trouble you with that, because I think we should all probably be agreed about it?—Might I say this, that I think when people are said to have delusions there should be a judicial enquiry to find out whether the delusion really is a delusion.

14,525. You make the suggestion that there should be some form of judicial enquiry?—Yes, to ascertain definitely that it is a delusion, before you certify them on the ground of it being a delusion.

14,526. That again has been dealt with by a good number of our witnesses. I take your view, but I do not think that we need pursue it really?—No.

14,527. Lastly, you want to give us some suggestion about the nurses. Your view is that the nurses should undergo special training before they are taken on in these places?—Yes.

14,528. Did you find the nurses of a good class in the hospitals?—A frightfully poor class at C., a terrible class of girls, so illiterate. The nurse who wrote the reports, the night nurse who looked after my ward and wrote the report, had no notion of spelling.

14,529. Earl Russell: Being unable to spell is not very important?—But she had not learned properly to write.

14,530. Deputy-Chairman: Was she an effective nurse?—No, she was the least normal person I met in the institution, I think.

14,531. She was one of those who you thought might possibly be under certificate?—Certainly: I should not be surprised if she was at this moment.

14,532. Mrs. Mathew: How old was she?—She was 25 or 27 perhaps. She was a very kind little girl.

14,533. Deputy-Chairman: Your view rather is, that you should get nurses according to the station of the patient?—Yes, I think so.

14,534. Where you are dealing with educated people, if possible, you should have educated nurses?—Exactly, because things that you seem to do may create misunderstanding if they do not understand you. I could give you an instance. I went out with

23 March, 1925.]

Miss C.

[Continued.]

the sister who was at C., who had been a parlour maid; she was promoted from a parlour maid to a sister pretty quickly. We were having tea at a restaurant one day during the war, and we had no milk. I leaned forward to the next table and asked the gentleman there would he mind if I took some milk from the jug while we were waiting. She thought that was very bad. It was a very ordinary thing, was it not?

14,535. It comes to this, does it not, that the more trained nurses you can get in all these cases so much the better?—Yes, they should be trained, and they should be better educated.

14,536. When you are dealing with ordinary diseases, you would not want a person of the same social status as yourself so much as a really educated nurse, a trained nurse. If you were ill you would not want a lady called in so much as a trained nurse?—Yes.

14,537. And that, I suppose, applies in mental hospitals just the same?—Yes; of course, they have got to be trained in their work.

14,538. Are there any other special points you would like to bring before the Commission?—Yes. I think the question of seeing your certificates is terribly important.

14,539. You do not mean that that should apply in every case, do you?—I do, every case.

14,540. Do you mean all the particulars that have been furnished as well as the certificate?—Absolutely.

14,541. Do not you see that on some patients that might have a very bad effect?—I cannot see it; I cannot see that the truth can ever hurt you.

14,542. Are you not arguing rather from your own case?—No.

14,543. You knew perfectly well the substantial facts that were on your certificates, did you not?—No, I had not the faintest idea. If I had, I should have been out of C. long before I was.

14,544. I have looked through a good many of your letters, and letters from others to you. I should have judged that from reading the letters you appreciated the grounds of your being detained?—No, I have never seen the C. papers yet. I would like very much to see them. When I was in C. they told me I was always to continue in the attitude of mind which I had. That is an absolute fact. That was why, when I got my mother's letter and saw I was not getting better and was going to be there for life, that I went to the sister and asked her did she mean the things she had said. If I had seen my certificate I should have had it in writing; I should not have had to take any of her words.

14,545. You had interviews with the doctors before they made their certificates, and you had an interview with the magistrate?—I had an interview with Dr. C., and the things he told me had nothing to do with the certificates. He has since denied he said those things.

14,546. Dr. C. and Dr. P. S., in making their certificates would be guided by what you told them; they would not write these certificates out of their own heads?—Dr. P. S. refused to certify the first time I saw him, before he had a consultation with the other doctor. They subsequently certified me; and that brings me to a point which I would like to bring before you. I heard here at one of the meetings I attended a suggestion that the doctors should be in consultation. That I absolutely disagree with; they should not consult.

14,547. No consultation in making the certificate?—Not at all.

14,548. Do not you think that two doctors putting their heads together might come to a more just conclusion?—Certainly not, I absolutely disagree with that.

14,549. In my profession we think that two lawyers putting their heads together would probably form a more just opinion than separately?—I cannot answer for your profession, it may be different, but

I can answer for the doctor's profession. I think in the case of sanity it is a wrong thing.

14,550. You think the doctor who may have seen the patient first may be the stronger man and may mislead the other?—Yes. Besides the man who is called in by the petitioner is prejudiced against you naturally. I mean, without meaning to be, he is.

14,551. *Sir David Drummond*: Do you not give a doctor any credit for honesty of purpose?—Certainly.

14,552. Why would you not conclude that the second doctor would give an honest opinion?—Because he might get information which was not accurate. He might be told a delusion was a delusion when it was not. Let him form his own opinion.

14,553. *Earl Russell*: On the last point you mentioned, when you say the patients ought to see what is on their certificates, let me put to you the case of a woman, say, who has been very badly demented, who has used terrible language, smashed furniture, possibly threatened the life of her child; that woman is removed to the asylum, and gets better and begins to be able to understand what has happened. Do you think it would help her recovery to see these terrible statements on the certificate of the sort of things which she had done?—I think it is right; I am sure it is right.

14,554. Even while she was still under treatment and not yet recovered, she ought to be told all these terrible things she had done which she does not remember and did not mean at the time?—I think nothing pulls you together like seeing it in writing—not what they have pretended to say. Dr. S. told me he always told his patients the truth, and I believe that, and I think that it is very much to his credit, and to his cures.

14,555. You remember, of course, that in cases of ordinary illness, in the case of perfectly sane people, the doctor very seldom tells his patient the whole truth for fear it may retard his recovery?—I am sure he acts from the highest motives generally and I have always thought it was a mistake.

14,556. You can imagine no case and nothing anybody has done being so bad that it would not be a good thing for them to see it in writing?—I think it is wholesome for them.

14,557. Now a question or two about C. I have been very carefully over the whole of the asylum, and I am rather interested in what you say about it, because it does not agree with the impression made upon me. You thought on the whole it was badly run, did you?—It was war time, remember. I thought it was all wrong.

14,558. What was your personal opinion of Dr. E.? Did you think he took an interest in his patients?—I think Dr. E. is a very kind man, but I think his treatment of patients is wrong.

14,559. What was your feeling towards him while you were there; did you feel he was taking an interest in you or not?—I think he was very sorry for me. He was kind; but he never told me any truth at all.

14,560. Is it your impression now that he was doing his best for you at the time or not?—I think he was in a very difficult position, because I was certified and put in on delusions which he really in his heart probably did not believe to be delusions, and he had to keep me there. I know he was very glad when I escaped.

14,561. He may have been. But then in your *précis* you say: "It seems to me that the doctor who knows you and your story, and wants to help you, is the best judge of where you should go if released for a month's trial." Would you put Dr. E. in that category—a doctor who knows your story and wants to help you?—I think certainly he would do the best for you—outside the institution, certainly.

14,562. Now in C. there is a considerable amount of freedom, is there not, for convalescent patients; I mean you were not locked up in the ward during

23 March, 1925.]

Miss C.

[Continued.]

the day?—No. You were not allowed to go to your bedroom; you had to be where the nurses can keep an eye on you.

14,563. So far as walking goes, and being your own master in the wards, you had a fair amount of freedom?—Yes, that was the convalescent ward.

14,564. You were able to associate with patients—not in the ward—outside?—No, we only met the patients who were in the same house with us.

14,565. You do not meet other patients in the grounds?—Yes; they come across from the other house sometimes, that is true. They used to come across to the garden, yes.

14,566. You really think now that if you had not escaped you would have been detained for ever, do you?—Yes; I am certain I should never have got out, I should have been hopelessly mad.

14,567. And from the last institution you were in you were discharged by the order of your petitioner?—No, certainly not; my petitioner did not let me out at all. Dr. S. let me out.

14,568. Were you discharged "Relieved"?—Relieved. That brings me to a point I was nearly forgetting. I was "relieved," and I lived for six months in my flat doing all my own business, and managing my own accounts. While I was at C. I would like to have done that too. Both Dr. E. and Dr. S. saw no reason whatever to bar me from managing money, because I always had attended to it and yet under the law I should not have done so.

14,569. I know of a lady patient at C. who has her own banking account, and her own cheque book.—Dr. E. said to me "I would be very glad to let you do it, but under the certification you cannot," but he said "when the next Commissioners come round you can perhaps get them to agree. If you can get them to agree to your doing so, I will give you permission."

14,570. Did you have any property or personal property to look after while you were there?—I had a little income of my own. My family did it while I was at C.; but while I was at S. it was never necessary; Dr. S. gave me permission to manage it.

14,571. *Deputy-Chairman*: On the first occasion there was some order made by the Master in Lunacy when you were at C.?—Yes. It seems a pity that if the doctors think you are only insane on one point, or that you have some delusion of some kind, you should be debarred from those other things in life which would help you.

14,572. *Earl Russell*: I quite agree. You may be perfectly well able to look after a poultry farm if you have one, even if you are certified on some other ground?—It should be up to the doctor therefore to decide that, he should decide in what way you should manage your life.

14,573. Or at any rate someone might be given an opportunity of deciding. As a matter of fact the doctor is not introduced in money matters much.—If your doctor thinks your mind is sufficient to manage business then you should get permission to do so, should you not?

14,574. *Mr. Snell*: It is very important that we should get clear in our minds the relative advantage of public institutions and these private institutions. You are making a complaint against the private institutions, and I just want to ask you, do you think it is possible that when you went into C. you were more depressed—may I say more irritable, more ready to notice the objectionable features of the place, than you were when at a subsequent period you went into the S. Mental Hospital?—Yes, I quite agree. I think I was much more ill when I went to C. than when I went to S.

14,575. I have heard that when people go to prison the second time they do not find it quite so horrible as they found it the first time.—That is true. I was much more ill, but I was not ill enough not to know the difference.

14,576. You think that C. was really inferior?—As a place for recovery infinitely.

14,577. When you were at the S. Mental Hospital it was not in the war time. We all had to go short of food during the war.—But it is not those points I dwell on.

14,578. Now with regard to the certificates, I think your point may be right for a person of education, but suppose you show a doctor's certificate to an uninstructed person (you know the horrible words doctors put in certificates) it might frighten the patient to death, a lot of these Latin words and things?—If a patient is so insane that these things have that effect that they cannot understand them, then I do not think it matters whether they see or not, but if they are sufficiently of sound mind to understand what is on the certificate and take it in, it is good for them to know.

14,579. *Earl Russell*: However sane you were, if you saw on your certificate you were a paranoiac that would convey nothing?—But it could be explained to you.

14,580. *Mr. Snell*: Then you know the condition of a patient alters from week to week, and even from day to day, and a certificate that was valid for one week might be quite wrong for the next week. There are difficulties in it?—The certificate tells you the reason for your being certified, therefore you know the reason and you can try to cure yourself, as well as the doctor trying to cure you.

14,581. *Mrs. Mathew*: I just want to know a little about the hours of the nurses at C. Do you think they were too long?—It was war time, of course, but they were very very long hours.

14,582. What hours were they, can you remember?—The night nurse came on about six in the evening, and she was there in the morning. Twelve hours is a long time, is it not?

14,583. Very long.—She was there making the beds after breakfast. Naturally she was getting very worn out.

14,584. *Sir Humphry Rolleston*: In the first paragraph of your *précis* you say: "I was told the doctor" (that is Dr. E., is it not?) "received a bonus on each patient detained there instead of a bonus on each cure." That is rather an important statement. Who told you that?—I was told by Madame B. who had been seven years there. She was a great friend of Dr. E. and knew everybody very well. She told me he got a bonus—that is my authority.

14,585. A bonus on each patient?—For extra work. Each patient there means so much more work. He got a percentage or bonus on each patient.

14,586. That is a friend of Dr. E.?—She was a patient, but she had also for a long time been a great friend with them all.

14,587. Then you had a private conversation with the Commissioners, but you did not find them very helpful?—Not in my case.

14,588. How was that? I mean they are there in your interest, are they not?—I think they accept so blindly all that has been said in the certificate and by the doctor that they do not consider your side much; if you feel you are wrongly detained, I cannot see they have any power whatever to help you.

14,589. You say they are definitely harmful in your case. Was that the personality?—It is very difficult for me to tell you, but Mr. Trevor who was very pleasant, and meant to be kind, gave me a terrible upset; the things he said did do me harm. I cannot very well go into it, because it is too troublesome, but he put more insanity on me than any one as far as I know.

14,590. It is disappointing. They are appointed in your interest?—I think they want to be replaced by some other form.

14,591. *Sir Ernest Hiley*: How many times did you see Mr. Trevor?—I only saw him once.

14,592. Did you see Miss Dendy more than once?—Once.

14,593. *Mrs. Mathew*: When you were discharged from the S. Hospital, how did that come about?—

23 March, 1925.]

Miss C.

[Continued.]

To begin with, Dr. S. wanted me to promise, and I did promise while I was there, that I would not try to escape. He is a public official. C. is a private place; there is no responsibility to the public. After my promise was up he said "If you do not promise it again, I will have to remove you somewhere else." Then he sent for my petitioners to see if they would like to take me out. He wanted me to go, and did not wish to have the responsibility of me, and he then said about C. again "Of course you can escape from there again if you like, it is not a public place; but you cannot escape from here." He said "I would like you to go home." So I consulted the matron, and she said "Do what he arranges for you, because he is trying to arrange the best thing for you" which is my argument you see; and he did arrange the best thing for me.

14,594. Would you think it would be well to leave more power of discharge in the hands of the medical superintendent?—Much sooner than in the hands of the attendants.

14,595. *Earl Russell*: There is just one other question I should like to ask; you told us that you saw at C. and had conversation with a perfectly sane patient who was being detained there simply because

she was a source of profit?—That is what the patient told me.

14,596. I must put it to you, Miss C. Surely you will admit that you were quite unable to judge whether she was sane or not?—I did not say she was being kept there for profit; I said that her husband wished her kept there. He was the petitioner.

14,597. I understood you to say that, in your opinion, she was sane, and was wrongfully detained. —Certainly. I was in the bedroom with her for several weeks.

14,598. Surely you do not say you were competent to form an opinion as to whether she was sane or not?—I think she was sufficiently normal to be at large.

14,599. You had not seen the case books?—No. I had not seen the certificates, no doubt.

14,600. How could you have formed a real opinion on the matter?—I think, if you live in a house with a person for two or three weeks and sleep in the same bedroom, you have a very good idea. She was a much more normal person than the nurse who was nursing us. I think I was quite competent to form an idea as to how she would behave outside.

Deputy-Chairman: Thank you very much, Miss C

(*The Witness withdrew.*)

Mr. B. called and examined.

14,601. *Deputy-Chairman*: You have had a very long experience, Mr. B., in a licensed house called L., between 1901 and 1918?—Yes.

14,602. And a very considerable part of that was voluntary?—That is right, yes. I have got a little statement which I am quite ready to read out as soon as the time is convenient.

14,603. Now is that dealing with the facts of your case?—Certainly; it is dealing with my whole experience; but if you wish to ask me any questions do you mind going right ahead?

14,604. It might be a convenient way to hear it?—This is my statement:—"As you observe I have brought along quite a little portmanteau of books and documents."

14,605. We shall not have to trouble you with many documents?—"but after all, I am inclined to say *cui bono*? I don't want to trot out my little grievances and criticisms, but I would say, broadly speaking, that my experience goes to show that there is, or shall I say was, something radically wrong with the system. That something may be summed up in one phrase, 'lack of personal interest on the part of those vitally responsible and apathy on the part of the public.' I believe it is not properly understood that this department is a distinct vocation instead of a mere subject for merriment." Now this is about L. "Between 1910 and 1920 L. bears a broken record, for in that comparatively brief period there were about a dozen superintendents. Dr. M., who died in 1910, was a good physician, who took his duties and responsibilities very seriously, because when you think of the suicides that take place from time to time, it is a post of, in some respects, extraordinary difficulty." When he died, there was no one to step into his shoes, no one to carry on the tradition.

14,606. May I put one or two questions on that? What sort of house was L.? How many patients were there?—I believe it was licensed for about 70. When I arrived, there were about 45; when I left there were about 25.

14,607. Licensed for 70?—I think so. You can confirm that, of course. I expected that question, and I have been trying to find out, as a matter of fact.

14,608. You were admitted in 1901?—On the 12th September, 1901, at 6 o'clock.

14,609. You were admitted, were you not, on an urgency order?—I am not quite sure; I believe so,

but I have not seen it. I have an account of my arrival here; it is only a few lines if you like to hear it.

14,610. Before you were admitted you had applied to become a voluntary boarder at the D. Hospital?—Yes.

14,611. And, of course, they could not admit you until you were certified?—No. I wanted to be under medical supervision for a few weeks; that was my idea absolutely, being in a very run-down condition.

14,612. I was just looking at the order for reception.

14,613. *Earl Russell*: Do you recollect anything about your examination before reception; what actually took place before the order was made, who saw you, and where they saw you, and what they did?—I have got it all down here, chapter and verse.

14,614. If you could tell us quite shortly that will do?—The worst of it is, I cannot find the exact page. Anyhow it was at P. on the morning of the 12th at 8 o'clock; I had an attic there, very nice quarters over a dairy, and Mrs. H., who is the lady there, came up the stairs to me and said, "Oh, there is a gentleman downstairs who would like to see you," and I got into a bit of flutter. I kept him waiting 10 minutes perhaps. I went down and there I saw the family doctor, Dr. R. He scanned me very carefully, and said, "You have not been very well lately, Mr. B." I said, "Yes, that is quite true; I have been keeping to my room lately, but otherwise there is nothing much the matter with me." I was really recovering. I had had a severe indisposition, retention of urine, and that had gone on for months and months, but that was improving; in fact, the worst of that was over.

14,615. *Deputy-Chairman*: I do not know that we really need trouble very much with this. You were seen by that doctor and one other doctor?—Yes. Dr. W.

14,616. They made their certificates, and then a justice, Mr. T. B., saw you?—No, he did not.

14,617. No, it would not be necessary that he should see you then. At all events after you were admitted to the house did you see the magistrates?—No, not for some time. Dr. M. came to see me when I was in the big sitting-room after my arrival. I confess that when he first confronted me I was attracted by his urbane manner, but he was very cryptic and silent when I talked to him about my

23 March, 1925.]

Mr. B.

[Continued.]

detention. He explained that my relatives, and not he, were responsible for it; of course, that is technically known as the petitioner. After a time not only was I allowed out without an attendant, but I got *carte blanche* to take patients out, and that mollified me considerably.

14,618. Did he suggest to you that you should see a justice of the peace?—No.

14,619. Did you see one after you were in the house?—The visitors in the usual way.

14,620. *Earl Russell*: Do you remember being served with a notice saying you were entitled to see a justice of the peace if you wanted to?—No, and in connection with that may I say that a patient complained he had asked for this notice and the attendant refused to give it to him.

14,621. *Deputy-Chairman*: You are not complaining of the original detention order at all, are you?—Yes, I am.

14,622. Why?—I do not think it right; I was not mad. I was in a very run down condition.

14,623. But you had yourself been applying to go to the hospital for mental treatment?—I have got a note about that. Looking back I do not think that my certification was essential to my recovery, because I was almost on the mend when the doctor arrived on the scene. Nevertheless I derived much benefit from the isolation.

14,624. After you had been at L. a very few months you were allowed out alone?—After seven months I was allowed out, yes.

14,625. Alone?—Yes.

14,626. And after two years you were given absolute parole and a key?—Yes, of course that is in my letter to the Commission.

14,627. Yes, you have set out the facts in this letter.—Yes, as clearly as I can.

14,628. Then you were not discharged from your certificates till 1913, and after that you became a voluntary boarder from time to time. You were admitted from time to time, and went away; then came back and went away again—half a dozen times?—No, there is a little exaggeration about that. I am not complaining in that particular way.

14,629. Let me just remind you.—In 1917. I went out.

14,630. You left on the 3rd August, 1917?—That was really the first holiday I had, in 1917, yes.

14,631. You forget—you were discharged “relieved” in 1913?—Yes.

14,632. Then you went back and left again in June?—I came up to London for a few days, yes.

14,633. And you went back from time to time?—If you do not mind my saying so, those were erratic wanderings. Just at that time I came up to London at my solicitor’s wish. My case was in the hands of the law at that time.

14,634. As a matter of fact you went back to the house in 1914 and 1917 and in 1919?—Yes.

14,635. You were perfectly happy to be there?—Yes, that voluntary business was really from 1903. There was no radical change when my certificates were revoked. I had the same privileges there; I had the run of the house, and all that sort of thing.

14,636. And all the time you were there as far as you were personally concerned you were very comfortable, were you not?—Exceedingly so.

14,637. You have nothing to complain of?—I have—I will tell you. The one fly in the ointment was a bullying attendant, that is what I wrote in my letter. There was not supervision by the medical superintendent. They put things into his charge, and the man was not fit to be an attendant, because he had not the qualities for it; but he was a smart sort of fellow, not a bad fellow, would do well in many things, but as for forbearance and kindness with regard to the patients I had complaints over and over again from them, because I was a sort of go-between between the patients and the doctors for years.

14,638. Were you able to call the doctor’s attention to that case?—Yes, I have got a note here, but there

are so many cases. The doctor does not want to be bothered with these things.

14,639. How many attendants were there at the house?—It varied, sometimes half a dozen. Before the war they rather accumulated, when the war came along off they went, a good many of them; very nice young fellows too, many of them.

14,640. Were they all male attendants?—Yes. That is another thing; I think there is not the least doubt that female influence would be a great advantage.

14,641. Of all the attendants that were there during your time was this one you have referred to the only one you have to complain of?—Practically he was.

14,642. Did I understand you to say that Dr. M. died in 1910?—I think that is so.

14,643. And then after that there was a succession of medical superintendents, one after another?—Yes. Dr. N. came along and did a lot of good. In some ways Dr. M. was very conservative. I have got these things written down better than I can talk them. Dr. M. had got into rather a groove, and the house had got into a state when it really required renovation. Dr. N., when he succeeded Dr. M., saw this and got a lot of plumbers and carpenters and they were months in the house cleaning and renewing the place right through; and Dr. N. did a lot of good in one way.

14,644. *Earl Russell*: What about the sanitary accommodation and the bathing arrangements—were they satisfactory?—Not very satisfactory. I used to clean out the water closet; I have cleaned that out hundreds of times.

14,645. *Deputy-Chairman*: Was there sufficient sanitary accommodation?—Yes, in the ordinary way.

14,646. Was there any doctor there except the medical superintendent?—No.

14,647. But during the whole period the medical superintendent was the only doctor in charge, was he?—Yes.

14,648. *Earl Russell*: No assistant doctor?—No. I do not know whether once or twice they had an assistant—no, they did not have. In fact, as regards that I would like to mention that there was an old gentleman who had been there for years and years, and he finally left, and almost his last words were—I have got them here—that it wanted someone between the attendants and the doctor.

14,649. You yourself were very much interested in the patients, were you not?—Certainly.

14,650. And you helped to look after them part of the time?—Yes, that is right.

14,651. And as far as you could see they were well looked after in this place?—I have told you in my *précis*.

14,652. That there was not adequate supervision of the attendants?—That is what I complain of.

14,653. There was not supervision by the medical superintendent?—That is my contention all along.

14,654. And in consequence was there any cruelty by any of the attendants?—Very rough handling. I cannot say I can put my fingers on one particular act of physical cruelty, but there was rough handling on many occasions.

14,655. *Deputy-Chairman*: You told us just now that there was only one attendant as far as you knew that you could really find fault with?—I do not know about trying to find fault. I just took these young men as I found them, and I got on very well with them.

14,656. *Earl Russell*: We want to know how you did find them?—There was one fellow called D., I recall him very well; I remember him chasing a patient, four of them chasing an unfortunate patient (and this patient went to the war afterwards); and they got him by the hair. I happened to be near the door, and intervened very resolutely about it, but of course my position was a very difficult one, because I was neither flesh, fish nor fowl; I was not in any particularly defined position. I was supposed to be a patient, so if I interfered in any way I was always liable to be jumped on.

23 March, 1925.]

Mr. B.

[Continued.]

14,657. *Deputy-Chairman*: What were you paying during the time you were there?—I could not say; I have no idea.

14,658. Do not you know what fees were paid?—I have got that down; I do not think it was very much—about £3 a week.

14,659. Were the patients on a different footing, some paying more, and some paying less, or was it a standard fee?—I could not say; I do not know the financial system.

14,660. You were not managing your own financial affairs, of course?—No.

14,661. And some time after you had been there, apparently you were very much surprised at receiving a notice from the Master in Lunacy with reference to your finances?—Yes; I was very much surprised about that.

14,662. Up till that date, that is 1912, how had you been provided for? Who paid the fees?—My mother died, and then my eldest brother took on the responsibility.

14,663. And the Master in Lunacy proposed to make him the committee of your property, did he not?—Yes.

14,664. And he was appointed, I suppose?—Yes.

14,665. Until after there was a public inquisition which found you of sound mind?—Yes; it took a long time.

14,666. But during the interval between 1912 and 1920 when the inquisition was held, you had been going backwards and forwards to this house from time to time?—I would not put it just like that; you do not expect anyone to stay at a place for ever.

14,667. That is putting it very shortly, is it not? You voluntarily went back from time to time?—I only properly and voluntarily went back in 1919. I came to town and could not get settled down. Then I went for a cycle tour and went back early in 1919. I was invited there for a few weeks, and then the doctor said: "I leave it to you. Would you like to stay or quit?" and I said I would like to stay for the winter, so I stayed there right through the winter.

14,668. During the last few years since 1920 you have been in London, have you not?—During the last five years I have been in London, and in the same room that I am occupying now.

14,669. While you have been in London you have been interesting yourself to some extent?—In industrial questions.

14,670. And in the working of the lunacy administration in London, have you not?—No. It is quite true I am a member of the Lunacy Reform Society. I was one of the first members, and attended their first meeting about five years ago, but I have done no active work for them. I have visited a patient twice in the last year, that is all.

14,671. May I refer you to a passage in your letter which I do not quite understand. You say "L. was a charming and delightful retreat, but what a contrast to come to London, and see something of the work of the London County Council." What do you mean by that?—Because the system in L. is so backward. No one seemed to care about their work and duty. The London County Council are such a progressive body—at least some think so.

14,672. You are not contrasting the London County Council work in the asylums?—No, just the method of interest in the work, that is all.

14,673. Your point against the asylum is that apparently the medical superintendent and the attendants do not take sufficient interest in the welfare of the patients?—That is it, absolutely.

14,674. And you think, as far as you have observed, the medical superintendents leave too much to the attendants?—That is right, yes. On that point I have got one or two cases here—two special cases here.

14,675. I think we can take that from you?—A man called F., a farmer, struggling in the bath, and no one there at all. Another case, an engineer just

received in a state of mania, and he was with four attendants sitting on him—that is the sort of thing.

14,676. I suppose when a man is in a mania of that kind it is absolutely essential that he should be restrained?—It is not essential to sit on him though, is it? Of course it is very essential that he should be restrained, you are quite right, and in many cases they are afraid to do it.

14,677. It requires two or three attendants from time to time to restrain a man?—Yes, but there is a method of holding him, and all that sort of thing, which, of course, Dr. Conolly has dealt with in his book written about 50 years ago, and I do not think anything can be improved on what he said.

14,678. There is another point that you refer to in your *précis*—you say there is a great lack of occupation. At L. what grounds had you? Was there a farm attached to the house, or large grounds?—Some very nice grounds, indeed.

14,679. Was gardening one of the occupations?—Yes, but Dr. M. did not care much about the gardening himself. It was not in his line, you see, and then he was very conservative about trusting any patients with tools, and that sort of thing.

14,680. He gave you your liberty almost at once?—He gave me power to go out by myself after seven months.

14,681. Did you occupy yourself in the garden at all?—Not for a long time, not for many years. For some years I was doing practically nothing. It was only on my initiative that I did go to work in the garden. I put in a lot of work there, about five years' eventually. I am very glad I did, for I got the utmost enjoyment out of it.

14,682. What more do you think could be done for a patient in the way of giving him occupation?—Walks and small games. My experience is that the first question is interest. If you once take an interest in the patient it is wonderful what you can get out of him. Then you get improvement, and you might get an absolute cure in many cases, which were supposed to be hopeless.

14,683. I suppose in your experience there were a great many people sent out relieved from L.?—There were some, yes, but of course you see L. has great advantages in many ways; for a patient arriving is quite an event, whereas in these big county asylums it is a sort of thing happening every day, but in L. perhaps a patient will arrive once in six months. It was like getting a microscope on them, if you can understand. The people at L. have every opportunity to deal with each individual patient.

14,684. The medical superintendent would have no difficulty there in knowing all his patients well?—It was delightful in that respect.

14,685. In what respect do you suggest that further occupation could have been given to the patients?—It must be done individually to a certain extent. There is one patient at L. now who is clamouring for a bicycle, but I am bound to say I do not feel inclined to put my hand in my pocket and buy a bicycle for him, when his own brother ought to.

14,686. You do not suggest that the medical superintendent should be driven to that expense?—A bicycle in the country there is a lovely thing to have.

14,687. There are certain risks attached to bicycle riding too?—Yes; Dr. M. asked me to be careful, I remember, the first time I took him out, but I always found him absolutely *au fait* on the bicycle in the most crowded streets; he never lost his nerve at all.

14,688. Did he lose that exercise when you left?—That is right.

14,689. Have you seen something of other asylums besides L.?—Yes, I have, B. Asylum. I went to see a terrible case who was at L. for some time.

14,690. You make some observation in your *précis* about V. Is that another asylum you have been to?—Yes.

23 March, 1925.]

Mr. B.

[Continued.]

14,691. At the private asylum, L., I suppose you went to bed at any time, half-past nine or ten, whatever it might be. All the patients were not sent off at half-past seven?—Well, yes, that was about the regular time, sometimes earlier.

14,692. Would that apply in all cases, cases like your own?—No. For the first year or so I was there I was absolutely one of them, and of course it was very unpleasant to find oneself cheek by jowl with a fellow muttering.

14,693. You were rather interested in those cases, were you not?—I got gradually interested, yes.

14,694. They did not trouble you?—I did not go there with that idea, of course, but it is a sort of interest that one may have, or may not have, I suppose.

14,695. You take objection in your letter to the patients being sent to bed so early in these places.—That is at V., I noticed that particularly. I got run down here in London in 1918. I went to the Board of Control and asked them to recommend me a place where I could stay because in my condition then I did not want to go to a hospital. Then I thought to myself; "I will learn something more about this business and get a few more tips." The Secretary of the Board gave me a choice of two, that is B. and V. I went to V. and I stayed from February to July 1919.

14,696. How did you get there—you were not certified?—I went as a voluntary boarder, just for a few months.

14,697. Just give us quite shortly your experience at V., whether you found anything to take objection to.—It was a very large place; they say it is the largest private asylum in England; it has magnificent grounds. I may mention one little point while I think of it. At L. I always used to have a siesta in the afternoon; I found I had to abandon that when I got to V.; even as a voluntary boarder I could not go up to the dormitory and have a lie down.

14,698. You had very comfortable rooms, arm-chairs, and so on?—Of course there is everything there in that way. That place is divided into galleries, seven galleries, and I was in No. 1 which is considered the best. In No. 7 the very difficult cases are put. I got very friendly with the ground man there, and, with other patients, helped to roll the ground.

14,699. You enjoyed yourself in V.?—I went there to enjoy myself.

14,700. And you found the surroundings comfortable there, too?—Yes. Still, there is something in the atmosphere which I am bound to say is depressing. I should like to say I visited L. again the other day, and I found it very much improved in that sort of atmosphere, the arrangement of the rooms and everything, no doubt very great care has been taken. The new doctor, Dr. B., has got the place absolutely 'tip-top' now.

14,701. Did you observe at V. anything to which you ought to call special attention, do you think?—In No. 4 gallery I thought the people there were sent to bed very early. They had not got the man power to attend to them. It is difficult.

14,702. Were the attendants a good set of attendants there?—Yes.

14,703. A kindly humane set?—Yes.

14,704. Was the diet good there?—It was rather too much for me, a rather heavy diet. I did not want meals every two or three hours in the day.

14,705. Is there any other thing you would specially like to call the attention of the Commission to?—I have got some rather interesting statements here—of course I do not know that I can hit upon them. There is one thing, you spoke about the charges. I may say I got a complaint the other day from the widow of a man who died in L.—died by his own act. She told me the charges were very excessive.

14,706. *Earl Russell*: I would like to ask you a few questions if you will try to answer me shortly, otherwise I do not think we can pursue it. You have

been in these places for some time, and I understand you have seen the other patients that have come in?—Yes.

14,707. And of course you have had the opportunity of being well acquainted with them?—Yes; that is why I have written some of these things down, so that I can read them straight off and finish it.

14,708. If you please, I do not want that; if you would not mind answering my questions. You have had the opportunity of being well acquainted with them?—Certainly.

14,709. Are you under the impression that you have come across anybody who was wrongfully certified, or wrongfully detained in these institutions?—I have thought of that a good bit, and I should say "No." There are just two rather doubtful cases. There was a young fellow when I first went there, and I am bound to say I did not see much the matter with him. Then there was another man who came in with slight depression. He was not in the house very long; it depressed him very much to see the demented patients circling round and round with nothing to do.

14,710. Those are the only two cases you can recollect in your experience?—Yes.

14,711. As regards cruelty, I understood you to say that although there was rough handling there was nothing that you could call deliberate cruelty?—But there is a lot of bullying, which, in my opinion, may be worse.

14,712. Bullying in what sense?—I can only tell you I drank the cup of humiliation to its depths.

14,713. I should like to have something a little more specific?—When you come up against a bully who is determined to repress you and restrain you in every possible way, in your position what can you do? You are entirely at his mercy.

14,714. I want to know in what way he tried to restrain and repress you. Were you made, for example, to sit in a particular place?—No. I was prevented from going into a better room, which is perfectly legitimate.

14,715. Was it a room to which the patients in the ward you were in legitimately had access?—Yes.

14,716. And you were prevented, from mere caprice, do you mean, as an exercise of power?—Yes, that is it. There is another case. I asked him, "Will you unlock the door for me, please," and his answer was, "Go to hell." I wish I had reported that, and got the fellow dismissed.

14,717. You said he would not unlock the door for you?—The front door of the house.

14,718. In order that you might go into the grounds?—Yes.

14,719. And that would have been a legitimate thing for you to do?—Yes, because the gates outside were closed.

14,720. And that again you mean was a mere capricious exercise of power on his part?—Yes.

14,721. Tell me about the lavatory doors. Were the lavatories always accessible when required during the day?—Yes. There was a lavatory outside, and there was one patient very troublesome, always using it, and I think they had to lock it up sometimes.

14,722. But not unreasonably?—No.

14,723. Tell me about shaving—were people who wanted to shave allowed to shave themselves—those who were fit to?—There was a barber who used to come in; they did not allow shaving.

14,724. There was nobody who was allowed to shave himself?—No.

14,725. It is no good asking you, because I see you did not.—I did at that time.

14,726. Were you allowed the use of a razor at that time?—Yes.

14,727. Now, one more question only. Were the wards cheerful and agreeable and pleasant?—The wards were one in number, that is all. It reminded one of nothing so much as a tap room in a bar. I have got my account.

14,728. I do not want to give you the trouble of reading details.—When I first went to L. I went into

23 March, 1925.]

Mr. B.

[Continued.]

the place; I realised perfectly well I had been trapped, but nevertheless felt optimistic. I got into the front room; that was the best part of the house, the front of the house was quite all right. Then an attendant comes along, this gentleman I have just mentioned to you, and he said, "Will you come this way, Sir?" Then I followed him down a flight of two stone steps into a gloomy corridor below, where I found out the sitting rooms were situated. In this narrow room there was very little furniture, but there were two engravings, and one was an engraving of the Achilles statue, and that heartened me very much, and I do think pictures do influence people.

14,729. Were there ever flowers in the ward?—I do not think I troubled much about flowers; there were plenty in the garden outside. I wish you would go and see it yourself, I am sure you would like it.

14,730. *Sir David Drummond*: You have attended nearly all our meetings, Mr. B?—Yes.

(The Witness withdrew.)

(After a short adjournment.)

Miss B. called and examined.

14,733. *Deputy-Chairman*: We understand that you wish to give evidence before the Commission and you have furnished us with a statement of the matters you specially wish to refer to?—Yes. I sent a letter first and then a lawyer made a sort of summing-up of it all.

14,734. I see from your letter that you think you were detained too long?—I was kept for two years and eight months beyond the time.

14,735. I will deal with that a little more fully presently. In your letter you say, after you had been under care for two years and some months, "I only managed to get out on April 4th, 1923, after I had said I must have paper and pen, for I was going to put my affairs into the hands of a lawyer and summon my relations." Then a change came over things and you got out?—Yes, immediately.

14,736. May I ask what you mean by saying "I must have paper and pen"?—Because I was not given anything.

14,737. Could you not write letters?—Never. I have listened to all the evidence that has been given before the Commission about the letters and the letter boxes; and I was not allowed anything. I did not get a letter for two months. I wrote one and they tore it up.

14,738. You were at P.—a licensed house?—Yes.

14,739. Of course you were a paying patient?—I was paying 7½ guineas a week.

14,740. Did you have a separate room?—No, there was no accommodation of any kind for taking patients like that. I was in a room once with a lady for three or four weeks, shut up in a room with her with a nurse watching us all the time.

14,741. Was that a sitting-room?—No, a sleeping room. There was no separate accommodation for sitting-rooms. There was a big room; there was a skylight in it, but the only air was over the washing-up sink at the end.

14,742. Still you had your large living room and so on?—We had a tiny living room with no fire in it.

14,743. What other room?—This big room and a place which was a dining-room.

14,744. In those rooms there would be writing materials, would there not?—Certainly not. All my writing material was taken from me the moment I arrived, and my purse, and I never saw them again until I came home.

14,745. How many patients were there at this place; is it a small place?—The matron always said she had 60 people to look after; that was including everybody. I have a list of the ladies; of course I do not know about the men.

14,731. I was just wondering whether you found them interesting?—Some of the points, because, naturally, I have been through the mill, and unless you have been through the mill you cannot possibly tell.

14,732. Do you think we have made much progress up to now?—I do not think that we could have had a better Chairman, if you do not mind my saying so; and I think it is magnificent, the work that is being done. I mean it gives me absolute satisfaction. I do not know why the other members of my Committee do not agree with me. However, that is my considered opinion, that it is absolutely safe in your hands, the whole thing.

Deputy-Chairman: Thank you. I hope you will understand that though we have not taken, of course, all the matters you have written down, I think you have covered the ground extremely well; and we are much obliged to you.

14,746. There was a man's side as well, was there?—There was a man's side as well.

14,747. I am told that there were 24 ladies?—I could not tell you about that.

14,748. What medical superintendent had you?—Dr. N. and Dr. T. were the only doctors.

14,749. Who was the superintendent?—Dr. T. Dr. N. was the young partner; he was away for months and months, and when he was there Dr. T. was often away.

14,750. Were not the other patients using pen and paper and writing letters?—They were allowed to; sheets were given out and they kept a book as to when they wrote. I was never told I could write to anyone; I was not allowed to have the things. I was told, "Your friends do not write to you." My friends were asking to write to me. With regard to all the rules you have heard about these places, not one of those rules was ever applied to me.

14,751. You mean there was no letter box with a notice on it?—No, certainly not.

14,752. And no notice that you could write to the Commissioners?—The Commissioners came and never spoke to me at all.

14,753. In your recollection you had no opportunity whatever?—I had no opportunity whatever, unless I cudgelled it out of them. The matron was furious because she was away once and I got Dr. T. to let me write.

14,754. What was the name of your matron?—Miss R.

14,755. Do you know if she is still there?—I imagine so; I do not know, because I send lots of things to the patients now, but they are not allowed to write to me.

14,756. Could you at any time communicate with Dr. T. or Dr. N.?—Dr. T. used to come up and listen to me, and say, "Oh, no, Miss B.," and run off again. I used to say, "I have not got delusions, doctor." He said, "That is all right." He was always running about, saying, "Festina lente." One laughs now, but it was terrible at the time. My aunt was dying all the time, and I could not get out to her.

14,757. You have been making certain statements about the house—the want of ventilation and want of comfort?—There was no comfort at all.

14,758. Did you appeal to the doctor about those things?—It was no good appealing about anything. If you appealed they just treated it as folly. You cannot appeal when you are a private patient. I did, when the row was so awful in the dormitory. The young nurse said she was going mad. I said,

23 March, 1925.]

Miss B.

[Continued.]

"I do not wonder, but what do you think I am like?" I was in bed all the time.

14,759. When you first went to the house did you have a separate bedroom?—No. They moved me straight into the dormitory and put me into the padded room simply because I jumped out of bed and wanted to see the matron. I was put straight into the dormitory, where the noise was simply awful.

14,760. How many beds would there be in it?—There were five beds, and the nurses ran in and out the whole of the night. It is the passage room for all of the lavatories. They carried through everything for the other rooms. This went on all night. I shall never forget it.

14,761. How long were you in the padded room?—I jumped out of bed and asked to speak to the matron; I got thoroughly frightened. Then I was dragged across to the padded room. I was in the padded room just before Christmas, with a nurse watching me day and night. It sent me quite off my head. What else could you expect? These nurses were young girls, perpetually changing, talking of their love affairs all night. It was perfectly hideous.

14,762. After you had been in that room for some months, where did you go next?—The next thing was I was taken to the dormitory, because they wanted the padded room for another patient.

14,763. As I understand, at this place you were paying considerable fees?—I was paying enormous fees. I did not know what I was paying until I got out.

14,764. Were there not separate bedrooms for patients who paid considerable fees?—Miss V. and Miss H. were the only persons who had bedrooms to themselves. Miss V. had a bedroom to herself.

14,765. What was the accommodation at this place? There were 24 ladies. You have described the reception dormitory?—It was the ball-room of an old hotel; it was the ball-room where they had this sort of general meeting room with a coke fire in it. The bedrooms opened off from that like a rabbit warren. It is a very, very old house. This was on the top of the house.

14,766. Were there not a good many separate bedrooms?—There was a wing down below; built in 1911; there were separate bedrooms there. Some were used for the men and some were used for the ladies. We used the top wing. When there was a great press they put one or two downstairs. There were plenty of bedrooms always.

14,767. How many dormitories were there altogether?—Only the one dormitory, and all the rest were bedrooms.

14,768. Is the reception room what you call the dormitory?—No, the dormitory led off that.

14,769. How many beds would there be in a dormitory?—Five, I think.

14,770. That only takes five. What other sleeping accommodation was there?—There were all these different bedrooms. Miss H. had one to herself and Miss M. had one. There was one with three people in it, and there were these two old ladies outside the padded cell, and the matron's room at the end.

14,771. When you came out of the padded room did you go into the dormitory?—Yes. The padded room was used as an extra room.

14,772. *Mr. Jowitt*: There was one bedroom where five were sleeping?—That was the dormitory.

14,773. There was one room where five people slept, and there were two rooms in each of which three people slept?—Yes, and one in which two people slept, and these others were little single rooms, and then there was the matron's room.

14,774. *Deputy-Chairman*: I see you say in your note you were forbidden for many weeks to write to any of your friends and relations?—I was kept there for weeks without writing. The first note I wrote was soon after I got there, and they did not send it. Then after that I was allowed to write one which they did send. Then it was months before I wrote

again. I was not allowed to have letters. My friends were told not to write. I was lost to the world.

14,775. I think you suggest that after you had been in there some months you were in a condition to be discharged?—In June I was well.

14,776. Does your memory really go back?—My memory goes the whole way, because I was ill for such a very short space, and I made notes in my own mind. I could not make notes on paper.

14,777. I find from the medical notes that were made about you that on the 21st June, 1920, for instance, you managed to take your food with difficulty, and that sometimes—only rarely—tube feeding was necessary?—I want to explain to you why that was. They were so extraordinary. I said, "Very well, I shall not eat anything until I get back to R," so I declined to do it.

14,778. Do you mean you were deliberately putting yourself on starvation?—Deliberately. There was my aunt dying at home whom I had looked after all my life, and I never saw her again. It was a most cruel thing.

14,779. You complain that you were detained there too long. Have you any other complaint against your treatment?—I did make notes about my hands, did I not?

14,780. Yes, you have made some notes about them. —You have only got to look at them. I have just had an operation for this thumb—in January. I do not know of anybody who would sit in a padded room all the night on a filthy mattress.

14,781. Recollecting the mental condition you were in, according to your own account, you would surely call the doctor's attention to that, or the nurse's or the matron's attention?—It was no good calling attention to anything. I said how filthy it was, to one of the nurses, and she said, "It is your own fault for being in here."

14,782. Could you not get behind that?—It was not the slightest good calling attention to anything.

14,783. There were a good many patients in there who were treated properly?—Some were treated very properly indeed. It just depended.

14,784. What did it depend upon? — Apparently whether the matron took a fancy to you or whether she did not. A Miss S. came in and some of the nurses began to treat her badly, and the head nurse said, "Be careful what you say to her, because she is a favourite."

14,785. Your suggestion is that the matron had some regard to some patients and not to others? —To my sister she was very good.

14,786. Was your sister there as a patient?—My sister was there as a patient, only for a short time.

14,787. Was that before you were there?—Before I was there.

14,788. Your sister had no ground of complaint, had she?—Not the slightest. They wanted her to come home before she was well.

14,789. How long was she there?—She was there from December, 1914, to the January year—that was 13 months.

14,790. Has any other member of your family been there?—No; we did not know anything about it. My sister was taken ill in India; she had a very good appointment there. I went down to P. with my other sister, we took her off the boat at P. and Dr. F. said it was a good home to send her to.

14,791. It sounds a little strange that she should have been there for a year and a month and have been quite comfortable and that you should have followed her and found the condition of things was so different?—I will tell you why I think it was. To begin with I must tell you that the matron brought my sister home. I was living with my aunt then. We had the matron stay with us for the night. We were always noted for receiving everybody hospitably, and she was treated very hospitably. She had her breakfast in bed next morning, and so on. She has told me since that I was rude to her

23 March, 1925.]

Miss B.

[Continued.]

on that occasion, and when she heard I was coming she said, "The other one was grateful. We will make gratitude do for both." She was a frightfully ignorant woman.

14,792. How long had she been there?—For years; I think she had been there for 20 years. She had a keen class hatred; that is the only way to express it. She came from a cottage home. She was always hurling it at me: "You B.'s are better educated than I am." I had never come up against class hatred before, and I did not know what it meant.

14,793. She did not show that in any of the other cases?—No. They always made out that nobody ever paid anything. At least, it struck me that possibly, from the way I was being treated, the head nurse thought I was not paying, too. She had to take me to the dentist, and I got her by herself, so I said, "Now, nurse, you know what the accommodation is. Do you know that I have been paying 7½ guineas a week?" She said, "I had no idea. Are you sure your people have paid up?" I said, "We are not like that."

14,794. Did not your people come to see you from time to time?—Hardly ever. I have written it all down here in case I make any mistakes. I went down on the last day of January, 1920. Mr. W., my brother-in-law, came to see me on the 1st April, and then on September 29th, 1920. Of course, I was taken out of the padded room—

14,795. Was he your solicitor?—He was the doctor who signed my certificate. Of course, I was taken out of the padded room and had a pair of stockings given me and a handkerchief, but it was quite useless to visit me then, or at any other time, as you could hear everything that was said, and I was only told and scolded if I dared say anything, and, of course, he naturally believed every word they said.

14,796. Could you not see the doctor alone?—I saw him in a room up there; you could hear every word that was said, all over the corridor. The thing was, of course, that I realised he was told that no doubt I was a dangerous patient, because they were calling out, "If you want me, Mr. W., I am here." In April, 1922, there was a very nice nurse, an old woman, who had grown-up children; we had her and one other nurse of a proper age. She was very kind to me, she saw I was well, and she said, "I cannot think why you were here. I wish I could see your people." I said, "I should go and see them; they live in R. Will you write to them?" She said, "I will."

14,797. Had you no visit between April and September?—Yes, I had the visitors, but whatever I said was no good. The nurse said, "Very well, I will write." So she chanced very much on that. She said to me, "Your sister would never tell, would she?"—not dreaming anybody would tell Dr. T. about what happened. So she gave me a paper and a pen in the middle of the night, and I wrote an account of how I had been treated. She wrote a covering letter with it, saying that she was an old woman and had been with me for a long time as night nurse, and Dr. T. had repeatedly said that my brother-in-law should come, and she sent this. My sister took the letter and posted it back to Dr. T. Of course, there was a most frightful row, and the nurse was dismissed and went. That settled me.

14,798. Would you mind telling me the visits you had after September?—No one of any kind visited me again until April, when Mr. W. came.

Mr. Jowitt: Which year is that?

14,799. Deputy-Chairman: April, 1921?—Yes. Then in July my sister, Mrs. H., rushed in without my knowing she was coming, on her wedding tour, and stayed half an hour.

14,800. Could you not talk to her?—I talked to her downstairs, and told her I was quite well, and begged to go home, with the usual result. She said, "The doctor has settled this." They treated it as a rule. My brother-in-law came again in April, 1922, with the usual result—quite useless. In October of the same year he came again, and informed me that

I should not come home until the Commissioners said I was well. I knew what the Commissioners said, but no Commissioner had spoken to me except in the first three months I was there. The second Commissioner, whose name I do not know, came on the day of Mrs. S.'s funeral, and only said "Good afternoon." I thought he was somebody who had come down for the funeral, and had just come to see the place. So it seems difficult to me always to imagine what a Commissioner is supposed to do.

14,801. Then you had no visits from your relatives except by Mr. W?—Only these visits every six months. Dr. Bond had never been before. However, when Dr. Bond came in June, the end of June, I think, in 1922, I told him my whole story. I thought I would try. I had been told I was never to speak to anybody. I thought I would have a try. There was another patient in the room the whole time. I told him my whole story, and he expressed surprise that I had never been home, and said he would see into it; and I was foolish enough to believe that he would do so. That was the last I heard of his visit either from him, my relations, or Dr. T. Mr. W. came in October, 1922, for half-an-hour, with the same result as before; and my two sisters (who had never been before) rushed in about 7 o'clock one evening in December for half-an-hour. I had never been told they were coming. The result was the same. They said, "Of course you must be self-controlled. You cannot come out until the doctors say so." Dr. N. and Miss R. were rushing in and out of the room most of the time, so I hardly ever got them to myself. Dr. Bond came in December, late, before Christmas, but this time I naturally refused to speak to him.

14,802. Perhaps you think now it is a pity you did not?—It was not, because I came out. Dr. Bond came in December, but I naturally refused to speak to him, and when he left the room that was the last Commissioner I ever saw in P., and did not speak a word to him. Now bear in mind that my brother-in-law had said, "You cannot come out until the Commissioners say you can."

14,803. Then you got a good deal better at the beginning of 1923?—I was quite well. I went in in 1920 and I was quite well in June.

14,804. Let me put it in this way. I follow that you think that was so?—I know you will never believe me. I have got so used to that, that I do not take any notice of it at all; I am hardened, really.

14,805. You must not take it from me that I do not accept your evidence?—I do not think that.

14,806. As a matter of fact the doctors themselves realised an improvement at the beginning of 1923?—In 1923 they were perpetually telling me, "You will never go home."

14,807. At all events they gave you a discharge in April?—In April, 1923, but not until I threatened them. Dr. N. was abroad—

14,808. It was Dr. T., was it?—Dr. N. went off the day after the Commissioner came.

14,809. When you say you threatened him, will you tell me exactly what you did?—I will tell you. Of course it is all so childish. I had to think it over. My own people said I could not come out until the doctors said I was well. Dr. T. and Miss R. both told me they had to keep me, much as they disliked it. Mr. W. said it depended upon the Commissioners. I dealt with Dr. Bond without the slightest result. So I determined to try for a lawyer, and in March I said to the matron, who settled everything, that I demanded writing paper and a pen and was going to write to a lawyer and summon my relations. I had previously borrowed a pencil from a nurse who had lent it. On a bit of drawing paper I made out a note to a lawyer friend of my own. I did not write to my own lawyer, as he had sent the paper announcing that I was being deprived of the management of

23 March, 1925.]

Miss B.

[Continued.]

my money; so I supposed he would act for my family. The matron, as usual, went into a great rage—she had a most awful temper—and shouted, “You shall have it.” The next day she quieted down, having evidently taken counsel downstairs, and said, “You can have paper if you wish, but you will be a great fool if you do, as matters are being arranged, as you wish, and Dr. W. has been written to.” I had been told so many untruths, but this sounded more truthful, so I said I would wait a few days; and soon, in a few days, I got letters from Mrs. W. and Mrs. H. recording their surprise at my recovery. Mr. and Mrs. W. came down a week after Dr. T. wrote, and I returned to them on April 4th.

14,810. That explains it. You did not in fact get so far as writing to the lawyer, but you threatened to do so?—I had got the copy all ready.

14,811. *Mr. Jowitt*: Have you got the letter you had prepared to write to the solicitor?—It was a draft on a block of drawing paper. I could not do anything, you see. You were not allowed to write to a soul.

14,812. *Deputy-Chairman*: You were discharged by Dr. T.?—Then I want to tell you what I did after that, because this is where the senselessness comes in. I must tell you that in December, 1922, they brought an enormous box containing all my possessions, and settled me in for life, and they left it. I cannot tell you how that made me feel. My old maid tells me (my family have hardly held any communication with me on the subject) that when they came back in December they were told I should not be out certainly for eight years, and it might be never. Then after I threatened that letter, my brother-in-law came down and expressed how surprised he had been.

14,813. That was when you were discharged?—Yes, my home was gone and broken up. I went back to my brother-in-law on April 4th, and stayed with him, I think, to the 1st of May. Then on the 1st May I went up to my club, where you get a room, for a fortnight. Then I looked about and got a bedroom at H. Street, where I have been ever since. I went to my lawyer, and I cannot tell you how kind he has been. He said, “Do not speak to the Commissioners until you have got your money straight.” I wanted to go to Switzerland to climb. So out of his own pocket he lent me £100 to go and climb. He just managed to do it before the Courts closed.

14,814. Your affairs had meanwhile been put into Chancery and had been before the Master in Lunacy?—Yes. Everything was gone.

14,815. Did the solicitor get them restored to you?—Yes. But I did not want to go to Switzerland before I could write my own cheques.

14,816. Still, with £100 in your pocket you would have been all right, even in Switzerland?—Yes, I should have been, but I did not want, until I could pay by cheque, to go anywhere. I saw the Chancery Visitor in the last days of July. I said, “When I come back I am going to ask to see Dr. Bond.” He said, “Will you leave it to other people?” I said, “It depends upon what you are going to do.”

14,817. Did you have another interview with Dr. Bond?—Yes; I have all the papers here.

14,818. I do not think we need trouble you to go into those, because the only point we really want now is to ascertain what happened while you were in this house?—What I do want you to realise is that on coming out I went to Dr. Bond and laid the whole thing, the terrible treatment of patients, before him, and I got the answer of a child.

14,819. I think you may assume that anything you said to Dr. Bond about any other patients is sure to be carefully considered by him?—Would you like to see the letter?

14,820. He would not write the details to you, you know?—Of course we all knew it happened in the home, and we told him. You do not know what it is to see those sort of things.

14,821. Shall we get back to your own case while you were in the house?—Yes. Might I finish this about coming out?

14,822. If you please?—Then I went straight off on July 23rd. I sent for my guide and in 16 days I climbed the Zinal Rothhorn, Monte Rosa, Dufourspitze, Lyskamm, traversed Ringsfischhorn, and climbed the “Dome”—all in 16 days. We had no porter with us; it was simply my guide and myself. Of course you could not have done that if you had been out of your mind in March.

14,823. I would say that, having done it, you are not likely to be out of your mind next March?—My guide trusted his life in my hands; we were all alone on the glaciers.

14,824. Now will you tell us how you yourself were treated while you were under care at P.? You complain of ill-treatment?—What exactly did happen was this. I naturally first of all tried to get out of the padded room. I had a huge bed sore on my back. I tried to get out. The nurse seized my finger and dislocated it, twisted it right round. It will never go back, of course. She said, “I am a past master in these things”—and just went like that—(describing).

14,825. *Sir David Drummond*: Why did they put you in the padded room?—Because I tried to get out of bed first of all to speak to the matron.

14,826. *Deputy-Chairman*: Were you very violent at that time?—I was not the least violent, except when I got out. Then when I got into the padded room delusions swarmed over me. I tried to put an end to myself. I climbed the Obergabelhorn in the year 1919, the first year after the war, with a friend, and an English lady asked if she might go with us, with her own guide. We hated doing it, but she was very keen to come, and she went with us. She was killed, unfortunately, by a stone which she pulled over herself. My guide should have said, “Do not touch that stone,” and I should have waited to tell her. I was not at all well at that time, and it got on my mind. I thought it was my fault.

14,827. You thought that you had loosened the stone?—I thought I might have loosened the stone. It was not that so much as that if I had told her guide, he would have told her. I did not realise it. I felt the stone was a little bit loose, but it never struck me that anybody would pull at it.

14,828. Now when your thumb was injured, was it injured by accident?—No, on purpose. The nurse seized it like this (describing)—to prevent me getting out of the room. She did a sort of jiu jitsu thing she had been taught. Then with regard to *this* hand I said one day, “I shall not take any more food.” I held on to the back of the bed and the nurse dragged at my thumb. Dr. W. has recently operated on it and cut it open from *there* to *there*—(describing)—and has put it back again in its place and hopes it will be all right.

14,829. Can you remember when this was?—This thumb was hurt very early. It must have been, I suppose, in April or May. I could not really tell you.

14,830. But it was very soon after you got there?—Yes. The other was later on. I was not allowed to work or do anything. I just sat with my hands folded.

14,831. I suppose you could not do anything much?—I could have worked.

14,832. With your thumbs like that?—They had been very painful, but it was not until I began to work. Then in two weeks’ time they found out I could work very well, and I was put to hard work. Of course, then this thumb immediately began to get very painful, and so I showed it to Dr. T. and said, “This hand is dislocated.” He said, “Nonsense. A little rubbing, I think.”

14,833. Let us take the first occasion, when your left thumb was injured; did you make any complaint?—I showed it to the head nurse and she said, “That is your own fault.”

23 March, 1925.]

Miss B.

[Continued.]

14,834. Did you make a complaint to the doctor?—No, I was not spoken to.

14,835. You could surely have shown it to the matron?—I very nearly did show it to the matron. They did not care. I am rather a good hand at bearing pain. Another thing is that it was no use. I was told everything was my own fault.

14,836. What strikes me is this, Miss B. Let us assume you were in the condition of mind you think you were—in the same condition that I am in. If somebody had dislocated my thumb like that, and I had had an opportunity, I should have immediately applied to a doctor?—It never would have struck me to apply to Dr. T. I showed it once to the nurse who did it. I said, "Look what you have done," and she said, "That is your own fault entirely."

14,837. But it seems an odd thing that you did not call the attention of the doctor to it?—It no doubt does. I felt I was in the hands of fiends.

14,838. Take the second case.—The thumb on the right hand she almost pulled right off. Then after a while I began to work, and it got frightfully painful. I knew it was dislocated. It was only when began to work that I realised how bad it was.

14,839. Surely if your thumb were dislocated the best thing you could do would be to send for the doctor?—I was not allowed to. I cannot move it now.

14,840. *Sir David Drummond*: Did not you show it to the doctor the next time he passed?—I showed it to him, and he said, "A little rubbing, I think." I knew that was useless. So when my brother-in-law came down I showed it to him.

14,841. What steps did he take?—None. I have never told the surgeon this. I showed him both hands and he looked at them and did not say one word. That was in April, 1922.

14,842. And all this time you had this dislocated thumb?—Yes. I had been working then, and by that time you can imagine what it was like.

14,843. Had it not occurred to you to show it to the doctor?—I had shown it to Dr. T. long before that. There was no care; they did not care.

14,844. Any doctor could have seen it at once?—Of course he could, but there was no care there. People just died. You might die of anything, and nobody cared a halfpenny hang about you.

14,845. *Deputy-Chairman*: Did this place belong to Dr. T.?—Yes.

14,846. If it were Dr. T.'s own private house, and he was making a living by taking these patients, it would obviously be in his interest to treat them well, in order to get a reputation for his house?—There was no occasion to. They had got me safely there.

14,847. From a doctor's point of view it must have been in his interest to run his house so that it had a good reputation?—I can only tell you what did happen to me. Then I showed it to Dr. N.; he was supposed to be the surgeon, and he did not take any notice. When I came up and saw him in London I told Dr. Bond about my hand.

14,848. You had had a long interview with him at P. in July, 1922?—Yes.

14,849. Did you complain to him and show him your hand then?—How could I? The only thing I was thinking of then was to get out.

14,850. It strikes me as being such a very serious thing. Supposing my thumb were out of joint all this time: if a Commissioner to whom I could appeal came into the room and I had an interview with him, one of the first things I should do would be to say: "I have been ill-treated here, and my thumb is even now out of joint."—I think if you had had the experience I had had of them by that time, you would not have dreamt of saying such a thing. There is no court of appeal for anybody there. When you are once in, you are like a convicted prisoner. Then the matron hit me on the hand, *here* I was kept in bed months on end. I could have knocked the place down. All my muscles were perished. I said

to her, "I want to go out." She banged me on the hand with a huge bunch of keys and it came out in a huge bruise. She used to drag me by my hair.

14,851. There again, did you complain to Dr. T.?—I wrote a letter to my family, which they returned to the nurse. I wrote and told them.

14,852. That was much later on?—I had not any chance before.

14,853. We want to get at the facts about this. As far as one can judge, your sister was there for a year or more, was treated very well, and was very comfortable. It seems an odd thing that you should come a little later and, under the same supervision and management, find everything wrong?—There was always favouritism shown. If you want to know what I honestly think about it, it is this: my sister only paid four guineas a week for everything. I used to pay the cheque for her in advance; it was regularly paid. It was four guineas for everything. I think she gave them all very handsome presents when she left. I am afraid they had not realised that we were quite as comfortably off as we were, and they were very sorry they had not charged her more. The other day I was talking to a doctor, and I mentioned my sister having been there, and the doctor said, "Was it your sister who was taken ill in India?" and I said, "Yes." She said, "We had a nurse from P. seeing us, and she told us they had got a lady who had been taken ill in India, and they had not seen a penny of her money yet." Of course, I knew that was just how they were speaking about me. I have brought my pass book so that you should see that Dr. T. had always been paid as far as I am concerned.

14,854. Was there a committee appointed for you—a trustee?—A receiver; yes.

14,855. I want to ask you one other question about the condition of things. Were the lavatory and sanitary arrangements good in that place?—I should say they were horrible sanitary arrangements. You had to go through a dormitory down below, and the washing place was in the same place. The whole time I was washing, the kitchen maids would be running in, emptying pails and pans.

14,856. Do you mean you had no privacy?—There was no privacy whatever. There was a choice between that or washing in the lavatory with the most insufficient screen, with everybody rushing through there in the dormitory. The only time I ever had privacy in washing was when I was in the two small rooms. There was one bath downstairs. We used the one bath which all the nurses used to use. I was only allowed a bath once a week. It was most disgusting.

14,857. What have you to say about the food and diet?—The diet was starvation. We had bread and scrape three times a day. For breakfast when I first went there we had—you could not call it porridge; it was little bits floating in milk, and sometimes you were given a tiny mite of baked potato. We had that for two years for breakfast. There were three slices of very thin bread and margarine. I believe they sold quantities of butter. There was a huge farm attached to the place. I saw chickens—they had got hundreds of chickens. For tea we had five slices, and sometimes six, of this thin scrape, and about half a teaspoonful of jam for each person; it did not cover one slice; and a very thin piece of always the same cake, the kind of cake that you buy for 5½d. or 4½d. a pound. If you asked for another piece and there was any more you might be given another slice.

14,858. Did you have any meal after that?—We had in the evening for the first part of the time what they were pleased to call pearl barley, and one or two slices of bread and butter sent in, and the last time there were scrapings of cold pork or beef, and I think twice there was a drum-stick of a chicken.

14,859. Did you get a good dinner in the middle of the day?—The first part of the time there were only

23 March, 1925.]

Miss B.

[Continued.]

scraps. I think the rationing had taken an effect on them, and I think they had found they could make on people. The last part of the time we got fairly good helpings of meat. The poor young nurses used to ask for more, and there was not anything for them; everything was finished.

14,860. Were any patients paying larger sums than yourself?—One lady who took drugs paid eight guineas a week. They made a great fuss of her; she was a very wealthy lady.

14,861. Did the average patient pay about the same as yourself?—I should not think so. I am very socialistic. I am quite willing to go into a hospital and share, but I was paying seven and a-half guineas a week and was with one woman there who used to eat with her hands!

14,862. But they were all paying private patients?—They were all paying patients, but I mean they had not any manners. That woman used to eat with her fingers; she used to put potatoes and things down her stocking. There was an awful old farmer's wife who jeered at me all day. It drove one nearly wild.

14,863. They were of a different social status, rather?—They were entirely so; there was hardly anybody of the same social status.

Deputy-Chairman: I think some of the other members of the Commission may wish to ask you a few questions.

14,864. *Sir David Drummond*: At what date had you quite recovered?—I was quite well in June, 1920. All the rest of the time I was driven nearly wild.

14,865. Then anything that happened afterwards, as shown in the note, delusions, and so on, did not occur?—No, they did not occur.

14,866. We have notes before us to the effect that weeks after the date you mentioned you had delusions?—I can tell you most truly what the delusions were. I lost all knowledge when people were treating me like that.

14,867. You had no delusions, had you?—No.

14,868. You never thought they wanted to take you to a house of ill-fame?—I did. I had no conception for months. I did not think about the house of ill-fame before that. I had no conception when I was kept in a padded room, that anybody in their senses would keep anybody they were trying to get well like that. I thought I was in some peculiar house. It was no delusion, because Dr. T. kept saying to me, "If you do not behave yourself you will go elsewhere." I did not know what he meant.

14,869. You thought he meant to take you to a house of ill-fame?—I certainly thought so. I had no conception that anybody was treated like that in a lunatic asylum. How would you feel if you lived in the half dark in this padded room with these women screaming outside from the end of February till December?

14,870. The point I wish to be clear upon is this. You thought you had recovered at a certain date. Weeks after that date it is in the note that you had this delusion. Could you say you had recovered then?—I had recovered. My delusion was the whole time I was there. They kept on saying they were going to send me elsewhere.

14,871. *Mr. Jowitt*: I have just a question or two to put to you. You were in the padded room from May, 1920, to the end of 1920?—Much earlier than that. I went there at the end of January. I was in the padded room by the end of February.

14,872. And you were in the padded room for ten months?—I should think it was till December.

14,873. May I ask you to agree with me to this extent: For the first two months or so you were in the padded room you were suffering from delusions?—Yes. Truly I should never have been so bad if I had not been put there.

14,874. During those first two months when you did have those delusions, you were rather violent, I suppose?—Only that I was trying to get out of the padded room; no other violence.

14,875. But you were violent?—Of course, you cannot get out of a room without being violent. I did not hurt anybody.

14,876. Was the nurse in the room with you?—The nurse sat outside.

14,877. And every now and then the nurse used to come in?—Yes.

14,878. Was it on one of the occasions when the nurse came in that you made for the door, trying to get out of the door?—I always tried to get out of the door.

14,879. Was there then some struggle between you and the nurse?—Certainly.

14,880. Was it in this struggle that the accident happened to your thumb?—Yes.

14,881. Now having had that accident to your thumb in that way, I understand you did not complain to any of the doctors about it?—I think I only complained to the nurse. I had little feeling about the nurse.

14,882. You did not complain to your brother-in-law, who himself is a doctor?—Not till I showed him my hands.

14,883. That was the other hand, a year later?—I showed him both hands.

14,884. The right hand was a year or two later?—I complained to Dr. T. when it became so painful, when I began to work.

14,885. Did the food remain bad all the time?—All the time.

14,886. Your mental condition when you went out was better than when you went in?—But I was perfectly well by June.

14,887. Was your physical condition better, too?—My physical condition was always good. I was blown out to the most frightful degree by this dreadful milk diet. It was all a sort of wretched fat. Might I just tell you what happened? The doctor was injecting that awful hyoscine, or whatever it was; it made my eyes look funny, and I felt dreadful all over.

14,888. *Deputy-Chairman*: When was this treatment begun?—Dr. N. rushed in and gave it me one day when I was trying to get out of the padded room. Then I began to hope I might go into a sort of everlasting sleep. Then one day I said, "You might give me an injection," and he did. Then another day I was sitting talking quietly to the matron, and he rushed in and injected something into my arm again.

14,889. How many injections were made altogether?—I could not tell you, but I was all over little marks.

14,890. *Mrs. Mathew*: I just want to know about your thumb. Did you go to Switzerland with a dislocated thumb?—Yes, I did, and made it worse, naturally. I traversed the Matterhorn down the Italian side this last year. The nuisance of it was it was always freezing, so I had no end of trouble. When we were on the "Dome," we nearly had to come back; that was partly why I was so anxious to have the operation. Coming down the ropes on the Italian side last year my hand came right off the ropes, and I had the greatest difficulty clinging with my left hand. It was awfully bad this last autumn. The doctor did not want to operate, but he said in December, "I could help you," so I chanced it. On the 8th January I went to have this done, so I thought the most satisfactory way would be to ask the Harley Street doctor about it. I want for my own sake to get everything straight.

14,891. *Deputy-Chairman*: I do not think really we shall want evidence that your thumb is dislocated?—I should like you to appreciate what I feel about it, that I have been treated as a sort of half fool ever since I came out. I have tried to speak to my family. Nobody has spoken to me. I want to get it straight now, because I do not want any longer to be treated as a fool.

14,892. *Mrs. Mathew*: You had been to Switzerland before and you knew all about mountaineering?—Yes; I had been for years.

23 March, 1925.]

Miss B.

[Continued.]

14,893. *Deputy-Chairman*: I gather you are not quite restored to friendly relations with your relatives?—We are on perfectly friendly terms, but I mean all family ties are gone. I could never tell them or consult them about anything. If it had not been for the doctor and the lawyer after I came out I do not know where I should have been.

14,894. Before you leave us, is there any other point you would like to lay stress on?—I would like to read what I have written, because that is what I want you to have.

14,895. If you please; you have read the first part I think?—This is the beginning: "Kept in padded room from March, 1920, for many months until nearly Christmas 1920, in fact until the room was wanted for another—only put there because I asked for matron and jumped out of bed to try and get her. Lay for months on a filthy mattress, left in dreadful condition by dirty patients only one on hard floor—smell horrible—got a huge bedsore on my back, about three inches wide and long. Patients used the outside room, out of which padded room opened, sometimes for all purposes. State of atmosphere needs no comment and no window opened more than a foot in the place and some—padded room did—only at the bottom at all. Padded room bitterly cold, draughts, no bed socks or hot water bottle and filthy pillow without case—no sheets—got a sore ear from being kept there day and night, but would not sit in my night dress in room outside with the bedridden old women, as that was far worse—given no work—no books not even Bible and prayer book, told to sit with hands before me—should have gone mad, but went on in my head with foreign languages." That was my only comfort. I knew a lot of foreign words and I went on with my foreign languages, and a wonderful lot I can talk now. "Dr. T. used to run in and treat one as a fool." He would say, "Good morning. Where is Newcastle? Is it in the north or in the south? How do you pronounce the name of those slippers, 'Mocassins or Mocassines,' " etc., etc., always insisting that the reason of my illness was nothing but a lie—and I was perpetually told I should never come out until I acknowledged it as such. Not allowed to write for months at a time and then only when they had read the letters and this I understand from Dr. Bond is strictly contrary to the law, as I had the right to seal up any letter to him or to Mr. W. and write to them when I chose to. Always told my relations did not want me home and at last told "that they only asked not to be worried when I asked to write" and "that my friends did not write to me and had evidently forgotten me." "

14,896. Although that may be very interesting, I am not sure that it will add anything to what you have told us.—I did want you to know what went on

in these places. With regard to the nurses, it was "often pandemonium at night with all the things being brought through to the lavatories below and no other entrance to them day or night; the last summer rats got into the house, came out in the dormitory at night and one died in the sitting room; and we had to eat our meals there while it decayed. The so-called nurses were utterly untrained girls out of shops or cottages—some so rough one would not have taken them for servants—utterly ignorant of the simplest ideas of nursing and they learnt none there—sore backs, the most usual thing among patients. These girls were all paid £20 a year and put into uniforms as nurses. Once there were two older nurses for night, paid £24, really as untrained as the rest only far kinder." Then there is an account of food. Then comes this: "My whole cost could not possibly have exceeded £1 ls. a week and I paid 7½ guineas for far worse than workhouse accommodation and an extra £2 quarterly for something I never had—altogether Dr. T. had over £1,000 of mine for nothing but misery. I wrote and drew attention to the fact that extras were on the last bill (which was undated) which I had not had—as I never had even an extra cup of tea and asked that the mistake might be rectified. I wrote a list of all expenses. Dr. N. cashed the cheque immediately and wrote a note with it entirely ignoring my letter. Money was all they cared for from first to last. There was no treatment of any kind. If one got out at all, it was only for one hour in the afternoon—in that miserable drive." You could not call it a garden.

14,897. They were large grounds, were they not?—We never went into the large grounds. The little ground we had was the drive. I was never allowed out for a walk. I took one walk in two years, when I went to the dentist. "I had one walk only and the only other time I was out was going to a dentist who made me two sets of teeth I could never wear." Never allowed inside church but once and then when it was found convenient suddenly to announce I was well. Then I want to leave with you these papers (*handing in the same*).

14,898. We need not trouble, I think, with the passbook. We will take it from you that the fees were all paid.—Very well. You do not want the bills?

14,899. No, I do not think so.—I do want it cleared up once for all.

14,900. We quite appreciate the position. We are very much obliged to you for giving us your evidence, and I hope you think that we have given you a full and fair hearing?—Yes, I am sure you have. Only I do want you to know why I did it. I have been to everybody straight. I went to Dr. Bond and I warned Dr. T. that I was not leaving matters there.

(*The Witness withdrew.*)

(*Adjourned to Friday, 17th April, at 10.30 o'clock.*)

5, OLD PALACE YARD,
WESTMINSTER, S.W.1.

TWENTY-SEVENTH DAY.

Friday, 17th April, 1925.

MEMBERS PRESENT :

THE RIGHT HON. H. P. MACMILLAN, K.C. (*Chairman*).

THE EARL RUSSELL.

SIR HUMPHRY ROLLESTON, BART., K.C.B., M.D.

SIR ERNEST HILEY, K.B.E.

SIR DAVID DRUMMOND, C.B.E., M.D.

MR. NATHANIEL MICKLEM, K.C.

MR. H. SNELL, M.P.

MRS. C. J. MATHEW.

MISS MADELEINE SYMONS.

MR. P. BARTER (*Secretary*).

MR. W. FAIRLEY (*Assistant Secretary*).

Chairman: Since we last met, the death of Sir Thomas Hutchison, which occurred with tragic suddenness in Edinburgh last Sunday, has deprived us of the assistance of a valued member of the Commission. He was greatly interested in our work. Endowed with an instinctive aptitude for affairs and a philanthropic outlook on all the problems of social life, he was well fitted to make a notable contribution to our deliberations. He leaves behind him a record

of conspicuous and varied public service, and by his death a career of great usefulness has been prematurely cut short. We lament this morning the loss of a genial and helpful friend and a much esteemed colleague. I propose that we should transmit these few and inadequate words to Lady Hutchison and her son with a message of respectful sympathy from us in their great sorrow.

Sir H. ARTHUR ROSE, D.S.O., and Dr. HAMILTON C. MARR, called and examined.

14,901. *Chairman*: This morning we have with us Sir Arthur Rose, who is Chairman of the General Board of Control for Scotland, and Dr. Marr, the Senior Commissioner, is also in attendance with him. We are to have the advantage of evidence from these gentlemen upon the system of Lunacy law and administration in Scotland. It may be well to remind the public that the scope of our Reference does not extend to Scotland, and therefore that in receiving this evidence we are receiving it for the purposes of comparison and instruction, rather than with a view to any practical recommendations being made by us with regard to the law of Scotland; but I am sure we shall derive much assistance from the witnesses who are coming to-day and the two following days upon the methods of the sister country. Sir Arthur, you have been good enough to furnish us with a *précis* setting out the existing law which you apply in Scotland, and I propose to go through it with you in some detail to-day; but, first of all, let us take from you your own designation—you are Chairman of the General Board of Control for Scotland?—Yes.

14,902. When were you appointed to that office?—Two years ago.

14,903. I forget, who was your predecessor?—Sir Thomas Mason.

14,904. The Chairman of the Clyde Trust?—Yes. He had retired at least a year before I was appointed.

14,905. And you yourself occupy that position not as a whole-time officer, I understand, Sir Arthur?—Quite.

14,906. In other words, you are a man of business in Leith, are you not?—Yes.

14,907. And the office which you hold is an honorary office in the sense that you are an unpaid Chairman?—That is so.

14,908. With regard to the General Board of Control for Scotland, I think prior to 1913 it was known as the General Board of Commissioners in Lunacy for Scotland?—That is so.

14,909. And under the Mental Deficiency and Lunacy (Scotland) Act, 1913, your Board was, in 1913, re-established under its new name?—That is right.

14,910. Just as the English Board of Control also received a new charter in that year under the corresponding English statute?—Yes.

14,911. It would be useful, I think, to get at the very outset some information from you as to the composition of your Board. At present, does it consist of five members?—It consists of five members.

14,912. Are these yourself, as Chairman, a layman—unpaid layman if I may once more emphasise the fact—and two unpaid Commissioners?—Yes.

14,913. These gentlemen at present are Sheriff Macphail, who is the Sheriff of one of the Scottish counties, and Mr Prosser, who is a Writer to the Signet in Edinburgh?—Yes.

14,914. It is usual in practice, I think, that these unpaid Commissioners should be selected from the legal profession?—That has usually been the case.

14,915. And these gentlemen are also unpaid Commissioners?—That is so.

14,916. Then, in addition, are there two paid Medical Commissioners, who are whole-time officers?—Yes.

14,917. One of them we have the pleasure of having with us this morning, Dr. Marr. Who is the other?—Dr. Sturrock. There is one vacancy.

14,918. Yes, there is a vacancy at present in the office of paid Medical Commissioner which has not been filled up?—Quite.

14,919. Then turning to the Mental Deficiency and Lunacy (Scotland) Act of 1913, I think we will find the constitution of your Board and its functions in Part II of the Act, Section 19?—Yes.

14,920. While there was a reconstitution at that time of the Board under its new title, all the previously existing powers of your code were carried on?—Yes.

17 April, 1925.]

Sir H. ARTHUR ROSE, D.S.O., and Dr. HAMILTON C. MARR.

[Continued.]

14,921. There has as yet been no consolidation Act in Scotland such as the 1890 Act for England?—Unfortunately not.

14,922. *Sir David Drummond*: Why was the vacancy not filled up?—For reasons of economy chiefly. (*Dr. Marr*.) Two of the Commissioners retired simultaneously two years ago, and instead of filling up the two vacancies, for reasons of economy, it was decided to fill up only one vacancy.

14,923. *Chairman*: So there is at present a vacancy?—Yes. It is not intended to fill up the third vacancy in the Commissionership in the meantime.

14,924. At the moment there are two paid medical Commissioners, full-time officers?—That is so.

14,925. And three unpaid officers who are laymen?—That is so.

14,926. One of whom is the Chairman, and the other two are lawyers?—The Mental Deficiency Act made provision in 1914 for a third paid Commissioner, and that third paid Commissioner was appointed. But, owing to the war, and the Mental Deficiency Act being not in full practice, it was decided to do away with the third Commissionership in the meantime.

14,927. There is provision made for that in Section 19, sub-section (2)?—Yes.

14,928. "In addition to the two paid Commissioners, for whose appointment provision is made by the Lunacy Acts, there may be appointed by His Majesty on the recommendation of the Secretary for Scotland, at any time after the passing of this Act, a third paid Commissioner, who shall be a duly qualified medical practitioner."?—That is so, and that third paid Commissioner was appointed, but resigned two years ago.

14,929. Then may I take it that the appointments to the Board are made by His Majesty on the recommendation of the Secretary for Scotland?—(*Sir Arthur Rose*.) That is so.

Sir Humphry Rolleston: Why is it the medical members are paid and legal members give their services for nothing?

Chairman: You must think of the national characteristics upon that matter, I think, *Sir Humphry*. There is a tradition of public service in these matters in Scotland.

Sir Humphry Rolleston: Are the legal Commissioners whole-time Commissioners?

14,930. *Chairman*: None of them are whole time except the paid medical Commissioners. One of them is an active Sheriff of a county, and the other is a well-known solicitor in Edinburgh, and *Sir Arthur Rose* tells us he has some time to spare for his own business?—(*Sir Arthur Rose*.) A certain amount.

14,931. Then, in addition to the Board properly so-called, have you Medical Deputy Commissioners?—Yes.

14,932. Who are not members of the Board, but who have important duties to perform?—Yes.

14,933. At the present moment have you three such Medical Deputy Commissioners?—Yes.

14,934. And of these, one is a woman?—Yes. Again a vacancy exists in that branch.

14,935. With regard to that matter, again referring to Section 19 of the 1913 Act, provision is made to this effect, that "In addition to the two Deputy Commissioners for whose appointment provision is made in the Lunacy Acts, the Secretary for Scotland with the approval of the Treasury, may at any time after the passing of this Act, and from time to time appoint not more than four duly qualified medical practitioners to be Deputy Commissioners of the Board, of whom at least one shall be a woman"?—Yes.

14,936. That power has been exercised to appoint three, but there also you are one short?—That is right.

14,937. These Deputy Commissioners are paid, of course?—Yes.

14,938. And is their province specially to concern themselves with the patients in private dwelling-houses?—That is so.

14,939. In contradistinction to those resident in establishments?—Yes.

14,940. Then we may also bring out a distinctive feature of the Scottish system, and that is the division of Scotland into lunacy districts.—Yes.

14,941. I think that since 1857 when modern legislation in this matter begins, there has always been a division of Scotland into lunacy districts?—Yes.

Earl Russell: As against our county divisions?

Chairman: Yes; it corresponds to some extent to county divisions, but the areas are not always co-terminous.

Earl Russell: It is a species of grouping?

14,942. *Chairman*: Yes, exactly.—There are 27 districts.

14,943. At the moment there are 27 districts if we include Greenock as a district; but Greenock is a district, as I understand, only for mental deficiency purposes?—Yes. (*Dr. Marr*): There are 27 lunacy districts altogether, including large city districts which are districts of themselves, that is to say, the parish council is *ipso facto* a District Board of Control.

14,944. Now it does not follow that each District Board will have its own asylum. Provision is made, is it not, that a District Board may send its patients to the asylum of another district under contractual arrangements which are provided for?—*Sir Arthur Rose*: That is so.

14,945. Therefore we shall not find in Scotland 27 district asylums, but only 21?—Not necessarily to another district asylum, to any asylum with which they care to contract.

14,946. Then with regard to this division of Scotland, I think that the districts consist of groups of counties, or single counties, or parts of counties?—That is so.

14,947. And in the case of the principal towns the lunacy districts may consist of a single parish, in which case the parish council becomes the District Board?—Yes.

14,948. And the parish council, of course, as we know, is a popularly elected body?—Quite.

14,949. *Earl Russell*: Is this grouping geographical, or is it by population? What is the general principle that governs it?—Geographical chiefly, but, of course, limited on account of population.

14,950. *Chairman*: But it is a regional division of Scotland really?—Yes.

14,951. And was advantage taken of the Act of 1913 to reconstitute those District Boards of Control also?—That is right.

14,952. Where the lunacy district happens not to consist of a single parish, where the parish council is the District Board, is the District Board of Control an elective body?—Yes.

14,953. And is it elected by the county council, or county councils of the county or group of counties comprising the district, the magistrates of burghs which are situated within the county or counties, and one third by the remainder of the parish councils of the parishes within the district?—That is so.

14,954. In that way you get representation of the county authority, the burghal authority, and the Poor Law authority?—Yes.

14,955. *Mr. Micklem*: Does that mean one-third by each?—Not necessarily; the numbers are laid down by the Board.

14,956. *Chairman*: Then if the District Board contains no women, is there a statutory obligation on the District Board to co-opt not more than two women?—That is right.

14,957. Then, I think, the actual number of members of the District Board is fixed by your central authority?—Yes.

14,958. And is apportioned among the electing bodies as nearly as may be in accordance with the valuation of each county or burgh?—That is so.

14,959. Does the number of members of these Boards vary from 11 to 34 according to the size and circumstances of the district?—That is so.

17 April, 1925.]

Sir H. ARTHUR ROSE, D.S.O., and Dr. HAMILTON C. MARR.

[Continued.]

Earl Russell: Does this District Board correspond more or less to our Visiting Committee?—

14,960. *Chairman:* Yes, exactly; it is elective at second-hand really.—That is so.

14,961. And it is probably a rather more comprehensive body than the Visiting Committee with which we are familiar in England?—Yes.

14,962. We shall come to its powers in a moment. It is much more like a local authority. We have then at once a picture of the organisation of the lunacy administration in Scotland, the General Board at the top with a series of District Boards throughout the country, comprised as you have explained to us.—Yes.

14,963. That is a general outline of the organisation?—Yes.

14,964. Now as regards the position of these bodies and the legislation, I think that in Scotland unfortunately you have had no Consolidating Act?—That is so.

14,965. Therefore you administer the law at present under the statute of 1857, which has been amended in 1862, 1866 and 1913?—That is so.

14,966. And also there are certain other intermediate statutes which have modified the law in certain minor respects?—Yes.

14,967. You have accordingly rather a complicated code to handle?—Distinctly so.

14,968. Then let us pass at once to the functions of the General Board of Control. I think that they have the general supervision of the administration of the Lunacy law in Scotland?—Yes.

14,969. And, as we proceed, we shall come across the various matters in which they take an active part. Let us just see how you conduct your business. Have you board meetings from time to time?—Yes. We have two statutory meetings a year which must be held, otherwise we meet normally monthly, and as frequently as necessity and the business calls for otherwise; but as a general rule a monthly meeting suffices for the formal part of the work.

14,970. And do you, in addition to those stated meetings and those monthly meetings, from time to time have local meetings for the investigation of any case that may arise?—If the local necessity arises we do not hesitate to have an enquiry locally.

14,971. And do you also have conferences from time to time with local bodies either in Edinburgh or in the country on matters of local importance affecting them?—Quite frequently.

14,972. Do the Commissioners visit any property that is proposed to be acquired by the District Boards?—Yes, invariably.

14,973. And do they examine and approve all plans and estimates?—Yes.

14,974. Then is there daily attendance at the Board of Control by one Medical Commissioner?—Yes.

14,975. I think the principle on which you work is that one of the Medical Commissioners shall be on inspection work, while the other is in daily attendance?—That is the usual arrangement.

14,976. Is there a duty imposed upon the Medical Commissioners of visiting each establishment twice a year?—That is right.

14,977. And reporting to the Board?—Yes, seeing each patient individually twice a year in institutions.

14,978. So it is not merely an inspection of the institution but a visitation of each individual patient?—That is so.

14,979. *Sir David Drummond:* Might we hear about that?—Perhaps Dr. Marr had better speak to that.

14,980. *Chairman:* Dr. Marr will either visit or be in the office, as the case may be. Would you tell us about the actual visitation?—(*Dr. Marr:*) We are bound by statute to see each patient twice yearly; that is to say, a Commissioner sees every patient in the institutions twice yearly, but an individual Commissioner sees every patient once yearly in institutions under this arrangement. When we go to the institution of course we go like a thief in the night; we are not known to be coming, and we

immediately commence our inspection. We have a book, and the patients' names are ticked off as they are seen.

14,981. Now I would like to know about the seeing, because "seeing" may mean many different things.—I, for instance, stop before each patient and simply tick off the name as I see the patient. I go round the whole of the place.

14,982. But are the patients brought before you?—No, we go round and see them; we go into the institution, because otherwise it would upset the patients, and we want to see the patients in the normal circumstances.

14,983. You will start with the book in your hand?—Yes, take any part; sometimes we begin with the workshops; sometimes we begin with the laundry, and sometimes we begin with the kitchen; sometimes the far off part of the institution, chronic wards. We do not take any special routine, and every patient we see in the institution. We do not see a patient unless we have a pencil mark at the side of his name. If he is on parole, we note in our inspection that this patient was not seen because he was absent on pass.

14,984. I want to know more about seeing them. You find them in their ordinary surroundings as you pass through the institution. To what extent do you make an examination of each individual patient, or enter into conversation with them?—If the patient wishes an interview, then you stop and have a talk and examine the patient to see if he is really a case which should be considered. If they want an interview we give an interview in every case, no matter whether we have interviewed the patients on several occasions.

14,985. We have heard complaints made that these official visitations are apt to become mere formalities?—We never look upon that as a formality. We have always looked upon it, from our point of view, that our duty primarily is the interest of the patient. We are *in loco parentis* to the patient, and that is our primary and basic duty, and everything else must be subordinate to that.

14,986. Do you think that any patient who really had some case of complaint, or wanted to bring something before you, might be deterred from doing so because other patients were there, or the medical superintendent was there?—No; we have never had that experience; all they have got to do is to ask for a private interview.

14,987. *Earl Russell:* Do the patients in the ward when you go through know you are a Commissioner?—Yes.

14,988. How?—We should announce it to them—they all know, of course. We know our patients pretty intimately I should say, considering that these are approximately 20,000. Of course, generally speaking, the complaints are usually relating to their mental condition. In some cases, it may be a desire to get out, or they feel that they have been illegally detained. Of course these cases we go into very carefully.

14,989. *Chairman:* With regard to the private interview, if a patient, even although he has had a private interview before, says "I want to see you, Sir, alone," can he do so?—Yes, undoubtedly.

14,990. And do you have such interviews frequently?—Yes.

14,991. Where do you take the patient?—We either get a private room, or they are brought to me, and they have the interview alone.

14,992. Do you find these interviews useful in practice?—Very useful. Where there is doubt as to whether the patient should be retained in the asylum, we pay very serious attention to it; but, as a general rule, the patients want to air some grievance of some kind, particularly relating to the delusions. I may take an actual instance: in one of our Glasgow institutions there is a lady who has very marked hallucinations and delusions, a single lady, about being married. I have given her an interview ever since I was appointed some fourteen years ago, and the interview extends sometimes to half an hour.

17 April, 1925.]

Sir H. ARTHUR ROSE, D.S.O., and Dr. HAMILTON C. MARR.

[Continued.]

14,993. *Earl Russell*: She always asks for a private interview?—Yes, and we are told that the mere fact that we give her that interview soothes her and keeps her in a better frame of mind. She is in a very unfortunate position as far as her delusions are concerned, believing that she is married to a professor in a university who is dead, and that he has left a large sum of money.

14,994. *Chairman*: Do you find you sometimes get from the patients information about small matters of administration, and so on, which are rather galling to them—giving you hints?—Exceedingly useful information. If I may go back some 20 years ago, a middle-aged lady objected to the bathing arrangements in one of the institutions, which has a beautiful bathroom with about 14 baths in it, and she objected, and naturally objected, to being bathed in the presence of younger women on a general bathing day. I was delighted to have that suggestion from her, and recommended that curtains should be put between each bath, and that little cubicles should be arranged in the dressing room so that women bathing should have complete privacy.

14,995. Was that done?—That was done, and it has been done practically in every institution in Scotland.

14,996. Then do you find that you sometimes get quite intelligent criticisms?—Most intelligent criticisms.

14,997. *Sir David Drummond*: May I ask how long does that examination of the patients take?—The smaller institutions usually one day, but the larger institutions from two to three days; and sometimes I spend four days at the very largest institutions.

14,998. *Chairman*: We will get the figures as to the number of patients in the different institutions. You have not anything comparable to the large institutions here running up to 3,000 patients?—Nothing at all.

14,999. *Earl Russell*: I rather want to know when you are ticking the names off in the book do you speak to each patient, or do you simply tick them off?—If he is obviously very seriously demented I do not bother, but if there is any intelligence at all then I say "Good morning," and I ask "Have you anything to complain about?" I vary it. I do not make a routine of asking every one.

15,000. Even if there are 30 or 40 patients there, some of them will not speak unless they are given a chance?—That is so, especially depressed patients.

15,001. *Sir David Drummond*: You do not interest yourself in the case medically?—Yes, especially the hospital cases.

15,002. You do not visit the institution as a physician visits the wards?—I cannot possibly do that.

15,003. *Chairman*: That is to say, you do not make a medical examination of the patient?—Not at all; I could not possibly do it, or pretend to do it.

15,004. It is not your function, if I may say so?—That is so.

15,005. You are visiting the patients to see whether the law is being properly carried out, and that their welfare is being adequately attended to?—That is so.

15,006. *Earl Russell*: Still each patient has a definite chance of saying anything he may wish to?—Yes.

15,007. *Chairman*: Does the medical superintendent go round with you?—Sometimes; the matron or the charge attendant, or the assistant medical officer, very often with the medical superintendent.

15,008. May we take this general answer from you: Do you think that the visitation system as practised in Scotland by the Commissioners enables each patient who has any real cause of complaint either as to his detention or as to his treatment, to bring it before an outside authority in your own person?—That is so. I think it might safely be said that there is no case of injustice or want of observation as far as inspection is concerned in any institution in Scotland. There might be slight individual grievances, but if these are brought to our notice we usually pay special attention to them; but, generally

speaking, there is no case which I might say is capable of being neglected throughout our Scottish institutions.

15,009. Do you find among the complaints or criticisms you receive that there are ever complaints as to the treatment of the patients by the attendants?—Yes, on occasion, but very seldom.

15,010. What do you do in such a case where there is a complaint of ill-treatment?—We enquire into it, of course. Generally, if it refers to some accident that has taken place, or some injury, we first of all have a register of all injuries taking place in the institution, no matter how trivial they are, and we have evidence of that; and then if there is evidence of really serious abuse and we come to that conclusion, we recommend the superintendent of the asylum to report the case to the Procurator-Fiscal to make enquiry.

15,011. Perhaps it might be as well, since that official has been mentioned for the first time, to explain that the Procurator-Fiscal is the local Crown Prosecutor who, under the Scottish criminal system, is charged with all local investigations into criminal matters, and he reports to the Crown Office in Edinburgh with a view to proceedings being taken in serious cases.—That is so.

15,012. You have throughout Scotland in every district an official who is charged with the investigation of all criminal matters?—That is so.

15,013. And who takes the initiative in prosecuting all offences locally and in reporting to headquarters all serious offences?—That is so.

15,014. *Earl Russell*: In allegations of ill-treatment, even if you think them well founded—it is always very difficult to establish a case?—To some extent it is; on the whole it is not very difficult. If you have a recent injury, of course it is obvious; but the difficulty is to say whether a person has really been assaulted by an attendant if the injury has taken place some time previous to your inspection.

15,015. *Chairman*: I do not quite follow that the recent character of the injury will prove its cause.—When a complaint has been made to us, say, that the patient was ill-treated three months ago, we ask if there has been evidence of any injury; we find out if there is such an entry made in the register of accidents, and then in addition to that we enquire amongst other patients and find out what the superintendent has done with reference to this allegation.

15,016. You hold a sort of informal enquiry?—Yes. Sometimes of course the allegations are so obviously connected with the mental condition that we do not need to enquire into them.

15,017. *Earl Russell*: That is what I want to get out,—where you find, and how you find, your corroborative evidence. It is very difficult in these cases?—It is very difficult unless the superintendent has at once enquired.

15,018. *Chairman*: Have you ever found in your experience a case of some ill-treatment actually made out to your own satisfaction?—We have had cases of that kind, yes,—I do not say frequently; we have had two or three cases during the course of my 14 years, and there we have had an enquiry.

15,019. A formal enquiry?—A Board enquiry.

15,020. Whenever you find there is what I may call a *prima facie* case for investigation, do you hold a formal enquiry?—Yes, that is so.

15,021. And have you found the complaints substantiated in any cases?—In many of the enquiries we have not found them substantiated.

15,022. You have in some?—No, I do not think we have had any enquiries where there has been a substantial basis for alleged ill-treatment. The cases where there has been actually bad treatment have been dealt with by the Procurator-Fiscal.

15,023. Dealt with as assault cases?—Yes, dealt with actually in public.

15,024. *Earl Russell*: Still, you, generally, have looked into them first?—Yes. As a matter of fact we often originate the prosecution by suggesting that the case should be reported.

17 April, 1925.]

Sir H. ARTHUR ROSE, D.S.O., and Dr. HAMILTON C. MARR.

[Continued.]

15,025. *Sir Ernest Hiley*: How many of those cases have there been during the last five years?—I think I only remember two; one in Inverness.

15,026. *Chairman*: I remember the Inverness case myself, a really serious case that ultimately became the subject of litigation, I think.—Yes.

15,027. *Earl Russell*: Supposing a charge is made against an attendant, how do you find the other attendants act—do you find they back him up with their evidence?—I am speaking as an old superintendent. It depends altogether on how quickly the superintendent enquires into the alleged accident, so as to prevent co-operation between the other attendants in making a uniform story.

15,028. *Chairman*: I suppose you will find that many of the patients themselves have quite sufficient powers of observation and quite sufficient intelligence to assist you in an investigation of their case?—Yes, there are some patients whose word is absolutely trustworthy.

15,029. They may be merely affected by some delusion—apart from that they are quite capable of giving reliable testimony?—Yes.

15,030. If you find there is a *prima facie* case, then it either becomes the subject of an official inquiry by your Board, or they submit the case to the Procurator-Fiscal, who then takes the matter up and deals with it through the medium of the criminal law?—That is so.

15,031. May I take it that such cases are not of frequent occurrence?—Very infrequent occurrence.

Mrs. Mathew: Are these cases tried in open Court?

15,032. *Chairman*: Yes; any cases taken up by the Procurator-Fiscal in a county would go before a Sheriff and be tried in open Court?—Yes.

15,033. *Mr. Micklem*: Have you had any cases where the medical superintendents have dismissed attendants before coming to you?—Yes, or have suspended them, but they often dismiss them on account of alleged ill-use of patients, and then we make inquiry there to see the extent of the alleged ill-treatment of patients.

15,034. *Chairman*: The Sheriff, of course, has power to award up to two years' imprisonment, coupled with lesser powers of fining, and so on?—Yes. (*Sir Arthur Rose*): Might I just add to that, that we have only had one formal inquiry since I was put into this position?

15,035. That is to say, in the last two years?—Yes. It arose through a patient reading Dr. Lomax's book and giving us chapter and verse of corresponding incidents that were purported to have happened in this asylum, right throughout the book. It was felt by us that the allegations were sufficiently serious to justify a formal inquiry into the whole situation.

15,036. Just let me interpose at that stage. You have very strong powers under the Acts of Parliament for enforcing the attendance of witnesses, and getting documents and everything else. You are practically given the powers of a Court in these inquiries?—Yes; and there is quite a heavy penalty if our orders are disregarded; and the witnesses are all sworn.

15,037. Let us hear about this inquiry?—The inquiry dragged its way along the course of the forenoon with very wild charges of rather an indefinite nature, and suddenly the peculiar point emerged that the complainant had really no grounds for his allegations, but was in actual fact trying to get at the medical man who had certified him; and in the middle of the proceedings he withdrew entirely every allegation that he had made, after even having described how a bald-headed patient was hammered over the head with the leg of a chair, and various other things like that; and he suddenly admitted, and his agent admitted, that the whole reason for the allegations was that he had felt he had been improperly committed to this asylum, and he wanted us to take action against the medical man.

15,038. He was represented by a solicitor as well?—He was represented by a man in his own department; he was a solicitor.

15,039. *Earl Russell*: Of course that is a danger you are always exposed to?—Quite. As a matter of fact we quite welcomed the opportunity of holding the inquiry. There was sufficient *prima facie* evidence to justify us in making these investigations, and we did not feel it did any harm from the public point of view.

15,040. *Chairman*: We shall come across many matters of detail as we proceed, but we will try to keep the evidence on the lines of your *précis*. We have the composition of the Board now, and of the District Board. We also have from Dr. Marr a very full account of how the visitation is carried out by the Medical Commissioners, as well as their daily attendance at the Board's premises, where, I suppose, all the documents that come in are surveyed and examined?—(*Dr. Marr*): That is so.

15,041. And the register of patients kept?—Yes.

15,042. Now I think it might be useful to obtain a few statistics from you, because, of course, we know in Scotland the matter is on a very much smaller scale than it is in England. I think you have before you, Sir Arthur, a few figures which we had better get on the note. First, in all were there at the 1st January, 1924, 18,266 registered lunatics in Scotland?—(*Sir Arthur Rose*): That is so.

15,043. And of those were 9,112 male and 9,154 female?—Yes.

15,044. It is rather remarkable, quite a "50-50" division?—Yes.

Earl Russell: A much more even proportion than in England.

15,045. *Chairman*: Yes, it is very curious. Then, again, classifying them, 2,887 of the registered lunatics are private patients, and 15,379 pauper patients?—That is so.

15,046. Of the private patients, 2,887 in number, there are 1,539 males and 1,348 females?—That is right.

15,047. Taking the pauper patients, 15,379 in number, there are 7,573 males and 7,806 females?—Yes.

15,048. I think it would next be useful if we were to have from you a short description of the different places in which lunatics are to be found in Scotland. Let us just get that, because the system is a little different again in Scotland from what it is in England. First of all, shall we take what are called the public asylums proper which are a group which consists of the Royal or chartered asylums in Scotland?—That is so.

15,049. These are the only places which are rightly described as public asylums?—Yes.

15,050. I think they are seven in number, are they not?—Yes.

15,051. It might be interesting just to note them. There is the Aberdeen Royal Asylum, the Crichton Royal Institution, the Dundee Royal Asylum, the Edinburgh Royal Asylum, Glasgow Royal Asylum, Montrose Royal Asylum and Murray's Royal Asylum—these are the seven?—Yes.

15,052. These are institutions, are they not, which are not carried on for gain?—That is so.

15,053. They are all philanthropic institutions with endowments?—Yes.

15,054. And are institutions into which patients must be received if ordered to go there?—That is so.

15,055. In four of those seven institutions are paupers received?—Yes.

15,056. In three, namely, Dundee, Glasgow and Murray's, are there no pauper patients at all?—That is right.

15,057. Just to complete the statistical information, were there 3,595 patients in these seven public asylums on the 1st January, 1924?—That is correct.

15,058. Now in addition to those seven institutions, have you the district asylums to which allusion has already been made?—Yes.

15,059. These are the asylums which are provided by the District Boards?—Yes.

17 April, 1925.]

Sir H. ARTHUR ROSE, D.S.O., and Dr. HAMILTON C. MARR.

[Continued.]

15,060. And with the construction of which, or extension of which, you as a Board have extensive and important powers?—That is so.

15,061. They are, as we know, 21 in number?—That is right.

15,062. And do many of them receive private patients as well as rate-aided patients?—Yes.

15,063. I think by far the greatest number of patients in Scotland will be found in those asylums?—That is right.

15,064. I think the number at the 1st January, 1924, was 11,649?—Yes.

15,065. Then is there in Scotland only one private asylum?—That is right.

15,066. That is to say, an asylum corresponding roughly to what we call a licensed house in England?—I suppose that is so.

15,067. And that is called New Saughton Hall?—Yes.

15,068. There is just the one private asylum which receives only private patients for remuneration?—Yes.

15,069. It is quite a small institution, is it not? I see it had at the 1st January, 1924, 54 patients only?—That is so.

15,070. Then there is also one parochial asylum?—Yes.

15,071. That is rather a small institution at Greenock, is it not?—Yes.

15,072. And is really rather a vestige of a previous system?—Yes.

15,073. But it remains in a category by itself?—(Dr. Marr): It is really on the status of a district asylum, the District Board of Greenock.

15,074. But it has a peculiar legal status, because it is the survival of a previous system, and it is what is known as an institution with an unrestricted licence?—Yes.

15,075. It has nothing to do with you, of course?—We license it. It is more like the lunatic wards. We have to license all parochial asylums. The only one left unconverted was Greenock Parochial Asylum, and we have to license the number of beds in Greenock Parochial Asylum, limited to 200 beds.

15,076. At Greenock Parochial Asylum there are 222 inmates, or were at the 1st January, 1924?—(Sir Arthur Rose): That is so.

15,077. Then we come to a not unimportant class, the lunatic wards of poor houses?—Yes.

15,078. The poor house in Scotland is the equivalent, is it not, of the workhouse in England?—Yes.

15,079. And they also come under your supervision, and there are 14 instances of lunatic wards of poor houses?—That is right.

15,080. On the 1st January, 1924, were there 883 persons in those lunatic wards?—Yes.

15,081. Taking those five classes which we have enumerated, I think we would find, on the 1st January, 1924, that of your 18,266 registered lunatics 16,403 were in these institutions?—Yes.

15,082. And then we come to a class of much interest to us here and which we hope to hear more about in a little: patients in private dwellings?—Yes.

15,083. Do we find the balance, namely, 1,863, of the registered lunatics of Scotland are in residence in private dwellings of one kind or another?—Yes.

15,084. That is a matter on which we want some further information later. Then the only other institution in Scotland is one with which we are not concerned, the Perth establishment for State and criminal lunatics?—Yes.

15,085. That really falls outside our survey, and we have not been considering Broadmoor either in England?—Quite. These are inspected by us.

Earl Russell: Could we have the total population of Scotland?

15,086. Chairman: Yes. (To the Witness): Could you give the total estimated population of Scotland on the 1st January, 1924, so that we may have an

idea as to the extent to which lunacy prevails in Scotland?—4,915,500.

15,087. Should not one bear this in mind, that in addition to the 18,266 registered lunatics there may be persons who are of unsound mind resident with their own families?—That is so.

15,088. So that these figures are not exhaustive of what you may call the insane population of Scotland?—Quite.

15,089. Now, taking first of all the different classes of institutions which you have enumerated, we are much concerned, Sir Arthur, with the various methods of admission to institutions, and they do vary, do they not, in Scotland, to the same extent as in England?—Quite, up to a point.

15,090. Let us take, first of all, the seven Royal or chartered asylums of Scotland. You have already told us that they are philanthropic institutions, and they roughly correspond to what are known as registered hospitals under the English Lunacy Acts?—Yes.

15,091. Do they receive patients at high rates of board as well as others on more economical lines?—Yes.

15,092. And they have charitable funds at their disposal which are utilised for the reception and treatment of poor private patients?—Yes.

15,093. As regards your authority in relation to those institutions, I think you have no power to make rules and regulations for their good order and management?—That is so.

15,094. But you have power to prescribe the books and minutes and returns which have to be made?—Yes.

15,095. And have you some limited powers with regard to the plans of these asylums and alterations and additions to them?—Yes.

15,096. But apart from legal powers, do you find that in practice you are frequently consulted in connection with any alterations made in such premises?—That is so.

15,097. The district asylums are erected or acquired and managed by the District Boards of Control themselves, are they not?—Yes.

15,098. But are the sites, plans, specifications and estimates all submitted to your Board?—Yes.

15,099. And they require the sanction of your Board before execution?—Yes.

15,100. I think no other sanction is required in your case?—No.

15,101. You do not have to pass them on to the Scottish Board of Health?—No.

15,102. In England, as we know, the plans go not only before the Board of Control, but also before the Minister of Health, but in Scotland the General Board of Control is the final authority on premises as regards the district asylums?—Yes.

15,103. In their case I think you have power to draw up rules and regulations for their management?—Yes.

15,104. These require the approval of the Secretary for Scotland?—That is so.

15,105. Then it is a feature, is it not, of the district asylums, that if they have spare accommodation they may receive private patients. —Yes.

15,106. But for such reception is the sanction of your Board required?—Yes.

15,107. I think as regards the actual accommodation and treatment, private patients in district asylums get exactly the same as the pauper patients?—Exactly the same.

15,108. And should the accommodation run short, I think the pauper patients get the preference?—That is so.

15,109. Then with regard to the single private asylum in Scotland, there were formerly a number of them, I think, but they have dwindled to the single instance. There you have private patients of the wealthier classes, and your functions in relation to it consist in licensing and making rules and regulations, of course apart from visitation, which applies to them all.—Yes.

17 April, 1925.]

Sir H. ARTHUR ROSE, D.S.O., and Dr. HAMILTON C. MARR.

[Continued.]

15,110. Then with regard to the single parochial institute at Greenock, there also, I think, you make regulations for its administration.—Yes.

15,111. *Sir David Drummond*: Do these private patients enjoy no advantages?—Not in the district asylums. (*Dr. Marr*): The service patients who are private patients do get little privileges, 2s. 6d. a week.

15,112. *Earl Russell*: But they get those as service patients, not as private patients?—That is so. The accommodation is exactly the same.

Sir David Drummond: Are we to understand there is only one private asylum in Scotland which accommodates 56 patients or so, where the patient is able to pay for what he wants?

15,113. *Chairman*: No; four of the seven public asylums, that is to say, the Royal or chartered asylums, take in nothing but private patients who pay.—And all the other Royal asylums take in private patients.

Chairman: The other three take in private patients, but also pauper patients as well.

Sir Ernest Hiley: Is there any prohibition in Scotland against licensing, similar to what there is in England?

15,114. *Chairman*: In England in 1890 the number of licensed houses was limited, and is a diminishing quantity; there can be no new licensed houses. I do not think there is a statutory limitation in Scotland.—The general policy of our Board is to do away with the private asylum, and this particular asylum is merely a survival.

15,115. But on the particular point, I think, if my recollection serves me, there is no similar statutory embargo on the number of houses that may be licensed in Scotland. It is a matter of practice with your Board not to license more?—That is so.

15,116. But the case of the wealthy private patient, who wishes the amenities of private life as far as possible maintained, is adequately met in Scotland by the Royal Institutions?—That is so.

15,117. Of course Crichton is well known to us as being probably the best equipped asylum in the Empire—at least it so says of itself, and we accept it.—There is the Royal Asylum in Edinburgh, and all the other Royal asylums have most excellent equipment for the very wealthiest patients.

15,118. What have you to say (this is very important) as to the policy which your Board has been pursuing? You tell us that while there is no statutory restriction on the number of such institutions you may license, in practice they have dwindled to one in Scotland. On what principle is that practice founded?—Generally, the Board do not wish the principle of private or personal profit to come in on the treatment of the insane. Of course, as you will find, in the case of private dwellings we can license to the extent of four patients, but with regard to private asylums the policy of the Board, as I have said, has been to do away with private asylums, on the ground that they do not think it desirable to have any person having a pecuniary interest in the insane.

Earl Russell: You are free from our difficulty in England, by having these very excellent chartered institutions, but how would you meet it in our case?

15,119. *Chairman*: I wish you could help us there.—You would have to have chartered institutions in the same way, I think.

15,120. But the Royal asylums in Scotland are of course, managed, are they not, by governing bodies appointed under their Charter or Act of Parliament?—That is so.

15,121. These, of course, are persons who have no pecuniary interest in the institution at all?—None at all.

15,122. The medical superintendent is a salaried official appointed by them?—All the officials are salaried officials.

15,123. Therefore, although patients in the Royal asylums may make large and profitable payments, these payments all enure to the benefit of the insti-

tution, and not to any private person's profit; that is the feature?—That is so.

15,124. And I suppose it is on the principle of bearing each other's burdens, that is to say, the wealthier patients in those institutions whose payments yield a profit enable the poor patients to be accommodated?—Yes. Concrete instances occur in all our Royal asylums. That very lady I instanced is being maintained as a patient would be maintained who is paying £500 to £1,000 a year, and her only payment is £35 a year to the Glasgow Asylum.

15,125. And she gets those benefits, because the institution is endowed and also because the institution receives from its wealthier inmates a profit which can be applied to the welfare of those less fortunately situated?—That is so.

15,126. *Mr. Micklem*: Is the treatment and accommodation for all patients in the Royal asylums alike, or do those who pay more get different treatment and provision?—The treatment is the same, but the accommodation is different; that is to say, you may have a separate villa, you may have a separate sitting room and bedroom; you may have only a bedroom with a conjoint sitting room; but the question of payment has more to do with accommodation really; the treatment is the same for pauper and for private patients.

15,127. *Sir David Drummond*: Do you recognise that a large number of patients go to these Royal institutions from this country?—From England and from Ireland.

15,128. The accommodation is abundant—is ample for all?—There is ample accommodation.

15,129. Even though a large number go from this country?—That is so.

15,130. We are obliged to send over the border a number of our private patients because we have not the accommodation.

15,131. *Mr. Snell*: Are those counted in the statistics as belonging to Scotland?—Yes.

15,132. So that really your proportion is less?—Yes.

15,133. It does appear, if large numbers go, that the proportion of insanity in Scotland should be lowered.

Sir Ernest Hiley: There are paying patients that go.

Mr. Snell: I quite understand that.

Chairman: I have no doubt that Scottish patients may benefit by the greater affluence of English patients who come to Scotland for the benefit of those institutions.

15,134. *Sir Humphry Rolleston*: Does that amount to very much? I mean Scotch people do come to England.—We have no fewer than 50 cases in England, not necessarily registered lunatics, but 50 cases not able to look after their own affairs.

15,135. *Sir David Drummond*: I suppose you have no statistics—you cannot say how many?—We have no statistics regarding nationality. They could be quite easily furnished if you think it an important point. I do not think it is.

15,136. *Chairman*: I do not think so. Of course, the statistics you have given us are of registered lunatics. Those will not include voluntary patients?—No.

15,137. And, as we shall hear in the sequel, the voluntary system has been greatly developed in Scotland, and many of those who come from across the Border may be persons who have come voluntarily for the purpose of getting the benefit of the institutions?—They generally come voluntarily.

Mr. Snell: What I wanted to find out was whether any number of persons from Ireland or England went to Scotland because the treatment there was more agreeable in these chartered institutions—whether the houses themselves were an attraction.

15,138. *Chairman*: Can you tell us, Dr. Marr, or Sir Arthur, whether the Scottish method, and particularly the existence of those institutions, has proved a source of attraction to persons from either England

17 April, 1925.]

Sir H. ARTHUR ROSE, D.S.O., and Dr. HAMILTON C. MARR.

[Continued.]

or Ireland, or elsewhere?—No doubt. I think particularly the Irish patients go to the Crichton Institution—there used to be a great many Irish patients there, and there is no doubt it was the general treatment there under Dr. Rutherford that first initiated that movement of the Irish patients to this country.

Mr. Snell: I wanted to find out why people went from England. I can understand the Irish conditions may be quite different, and it would interest us to find out whether English people felt that English institutions did not offer so good a chance as the Scottish.

15,139. *Chairman*: Have you found many English patients have been attracted?—Quite a number; I would not say a very great number, but quite a number.

15,140. *Earl Russell*: That would depend very largely upon the opinion of their medical advisers rather than on their own?—Yes, that is so. (*Sir Arthur Rose*): We can get these figures if you wish them.

Chairman: I think it is hardly worth the trouble of taking out the statistics, except that it is rather instructive. You naturally find a flow of patients to the places where they get the best treatment. That may depend to some extent upon the reputation of the medical superintendent of the institution, or it may depend upon the fact that the doctor in attendance on the case has himself come from the district or knows it, or it may depend upon the superior treatment given, or the greater amenity of the life in those institutions.

15,141. *Sir David Drummond*: And it also depends upon the fact that in the North of England a very large proportion of the doctors are Scotch, and they send their patients over the Border?—(*Dr. Marr*): I think there is more in that perhaps than in anything else. The doctors in suggesting institutions act just in the same way as a consultant would do with regard to a surgical case or a medical case, and send them to Scotland.

15,142. *Earl Russell*: Recommend what they know?—Yes.

15,143. *Mr. Snell*: Would there not be some real medical ground for removing a patient so far from his friends. One of our difficulties is to keep patients near to their friends, but if they are moved hundreds of miles away is there a real reason for it?—It depends upon the circumstances; in some cases they go voluntarily.

Chairman: Dr. Marr points out that a voluntary patient selects his own place with the assistance of his doctor. In the case of the involuntary or certified patient, it is the relatives who select it themselves, and they may petition for his admission to the institution, and they therefore have the choice of the place.

15,144. *Mr. Snell*: Then in those cases the relatives would presumably be well enough off to make the journey?—Yes.

Sir David Drummond: As a matter of attraction, I believe in Scotland it is not necessary to certify a patient until a certain period elapses, or until certain changes take place in that case after the patient has arrived in Scotland.

Chairman: That may be the attraction in Edinburgh. We come to the six months' question a little later.

15,145. *Earl Russell*: As a matter of law, I take it, a patient in a Scottish institution could not go there on an English certificate?—(*Sir Arthur Rose*): That is so. But on general principles we believe it is the extraordinary excellence of the way in which the Royal asylums are conducted in Scotland that attracts patients from outside; and it is because of this extraordinary high state of efficiency and comfort and general amenity (so far as it can be done in such an institution) that we, as a Board, have been able to limit any development of the private asylum.

Chairman: In short, the need is not felt in Scotland for licensed houses, because the need is catered for otherwise.

Earl Russell: They do not suffer from our difficulties?

15,146. *Chairman*: Yes. As regards the pauper inmates, who defrays the cost of their maintenance and treatment?—The parish of settlement.

15,147. There are lunacy assessments in Scotland. Is there a precept addressed to the parish council to rate, or to the city, if it happens to be a parish co-terminous with a district?—(*Dr. Marr*): The parish rates for maintenance purposes, and the city rates for providing; the parish always rates for maintenance.

15,148. *Earl Russell*: I thought I saw something here about half the cost.—That is in connection with the Mental Deficiency Act.

15,149. The entire maintenance is charged on the rates, much as it would be here?—Yes, with the exception of the relief of a lunacy grant—local taxation. In Scotland, it is a consolidated or a lump sum. In England it is 4s. per head per patient.

15,150. *Chairman*: It is over £100,000—the annual State contribution?—£115,000.

15,151. How is that allocated among the different institutions?—Since the war it has been stereotyped, but for each registered pauper patient the grant is paid on that basis.

15,152. Simply divided up?—Simply divided among the paupers registered.

15,153. *Earl Russell*: *Per capita*?—Yes, *per capita*: it comes to about 2s. 8d. per week.

15,154. *Chairman*: Now let us come to the question of admission to those different institutions. First of all, let us take the Royal asylums, and let us take there the case, first of all, of the ordinary insane person. In that case, is the admission to the institution dependent upon an order being pronounced by the Sheriff?—Yes.

15,155. And is the Sheriff's order made on a statutory form for private patients and pauper patients alike?—That is so.

15,156. Now just at this point we will get on the note a description of the Sheriff in Scotland. The Sheriff in Scotland is the local judge, is he not, of the territory allotted to him?—That is so.

15,157. And includes the Sheriff-Substitute?—Yes.

15,158. Is the principle this: that Scotland is divided up into areas corresponding to counties over one or more of which a Sheriff is placed who is resident in Edinburgh, except in the case of the Sheriff of Lanarkshire who resides in Glasgow; and the Sheriff is a practising member of the Bar in the ordinary case?—Yes.

15,159. He has Sheriff-Substitutes who function as the local judges throughout his district.—That is so.

15,160. Stationed at different points, in different populous centres?—Yes.

15,161. And the Sheriff-Substitute may be taken to correspond roughly to the County Court Judge in England?—Yes.

15,162. He is in practice almost invariably a member of the Bar?—Yes.

15,163. Although a member of the Solicitors' branch of the profession may be appointed, and there are some who have come from that source.—Yes.

15,164. Then they have very responsible jurisdiction, have they not? The Sheriff-Substitute can appeal to the Sheriff?—Yes.

15,165. They have practically unlimited jurisdiction in civil cases as regards pecuniary amount; and they have also extensive criminal powers which the County Court Judge in England does not possess?—Yes.

15,166. And may we take it that the Sheriff-Substitutes of Scotland are trained lawyers of very considerable experience?—That is so.

Earl Russell: The criminal powers correspond pretty well to Quarter Sessions?

15,167. *Chairman*: Yes; they have powers of imprisonment up to two years, and they have corresponding powers of fining, of course. They can try

17 April, 1925.]

Sir H. ARTHUR ROSE, D.S.O., and Dr. HAMILTON C. MARR.

[Continued.]

cases with a jury on indictment as well as summary cases, which they dispose of themselves. And a Sheriff-Substitute will be found in all the populous centres of Scotland?—Yes.

15,168. The Sheriff really is the judge of appeal from the Sheriff-Substitute?—Yes.

15,169. But he also has power to sit as a Judge of first instance, and all the powers that are given to the Sheriff may be exercised either by the Sheriff properly so-called, or by his Sheriff-Substitute?—Yes.

15,170. In Scotland therefore the principle has been to take advantage of the existence of those local or district judges for the purpose of pronouncing the orders for the detention of mental patients?—Yes.

15,171. And I think in Scotland the justice of the peace is not utilised at all?—No.

15,172. There is one exception—in remote districts he may temporarily act until a patient can be taken before the Sheriff?—That is so.

15,173. That is the only instance in which a justice of the peace functions?—Yes.

15,174. You have already mentioned what is a most important distinction between the English and the Scottish systems. In the case of those orders for admission to a Royal asylum there is no distinction between the procedure in the case of a private patient and in the case of a pauper patient?—That is so.

15,175. In each case alike is the procedure initiated by a petition to the Sheriff?—Yes.

15,176. And is that petition in a statutory form—must it be accompanied by two medical certificates for private and pauper patients alike?—Yes.

15,177. And must it also be accompanied by a statement of particulars of the case?—That is so.

15,178. Now who presents the petition to the Sheriff for the admission of a patient?—In the case of a private patient the nearest relative, the petitioner; in the case of a pauper patient, the inspector of poor of the parish to which the patient is chargeable, and in which the patient is found.

15,179. The inspector of poor in Scotland corresponds roughly to the relieving officer in England?—That is so.

15,180. He is the official representative of the parish council, the body in charge of the Poor Law administration in Scotland?—Yes.

15,181. You said the nearest relative is the normal petitioner, but it need not necessarily be the nearest relative, need it, in the case of the private patient?—It need not necessarily be the nearest relative, but anyone who has a special interest in the patient.

15,182. The Sheriff has to satisfy himself that the applicant is a proper person to act in the matter?—That is so.

15,183. As regards the medical certificates, which must be two in number for private patient and pauper patient alike, the form is practically the same for England, and we need not go into it. You are required to state facts observed by the medical practitioner himself, and those communicated to him, and the examination must be made independently. Have you any view, Dr. Marr, just in passing, as to the desirability of the doctors making their examination independently; because it has been suggested to us that consultation between the doctors is desirable, and that the risk of collusion is negligible?—I think the risk of collusion is negligible. It is more important, I think, to have a medical certificate given by a person who has some knowledge of mental disorders. The difficulty we have is that practically every medical man has a qualification in mental disorder which is a very abstruse and difficult department of medicine. That is, I think, where the confusion emerges more than anything else. That is to say, a newly graduated medical man is quite qualified to write a certificate as well as a man who has had 30 or 40 years in general practice or in special practice.

15,184. *Earl Russell*: Theoretically, of course, he is qualified to treat typhoid fever?—That is so, but he would not be appointed a Public Health Officer. He

would require a special diploma. I noticed that in France medical men before they are appointed medical officers of asylums must have a special course of five years in medicine and pass two special examinations.

15,185. *Chairman*: That is the qualification for the head of an institution, but does the French law require that a certifying doctor shall have those qualifications?—No; I do not think it is possible in the present state of medical science, but I think something should be done on the lines of the Mental Deficiency Act where the Board of Control has to approve of a certifying medical officer.

15,186. We shall hear later, I understand, from Dr. Carswell of what was done in Glasgow where a special doctor was set apart for the purpose?—Yes, and, as a matter of fact, we have gone further in Glasgow. The question of the erection of a third asylum was raised, and instead of erecting a third asylum—it was a very difficult time to consider such an expensive matter—new observation wards were opened at Stobhill, over a year and a half ago, and all the patients that require certification in Glasgow come there in the first instance.

15,187. We look forward with interest to hearing Dr. Carswell's description of that method which has been pursued there, but the features of it are the observation ward, and a specially selected official whose duty is to certify in all the pauper cases?—But this method is to reduce the certification to its normal limits.

15,188. That is a large topic of great importance, but its relevance to what we are discussing just now is this, that the expedient has been adopted in one area of Scotland of having a specially qualified doctor set aside for certification purposes?—Yes.

15,189. *Earl Russell*: I understand from the doctors themselves there is this difficulty, that when you pass a doctor as qualified into the world you pass him as qualified, and it is very difficult to differentiate between one qualified medical man and another?—Yes, but mental disorders should be put at least on as high a plane as ordinary physical disorders, particularly public health.

15,190. He is quite competent to sign every sort of certificate, for instance, death certificates; he is competent to certify that his patient has died of heart disease?—I do not think he is competent to deal with ordinary mental disorders.

15,191. *Chairman*: Is that in consequence of the complexity of the disorders?—Undoubtedly. The ordinary medical man has only had three months' lectures on mental disorders. He may not be asked a question on mental disorders in his final examination, and then suddenly he gets his degree, and he has to deal with a subject of which he has had no experience, and the most difficult and complex of diseases.

15,192. *Sir David Drummond*: Would it not be better to improve the education of the doctor in this direction, so that every man might be competent?—Undoubtedly, so that they have some qualification to deal with this very complicated and special subject.

15,193. *Chairman*: One of the difficulties in exacting a special qualification from a certifying doctor is this, that in the less populous areas you cannot get them.—With the Mental Deficiency Act we, as a Board, have to approve the medical officers. Naturally, in the present condition of affairs every respectable medical practitioner is approved of, whether he has special knowledge of mental disorder or not; but as time goes on, as we perhaps get people educated to the idea that mental disorders are a very specialised department, we might be able to draw this net closer.

15,194. *Earl Russell*: But may it still not happen in a sparsely populated county area that you may not find a certifying man available?—The difficulty would not occur under the system I suggest. In Scotland we have very sparsely populated areas, and the medical man is there appointed under the Mental Deficiency Act.

17 April, 1925.]

Sir H. ARTHUR ROSE, D.S.O., and Dr. HAMILTON C. MARR.

[Continued.]

15,195. *Chairman*: You may have no option, you know?—At first probably, if there is nothing against the man, it would not be a question of qualification.

15,196. I do not quite see that solution, because ultimately you will still have sparsely populated districts, and ultimately still have the country doctor in charge?—But the question of certification is a legal and social question more than a medical question.

15,197. Of course you always have the Medical Officer of Health for the county?—Yes.

15,198. *Sir David Drummond*: You are aware that in this country in a number of instances the qualifications involve an examination in mental medicine as well as in other subjects?—If that is so, that is satisfactory as far as I am concerned, if they have a diploma for psychiatry, but of course, you cannot expect it in every case, as the Chairman puts it.

15,199. *Chairman*: We note your observation upon it, and it is desirable, of course, in the public interest, that this responsible duty should be discharged by the most competent persons available. That is the ideal, of course. Whether we have reached a stage where a qualification ought to be prescribed or not is another matter?—I do not think we have reached that stage.

15,200. *Earl Russell*: It is also true that in 80 per cent. of the cases there is no difficulty?—Yes, I think so. It is the borderline case that is difficult.

15,201. *Sir Humphry Rolleston*: Are you not very anxious to do away with the separation between mental disease and bodily disease?—I do not see any separation.

15,202. It might seem inadvisable to have a special class of practitioner to judge of those people who are mentally diseased?—No, I meant the practitioner who would know the subject—not a special class.

15,203. Does that not apply to every specialist?—Yes, but mental disorders I think particularly require a specialist.

15,204. Will not every specialist say that?—Yes, I hope so.

15,205. *Chairman*: I think we see the difficulty, Dr. Marr. Now let us get back from this very valuable discussion of the qualification of the doctor to the main lines of Sir Arthur's proof. The features which strike us at this stage are that the magistrate is a qualified magistrate in this case, the Sheriff, a person possessing legal qualification, and that there is no differentiation in procedure between pauper and private patient, and that there are two medical certificates before the Sheriff will pronounce his order?—(*Sir Arthur Rose*): That is so.

15,206. Then in Scotland, I think, the Sheriff does not need to see the patient?—He can if he wants to, but he does not need to.

15,207. And, I think, in practice he does not generally do so?—Practically never.

15,208. So he confines himself to a scrutiny of the certificates to see whether they contain adequate evidence to vouch the statement that the patient is of unsound mind, and to justify him in pronouncing the detention order?—That is so.

15,209. *Earl Russell*: Was Dr. Robertson right in describing it as a mere formality?—Personally I consider it more than a mere formality.

15,210. *Chairman*: Of course one knows a good many Sheriffs oneself; some may treat it as a formality. I know that one or two regard it as a very anxious part of their work?—Quite, and they sometimes refuse to make an order.

15,211. But their task is not a task in supersession of the medical task in any sense of the term, but rather that of a person skilled in examining evidence. The Sheriff has before him statements and his duty is to see whether those statements support adequately the proposition that this is a person of unsound mind who ought to be detained?—That is so.

Earl Russell: He considers the same sort of material as on an *ex parte* application for an injunction

15,212. *Chairman*: Yes, on affidavits. He has before him two affidavits, and he must judge whether those are sufficient to justify him in pronouncing an order?—Quite.

15,213. And that is the point at which the public are represented in the process?—Yes.

15,214. Have you in Scotland had any complaints as to this procedure by means of the Sheriff and the two medical certificates?—No material complaints.

15,215. As regards expense, have you found that the two medical certificates involve you in considerable expense?—No, we have never had any complaints.

15,216. In England there is, in the case of the pauper patient, only a single certificate, and it has been suggested that a recommendation that there should be two certificates in England would involve a considerable additional charge upon public funds?—(*Dr. Marr*): With regard to pauper patients, the second certificate may be filled in by one of the medical officers of the asylum to which the pauper patient is sent.

15,217. *Earl Russell*: Really?—Yes. That is a point which we, as a Board, have noted for amendment in a Consolidating Act, because we would wish that the ordinary pauper patient should have the same privileges before certification as a private patient.

15,218. *Chairman*: Then in the case of the private patient there is this difference, that the two medical certificates must be by persons not connected with the institution to which he is being sent?—That is so.

15,219. *Sir Ernest Hiley*: Is the second certificate in the pauper case given after the patient gets into the institution?—Generally such patients are admitted on what is known as a certificate of emergency.

15,220. Then it would be given afterwards?—Yes.

15,221. *Earl Russell*: That would create great public alarm here, I think.—(*Sir Arthur Rose*): Still we have the one certificate which you have already from the independent medical man.

15,222. Of course we have it in a sense in the reports which are required to be made upon him when he arrives?—Yes.

15,223. *Chairman*: But the medical officer of the institution in giving a certificate would not receive a fee for it, would he?—(*Dr. Marr*): In certain cases he would. For instance, in Glasgow, which is a district, he would not get a fee because his emoluments cover his whole duties, but where a county is dealing with parishes, the District Board is appointed by the county council, but the patient is sent by the parish council; then the medical officer signing the second certificate would, and does, charge a fee.

15,224. Which is recouped by the parish council?—Well, the parish council pay him direct.

15,225. *Earl Russell*: What is the fee—a guinea each?—Yes.

15,226. So two certificates would cost two guineas as against one guinea?—Yes. (*Sir Arthur Rose*): We have raised the point with the district authorities, and we do not like this second certification by an official of the institution, and in one case, Lanarkshire, at any rate, it has been definitely stopped.

15,227. Of course we have a provision in England by which a medical officer of a workhouse can certify.

—Yes. (*Dr. Marr*): Of course there is great difficulty in the far off parishes, in the Outer Isles.

15,228. It is a thing you propose to make illegal?—Yes.

15,229. It could be met by the second certificate not being given before he comes in?—That is so.

15,230. That is the way you could get over your practical difficulty, is it not?—Yes. (*Sir Arthur Rose*): I think it is only fair to say we have never had any evidence of abuse from this practice. It is simply the possibility.

15,231. *Chairman*: Most of these requirements are precautionary and rather for the purpose of relieving any possible public anxiety than to remove existing abuses?—Quite.

17 April, 1925.]

Sir H. ARTHUR ROSE, D.S.O., and Dr. HAMILTON C. MARR.

[Continued.]

15,232. Dr. Marr referred to the emergency order which is an important feature in Scotland. May any patient be taken direct to an institution on an emergency order signed by one medical officer and addressed to the medical superintendent of the institution?—(Dr. Marr): That is so.

15,233. But that operates only for three days?—Yes.

15,234. And within that time proper certification must follow?—Yes.

15,235. And if no such order is made by the Sheriff, the patient must be released?—Discharged within three days.

15,236. Then after the patient has been received into the asylum, has he to be seen after two days, and before the expiration of 14 days, by the superintendent who must make a report upon his case?—Yes, and send a copy of that report to the Board of Control.

15,237. Along with a copy of all the documents relating to his case?—A copy of the certification, and the admission of the patient.

15,238. Yes. Is that the method by which patients reach these Royal asylums?—Yes.

15,239. And is that applicable to all the certified patients who are there?—Quite.

15,240. Then is there a class dealt with specially in the legislation of Scotland, namely, dangerous lunatics—that is to say, persons who are behaving insanely in public, and who may be threatening danger to others, or be offensive to public decency?—(Sir Arthur Rose): Yes.

15,241. No doubt the police are the people who come into contact with these persons, first of all?—Yes.

15,242. If there is no actual offence committed, are such persons handed over to the inspector of poor or to relatives?—Yes.

15,243. And then the relatives, or the inspector of poor, will take the usual steps of petitioning?—That is so.

15,244. If, on the other hand, there is immediate danger to the person himself or to others, he can be dealt with as a dangerous lunatic under Section 15 of the Act of 1862?—Yes.

15,245. And is provision made for the Procurator-Fiscal holding an enquiry into the matter before the Sheriff?—Yes.

15,246. We need not go into the detail of that procedure, but it may either go its whole length, in which case the Sheriff pronounces an order for the detention in a particular institution of the person in question, or the proceedings may be abandoned, and the inspector of poor proceed in the usual way by petition.—Quite.

Miss Madeleine Symons: Is it usual for the patients to go direct to the asylum?

15,247. *Chairman*: That is the next point we must take up. There is one feature we have heard much of in England, and a feature which many think objectionable, that the patient in transit to the asylum passes through Poor Law institutions in one shape or another, is taken for instance to a poor-house or workhouse, is there examined and certified, and ultimately passes into the asylum. Do I understand that in Scotland that intermediate stage does not exist?—Normally it does not exist.

15,248. Does the patient go direct on an emergency order to the asylum, or is the patient just kept at home until the proceedings are gone through, if there is no immediate danger or urgency?—If there is no immediate danger or urgency, they remain at home as a rule, but if there is immediate danger or urgency they are taken direct to an asylum.

15,249. So they never pass through the wards of a poorhouse at all?—No, but of course they are pauper patients. We have that feeling, too, of the stigma.

15,250. For the moment that is rather a slightly different point. The legal status is one thing; but looking at it from the point of view of the patient, some have thought it objectionable that *en route* to

the asylum the patient should pass through a Poor Law institution with the possibly unpleasant associations of that idea. In your case I take it the patient goes direct to the asylum from his house?—A certified patient.

15,251. Or, if he is found in the streets, what happens then?—(Dr. Marr): We have observation wards in all the big towns now. The patients go there.

15,252. Is that a Poor Law place?—No, observation wards are quite different; they are places for the treatment of cases that might not require certification.

15,253. They are not poorhouses?—They are parts of Poor Law hospitals.

15,254. *Earl Russell*: They would correspond to a Poor Law infirmary here?—Yes.

15,255. *Chairman*: That is the case of the dangerous lunatic, or the lunatic found wandering at large?—No; all cases, except the dangerous cases. The dangerous cases are usually sent direct from a Court.

15,256. *Earl Russell*: Suppose a man were found in the streets of Glasgow kicking up an insane disturbance, would they take him to an asylum, or to a magistrate, in the first instance?—In Glasgow they would probably report that case to the inspector of poor, and the case would probably be taken to Duke Street, or Stobhill. These observation wards are practically wards of a general hospital in every respect. That is to say, Stobhill, for instance, has consulting physicians, consulting surgeons, and all the necessary apparatus for treatment, and the wards for treatment of mental cases are visited by a visiting physician. They are exactly on all fours with the wards of an ordinary general hospital.

15,257. *Chairman*: But it is a parish hospital?—Yes.

15,258. Stobhill is a general hospital for all cases?—That is so.

15,259. You have certain wards which are exclusively dedicated to mental cases?—There are two wards.

15,260. Then it is just a general hospital, but it is not like the Edinburgh Royal Infirmary. It is on the rates, is it not?—It is on the rates.

15,261. It is a Poor Law infirmary therefore?—It is like the Edinburgh Infirmary in this respect, that they have visiting physicians; the only thing is that it is a Poor Law hospital.

15,262. *Earl Russell*: But he would not necessarily pass through the police court even though the police had apprehended him?—As a rule, he does not. (Sir Arthur Rose.) He would go to the police office until some other place was found. May I come back to your point, because I think we have wandered a little far away from it?

15,263. If you please?—Your point was what happens to a certified lunatic in regard to disposal?

15,264. Yes?—That is perfectly clear, they are taken direct to an asylum without any intermediate stage.

15,265. *Chairman*: Let us take an ordinary citizen, whether he is a person in the West end of Glasgow, or a person in the East end of Glasgow: it has been ascertained he is a person who needs to be detained in his own interests: the inspector of poor takes the initiative, or the relatives take the initiative. In either event the emergency order may be obtained at once on a medical certificate, upon which a patient is taken direct from his own house to a suitable institution?—Yes.

15,266. And within three days the necessary procedure for his permanent detention can be carried through?—That is so.

15,267. If, on the other hand, the case is not acute, the patient will remain at home until the necessary procedure is gone through, and then he is taken direct from the house to the institution?—Yes.

15,268. That is very important, because in England as far as we have learned, very few pauper patients go direct from their homes to the asylum.

Earl Russell: They do sometimes.

17 April, 1925.]

Sir H. ARTHUR ROSE, D.S.O., and Dr. HAMILTON C. MARR.

[Continued.]

15,269. *Chairman*: We have had some evidence of it, but may I say the usual rule is through the workhouse?—(*Sir Arthur Rose*.) Where the confusion arose through the mention of observation wards to my mind was this: the observation wards seem to bring in that intermediate step, but it is in respect only of non-certified patients; they are not lunatics, they are incipient cases, and a great many should never become certified. (*Dr. Marr*.) The majority do not become certified. (*Sir Arthur Rose*.) There is that stage creeping in, but for a different reason altogether, I presume.

Earl Russell: The legal difficulty in this country is that the emergency order under Section 21 of the Act of 1890 does not admit to the asylum. It is only the complete certification that admits.

Sir David Drummond: Just with regard to that point, may we ask as to whether the patient is advised as to the contents of the certificate?

15,270. *Chairman*: Yes, we have heard a great deal about that. In the procedure of certification what part does the patient play? He does not see the Sheriff?—(*Dr. Marr*.) He only sees the medical man, and very often, of course, the characteristic point about mental disease is that a person suffering from it does not think he is suffering from mental disease. He only sees the doctor examining him, but does not see his certificate.

15,271. He has no right, I take it, in Scotland to see a magistrate at all at any stage?—That is so.

15,272. Here we have heard much of the importance of the alleged lunatic having an opportunity of, so to speak, presenting his own case. We shall assume that it is a mistaken diagnosis, and that the patient is perfectly sane, but may be eccentric, and that two doctors have thought he is a certifiable person who ought to be detained. Has he no opportunity of presenting his case, so to speak, against detention, to any independent person?—At once, if he feels that he is being illegally placed in an institution, he has the power of appeal to us as a Board.

15,273. But at the stage of certification, which *Sir David* has in mind at present, he has no appeal against his detention to any outside persons?—That is so, unless of course by pure resistance. He has no appeal. (*Sir Arthur Rose*.) That is the point—he loses his freedom.

15,274. He loses his freedom on two medical certificates scrutinised by a lawyer?—That is so.

15,275. What have you to say as to the advantages or disadvantages of that? Do you find that in practice persons are liable to be detained who should not be detained, and who might have satisfied a judge that there was no reason for their detention in spite of the medical certificates which had been pronounced?—(*Dr. Marr*.) We have many complaints about undue detention, but where there are real grounds for undue detention, I think I am safe in saying that the Board have only investigated two cases within the last year, and these two cases applied to the Board immediately they had been put into an institution.

15,276. I think there is that safeguard, that although at the stage of certification the patient is in the hands more or less of the doctor and his relatives, there is in Scotland provision made for his being entitled to appeal after he is in an institution?—As soon as he is admitted into an institution he can say he is illegally detained, and as a general rule we are there next day. We got an appeal from Montrose one day, and I was up next day seeing the lady who appealed.

15,277. That is a statutory right?—That is a statutory right. All letters must be sent to the Commissioners at once unopened.

15,278. So that if I found myself an unwilling inmate of one of the institutions I could write a letter to the Board of Control, and it would be sent unopened; and would immediate action be taken upon that if I complained that I was being improperly detained?—Immediate action is taken.

15,279. *Earl Russell*: Does it come to anything further than the right he has here, to write to the Board of Control here and say he is wrongfully certified?—I do not know.

15,280. *Chairman*: The Board of Control in Scotland can, of course, if it pleases, invoke two independent medical men to make an examination at once in such a case?—Yes, we do that very frequently.

15,281. There is still a gap?—Excuse me. May I further amplify that by saying that the only time the patient can see his certificates is after he has been in an asylum, and has been discharged; then he has a statutory right to a copy of the certificate.

15,282. *Sir David Drummond*: It has been suggested to us that the patient should have conveyed to him the contents of the certificate, should see the certificate before it is presented, as it were?—I am afraid it would be a very difficult proceeding. I do not believe in subterfuge of any kind, but very often they have, in cases of religion especially, to use subterfuge and say the patient is not suffering from delusions when he is suffering from delusions.

15,283. *Chairman*: The kind of thing that has been suggested to us is this, that the doctor might include among "facts learned from others" a particular fact that might sound rather fantastic, and upon which he might have proceeded as part of the evidence; but the patient might have said it actually happened, and be able to prove that it did happen, so that the thing that was taken as symptomatic of the condition was in point of fact historically true. It was thought that the patient, if he had access to the documents, might be able to put his finger on one or two things and say, "You are quite mistaken about those things; those are things which happened, and are not delusions at all"?—I think these difficulties could be got rid of by limiting certification of patients actually to those cases to be certified for social and legal purposes, that is to say, a danger to themselves or a danger to others, or who had peculiarities that made them anti-social. In the other cases I see no reason why they should not be admitted to institutions as voluntary inmates.

15,284. That may be the solution of the difficulty. With regard to any case which is really appropriate for certification it would be undesirable probably to let them see the certificate?—I think it would be very dangerous to some of those people that they had delusions about.

15,285. On the other hand, with regard to the cases where the person is, although possibly deluded, reasonably intelligent in other matters and interested actually in his own case, these cases may be possibly dealt with under the other expedient of observation wards and provisional detention, and so on?—Yes.

15,286. But there is one gap in the procedure. You say that the patient may after admission address a letter to you which would be followed by action: but how will he know he may address a letter to you? Is there provision made to inform the patient that he may write?—There is no definite provision made, but all the patients are informed of their privileges as far as the Board is concerned.

15,287. *Earl Russell*: By whom, and in what manner?—In the institution, by the superintendent.

15,288. By a written notice?—No, we have no notice.

15,289. By verbal communication?—Verbal communication.

15,290. *Chairman*: He cannot give a verbal communication of much value to a person in a state of melancholic stupor?—If a person protests against his being there, it is the superintendent's duty at once to inform the patient how he has a remedy, if he himself has come to the conclusion that the patient should be detained. There are some cases the superintendent will not detain.

15,291. It has occurred to us, *Dr. Marr* (and perhaps *Sir Arthur* might consider this too), that the Lunacy code is so very complicated that the ordinary layman cannot readily grasp the various rights which

17 April, 1925.]

Sir H. ARTHUR ROSE, D.S.O., and Dr. HAMILTON C. MARR.

[Continued.]

a patient has and which the relatives have. Just as in the case of, let us say, the Savings Bank, and so on, the elaborate regulations are boiled down into leaflets for the comprehension of the public, so also when a patient is taken to an asylum under certification it might be useful if the relatives were furnished, and the patients were furnished, with some simple *précis* of the situation, explaining in simple and non-legal language that the patient may write letters and see doctors, and the rights he possesses, and the relatives' rights of visiting, and so on, because members of the public do not have access to Acts of Parliament?—(Sir Arthur Rose): It is well worth considering; we have had a similar point in view.

15,292. *Earl Russell*: What do you do about notices in the wards as to their right to write letters?—We have no notices.

15,293. So it is a mere accident that a person knows he has this statutory right?—(Dr. Marr): The only instance is where a patient on admission states he has been illegally sent into the institution. A medical man is always there admitting and receiving the patients.

15,294. *Chairman*: But he has no statutory duty to tell him?—No.

15,295. *Earl Russell*: But the patient has a statutory right to write to you, as in England, but he has no notice of that in the wards?—There is no notice in the wards.

15,296. Have you not considered putting up notices telling him about his rights?—I do not think it is desirable to put up notices in wards.

15,297. But there are notices put up in English asylums?—They usually do not read them.

15,298. *Chairman*: Under the Scottish method they like to have as few notices about the place as possible, but in England this notice is a statutory requirement; at any rate where there are private patients there must be a notice posted in the ward informing the patients of their right to send letters unopened to certain mentioned officials; and we have also heard a good deal about the desirability of having post boxes in the wards into which the patients can drop their letters and correspondence, without it having to pass through the hands of nurses?—(Dr. Marr): We have that in several of our asylums.

15,299. Do you approve of that?—In some cases, of course, letters necessarily reach a destination that might be annoyed by them, but I think in general it works there.

Earl Russell: But that is not the point. It is not that the letters should necessarily leave the asylum, it is that they should reach somebody in a superior position without being handled by the attendants in the ward.

15,300. *Chairman*: We do not suggest that the letter of a patient who posts half his dinner in an envelope should go; but a patient who writes a letter wants to have the solace of feeling that his letter is not passing through the hands of subordinate persons, and will reach a superior authority, and that the superior authority will of course deal with the matter properly.—Yes. Of course as a rule in Scotland we do not trouble so much with the letters, because we like to have as many patients as possible on parole, and these patients can post letters for others. As a matter of fact during the war, although the soldier patients were not certified, there was a hospital at Crookston for 350 cases of mentally afflicted soldiers: 150 of these soldiers every Friday went into Glasgow unattended by orderlies. They were all uncertified, but all mental cases who would have been certified but for the war. They were in a mental hospital, not in a neurasthenic hospital, and 150 out of 350 went into Glasgow every Friday and they sent letters. Of course they were sending them to Mr. Lloyd George and some of these people, but I never interfered because I knew the patients, and it would have deprived them of liberty if they had been stopped. I preferred that they should post the letters. I do

not think there is any objection to that course so long as they are really not dangerous to others.

15,301. I have been rather attracted personally by the idea of telling the relatives, and possibly the patient, if he is capable of understanding, a little about his rights and his privileges when he enters an institution. When we ourselves go to an hotel we like to have a few directions about it; and more especially when we go to an institution where one may be for some time, we want to know a little about how it is managed; and those intelligent patients who, after all, constitute a large part of the asylums seem to me to be entitled to know a little of the régime under which they are living?—Undoubtedly.

15,302. *Earl Russell*: Many of those we have seen complain of the secrecy and absence of knowledge—a sort of helpless feeling they have?—I do not know whether it is due to a natural proclivity, but a Scotsman or Scotswoman who is interned in an asylum usually assert their independence and want to know why they have been put there, and the superintendent tells them they can appeal to the Board, and we get letters frequently. I have no objection to your suggestion or anything that would help a patient in any way.

15,303. *Mr. Snell*: Would Dr. Marr think that the writing of as many letters as a patient wants to write is of any therapeutic value—does it help him at all?—Yes, I think so. It is a safety valve.

15,304. It helps him and does not over-excite him?—That is so, just as an interview with an official often helps the staff.

15,305. *Chairman*: It is an unburdening of themselves?—Yes.

15,306. *Mr. Snell*: I was wondering whether the depression following writing would be a greater evil than not writing at all?—I think if you took writing away from some patients you would deprive them of all that made life valuable. (Sir Arthur Rose): I should say that, from the quite considerable number of letters one does receive, this privilege is pretty well understood.

15,307. *Chairman*: There are people even in other capacities who have received such letters in considerable volume. Now I do not think we need deal with the criminal lunatics, or the lunatic soldiers and sailors to which you allude in your *précis*. I think we might pass at once to the voluntary boarders in the asylum. For the admission of a person as a voluntary boarder, I understand that in Scotland no formality is required except merely a written application to the superintendent of an institution for admission?—That is so.

15,308. That is all that is required in the first instance, and then I understand that the superintendent must communicate with your Board to get your sanction to his remaining on?—Yes.

15,309. And that you are apprised that there is in that institution a voluntary boarder named so-and-so who has been received there on a certain day?—Quite.

15,310. Can the superintendent detain that voluntary boarder for any period against his will?—Not for more than three days.

15,311. So that it is a 72 hours' period, which we find in Lord Onslow's Bill, which is the rule in Scotland?—Apparently.

15,312. Are there any regulations made with regard to voluntary boarders in Scotland?—(Dr. Marr): No regulations.

15,313. Where do we find the provision, for instance, that he may be detained for three days?—You will find the provision in Section 15 of the Act of 1866, and you also find it as altered in the Mental Deficiency Act.

15,314. I think Section 59 also of the 1913 Act deals with it?—That is so.

15,315. "If a person desires to submit himself to treatment in an asylum as a voluntary boarder under the provisions of Section 15 of the Act of 1866, it shall, notwithstanding anything contained in that Section, be lawful for the superintendent to receive

17 April, 1925.]

Sir H. ARTHUR ROSE, D.S.O., and Dr. HAMILTON C. MARR.

[Continued.]

such person on his written application to that effect, provided that such person shall forthwith make written application to the Board, or to one of the Commissioners as required by the said Section, and that such person shall not be detained for more than three days from the date of reception without the assent in writing of one of the Commissioners." That is the whole machinery that exists?—That is so.

15,316. But he may be detained for three days against his will?—Yes.

15,317. *Earl Russell*: Does that three days apply to when he first comes in?—After giving notice, if he gives notice.

Chairman: Let us look at the language. Lord Russell is right, I think—"and that such person shall not be detained for more than three days from the date of reception without the assent in writing of one of the Commissioners."

Earl Russell: That seems to me to be merely the ordinary three days' period.

Chairman: First of all, we get him on his own application entering the place; then, being in the place, he may be detained up to three days.

Mr. Micklem: No, he must get further leave within three days from the Commissioners.

15,318. *Earl Russell*: But that is not the three days' notice?—No.

15,319. Where is the three days' notice—what Act is that in?—It is in Section 15 of the Act of 1866.

15,320. *Mr. Micklem*: In Scotland if you can ever persuade a man to go into an asylum you never need certify him?—(*Sir Arthur Rose*): Not as long as he does not give notice that he wishes to come out. (*Dr. Marr*): It is over 50 per cent. of the registered patients.

15,321. *Chairman*: The only thing that occurs to one is this: I do not know whether these two Sections relate to each other, but under the 15th Section of the Act of 1866 it is provided as follows: "It shall be lawful for the superintendent of any asylum, with the previous assent in writing of one of the Commissioners"—now the previous assent is no longer required. The subsequent assent is sufficient?—That is so.

15,322. —"which assent shall not be given without written application by the patient"?—The patient always sends a letter.

15,323. Then observe the qualification: "to entertain and keep in such asylum, as a boarder, any person who is desirous of submitting himself to treatment, but whose mental condition is not such as to render it legal to grant certificates of insanity in his case." So that under the 1866 Act he must not be a certifiable person.

Earl Russell: No, he must be technically uncertifiable.

15,324. *Chairman*: Yes, but Section 59 says: "If a person desires to submit himself to treatment in an asylum as a voluntary boarder under the provisions of Section 15 of the Act of 1866, it shall, notwithstanding anything contained in that section, be lawful for the superintendent to receive such person on his written application"—which rather looks as if under Section 59 of the Act of 1913, a person, even although his condition might be such as to render it legal to grant a certificate of insanity, may come in as a voluntary boarder. I do not know whether that is so regarded in practice or not. Under the Act of 1866 it is contemplated that voluntary boarders should be persons in whose case it would not be legal to grant a certificate of insanity?—Yes, quite.

15,325. *Earl Russell*: That is non-certifiable persons?—Yes.

15,326. *Chairman*: Can a certifiable person in Scotland now become without certification an inmate of an asylum as a voluntary boarder?—Yes. That was the object of this amendment in the 1913 Act.

15,327. *Earl Russell*: But we still have not got the three days' notice under which he can be discharged?—(*Sir Arthur Rose*): If you read a little further, it is in the 1866 Act. Shall I read it?

15,328. *Chairman*: Please, Sir Arthur?—"Provided always that every such boarder shall be produced to the Commissioners at each of their visits to such asylum, that no boarder shall be detained for more than three days after having given notice of his intention or desire to leave such asylum, unless on certificates of insanity and an order by the Sheriff."

15,329. *Mr. Micklem*: Which Act is that?—That is the 1866 Act. There is this peculiar point of the mental condition of a voluntary boarder, as to whether now a person who could be certified can come in as a voluntary boarder. To us lay members of the Board, this question does give a certain amount of trouble, because the question arises if a person is certifiable is he fit to express voluntarily a desire to enter an asylum?

Chairman: I appreciate that from the legal point of view also; it is very difficult.

15,330. *Earl Russell*: That trouble would be removed by the provision in Lord Onslow's Bill as to the people who are not in a position to give consent, although the words they use are "persons of no volition"?—It does not entirely meet the case, I think. One cannot help having at the back of one's mind the question as to whether a voluntary inmate is not a compulsory voluntary inmate if I might say so. If you are not prepared to be a voluntary inmate, the only alternative would be to have you certified.

15,331. True; but even so, one is very anxious to get them in on a voluntary footing if one can, for the sake of their after life and their reputation, if they are likely to recover?—I was thinking of it from the point of view of the patient. Is he there as a voluntary patient—if he is there under a threat?

Chairman: It is very difficult; I have felt it very much myself from the legal point of view. If a person is a voluntary boarder, that is to say, has gone there of his own free will, that assumes he has a free will to exercise, and therefore that he is not insane; but that is a very crude and lawyer-like way, if I may say so, of putting things, because we are dealing here with a pathological state and a person may not be certifiable.

Earl Russell: I think the doctor will tell us that many a certifiable person has what they call pretty considerable freewill.

15,332. *Chairman*: Yes?—In Scotland a certified lunatic can, in certain cases, make a legal will.

15,333. *Sir David Drummond*: As a matter of fact, is it not true that quite a number of people are admitted as voluntary patients who are not capable of offering any opinion upon the question themselves?—(*Dr. Marr*): I do not think so. At our inspection voluntary patients are produced to us, and we ask them "Are you here of your own free will?" If we come to the conclusion that they are not properly voluntary patients, we suggest they might be certified.

15,334. In other words, people are admitted who are certifiable, and are really not capable of discussing the question; they do not quite know where they are?—I do not think we have had much experience of that type of case.

15,335. *Chairman*: Is that necessarily so? I mean I could conceive quite well a person who to the medical mind might be a certifiable case, and yet who could say "I have quite sufficient intelligence to realise that the best thing I can do is to get into this institution and to get treatment there." There may be a pathological state affecting some part of his mind, and yet he might be able to appreciate the disability of his condition, and would say "I should like to be in this institution, and I wish to come there." The question of assessing the value of his volition is a very difficult thing; it is a psychological problem?—Very difficult. Take a case where you get a person maniacal perhaps every two or three or six months, and in the intervals they are quite as normal as any person possibly could be. They

17 April, 1925.]

Sir H. ARTHUR ROSE, D.S.O., and Dr. HAMILTON C. MARR.

[Continued.]

come often voluntarily and beg to be admitted to the asylum.

15,336. Of course, what we are all concerned with is, on the one hand to preserve that very desirable feature, and on the other hand to protect the case which is, or ought to be, a voluntary one from becoming an involuntary one; in short, to preserve the truth of the voluntary status, and to prevent it being really a cover for involuntary detention. There have been cases you know in which voluntary patients have complained that while they went in voluntarily, they found themselves compulsorily detained. I do not say these are Scotch cases, but such cases have come under one's notice?—(Sir Arthur Rose): I would not like it to be felt that I was taking any general objections to the system; I was merely rather trying to look for possible loopholes, because the voluntary system with us in the case of the majority of the patients is an enormous boon—there is no question about that.

15,337. There must be some practical device whereby the difficulty could be overcome, but it is not easy to see?—Not at all easy.

15,338. I am not at all sure that I like the provision in Lord Onslow's Bill of the substitution of volition of other people.

15,339. Mr. Micklem: When you say a great boon you mean because they are not certified?—Yes, because they are not certified. The great majority of them are fully cognisant of the type of institution they are going into, and why they are going into it, and they obtain a great deal of benefit from that voluntary admission.

Chairman: A voluntary patient is prepared to go at the incipient stage of the disease when the treatment may be preventive and beneficial, instead of waiting for a ticket of admission for achieved insanity.

15,340. Sir David Drummond: The professional impression in this country is that certifiable patients are admitted to Scotch asylums at a time when they are absolutely incapable of offering an opinion upon the question of voluntary admission?—(Dr. Marr): I would say you are correct as far as certifiable patients being admitted as voluntary patients are concerned, but otherwise I say it is quite erroneous. They write a letter asking to be admitted and give every indication that they are quite competent to manage and deal with their own affairs, and have really not been compelled to go in.

15,341. Chairman: You have seen a great deal of these voluntary patients. Just tell us of their appreciation of their position; do they realise that they are there voluntarily, and do they appreciate the fact that they are there in that capacity and not as certified patients?—Undoubtedly. If their mental condition has been so bad we would say "This is not a case for a voluntary boarder, give your notice to the medical superintendent."

15,342. Do they realise their privileges and their freedom?—Undoubtedly; they would not be there unless they realised that; they have to write the letters.

15,343. Sir David Drummond: Do you mean before their admission?—Before their admission.

15,344. Surely you are not telling us that that occurs in every case?

Chairman: They must.

Sir David Drummond: Dr. Robertson will tell us something different.

15,345. Sir Ernest Hiley: Does the patient write the letter himself, or is it put before him and he has to sign it?—In some cases it is signed, in other cases where he is delirious or something—

15,346. It is a genuine letter, not a printed form?—No; they write the letter.

15,347. Expressed in their own language?—Yes.

15,348. Earl Russell: It is an individual letter?—Undoubtedly.

15,349. I suppose these patients may differ from all others in that when you go round they never ask to be released?—If they get worse and have no conception

of their idea of being voluntary patients and say "Why am I detained here?" we explain to them that they can give three days' notice to the superintendent, or we suggest this patient is no longer really in the category of a voluntary patient and must be certified.

15,350. Chairman: The *précis* before us rather suggests, you know, that the voluntary boarder in Scotland is a person whose state is not such as to render it legal to certify him?—I think we are going beyond that, and we recognise that it would be a misfortune for some of the people if they could not get in on their own.

15,351. I think the essence of the idea is the avoidance of certification: whether they are in a condition reasonably to appreciate their own situation and voluntarily to subject themselves to treatment, without really the necessity of any examination as to whether they are certifiable or not certifiable?—Quite. There is a very interesting point that may answer Sir David Drummond's question. There are so many admissions, say, 50 admissions of voluntary patients during a certain period of inspection; you will find that probably the whole 50 have disappeared when the next six months' inspection takes place—that is to say, that they have been discharged either as recovered or greatly improved, and you have a new set of voluntary patients in practically every six months.

Sir David Drummond: I am altogether in favour of the Chairman's view of it. We want to avoid certification, and I do not at all object to the certifiable patient being admitted as a voluntary patient; but my contention is that some of them are not capable at the time they are admitted of writing a letter and requesting to be admitted.

15,352. Chairman: I think that probably the Scottish procedure Sir David may have in mind is the provision under which, without any certification whatever, persons who are in a doubtful state of mind may be boarded for six months. That is another procedure altogether?—That is in a private house where they have to fill in a form G, a copy of which is not sent to us.

Sir David Drummond: We are probably at cross purposes.

Chairman: You will hear about that from Dr. Robertson, but for the moment we are really on the voluntary boarder system in relation to the asylums.

Sir David Drummond: You must not take what I have said as applying to your answer. Your answer is probably perfectly correct.

15,353. Chairman: For the moment we are dealing with the voluntary boarder question in relation to asylums, how they get in there, what are their rights there, and how they may leave. What has always struck one as a practical problem in that context is this. A person enters the institution as a voluntary patient—all the procedure is correct. Unfortunately the disease in his case proves progressive, and he becomes thoroughly insane. Now what happens in that case? He has ceased to be voluntary because the conception of being a voluntary patient is that the volition continues; it is a continuous act of will to remain on in the place. That is destroyed of course by the complete absence of reason. In such a case is the patient certified in the asylum?—In many cases he is certified in the asylum, but in general it is recommended that he should go to some other institution—that is to say, discharged as a voluntary patient from that institution, lest it might be considered that the voluntary admission was merely just a sort of step whereby patients were admitted into the institution for the purpose of certification.

15,354. That is exactly the point; one wants to avoid the idea that a voluntary patient will find himself becoming an involuntary patient, and he feels "If I go in there, the same thing will happen to me as happened to my friend."—Of course there are no legal objections to that course, but in general we suggest the alternative course I have indicated.

15,355. Earl Russell: As against that, what effect has the change of surroundings on the patient's own

17 April, 1925.]

Sir H. ARTHUR ROSE, D.S.O., and Dr. HAMILTON C. MARR.

[Continued.]

health?—Very often it is an improvement, a change to another institution often does a great deal of good.

15,356. *Mr. Snell*: What happens to your voluntary patient who becomes worse and wants to leave?—All he has to do is to give three days' notice.

15,357. And then, however ill he is, he may leave?—The superintendent is bound to discharge him.

15,358. *Chairman*: If he is in the condition Mr. Snell figures, then the three days' interval is really utilised for the purpose of getting him certified?—Very often the friends are informed that he wishes to leave; and if the superintendent thinks he is not in a suitable condition for leaving and might be in danger, then he notifies the relatives that they should have him certified.

15,359. The three days' interval is just intended as a protection against the possibility of the man going out in a state not fit to be at large?—Yes.

15,360. *Mr. Snell*: The friends take the initiative?—Yes.

15,361. Suppose he has no friends, the institution itself would not take those steps?—No.

15,362. *Chairman*: In Scotland every case of certification must proceed upon a petition by some individual?—That is so.

Mr. Snell: Suppose a person has no friends or relatives, and as such gets worse and wants to leave, what happens to him? Is he just turned adrift until he commits suicide?

15,363. *Chairman*: He might present himself at the door of one of your institutions. He might say "I have got £50—will you take me in"?—of course you would, I have no doubt?—Yes.

15,364. He would write the necessary letter to the Board of Control?—Yes.

15,365. The superintendent would house him there. But then, to take Mr. Snell's case; suppose he proceeded to get very much worse, who is to have the carriage of the necessary proceedings for the certification?

From a monetary point of view and the difficulty of arranging his affairs, a curator must be appointed in the first instance.

15,366. A voluntary boarder need not be a person of any means, because he may become a voluntary boarder at the instance of his parish council?—No, the parish councils do not adopt it, because they lose the Government grant.

15,367. But I understand from some information I have read in these papers before me that some parish councils are taking a more generous view of the situation?—Yes, ten of the poorest parishes in Argyllshire have decided to do away with the Government grant, in order to allow patients to be treated at the early stages of their disease, and they send them in chargeable to the parish wholly, without any relief from the guardians. The Lunacy grant unfortunately is distributed on a basis of certification only, to certified pauper lunatics.

15,368. *Mr. Snell*: So that the pauper case must really wait for treatment until his disease is of certifiable intensity?—That is so; if the inspector of poor does not want to lose his Government grant which I think, of course, is a mistake.

15,369. *Earl Russell*: Suppose this man has come here with his £50, and he has given notice to leave, and, at the end of the second day, there is nobody to present a petition, what are they going to do—will they communicate with the inspector of poor to get him certified?—Yes.

15,370. *Mr. Snell*: The institution would take that step?—Yes, they would take that step. In fact I have had a case, not when I was a Commissioner but Superintendent of an asylum, when a patient came out with his own certificate and walked all the way to Glasgow—went and got hold of the inspector of the poor, got the certificate filled up and went to the Sheriff and paid the Sheriff's fee. I cannot say whether he was an Englishman, but he was in Scotland.

(After a short adjournment.)

15,371. *Earl Russell*: Before we leave the voluntary boarder, I want to ask this, because I think it is rather a material question. You find in Scotland that all he has to do is to go in on his own requisition, and then give notice to the Board of Control; do you think that that is ample protection for the public?—(*Sir Arthur Rose*): He does not give notice to the Board of Control—the superintendent does.

15,372. What I mean is he goes in simply on his application then and there, and the only formality necessary is the subsequent notice to the Board of Control?—Yes. I think I can say that our experience so far has been that there was sufficient protection.

15,373. The reason I am asking is because there are very elaborate safeguards in Lord Onslow's Bill, which I daresay you are aware of?—Yes. I do not think our experience has been that there has been any abuse of this system.

15,374. Nor really can there be if you are there to enquire at once?—Almost at once.

15,375. *Chairman*: It is very attractive as a solution of the whole thing.

Earl Russell: It seems to me that the provisions in Lord Onslow's Bill would put any one off. You have read them, and they are very severe?—Yes.

15,376. *Chairman*: I thought we might pick up at this stage the points which always interest us, namely, the opportunities for communication between inmates of institutions and the outside world, the points of contact which are provided for. You have explained the visits of the Commissioners. Then I think there is also provision made, is there not, for the Sheriff himself inspecting an asylum at any time he pleases?—(*Dr. Marr*): Yes, he has the right to inspect an asylum.

15,377. Then, I think, three justices of the peace may inspect?—(*Sir Arthur Rose*): Yes.

15,378. Then, I think, also representatives of the Poor Law authority—guardians, as they call them in

England, parish councillors in Scotland—may also go and see their patients in the institution?—Their own patients.

15,379. Then you have told us about the facilities for writing letters. Do you think that these various provisions for inspection, and for communication with the outside world give the patient a feeling that he has means of getting in touch with outside authorities to an adequate extent?—Generally speaking, I think, yes. Of course you do get the sad case of patients who think everything is against them; you cannot help that. (*Dr. Marr*): I think you might add as a means of helping them a condition of affairs which we are encouraging very much. Sir Arthur is quite cognisant of them. There are a great many visitors to patients at institutions, and these visitors sometimes come long distances, and it was found there were no places provided where the visitors could take their friends and have a cup of tea, and so on. Now in several of our institutions they have what is called the village shop, the institution shop, where the patient's visitors can come, buy little things, sweets and flowers, and there is a room set apart where they can have a cup of tea and light refreshments. Of course they pay for these at cost price. The patient goes in there, and they have quite ample means of freedom and talking to each other. In Bangour again, one of the Edinburgh District Asylums, the question of letters has been dealt with to this extent, that they have a room set apart, also like a shop, where they can go and write their letters, and which also forms a library and reading room, and the patients can go in there and write their letters.

15,380. Not so much like a shop as like a club reading room?—That is so.

15,381. There is special statutory provision made for any patient being visited by his minister, or by his relatives, and then Section 61 of the 1913 Act further extends the right of visitation by relatives and others?—Yes. If a visitation by relatives is refused

17 April, 1925.]

Sir H. ARTHUR ROSE, D.S.O., and Dr. HAMILTON C. MARR.

[Continued.]

to any patient it must be recorded in a book, the reason for refusing the visit, and I may say that we have no such record in any of our public asylums—that is to say, visitation has never been refused.

15,382. *Earl Russell*: The book is blank?—Yes.

15,383. *Chairman*: I was also struck with the provision which seems to me to be very useful in Section 48 of the Act of 1857: "It shall be lawful for the Board at any time to give an order in writing for the admission to any patient confined in any house or asylum of any relation or friend of such patient (or of any medical or other person whom any relation or friend of such patient shall desire to be admitted to him), and such order of admission may be either for a single admission, or for an admission for any limited number of times, or for admission generally at all reasonable times, and either with or without any restriction, as to such admission or admissions being in the presence of a keeper or not, or otherwise." Then if admission is refused to a person holding such an order, it is made an offence. So that actually enables the friend of any patient who is in an institution to get an order for a medical man of his own selection to have access regularly to the patient?—That is so. (*Sir Arthur Rose*): I think we can say that has not been taken advantage of, or very seldom.

15,384. The value of many of these powers is not so much the fact of their being exercised, as the fact that they exist?—(*Dr. Marr*): That is so.

Sir David Drummond: Would that order be available all through the patient's stay in the asylum, or would it require to be renewed?

Earl Russell: You see they may make it in general terms if they like.

15,385. *Chairman*: Now let us turn to the question of discharge. What is the normal method of discharge of patients from institutions in Scotland, *Sir Arthur*?—(*Sir Arthur Rose*): The superintendent of the asylum recommends the discharge. He says that the patient is fit for discharge either as cured or under various other categories, and the effective act is a minute by the parish council, I think it is. (*Dr. Marr*): The superintendent discharges on his own authority as recovered. Where the patient has not recovered, in the case of pauper patients, they require what is known as a minute of the parish council authorising a discharge.

15,386. Pause a moment there. If the patient has recovered, does the medical superintendent discharge at his own hand?—Yes, straight away. (*Sir Arthur Rose*): Yes, I was wrong there. (*Dr. Marr*): Of course, if the patient has no friends, he informs the inspector of poor he wants his discharge so that arrangements may be made.

15,387. But in the case of the recovered patient, the discharging authority is the superintendent himself?—Yes.

15,388. *Earl Russell*: Your District Board is like our visiting committee I said just now, but I am not sure that it is. Does it visit the asylums?—It is practically an *ad hoc* Board.

15,389. *Chairman*: Does it visit officially?—Yes; it has its meetings frequently at the asylum.

15,390. *Earl Russell*: Does it control such things as the catering, and that sort of thing?—Yes, everything in connection with the asylum.

15,391. *Chairman*: But, on the other hand, it is not a discharging authority apparently?—No. The discharging authority of patients not recovered is the parish council at whose instance the patients are sent in; and, in the case of the private patient, the petitioner.

15,392. *Sir Ernest Hiley*: Can a District Board of Control visit the private patients in private houses?—No. The private patients in private houses, in licensed houses, are visited by the Commissioners, or Deputy Commissioners.

15,393. *Chairman*: The District Boards' functions, I understand, are confined to the District Asylums?—Yes, and boarded-out cases from the District Asylums.

15,394. *Mrs. Mathew*: The medical superintendents have definite powers to discharge?—Yes; they discharge all patients as recovered who can be discharged as recovered; they simply send them away.

15,395. *Chairman*: No judicial step of any kind whatever?—None whatever. As soon as they notify the patient has been discharged as recovered, a patient can go at any time.

15,396. *Earl Russell*: Is a boarded-out case still carried on the books of the asylum?—No, it is cut off from the asylum. The only types of patients carried on the books of the asylum are two classes, one on pass and one on probation. The pass indicates a 28 days' leave practically, often given to allow the patient to go home and see friends, or a little holiday to the patient. Probation implies that the superintendent is not quite clear that the patient's recovery is going to be a permanent one; he thinks that the patient might perhaps become ill again; he hopes that the patient will remain well, and he sends the patient out on probation for a year or less.

15,397. You do not do as we do in England, send him out for a month?—28 days' pass.

15,398. *Chairman*: That is parole really, is it not?—Yes.

15,399. *Earl Russell*: The usual trial in England is a month?—We do not call it "trial." We do not think 28 days would be long enough for a trial. We call it "probation," where it is longer than 28 days.

15,400. *Chairman*: And it may be as long as a year?—It may be as long as a year, and it can be renewed.

15,401. The normal case of the recovered patient in Scotland is this, that when he recovers in the opinion of the medical superintendent, he is there and then released?—That is so.

15,402. Now if, on the other hand, he has not recovered but has improved, and has ceased to be a danger either to himself or to the public, and is therefore safe to be released from the institution, that is done in the case of the private patient by the petitioner, and in the case of a pauper patient by the parish council?—Through the inspector of poor.

15,403. Who, after all, was the petitioner who put him in?—That is so.

15,404. Then there are other ways, are there not, whereby a patient may be discharged: the Board has itself power, has it not, to discharge in Scotland?—We have power to investigate and see cases, and if we think they no longer require asylum care we can discharge. At one time we had only power to discharge recovered cases, but now, in addition, we have power in the case of patients no longer requiring asylum care to order two medical men to examine these patients, and, if so resolved on, the Board can discharge those patients.

15,405. Is that resorted to much in practice?—Recently a number of cases have turned up; I would not say there are many cases.

15,406. That is a case of direct discharge by the Board on report to the Board by two medical men?—Yes. (*Sir Arthur Rose*): We have a good many applications for the appointment of two medical men. In many cases the patient is so well known to our Medical Commissioner and, in some cases, to ourselves, as to make it quite apparent that the appointment of two outside medical men is useless. If there is the least doubt in our minds at all, then we do not hesitate to employ the two additional outside medical men.

15,407. Are these two outside men paid from public funds?—As a rule they are paid for by the patients' relatives. We have a small grant, I think it amounts to about £30 a year, for this purpose; but even that would not delay us for a moment. I think we would stand the row with the Treasury if there was any question about it.

15,408. Does that apply equally to private patient as to pauper patient?—All classes of patients are alike in that respect.

15,409. Are these the main methods by which patients may be discharged: either on recovery by

17 April, 1925.]

Sir H. ARTHUR ROSE, D.S.O., and Dr. HAMILTON C. MARR.

[Continued.]

the medical superintendent, or by the Board itself on report from two independent medical men appointed for the purpose, or, in the case of patients not recovered, but relieved and safe for release, on the application of a petitioner in the case of the private patient, or of the inspector of poor in the case of the pauper patient?—Yes.

15,410. Do these exhaust the normal methods?—(Dr. Marr): These are the normal methods. There is another method of discharge where a lunatic patient escapes and is absent for what is known as the statutory period of 28 days—his name is then automatically removed from the register, and, in the case of mentally defective cases, it is three months.

15,411. *Earl Russell*: I see here from your *précis* that in the case of a dangerous patient, a private patient whom it is desired to discharge, instead of a barring certificate of the superintendent which we have in England, you have to have a rather elaborate proceeding by the Procurator-Fiscal to stop it?—Yes.

15,412. In this country the superintendent can give a barring certificate and say he does not consider it safe to discharge?—The superintendent can only discharge the person if he is cured.

15,413. But the petitioner who desires to remove a private patient can always do so unless he is dangerous?—Yes, that is so.

15,414. But if he is dangerous in Scotland you have to bring in the Procurator-Fiscal?—The superintendent has to notify that he is not prepared to discharge him on account of his danger.

15,415. Would it not be better for the superintendent to give a barring certificate of his own motion?—That only refers to criminal cases sent in at the instance of the Procurator-Fiscal. It does not refer to dangerous lunatics.

15,416. Take your second paragraph on page 8. I do not know if that refers to criminal lunatics, it does not say so—the paragraph beginning: “If the discharge is desired of a private patient not detained as a dangerous lunatic”?—(Sir Arthur Rose): Yes, but then he has not been brought in as a dangerous lunatic.

15,417. That is what I say, but still the superintendent cannot give a barring certificate; apparently only the Procurator-Fiscal after some proceedings can stop the discharge?—Yes. (Dr. Marr): As a matter of fact, no case has arisen where a superintendent has done so.

15,418. *Chairman*: But is the procedure this, that if the petitioner wanted a private patient out, and the superintendent said, “But to let that person out will be a very dangerous thing to the lieges or to himself,” and the petitioner nevertheless insists and says, “I do not care, I want my relative out,”—in Scotland is the only way of protecting the patient to go to the Procurator-Fiscal?—That is so.

15,419. In England you can get what Lord Russell has alluded to, a barring certificate. The medical superintendent can say “I do not propose to let this man out,” and then there is an appeal from him to the Board of Control.—The only method we have is to report the case to the Procurator-Fiscal, and he takes action or not, according to his discretion.

15,420. That is an outside authority?—That is so.

15,421. Now I think we may pass on a little more rapidly to the next category. What you have been telling us hitherto as to admission and discharge has been applicable to the Royal Hospitals and to the District Hospitals?—Yes.

15,422. Now we may pass to the other category, the lunatic wards of poor-houses. In their case is a licence by your Board essential before any pauper lunatic can be received?—Yes, and renewed annually.

Sir David Drummond: Before you pass from that, I am not quite clear about the top of page 9, “This provision applies to all paupers.”

Chairman: That is in the case of paupers being removed to England and Ireland.

Sir Ernest Hiley: Then it goes on, “and when a pauper who is a lunatic is to be removed, his presence in Court is required.”

Sir David Drummond: That is the point.

15,423. *Chairman*: That is only transfer to England and Ireland?—That is so.

15,424. Is that not dealt with in the 1913 Act?—He does not need to appear now, under the amendment.

Earl Russell: But still it says in the *précis* that he is.

15,425. *Chairman*: Yes. Section 63 of the Act of 1913 says: “Notwithstanding any enactment to the contrary, a Sheriff to whom application is made for warrant for the removal of a pauper lunatic from Scotland shall be entitled to dispense with such pauper being brought before him.” You are a little out of date in regard to that question?—(Sir Arthur Rose): Yes; I am sorry.

15,426. Now in the case of these licensed wards of poorhouses, are the patients received there without any order from the Sheriff?—Yes, one certificate.

15,427. And what is required for the admission of a patient into one of those lunatic wards?—(Dr. Marr): A definite form with one certificate stating that the person is a fit and proper case for the lunatic ward of a poorhouse—that is to say, no longer requires asylum care.

15,428. Can a person not go there direct?—Some are sent direct on this one certificate.

15,429. On the application of the inspector of poor?—On the application of the inspector of poor to our Board.

15,430. *Earl Russell*: It involves deprivation of liberty, of course?—Yes.

15,431. *Chairman*: It is detention in the fullest sense of the term?—Yes.

15,432. *Earl Russell*: Does notice of these have to be given to your Board?—We have to sign the permission for the patient to be admitted to the wards. (Sir Arthur Rose): We really are the detaining authority.

15,433. *Sir Ernest Hiley*: There is no Sheriff in this case?—No.

15,434. You act?—Yes.

15,435. *Chairman*: How is it decided in the case of an individual whether he should be dealt with by an ordinary petition by the inspector of poor to the Sheriff, and then relegated to an institution by the Sheriff, or, on the other hand, sent under this procedure to the lunatic ward of a poorhouse, taking a pauper case?—(Dr. Marr): In many of the cases they are simply transferred from the asylum on a transfer certificate.

15,436. That is probably a very useful thing, because it enables you to pass out from the asylum the cases which are really harmless, though still lunatic, and put them in the lunatic wards; but take a case that is destined for the lunatic ward from the beginning, and which goes there without passing through an asylum first. In whose discretion would it be to decide whether this patient's destination should be an asylum or should be a lunatic ward of a poorhouse?—The inspector of poor.

15,437. I suppose he would be guided a good deal by the class of the case?—That is so.

15,438. If it was just a harmless old lunatic who was not obviously likely to recover, I suppose the lunatic ward would be his destination?—That is so. (Sir Arthur Rose): It initiates with this officer, but we have finally to decide that it is a suitable case.

15,439. The responsibility really rests with you?—Yes. (Dr. Marr): We inspect these cases just in the same way as we inspect the other institutions.

15,440. *Earl Russell*: It is, in effect, a classification by you?—Yes.

15,441. *Chairman*: What is striking about it is that there is no order of any kind whatsoever, and one medical certificate is enough?—Except, of course, where they transfer, then the existing order stands; they are still certified.

15,442. But for direct admission to lunatic wards of a poorhouse nothing is required but the application

17 April, 1925.]

Sir H. ARTHUR ROSE, D.S.O., and Dr. HAMILTON C. MARR.

[Continued.]

of the inspector of poor fortified by one medical certificate, and sanction by the Board?—That is so.

15,443. *Mr. Micklem*: And that patient could subsequently be transferred to an asylum if he required certification?—Yes.

15,444. *Chairman*: The patients in the lunatic wards admitted on this basis are not certified patients?—That is so.

15,445. But are they included in your register of lunatics?—It is a point whether we have really any power to detain these people. That is a point that has emerged. According to our Acts, they can only detain a person sent on the Sheriff's order. In the case of lunatic wards, if a man is admitted only on the one certificate, I do not think we have legal power to detain that person.

15,446. *Earl Russell*: What the Act says is, it shall be lawful to sanction their reception?—That is so.

15,447. *Sir Humphry Rolleston*: In point of fact they do not leave, do they?—No; they are usually what we call the chronic type of case, cases that are not capable of recovery. Those that have a chance of recovery are certified and sent to the asylum.

15,448. *Mr. Micklem*: Would you not send to the wards those who were incipient cases, which might get better?—No; we keep them in special observation wards. These wards are more for chronic hopeless cases that do not require the expensive treatment of asylums, and they are welcomed often in poorhouses because they are such active workers as a rule, some of them, willing to help and anxious to do so.

15,449. *Earl Russell*: This seems rather curious: I see in this case you do not require a resident medical officer unless there are more than 100 patients there—is that so?—Generally in a poorhouse there is a resident medical officer; but if there is no resident medical officer, there is a visiting medical officer who is within call.

15,450. It is merely the fact that he does not live in the building, you mean?—Yes.

15,451. *Chairman*: A curious point arises on this. The power to receive these persons into lunatic wards is expressed thus in Section 4 of the Act of 1862: "It shall be lawful for the Board to sanction the reception of pauper lunatics into lunatic wards of poorhouses without the order of the Sheriff, according to forms and subject to regulations approved of by the Board." What strikes one about that is this: that the persons who may be received are pauper lunatics?—Yes.

15,452. Then when you turn to the definition of "lunatic" you find a lunatic is a person certified by two doctors?—That is so.

15,453. I do not quite understand how one reconciles those two ideas?—It has been a difficulty.

15,454. *Earl Russell*: Where indeed do you get your one medical certificate—is that from your own regulation?—No.

15,455. It is in the Act, is it?—Yes.

15,456. *Sir Humphry Rolleston*: Does not the definition of "pauper lunatic" cover the Chairman's point?—A lunatic is defined in one of the Acts as a person certified by two medical men.

15,457. *Chairman*: "Lunatic" has one definition, but "pauper lunatic" has got another?—You will find it is a difficulty that you may have. If these people walk out of the place we have no power to detain them.

15,458. It looks to me rather like a flaw in the legislation?—Undoubtedly. We have no power to keep a person by regulation.

15,459. Where do we find the one medical certificate being sufficient for this purpose, do you know?—I think you will find it in the regulations of the Board.

Earl Russell: That is what I put to you just now—it is in the regulations.

Chairman: I have got in front of me one of your forms. It is Form C., entitled "Application to the General Board of Control to sanction the reception of a pauper lunatic into the lunatic wards of a 'poorhouse.'" It begins: "As it appears from the sub-joined statements (and accompanying medical certificates) that . . . a pauper lunatic of the Parish

of . . . is of unsound mind, is not dangerous, does not require curative treatment, and is a proper person to be placed in the Lunatic Wards of the . . . Poorhouse. May it therefore please your Honourable Board to sanction his admission." The pre-requisites are then, unsoundness of mind, not dangerous, does not require curative treatment, and a proper person to go to the ward.

Mr. Micklem: Apparently two certificates are required?

Chairman: Yes. On the printed form I have in front of me there is provision made for a statement by the inspector of poor, and a statement by the medical officer, and then it goes on to give two medical certificates—not one. Then it says: "The following medical certificates are not required in the case of a registered insane person who at the time of application is a duly certified inmate of the Lunatic Wards of a Poorhouse."

15,460. *Sir Ernest Hiley*: What is a "registered insane person"?—A person who has been certified by two medical men under a Sheriff's order. We have registered all the patients in the lunatic wards.

15,461. *Chairman*: Just look at that a moment. It struck me when looking at the form that two medical certificates must be appended. Is something wrong with the form?—No, that is quite right.

15,462. You have not got my point. You have just told us that the reception of a pauper lunatic into the lunatic wards of a poorhouse may be effected on one medical certificate—is not that so?—I see. I was taking the licensed house. No, it is on the two certificates, two medical certificates for a lunatic ward of a poorhouse.

Mr. Micklem: In the case of interim detention one is enough, as you will see on the next page.

Chairman: The *précis* says "one," you know.

Earl Russell: The top of page 10 says: "If he is not already a certified lunatic a second medical certificate is required."

15,463. *Chairman*: That is probably the answer?—I beg your pardon; I was confusing it with the licensed house.

15,464. If the person is going for the first time direct to the lunatic ward of a poorhouse, in that case two medical certificates are required?—That is so.

15,465. Coupled with a statement about the person, and the inspector of poor's statement also that he is of unsound mind, and suitable for this place—that is to say, does not require curative treatment, and so on. If, on the other hand, he is passing from an asylum, where he is already a registered lunatic, to the lunatic ward of a poorhouse, he does not require to have two medical certificates. He is already a certified person, but one certificate is necessary for that step?—The transfer certificate. Most of the cases going there are really transferred from asylums.

15,466. In the case of the discharge of patients from lunatic wards of poorhouses is the procedure just the same?—Yes. The cases that are sent in are not recoverable cases. They are discharged usually by minute of the parish council, if they are discharged at all, or returned often to the asylum.

15,467. Do you find these lunatic wards of the poorhouses are satisfactory institutions?—Very satisfactory, for a certain type of patient.

15,468. And do you find that you can give to the chronic type of patient a comfortable shelter and home in such places?—In some of the poorhouses the lunatic wards are very well equipped in every respect, and the patients are well fed.

15,469. And does the sending of the patients to these institutions have the effect of relieving the asylums of their presence, and so enabling the asylums to be devoted to the more directly proper task of dealing with the curable patients?—Yes, curing; and teaching of patients, too, educational work, which has also a good deal to do with the curing and helping of patients.

15,470. It appears that in England there is a comparable power of moving patients from asylums to Poor Law institutions, but it is not very much used,

17 April, 1925.]

Sir H. ARTHUR ROSE, D.S.O., and Dr. HAMILTON C. MARR.

[Continued.]

as far as I can gather. Is the corresponding power in Scotland largely taken advantage of?—Yes; the lunatic wards are usually well filled. Some of them—the majority belong to a combination of parishes. Sometimes they have a difficulty in filling them up. Perhaps the medical superintendent does not like to send cases because he may be dispensing with a good worker, but, generally speaking, they are very well supplied with patients from the asylums.

15,471. It is not a question of discharging; it is merely a question of whether a patient should be in one institution or another?—Yes, no longer requiring asylum care—that is the point.

15,472. Now I would like you to tell us something about the utilisation of private houses for the insane in Scotland. First of all, can a single insane person be received in any dwelling-house in Scotland?—Yes.

15,473. Does it require no form of licence or sanction?—Yes, if there is only one.

15,474. *Earl Russell*: He may be received for profit?—He may be received for profit. We do not require to license the house receiving that case.

15,475. *Chairman*: What control have you over such cases—are they notified to you?—They are notified to us if they are certified cases, and we visit them.

15,476. Then may a certified case be by order of the Sheriff sent to a house as a single patient?—There are some certified cases sent, but they are not sent directly by order of the Sheriff. They may land ultimately in a certified house, but they are not sent directly there.

15,477. How are these places selected for the purpose?—We keep a list of houses that are considered suitable, perhaps doctors or other people who are quite willing often to take patients for gain, and, if they keep more than one patient, we can give them a licence to keep up to four patients.

15,478. They may take one without a licence, but with notification?—Any more than one we can license, up to four, and do license up to four in the case of boarded-out patients, that is to say, patients who have been sent from an asylum.

15,479. *Sir David Drummond*: May the patient remain in his own house certified?—No; no certified patients can remain in their own house unless they are under guardianship. We have a number of lunatic patients in their own houses.

15,480. *Chairman*: Of course a lunatic may remain in his own house uncertified?—But certified often for the parish—that is to say, they participate in the grant.

15,481. But take the case of an ordinary person at home whose mind has unfortunately gone—then, unless they have to be subjected to some form of restraint, or unless they are being illtreated, they may remain indefinitely in their own homes uncertified?—Yes; they are not under our cognisance at all.

15,482. On the other hand, if a person keeps even one of their own relatives in their own home, subjecting him to restraint for more than six months, then you have to intervene?—We can only intervene under Section 57. (*Sir Arthur Rose*): That is one of the weaknesses, that we do not of necessity know of the detention.

15,483. I am thinking of Section 57 of the Act of 1913.

15,484. *Earl Russell*: But if a man's wife kept him in his own home when he was not insane, and kept him home and exercised restraint over him, could you interfere with that, even if you did know?—(*Dr. Marr*): The Act provides that we have powers of inspection, but these powers do not apply to persons living at home—not unless they were certified; and we have power of inspection.

15,485. *Chairman*: Under Section 57 if it comes to your knowledge that any person in a private house is being detained there and subjected to restraint or coercion or is being subjected to harsh or cruel treatment, then you can inquire into the case, “and if on such inquiry it shall appear that such person is

a lunatic and has been so for a space exceeding six months and that compulsory confinement to the house or restraint or coercion of any kind has been resorted to” then you may require the removal of such person to any asylum?—That is so; we have to make an application to the Sheriff.

15,486. *Earl Russell*: So you could interfere in the case of husband and wife, in that case, without ill-treatment?—Yes.

15,487. *Chairman*: In fact if a man locked his wife up for six months in a room—if that came to your knowledge—you could set up an inquiry and have her sent to an asylum?—That would be seclusion.

15,488. I am interested in this question of the single house where a patient may be received. To what extent is that utilised—the single house, as apart from the licensed house?—We cannot tell you that, because the cases may be admitted for six months. These cases have to sign what is known as Form G.

15,489. I am thinking of the certified patient in a private dwelling?—I beg your pardon.

15,490. The certified patient in a private dwelling is either in a dwelling which has not been licensed, or in a dwelling which has been licensed, because he may be one of a number up to four?—That is so.

15,491. Who sends them to these dwelling-houses?—There may be an application from friends; they do not want to send their relative to an asylum, and they may ask the names from the Board of certain qualified guardians, and if they are prepared to pay, these names are supplied to them, and a friend is often admitted there, not certified.

15,492. But a certified case may be sent to a single house, may it not?—Yes, but it has usually been in an asylum before.

15,493. Are lists of those houses in your hands as a Board?—Yes.

15,494. And do you make the selection for the particular patient?—We inspect them. We keep a list of a number of houses to which they can go. We ask them to make their own selection.

15,495. When you come to license a house for the reception of patients up to the number of four, do you inspect the house before it is licensed?—Yes, and then the licence is granted by the Board; and when the patients are admitted there they are inspected, generally by our Deputy Commissioners, twice yearly.

15,496. Is that the protection the patient has there?—Yes.

15,497. Inspection by your Deputy Commissioner?—Yes; and then the patient must be visited four times a year at least by a medical man in the neighbourhood.

15,498. *Earl Russell*: Whom does he represent—you?—No; the patient.

15,499. But you say he has to be visited by a medical man in the neighbourhood?—With regard to the parish council boarding patients, the medical man of the village is appointed to visit. Where it is a private case, they make their own arrangements with the practitioner in the neighbourhood to visit.

15,500. You require them to make an arrangement with some medical man in the neighbourhood?—Yes.

15,501. *Chairman*: So that the case really has a medical attendant?—Yes.

15,502. *Earl Russell*: Twice visited by the Deputy Commissioner and four times by the medical attendant?—Yes.

15,503. *Mr. Mickle*: The private patients there are not certified at all, are they—only the pauper patients?—Yes. Private patients usually go without a certificate, unless they come from an asylum.

15,504. *Sir David Drummond*: May they be detained in a private house like that, certified?—Yes, they may be detained in a private house, certified.

15,505. *Mr. Mickle*: May a private patient be detained if he wants to leave?—(*Sir Arthur Rose*): I think the point is a little confused. I think you are discussing what we commonly call the boarded out case, which applies strictly and solely to pauper patients. The true boarded out case, which is the big thing in Scotland, applies to a pauper lunatic alone.

17 April, 1925.]

Sir H. ARTHUR ROSE, D.S.O., and Dr. HAMILTON C. MARR.

[Continued.]

It is the District Board of Control who send him to this private house, and it is they who arrange for the local doctor to look after their own particular patients, in the interests of the patients, but this system, strictly speaking, does not apply to private patients at all. You can do it, but the whole of the legislation is really drawn up for the pauper patient. (Dr. Marr): But we have private patients in these circumstances.

Earl Russell: It is the boarding out system we want to know about.

15,506. Chairman: In the case of private patients, you had 74 of them in private dwellings on the 1st January, 1924?—Yes.

15,507. The rest, 1789, are pauper patients?—Yes.

15,508. Apparently there are a few cases of private patients in private dwelling houses?—Yes.

15,509. And they will be found either as single patients or as one of a group of up to four in a licensed house?—Yes.

15,510. Mr. Micklem: But uncertified?—(Sir Arthur Rose): No, all certified. (Dr. Marr): They are mostly curatory cases, that is to say, cases that have curators. We visit, even where they are not certified, all cases of curatory, to see that the patients' means are properly expended on them, and these are the cases that (I may have misunderstood you, Mr. Chairman) I referred to as single private patients in these cases, who do not require to be licensed, if there is only one patient.

15,511. Chairman: And such private patients in such private dwelling houses may or may not be certified?—They may or may not be certified. Many of them may be certified, but they may not be certified; they may be only curatory cases.

15,512. The 74 are certified cases?—Yes.

15,513. But there may be some others under curatory which are not certified?—Quite.

15,514. If they are certified cases and relegated to a single house, are they detainable against their will?—If there is a Sheriff's order. We hold that they can be detained under that.

15,515. Sir Ernest Hiley: That is when they are certified?—Yes.

15,516. Supposing they are not certified?—I do not think we have any powers to detain them.

15,517. Chairman: They are merely boarders, then?—That is so.

15,518. Being under curatory does not necessarily mean at all that they are insane?—It means that they have had two certificates from doctors stating that they are incapable of attending to their own affairs. Many of them are insane, of course, but they have not been certified as insane.

15,519. It is very common in the case of senile patients?—Yes; many are with their own relatives, and others are boarded with guardians.

15,520. Apparently in Scotland, then, you may arrange to have your insane relative housed in a private house?—Yes.

15,521. And that person may be housed there either certified or uncertified, as the case may be?—That is so.

15,522. The certified cases are under your direct control and charge, because they are registered lunatics?—Yes.

15,523. Those who are not certified are really just boarders in a private dwellinghouse of that sort?—That is so.

15,524. Mr. Micklem: But they cannot get there without your order?—If they are uncertified.

15,525. Chairman: If they are uncertified, they go there irrespective of you, but if they are certified they must be notified to you?—Yes.

15,526. Mr. Micklem: Would you mind looking at the bottom of page 10 of the *précis*: "Private patients. Insane persons may be kept for gain, that is, as boarders, in private dwellings singly, under an order of the Sheriff, in accordance with the forms and procedure required in the case of ordinary committal to asylums, or they may be kept in such houses, without an order of the Sheriff, singly or to

a number not exceeding four, with the sanction of the Board after application made on a form prescribed by the Board"?—Yes.

15,527. Now the form prescribed by the Board is here. There has to be a statement and a medical certificate, and then the Board sanctions the patient being put away?—Yes.

15,528. Those patients are not certified, are they?—They are not certified; they are placed under definite regulations of the Board.

15,529. They are still under your control to some extent?—I do not think we could keep them.

15,530. But are not you responsible for them? You let them go there; you sanctioned their going. Have you no responsibility?—I do not think we have any compulsory powers, though it has never been tested in practice. (Sir Arthur Rose): But we inspect.

15,531. You visit them?—Yes. (Dr. Marr): I think the point was, how could we keep them if they wanted to go away?

15,532. Chairman: I think perhaps I caused a little confusion myself. Are any of the persons whom you find in private dwellings in Scotland persons who have been the subject of an order by the Sheriff?—Yes, some are, but the majority are not.

15,533. Then those are not notified to you in any way, are they?—If the person has many of the boarded out cases there on the one certificate, they are all notified to us, and they are placed in a licensed house. They are certified in accordance with the form you read out.

15,534. Mr. Micklem: But they are not lunatics, according to the definition?—No.

15,535. They are uncertified lunatics in these private houses?—Yes, and they are on our registers, too.

15,536. Chairman: They seem to occupy rather an anomalous position. I do not quite understand where we are?—They are there by regulation, to some extent, and by law.

15,537. Mr. Micklem: It is a method of getting them taken care of as lunatics without certification?—Yes.

15,538. Miss Symons: Are those 1863 which you gave us in your list of figures all under the Sheriff's order and the two certificates?—Many of them are under two certificates; others again are sent on the one certificate. (Sir Arthur Rose): I think the Chairman quite appreciates the fact that there is a very curious legal point there with regard to the one certificate and the two certificates. We have been very much worried about it lately, as a matter of fact. It is a method that has worked, and we do not see any good reason for disturbing it until we know actually where we are, and we hope that in the meantime the Royal Commission will give us some guidance.

15,539. Chairman: We do not extend to Scotland, you know?—But it will be a repercussive effect. (Dr. Marr): It only refers really to the question of compulsory detention. I question very much if we can compel these patients to stay, if they simply said, "We are going to go away."

15,540. Does it apply only to the uncertified patient? Suppose the patient has been first of all certified by the Sheriff, has been in an asylum, and is then sent to a private dwelling?—That is all right; the Sheriff's order still obtains. But I am referring to cases where patients are sent on one certificate, with the sanction of the Board, to a private dwellinghouse.

15,541. Earl Russell: You think probably that that is a usurpation of power?—No; I think we are quite justified in law in dealing with those cases, but I do not know that we have compulsory powers to detain them.

15,542. Mr. Micklem: The law creates a separate class?—Yes.

15,543. Chairman: The only question is, what is the measure of the powers you possess?—That is so. (Sir Arthur Rose): If you look at these forms, generally the forms are that we give permission for certain people to receive them.

17 April, 1925.]

Sir H. ARTHUR ROSE, D.S.O., and Dr. HAMILTON C. MARR.

[Continued.]

15,544. We need not explore that, but is this the means that is used for working the boarding out system, Sir Arthur?—That is the method.

15,545. Now we wish to hear very much from you about the boarding out system in Scotland, and how it is worked?—Generally speaking, it is a provision for placing in suitable homes, very largely of the type of small farms, and crofts, even, the type of patient who does no longer require any material medical attention, and for whom a country life under circumstances to which he is used is probably the best condition into which he can be put. The numbers have been indicated to you already. It was a more popular method in Scotland a while ago. There has been a peculiar variation in the numbers boarded out.

15,546. Can we have some statistics of these, please?—In 1880, which is the first figure I have, the number of lunatics under private care was 1,415; that gradually increased until the year 1910, when the apex was reached, amounting to 2,843; since then there has been a decline, and on the 1st January, 1924, the numbers dropped to 1,789. Of course, that is partly accounted for by the fact that in the larger figures there were in all probability a considerable number of patients who would now be classified as mental defectives, but at the same time the use of this system has declined, for a variety of reasons. I am inclined to state as one reason the fact of the provision of farms in the various asylums, and a quite natural temptation to a medical superintendent to keep a good farm worker to give a hand in the ordinary work of the farm, where otherwise this man would have been a very typical and suitable case for boarding out, if he had not had a farm to work on in the institution.

15,547. That is understandable?—I think it is human nature. On the other hand, I suppose there are a number of other reasons why this system has not been so much taken advantage of, although in certain districts it is rather remarkable that the figures have remained pretty well constant. The most remarkable case I think we have is in the case of Moray, where in 1923 we had 156 pauper lunatics. Of those, 33 were in private dwellings which made 21.2 per cent. Comparing that with the 1909 figure, the percentage is identical. In practically every other district in Scotland the percentage has dropped 50.

15,548. It still remains true that at 1st January, 1924, practically one in ten of your registered lunatics is in a private dwelling?—Yes, that will be about the proportion.

15,549. What is the system on which you set about it? Do you select the private dwellings?—We have, as Dr. Marr explained, a complete list of guardians. It is quite a tradition in some families in Scotland—.

15,550. *Earl Russell*: By "guardians" you mean the farmers?—Yes, the householders. It has been rather a fine tradition amongst a number of families in Scotland always to take in a few cases of this sort. It has a certain advantage, because these people do a good deal of work about the small farms. On the other hand, they live simply as members of the family. I think we practically find no distinction between the treatment of the patients and the treatment of the members of the family. (*Dr. Marr*): We do not allow any distinction. They have to share in the life entirely, no matter how humble the home, or how wealthy the home.

15,551. *Chairman*: What is the inducement offered to a householder to take in a patient?—It is a practical motive. In some cases the patient is of value, and in other cases the work is of value.

15,552. *Earl Russell*: But he gets a servant for whom he receives payment instead of paying, to some extent?—Very often.

15,553. Are these nearly all single patients in single houses?—Up to four.

15,554. Are there many fours in a house?—No, they are mostly single patients.

15,555. What sort of sum per week would he receive for these people?—It varies very markedly, but on an average about 12s. a week.

15,556. That would represent in Scotland rather less than the cost of the man's additional food?—(*Sir Arthur Rose*): On a farm, yes.

15,557. *Sir David Drummond*: Is it necessary in these houses to engage any staff to look after these patients?—(*Dr. Marr*): No; they do it all themselves.

15,558. *Chairman*: Who looks after the clothing?—The clothing is provided by the inspector of poor. He is supposed to visit twice a year, and the medical officer of the parish in which the patient is boarded makes arrangements; he should visit four times a year.

15,559. Do they get any pocket-money or wages for what they do?—That varies, according to the home. Some homes are very kind to them. Some farmers will take them for nothing; it depends upon the individual; but the main point we insist upon with regard to boarding out is that the patient in that home shall share all the advantages of the home life.

15,560. *Earl Russell*: Is the patient not in any sense an imbecile? Is he quite sufficiently master of himself to know if he is being put upon in any way?—In some cases, but generally the cases which are boarded out are those that require no longer asylum care. A good many of them are defectives.

15,561. *Chairman*: Suppose the man fell into hands that were unsatisfactory; suppose that the man was being overworked and under-fed, let us say?—We have our Deputy Commissioners visiting twice a year, and they make reports on these cases.

Sir Ernest Hiley: That does not answer Lord Russell's question.

15,562. *Earl Russell*: I do not see how your Deputy Commissioner can possibly know. He may not know whether a man has been made to work 15 hours a day or not?—He sees the conditions under which he lives.

15,563. *Chairman*: All the patients dealt with in this way are patients whose intelligence is such that they could assert themselves if they were being put upon, or could communicate with you?—No, I would not say so.

15,564. Then what protection have they really against being put upon, as Lord Russell says?—We appeal to the humanity of the person; and in many cases of simple means, the minimum that we suggest has often, instead of lowering the tone in the village, raised the tone of the neighbours' houses.

15,565. We are not thinking so much of how it works in practice; it may be that the foster parents treat them well. One is thinking rather of the safeguards that may exist against abuse. This person is sent away from asylum care and committed to the care of persons who are not professional doctors and who may vary very much in their temperaments.

Earl Russell: And who have no ties of natural affection towards the patients.

15,566. *Chairman*: And who have a motive to get as much work out of them as they can and a motive to spend as little upon them as they can?—Such cases have a reason, and usually we have been dependent to some extent upon some neighbours who are always very willing to give information. The boarded out cases are scattered throughout the whole of Scotland.

15,567. *Earl Russell*: A good many places in Scotland are so isolated that the neighbours would not know what is going on?—No place is so isolated that it has not a neighbour of acute observation, particularly in the Highlands. (*Sir Arthur Rose*): I think you have to admit Lord Russell's point, that there is a possibility of a pauper patient being boarded out who is not fit to stand up for himself and who may be put upon. On the other hand, as Dr. Marr says, our information is very good from neighbours. I often hear gossip as I go about the country; but, on the other hand, I do not believe it possible that a farmer could for any length of time take advantage of a man without its being spotted; because if he is going to have heavy work and is not going to be adequately fed, our medical Deputy Commissioners are going to

17 April, 1925.]

Sir H. ARTHUR ROSE, D.S.O., and Dr. HAMILTON C. MARR.

[Continued.]

detect that at once. They give us definite reports on the physical condition of the patients. They do not hesitate to take off his clothes, and to see that he is adequately clothed. I believe the examination to be of a very inquisitorial nature. I think the safeguards are very complete. (*Dr. Marr*): There are two specific cases which meet your point, where a young girl, boarded out in Peebles, was considered to be overworked. The Deputy Commissioner's attention was specially called to that. He went down and investigated the conditions and questioned the neighbours, and went into the whole condition of affairs, and instructions were given that this patient was not to work the number of hours the farmer had been working her, and it was pointed out that any work the patient did was entirely of a voluntary nature and that she was not bound to work for the farmer at all; if she said she did not want to work, the farmer was bound to leave her alone.

15,568. Suppose one of these boarded out patients did not choose to get up at the time in the morning that the men started work, I suppose the farmer would return him to the asylum?—Yes, in a case of that kind he would report it; but he dare not insist that a person should work; he is not allowed to use force of any kind.

15,569. Of course, we realise that reasonable work is good for patients?—Extremely good.

15,570. *Chairman*: There is also this safeguard: you select the houses to which patients may be sent?—The guardians are known to us.

15,571. And they are very largely among the peasant class in Scotland?—Yes.

15,572. I should imagine that selected households of that class in Scotland, in the rural districts of Scotland, are for the most part very decent people?—One guardian died in Fife who had been a guardian for 40 years and had different patients under her care. Any change in the mental condition or physical condition of the patients or the comforts of the patients in any way are all noted down and reported upon, and they of course are seen by myself at the Board, and if there is anything unusual at all, it is very carefully noted.

15,573. But I was rather thinking of this: are you not rather fortunate in being able to find in the rural districts of Scotland a type of home life among the crofters and the small-holders and so on which is peculiarly well suited for your purpose?—That is so. I do not think you would find the same thing in big populous districts, or even in some country districts.

15,574. The type of person whom you select by preference is the solid country-man?—Yes.

15,575. *Earl Russell*: A God-fearing, honest man, which you have in Scotland?—Yes, a crofter or a small farmer.

15,576. *Chairman*: One has seen the type of house in Scotland, of course, and the type of people is not the type of person who, in the general case, would be either unkind or over-exacting or untruthful?—On the contrary, I think they are specially kind, particularly with the defectives. I can give you many instances where they actually go out of their way to help them. In one case a young man of 30 was sent to a night school; he did not make any progress there, and they asked their eldest boy to teach him something; he could not teach him, but the man is now learning from a little girl of 10, the daughter of the house. There are numerous instances where the guardians go out of their way to try to help to make the life of the patient very happy.

15,577. One of the reasons why it is said not to have succeeded in England is the inability to supervise the cases adequately. It has been tried in Suffolk and Norfolk, and has been abandoned since. One of the difficulties suggested was the want of supervision. Do you find that your Deputy Commissioners, who are always *en voyage* all over the country, are able to overtake the work of supervision?—Yes, quite adequately.

Sir David Drummond: Might we hear something about the character of the patients?

15,578. *Chairman*: Yes. There is the very important question as to who selects the patients for boarding out. What is the characteristic of that type of patient?—Generally the patient is selected by the superintendent of the asylum. He reports to the inspector of poor, who says, "I have so many vacant houses; could you give me three or four patients," and the superintendent selects these three or four patients and sends them to the houses.

15,579. *Earl Russell*: Are they regarded as non-curative cases?—They are regarded usually as harmless, chronic cases, not likely to be improved.

15,580. *Chairman*: But not dangerous either to themselves or to others?—That is so—quite harmless cases. Naturally the objection which Sir Arthur has noted is that the superintendent does not like to send away a man whom he has taught to drive a horse and cart, or even to plough, though he may no longer require asylum care. But generally speaking, the asylum superintendent takes a longer view of that, and says, "If I keep this man driving this horse and cart, I know I have perhaps to employ and pay labour for another man to drive the horse and cart, or I may have to educate other patients to do this." Still, he recognises that the asylum care is an expensive care, and it is his duty to give two or three other men a chance to be able to drive a horse and cart, and he sends out the case that he has educated to be able to drive the horse and cart to be boarded out.

15,581. When a patient goes out to board in that fashion, is he taken off the books of the asylum?—Yes.

15,582. But does he remain on your books?—He remains registered on our books as a boarded out lunatic.

15,583. *Sir David Drummond*: Is he always certifiable at that time?—Generally, yes; I should say in almost every case. Some do recover from the boarding out, and then they are discharged as recovered, but in almost every case they are chronic, incurable cases.

15,584. *Earl Russell*: Can you tell me what the patients themselves think about it? Are many of them able to express opinions as to the change from the asylum to the farm?—Yes. Generally, they would not like to go back to the asylum; they often get into the village, and have little trips, and then they also have means of amusement. There is one man who attends all the funerals for miles round.

15,585. What about the trouble of breeding among these people when they go out—are they unrestrained, either the men or the women?—We have had a few accidents of that kind, but I should say that these sexual accidents are practically so few that they are almost negligible. (*Sir Arthur Rose*): A really sexual case would not be sent out. (*Dr. Marr*): They are so well chosen that the accidents that have taken place are really negligible.

15,586. *Mr. Snell*: Has there been any experience of these defective boarded out patients getting into trouble for little acts of larceny, or anything of that sort?—It is almost negligible, but of course they are very carefully selected.

15,587. *Mr. Micklem*: Is it a financial advantage to the parish?—It is a very marked economy; there is no providing account. The average sum of 12s. is the total cost, whereas in asylums you have the maintenance account and you have your providing account.

15,588. *Earl Russell*: What is roughly the asylum cost?—About 24s. or 25s.

15,589. *Sir Ernest Hiley*: Does that include clothing?—It includes everything.

15,590. For these boarded out patients the Poor Law authorities find the clothing and 12s.?—Yes, that is the average, including all clothing; the cost of the boarded out patient is 12s. 6d. That includes everything; it is the average cost I am taking.

15,591. *Chairman*: Is it an economic proposition; that is to say, does the local authority make a saving?—Yes, a distinct saving.

15,592. It would seem to have several advantages: it gives greater freedom to the patient, restoration to

17 April, 1925.]

Sir H. ARTHUR ROSE, D.S.O., and Dr. HAMILTON C. MARR.

[Continued.]

society within limitations, it effects an economy from the point of view of the local authority, and it enables the patient to do economic work on the farm where he may be?—Yes, up to a point.

15,593. And to contribute in that way to the general national output?—Quite.

15,594. *Earl Russell*: Are these farms very widely separated, or are they mostly clustered in one part? I am asking you from the point of view of visitation. —Some of the boarded out patients are really located in villages—we have aggregations, as we call them. In the village of Gartmore there would be 40 or 50 in one village street, and where they have a nice house they can keep 2, 3 or 4 patients, who have a good garden and a good deal of liberty.

15,595. But does it obtain all over Scotland? Would you find some of these people in every district in Scotland?—In every parish in Scotland. At one time we had two cases in the island of Foula, between Shetland and Orkney.

15,596. It means a good deal in the way of inspection, then?—Our Deputy Commissioners visit every parish in Scotland. (*Sir Arthur Rose*): It is an effort. We really could do with the other Deputy Commissioner, if it were not for the economy, because they are pretty hard put to it to get round all these places.

15,597. *Chairman*: On the whole, Sir Arthur, you have had two years' experience of this system: do you commend it to us as a useful adjunct of the lunacy system?—I do not know that I can go so far as that, because I really do not know the English rural conditions. As far as we in Scotland are concerned, it is undoubtedly a very, very useful part of our work.

15,598. Advantageous to the patients and economical to the public?—Yes.

15,599. *Earl Russell*: You would not like to give it up in Scotland?—We should be very unwilling to do so. (*Dr. Marr*): Sir Arthur has seen it himself in the Western Highlands.—(*Sir Arthur Rose*): Dr. Marr and I even visited the Island of Rona to see a boarded out case.

Earl Russell: Apart from anything else, it means a saving of 10 per cent. in the upkeep.

15,600. *Chairman*: And has it the advantage of relieving the pressure in the asylums?—Yes.

15,601. *Sir David Drummond*: Do they only take patients for serving?—(*Dr. Marr*): They naturally like a person who works, but if they can get one woman or two women to do a little housework they are quite willing to take some helpless old person as a third or fourth.

15,602. *Chairman*: When one searches for the official sanction for this method of disposal, is it really to be found in Section 95 of the Act of 1857, which provides that every pauper lunatic should be sent to the asylum for the district in which his settlement is: "Provided that under special circumstances it shall be lawful for the parochial board with consent of the Board to dispense with the removal of any pauper lunatic to such asylum and to provide for him in such other manner and under such regulations as to inspection and otherwise as shall be sanctioned by the Board."?—That is so.

15,603. That is really the provision under which you board out?—Yes.

15,604. Then you get the provision as to the private dwelling-house which may be used as the place to which such patients may be relegated, and in conjunction with that you get the necessary statutory power?—(*Sir Arthur Rose*): Quite.

15,605. Now I want to pass to another topic altogether. We have heard from time to time that in Scotland there is a method whereby incipient cases may at present be treated without certification; and your *précis* refers us to Section 41 of the Act of 1857, which starts with a negative enactment against the reception of lunatics for gain in private houses, but concludes with a proviso that "this enactment shall not apply to any cases where the party so received and kept has been sent to any such house for the purpose of temporary residence only, not exceeding

six months, and under the certificate of a medical person, which certificate shall be in the form of Schedule G, hereunto annexed." Is the result of this that the proviso in effect authorises the reception and retention of cases in a house for a period not exceeding six months on a special certificate by a doctor?—Yes.

15,606. That is a feature which is quite foreign to the law of England?—Yes.

15,607. Is advantage taken of that provision?—(*Dr. Marr*): We do not know how far advantage is taken of that provision, which we as a Board regard as an excellent provision, because the Form G. on which the admission into a home of that patient is recorded is kept by the person who owns that home, and a copy of it is not sent to our Board; so that we have no notification of patients being admitted for gain into private houses. I think it would be an advantage from the point of view of those who are mentally afflicted, because I think I should be safe in saying that there are more cases of restraint and seclusion going on in these homes and outside asylums than there are in all the asylums.

15,608. The pre-requisite of that case is that the doctor should have certified that it is expedient with a view to the patient's recovery that he should be placed in such a house for temporary residence?—Yes.

15,609. And it also requires that he should state that the malady is not confirmed?—Yes.

15,610. Therefore we are really dealing with the case which is either incipient or as yet not fully diagnosed?—That is so.

15,611. And this seems to me to be the precursor of the idea of the observation ward or some such provisional place of detention?—Yes. Of course with a large parish like Glasgow, observation wards have been established under an arrangement with the Board of Health. At one time some of the patients admitted to the observation wards were only allowed to stay there for six weeks, but recently we have extended the time for a period of six months. We have no legal statutory powers over these patients, because they are not certified, and they are going into a Poor Law institution.

15,612. But the Schedule G. person?—No. Schedule G. is used there.

15,613. I was on the Schedule G. person for the moment. He is a person who, without any judicial order whatever, is received on a certificate by a doctor that the patient is afflicted: the certificate continues:—"state the nature of the disease"—"but that the malady is not confirmed, and I consider it expedient, with a view to his recovery, that he should be placed (specify the house in which the patient is to be kept) for a temporary residence of (specify a time not exceeding six months)." Then the patient may be kept for six months in a place without being subject to the penalties provided in Section 41?—That is so.

Earl Russell: Does it include the power of detention?

Chairman: I rather think it does. "Provided that this enactment shall not apply to any case where the party so received and kept has been sent to any such house for the purpose of temporary residence only, not exceeding six months, and under the certificate of a medical person, which certificate shall be in the form of Schedule G." The word "kept" is used.

15,614. *Earl Russell*: But "kept," I think, only means kept as you keep a boarding house. I do not see any power of detention here?—(*Sir Arthur Rose*): That is an open question; as a matter of fact, it is another of these legal troubles; we do not quite know where we are. We have had some very eminent legal opinions on this matter.

15,615. And do they differ, like doctors' opinions?—I believe they have, on occasions. But the position has to a certain extent been an open one. What my Board do feel they want is a compulsory notification of the reception of any of these cases. We welcome the system. We think it is a good thing when it is conducted by such an institution as the Royal Asylum

17 April, 1925.]

Sir H. ARTHUR ROSE, D.S.O., and Dr. HAMILTON C. MARR.

[Continued.]

at Morningside, who, in running this type of establishment, are not by law bound to advise us, but, in view of our relationship, do advise us of every case of this sort they get in, and solicit our inspection and co-operation. What we are afraid of is what may happen in private homes.

15,616. *Chairman*: Where your relations of mutual confidence are not the same?—That is so.

15,617. *Earl Russell*: Do you find patients are detained under this?—Yes. There is a question as to whether they can be detained or not, and there again Professor Robertson may slightly differ, but it is a very difficult point. (*Dr. Marr*): By Section 54 of the 1913 Act we have powers of visitation in these cases, but I may say that the Board have refrained from visiting these cases, except where they have notification from neighbours or people that restraint and seclusion are being applied to persons in certain houses; but we have never exercised the powers, because we do not know of the cases; the cases are not notified. We would need to go into all nursing homes, and the Board have no wish to do anything of that kind.

15,618. *Chairman*: There was a legal difficulty as to whether it was competent for the Royal Asylum in Edinburgh to have such homes, but that is a different question altogether?—Whether, having a home, that home became *ipso facto* an asylum?

15,619. Yes. I am rather considering this with you now: here are houses in which persons may be received who are obviously of a special class; they are persons who are suffering from the initial stages of mental disease, and it is thought that they have not reached the stage of certification. It rather strikes one as a kind of intelligent anticipation of what all people are now looking to, namely, some means of having a provisional period for observation; and six months was selected as the limiting period for such persons residing temporarily, until it should be seen whether the malady was confirmed or whether it would pass off. Now apart from the legal difficulties, which we are here rather to surmount, if we can, is the scheme one which has your approval, Sir Arthur?—(*Sir Arthur Rose*): Distinctly so.

15,620. What one is concerned with at the moment is the policy of the thing, of course?—Especially from the point of view of getting hold of these cases in an incipient condition; I think I can say that my Board, both the medical members and the lay members, are very strong upon that.

15,621. *Mr. Micklem*: But you want to add notification, do you not?—Yes, to prevent abuse.

15,622. *Chairman*: You contemplate with satisfaction the establishment of homes more analogous to the nursing home that one goes to for any of the ordinary ailments flesh is heir to, where patients might go in the incipient stages of mental disease, and where they might be detained for a limited time, provided that you were notified they were there, and had powers of inspection?—That is so.

15,623. That is simply another form of approach to the question of provisional detention till a case has been fully examined and its proper disposal decided upon, which you deal with also in your observation wards, and that is probably the last general topic we need discuss with you.

15,624. *Sir David Drummond*: How would you propose to get over the diagnostic difficulty in admitting these patients, say, between a case of neurasthenia and a mental case that had come under your observation?—(*Dr. Marr*): The doctor sends a certificate in special terms that the malady is not confirmed—the Form G. You mean in establishing homes?

15,625. Yes?—I would allow anyone who wishes to come in for the treatment of early mental symptoms at any time, and refrain from using these places as certifying places at all. I would not allow them to be certified, in fact, in these places under any circumstances.

15,626. *Miss Symons*: But you would advocate provisional powers of detention?—Not of detention at all.

15,627. *Earl Russell*: This form is no use without detention?—All I take it that the Board desire is that a copy of Form G. should be sent to us so that we may see that these patients are not ill-treated in any way.

15,628. *Chairman*: Yes, but follow me: I have in my mind really three classes of cases: first of all, there is the case which is a clearly defined case of insanity, and as to which there is no difficulty in certifying and in relegating to an asylum; then there is, on the other hand, the voluntary case, where the insanity is not declared, where the patient feels he would be the better for shelter and care, and of his own wish goes in; then I find the intermediate category, namely the person who may be insane, who is not a voluntary patient, but who ought to be detained for the time being for his own well-being, and who as a consequence of that detention may effect a complete recovery in a fortnight or so, and may escape certification altogether. That person at the present time has to be certified to get the benefit of any treatment. I want to provide for that person by having some provisional method whereby he may be detained. Take the case of transitory mania; you must have detention?—My point was that if a person came in, he should not be detained compulsorily. If he wishes to go, then he must go somewhere else. I would rather have that (because most cases come in of their own free will, and are delighted to stay there) than have the impression going abroad, "This is a place that invites us in, and when we get in we are going to be certified."

15,629. *Earl Russell*: But you are excluding the case the Chairman put to you of a person who may be more or less maniacal at the time?—Of course, these people are being acted for by their relatives. Delirious cases are the very cases you want to treat in these homes.

15,630. *Chairman*: But you must exercise restraint on them: you must hold the patient down in his bed?—These are the cases that do not require restraint. They require nursing, but they are incapable of exercising their own free will; they are most easily nursed.

15,631. Let me put again the kind of case I should like to deal with. I quite understand the case of the voluntary patient, but what are you going to do about the case which is for the moment quite insane, suffering from mania, let us say, or an alcoholic case, as to which you can say: "Well, in a fortnight that probably will have passed off completely." At the present moment you have got to have that patient certified to get him any form of treatment at all. A person might need to be put in seclusion or under severe restraint, very possibly. One is very anxious to see if there is not some means by which a person of that sort could be temporarily detained against his will, under restraint, but without certification, because the thing is recognised as transitory. Does not your provisional ward in Glasgow achieve that?—Yes, but we do not allow any restraint there.

Earl Russell: It seems to me you call it nursing.

15,632. *Chairman*: Can the person get up and walk out?—I do not see anything to hinder him.

15,633. *Mr. Snell*: Suppose he is known to have strong suicidal tendencies?—That would be a different matter. He would be certified in some other place. They are certified actually from the observation wards.

15,634. *Chairman*: I have this conception; I do not know whether it strikes you as a useful one or not; we have been deliberating upon it a good deal:—that there should intervene a stage before final certification, a stage in which the case is under observation. In England that is achieved rather indirectly by keeping the patient in the Poor Law infirmary for continued periods, and very often it results in the patients never becoming certified at all, and some statistics have very strikingly shown that the recovery rate is very high at the initial stage. One is anxious

17 April, 1925.]

Sir H. ARTHUR ROSE, D.S.O., and Dr. HAMILTON C. MARR.

[Continued.]

to save that person from certification, and anxious also that he should get the benefit which one gets from skilled handling and treatment, but which one cannot get at the moment until one goes into the asylum, and one cannot go into the asylum until one is certified?—You want some compulsory powers?

15,635. Some people have suggested a clearing house institution where they might be detained for a period.

Earl Russell: Detention under a provisional order, without ever certifying the man.

Sir David Drummond: That is rather a different question. The question which Dr. Marr is discussing now is the nursing home point, and the whole question would turn upon the point of diagnosis. The suitable case would go to a nursing home. A case that was not suitable would be certified.

15,636. *Chairman*: I follow. The only thing is this: what would happen if you found the case in the nursing home required restraint?—I have been accustomed to think that no restraint is necessary. Delirious cases are very easily treated without restraint. Restraint in my opinion is used where there is a scarcity of nurses. If a patient has an adequate number of nurses, and is delirious, then I do not think restraint is used at all. In some of our asylums we have never used restraint for 20 years.

15,637. You and I must be using the word "restraint" rather differently?—I limit the term "restraint" to something that restrains the movements of the person.

15,638. You are thinking of mechanical restraint?—Yes.

15,639. Seclusion in a padded room, or something of that sort?—Naturally we call that seclusion. Restraint, of course, is limiting the movement of a person by mechanical means.

15,640. You dare not even hold a person down in bed for his own good, without committing a technical assault upon him?—And yet it is done every day in general hospitals, of course.

15,641. I know it is, and very much for the good of the patients, but the difficulty one finds is this, that the patient in the nursing home, being mentally unbalanced but not necessarily quite insane, may wish to do very foolish things: for the good of the patient you may have to exercise moral suasion, but I should think sometimes you have to use physical suasion?—Nurses guide the movements.

15,642. But that must at the end of the day mean that you have to hold the patient down. That is what bothers me a bit—as to how you are going to justify the measures of physical interference with the actual liberty of the subject to do as he pleases, without some kind of legal warrant for it?—I see your point.

15,643. *Sir Humphry Rolleston*: Will not this question be settled to a certain extent by the observation of cases such as Dr. Comrie treated? Was there not a good deal of psychological restraint and tact?—It is used very much in those institutions I speak of, Stobhill and Duke Street, where patients are just admitted as into the ordinary wards of a hospital, and their mental condition treated as if they were suffering from an acute bodily condition. There are no special means of restraint or seclusion in any way.

15,644. *Chairman*: Of course the public have a misconception about insanity, and think that cases are all noisy and violent. Those are the rare cases, really, but at the same time they do occur, and you must have means of dealing with the person who for the time being is actually violent and who is prepared to assault any person who comes within his reach?—There are so few of that type who are really acutely insane. They are very easily nursed by people by simply being put to bed. They do not need to sit on them, if they are properly instructed.

15,645. *Earl Russell*: I do not want you to think that we like restraint for its own sake?—The public have an antipathy to going into an asylum or mental place of any kind; and these cases are so few that I would rather give up the compulsory powers, lest it

might be said that these patients come in there and are certified from there, whereas they meant to use them only as nursing homes. That is my point.

Sir David Drummond: They cannot be detained in a nursing home if they become noisy. A nursing home is not suitable for that type of patient.

15,646. *Chairman*: And that patient would probably then be certified?—Yes, if they are homicidal they go somewhere else to be certified.

15,647. The problem may find its own solution. One had a kind of feeling that a patient in such a place might suddenly become violent, and say, "I want to get out." You would have a duty as a good citizen, apart from your duty as a doctor, to stop him. You must do something at your own hand?—Yes.

15,648. I should have thought that at any rate a power to require 24 hours' notice, or something of that sort, before leaving, so as to enable you to take steps for the protection of the patient, would at least be of some value?—Yes, on the same lines as a voluntary patient admitted to an asylum?

15,649. Yes. One looks very jealously at any interference with the liberty of the subject, and one has objections to starting institutions which are halfway-houses without being perfectly open about their powers; one would much rather state the powers candidly and frankly than let them be more or less concealed?—Certainly. (*Sir Arthur Rose*): Of course what would make a very big difference to me personally is the type of body responsible for running these homes. I might be quite prepared to agree to Form G. being made a compulsory form for six months. I am not at all sure that even with notification I should be quite happy with a strictly private asylum, which as you know we do not like in Scotland.

15,650. There is just one other matter I want to ask you a question about before we part, and that is with regard to the general compulsoriness you have for making your wishes effective on the districts under your charge. Is one of your important levers the fact that you have the distribution of the grant of £115,500?—That is so.

15,651. Can you in that way, in addition to your other powers, make your wishes effective by withholding your grant?—The power is there.

15,652. I am going to suggest that, rather than take you through them, we might simply incorporate in your evidence the enumeration of the various powers which you possess. The additional powers over and above those you have already alluded to in your evidence have been summarised so well at the end of your *précis* that I suggest we might append them to your evidence rather than go through them?—Certainly.

(The following is a summary of the additional powers referred to):

"(a) Powers enforced by application to and consent of judicial authorities: (1) In the case of any obstruction arising in the execution of the Act, or refusal or neglect of County Councils or Magistrates of Burghs to do what is required of them under the Act, the Board may apply by summary petition to the Court of Session. *S. 72, 20 and 21 Vic., c. 71.* (2) If a District Board of Control do not take steps to provide adequate accommodation the Board may, with the authority of the Secretary for Scotland, apply to the Court of Session, who may appoint a person at whose sight all powers and duties of the District Board may be performed at the expense of the District Board. *S. 9, 25 and 26 Vic. c. 54.* (3) If any asylum or house is certified by two medical persons to be unsuitable in respect of the provision which is made for lunatic patients, any of the Commissioners may apply to the Sheriff for an order to remove him to some other asylum or house. *S. 91, 20 and 21 Vic., c. 71.* (4) If an order or medical certificate on which a patient is received is found to be incorrect or defective and there is failure to amend it within twenty-one days, the Board may report such failure to the Sheriff, who

17 April, 1925.]

Sir H. ARTHUR ROSE, D.S.O., and Dr. HAMILTON C. MARR.

[Continued.]

if satisfied that the order or medical certificates are incorrect or defective, may recall the order. *S. 5, 29 and 30 Vic., c. 51.* (b) *Powers enforced by suing for penalties.* (1) The Board may make rules and regulations in regard to books or minutes to be kept in all asylums or houses, and may enforce them by a penalty, for each infringement or violation, not exceeding £10. *S. 9, 20 and 21 Vic., c. 71. S. 20, 29 and 30 Vic., c. 51.* (2) At any enquiry which they hold, the Board may with the concurrence of the Lord Advocate compel witnesses to appear and give evidence before them under a penalty of £30. *S. 11, 20 and 21 Vic., c. 71.* (3) The Board can compel the licensing of asylums or houses kept for lunatics, and enforce observance of the law with regard to orders of reception, by a provision which prevents the sending of lunatics to unlicensed houses, or the sending of them to or keeping them in any asylum or house without an order, where an order is by the Act required, under a penalty not exceeding £100, or imprisonment for a time not exceeding 12 months. *S. 39, 20 and 21 Vic., c. 71.* (4) The Board may order the admission of a friend or relative or others to a patient confined in any house or asylum, and enforce their order under a penalty of £20. *S. 48, 20 and 21 Vic., c. 71.* (5) Any person wilfully making any false statement or return or report, or a false representation upon any plan or writing, or who shall refuse to give information required of him by the Act, or shall conceal or refuse to divulge any matter or thing as to which inquiry under the Act shall be made, shall be guilty of an offence and be liable to a penalty not exceeding £100 or imprisonment for a period not exceeding 12 months. *S. 101, 20 and 21 Vic., c. 71.* (6) An Inspector of Poor is liable in a penalty of £10 for failure to report cases of pauper lunacy occurring within the parish, as required by the Act. *S. 112, 20 and 21 Vic., c. 71.* (7) The Board can compel Inspectors of Poor to give particulars of the removal of pauper lunatics from asylums under a penalty of £10; and can, under a like penalty, compel the replacement in asylums of pauper lunatics so removed. *S. 10, 29 and 30 Vic., c. 51.* (8) The Board can compel a person who keeps any lunatic permanently for gain to obtain their sanction or the Sheriff's Order under a penalty of £20. *S. 13, 29 and 30 Vic., c. 51.* (9) Any medical person making a false entry of a medical visit under the Board's Regulations to a patient resident in a private dwelling under an Order of the Sheriff or sanction of the Board, or who makes such entry without having visited the patient within seven days of making it, is liable in a penalty of £10. *S. 13, 29 and 30 Vic., c. 51.* (c) *Powers enforced by withholding or withdrawing licence or sanction.* (1) The Board may make rules and regulations for the good order and management of Private, District, and Parochial Asylums and Lunatic Wards of Poorhouses, and may enforce such rules and regulations by forfeiture of licence. *S. 9, 20 and 21 Vic., c. 71. S. 3-4, 25 and 26 Vic., c. 54.* (The Board also make rules and regulations for District Asylums, but as they are not licensed this means of enforcement is not available in the case of such asylums.) (2) The approval of the Board must be obtained to the Plan, Specification, Estimate and Site of a District Asylum, and they may enforce their views by withholding approval as to these particulars. *S. 52, 20 and 21 Vic., c. 71.* (3) The Board enforce their views as to the rate of maintenance for pauper lunatics in District Asylums by withholding their approbation to a rate which they consider improper. *S. 73, 20 and 21 Vic., c. 71.* (4) Agreements or arrangements for the reception of pauper lunatics into asylums as boarders can only be made with the sanction of the Board, and private patients can only be received into District Asylums with their sanction. The Board can, by withholding sanction, prevent the reception of pauper lunatics from alien districts into District Asylums, or the reception into such asylums of lunatics not paupers, and they may withdraw sanction and require the removal of such patients.

S. 80, 20 and 21 Vic., c. 71; S. 8, 25 and 26 Vic., c. 54. (d) *Powers of direct or independent action.* (1) The Board may transfer a lunatic from a house where he is being improperly treated to another house or to an asylum at the cost of the lunatic's estate or of the party or parish liable for his maintenance. *S. 42, 20 and 21 Vic., c. 71. S. 18, 29 and 30 Vic., c. 51.* (2) The Board, on being satisfied by the certificate of two medical persons whom they may think fit to consult, may discharge any person confined as a lunatic, who has recovered or who can be set at large without risk of injury to the public or to the lunatic. *S. 92, 20 and 21 Vic., c. 71.* (3) If a Parish Council neglect to make provision for a pauper lunatic within twenty-one days after being called upon to do so, the Board may themselves take the necessary measures, and may recover expenses from the Parish Council. *S. 18, 25 and 26 Vic., c. 54."*

Chairman: Then so far as I am concerned it only remains for me to tender you our thanks for your most interesting and helpful evidence. Perhaps some of my colleagues may now wish to ask you further questions.

15,653. *Miss Symons:* I wonder whether Sir Arthur Rose or Dr. Marr could kindly tell us anything about after-care in Scotland, whether it differs from that in England, or whether it has been developed more fully?—(*Sir Arthur Rose*): There is a society which has been started on the same lines as Sir Leslie Scott's society—I call it Sir Leslie Scott's society because I think he originated it. This is a young and active body, and I think it is going ahead. We as members of the Board have done everything we can to support it. We have to stand aside a little bit to be able to criticise it, but we have got quite a reasonable Government grant, amounting, I think, to about £550. We have actually been able to provide accommodation for their secretary and organiser in our own office in Edinburgh, to prevent them being put to the cost of getting outside accommodation, and also because in that way we can keep in very close touch with what they are doing. It is going to take a little time to develop this after-care idea in the minds of the parish councils and of the local authorities.

15,654. *You are hoping to see it developed all over Scotland?—We are hoping to see it developed. We all feel that it will be a valuable adjunct to the work, no matter if the Mental Deficiency Act is put fully into operation or not.*

15,655. *Mrs. Mathew:* With regard to food, what are your powers of controlling it in the various asylums?—Might I say in regard to that, and generally with regard to our association with the local authorities, that the extraordinarily happy relationship between the local authorities and ourselves has been one of the great joys to me personally. We all look upon each other as colleagues engaged in one work, and if, which is very, very rare, there is any complaint about food, it generally comes through Dr. Marr or Dr. Sturrock, and the least hint in the reports of our Medical Commissioners simply causes the thing to be put right absolutely at once. I do not think, in regard to food, Dr. Marr, it has ever been necessary for you to make two observations in regard to the same thing?—(*Dr. Marr*): No. (*Sir Arthur Rose*): The food is very carefully tasted. It is always described in the reports we get from our medical colleagues. When the non-medical people go round the asylums they make a special point of looking at the food. The balance of the dietary is always carefully considered by our Medical Commissioners, and their criticisms are even sometimes hypercritical.

15,656. *Chairman:* Perhaps it is not unimportant to remember that Sir Arthur was Food Controller during the war.—For Scotland only.

15,657. *Mrs. Mathew:* Do you allow butter for your patients?—It is generally margarine. Of course, you have to consider the type of food the patients are used to in their own homes, and we try to improve upon that sufficiently to make it really curative. (*Dr. Marr*): In one of the institutions in Scotland they

17 April, 1925.]

Sir H. ARTHUR ROSE, D.S.O., and Dr. HAMILTON C. MARR.

[Continued.]

give butter, in a smaller institution; but in the larger institutions generally margarine is given. (*Sir Arthur Rose*): But you do not object to that from a medical point of view?—(*Dr. Marr*): No.

15,658. *Sir David Drummond*: I should like to have your opinion upon the functions of the superintendent of the asylum?—The functions of a superintendent are many, but I should say that his main work is the care and treatment of the patients, and anything that tends to do that in the best and most efficient manner and the most economical manner. I assume that you speak chiefly about administration?

15,659. Yes.—Superintendents are inclined to be led into administrative matters, and to neglect their medical work, but that is not necessarily a consequence of a medical superintendent being at the head of the institution. It is simply because the particular individual has not been capable of delegating his work to the proper party, that is to say, to the steward or to the farmer, all of whom ought to be competent men. The medical superintendent mainly, as I say, should concentrate his powers on the care and treatment of the patients. I do not think anyone but a medical man can be in charge of a large institution, because there is nothing that can be done in an asylum from an administrative point of view which has not some influence, directly or indirectly, on the care and treatment of the patients.

15,660. But you think he is able to delegate his subsidiary duties to others, so as to enable him to employ his time with the patients?—I think he ought to do so, because a farm naturally is better looked after by a farmer than by any medical superintendent.

15,661. I should like to know whether in Scotland the doctor is indemnified against a possible mistake he may have made in diagnosis in giving a certificate. What is his position?

15,662. *Chairman*: Perhaps I may answer that. There is a provision in the Scottish statutes as in the English statutes, that he is protected unless he has shown want of care.—That refers to certification?

15,663. Yes. He can be attacked on the ground of negligence, as in England. Just on that topic *Sir David* has raised, I would like your view, because you have been a medical superintendent yourself, although you are not one now. It is a burning question in lunacy administration as to whether the medical superintendent should not be entirely relieved of administrative duties so as to enable him to concentrate entirely upon his medical work. What do you say with regard to that?—I think it is impossible that he can do so with advantage to the institution. At the same time, if I may put it so, we had at our institution at Lenzie, which was one of the biggest asylums in Scotland, a reception house into which all new patients were admitted. I invariably saw all these new patients myself, though I had a big institution to administer. I left the administrative work to heads of departments, largely. I saw, of course, what was being done, but I certainly did not go in there proposing to be an expert. I simply got their reports.

15,664. In Scotland, as you tell us, the medical superintendent is the person to know whether or not his patients have recovered, and has the responsibility of discharging them if they have recovered?—That is so.

15,665. If his mind is taken up with farming affairs and so on, he will not be in a position to discharge that most vital duty?—I do not see why it should be taken up by those duties. Take, for instance, the work of the patients: they are not bound to work on the farm, but it is very important that they should be induced to work on the farm under certain circumstances, because the work is beneficial to their health.

15,666. *Earl Russell*: I meant to ask you that question before. Do you give them the same sort of inducement as in England—tea and tobacco—to make them work?—Some of the patients get extras. For instance, laundry workers and kitchen workers get extras; many of them get tobacco, and some of them get from the superintendent a day off, with 2s. 6d. or 3s. in their pockets.

15,667. *Chairman*: What I am thinking of is this: this branch of science is undoubtedly advancing; we hope it is; I mean the curative side of the treatment of the insane. That will involve on the part of medical superintendents even more study than in the past, greater technical knowledge, keeping abreast of the periodicals in their specialty, and interesting themselves in the pathological investigations and the great developments which we hope are on the horizon. Now a person who has not only to keep himself abreast of a very progressive and developing science, but also has charge of the medical condition of a large community under his hand, cannot, it seems to me, have very much time left to spare for the daily administration of the community. If he is not a person who is able to delegate these things to other people, may he not find himself absorbed in the administrative work to the detriment of the patients under his care?—That is true in some cases. I would rather have a bad head than a divided authority, because you must find someone on whom to put the blame. Any institutions we have had with lay superintendents have only been small institutions; but with one exception, and that exception still obtains, they have all been unsuccessful, and we have substituted in some of the small institutions for the lay superintendent a trained nurse, who has the medical interests of the patients and the care of the patients at heart, and that has been very successful in both Haddington District Asylum and in Elgin District Asylum.

Chairman: We will just have to balance these various views we have heard.

15,668. *Sir David Drummond*: Might we have your opinion on the question of female nurses?—I think that might be answered in some way by the answer I gave to a deputation of disabled soldiers who came to speak about female nursing in asylums. Their point was that they objected to female nurses, because they displaced male nurses in the asylums. I said to each of them, "You are all disabled soldiers. You have been in hospital during the war." They said "Yes." Then I said, "In hospital you had nurses to look after you, and you had orderlies to look after you," and they said, "Yes." Then I said: "Which of these did you prefer?" The whole of them said they preferred the nurses. Then I said, "If you, being sick in body, prefer the nurse, why do you deny your fellow man, who is sick in mind, the privilege of having a nurse to look after him?"

15,669. *Chairman*: I gather that you are an advocate of women nurses for mental cases?—Entirely. It was introduced in Scottish asylums more than 25 years ago—getting on for 30 years ago. The experience I had of it was that at first it was not successful, but we found that that was due to the head nurse not being the proper person. Once we had a good head nurse the thing went on in such a way that we should never think of turning back and nursing hospital cases with men.

15,670. I will ask *Sir Arthur Rose* to supplement what you have said. It has been, has it not, *Sir Arthur*, the considered policy of the Board in Scotland to foster the movement for women nurses in attendance on not only the women's side but the men's side in asylums?—(*Sir Arthur Rose*): In the hospital part of the asylums, not in the ordinary wards, for physical nursing as well as mental nursing.

15,671. Does that coincide with your view, *Dr. Marr*. (*Dr. Marr*): Yes.

15,672. *Sir David Drummond*: Were you speaking only of the hospital?—I was speaking of the hospital, but generally we have some senile cases under nurses. We require male nurses for patients going out to work, but these male nurses must have hospital experience; so I think, while it is necessary to have the attendants in male hospitals, they should be there in the capacity of orderlies—in a subordinate capacity.

15,673. *Sir Ernest Hiley*: I should like to ask *Sir Arthur* whether he has had any complaint from the local authorities as to the amount of the grants.

17 April, 1925.]

Sir H. ARTHUR ROSE, D.S.O., and Dr. HAMILTON C. MARR.

[Continued.]

I see your grant works out at about 3s. per week, as compared with 4s. in England?—(*Sir Arthur Rose*): Yes, we have a continual grumble about it. It is repeatedly stated that Scotland is not quite fairly treated in this respect, but I think we have almost accepted it as a thing that cannot very well be helped.

15,674. Have you had any difficulty with the Poor Law authorities with regard to your very extensive powers over the licensed wards of all workhouses?—No.

15,675. Your powers in Scotland are unique; they are not possessed by the Board of Control in England. Have you had any difficulty with the Poor Law authorities over them?—With one exception, I think I can say the Poor Law authorities are just as anxious to co-operate with us in the care of these particular patients as the District Boards of Control. You do get an occasional cantankerous person in every walk of life.

15,676. But speaking as the Chairman of the Board of Control, you value those powers over the workhouses?—I think it is essential we should have the powers, and having them there we do not exercise them. The whole thing is done by a system of co-operation.

15,677. Could you just tell me this. The inspector of poor is an official peculiar to Scotland?—Yes.

15,678. Have we got anything in the English Poor Law system quite like the inspector of poor?—I should doubt if you have, because he is an official of the parish council, but he has certain statutory powers of his own, and he cannot be dismissed by the parish council without the sanction of the Board of Health.

15,679. I take it he is more than the relieving officer?—I am not sure enough of your conditions to be able to say that.

15,680. He has very wide powers indeed; he acts, as it were, as the petitioner with regard to all these pauper patients?—That is so.

15,681. I was wondering whether we had in our Poor Law system any officer who embodied the same functions as the inspector of poor does in Scotland?—The answer to that would be a question. Have you anybody in the service of the English Poor Law authorities who cannot be dismissed by the Poor Law authorities?

15,682. We have; only the relieving officer is a relatively subordinate functionary in the English system?—Yes.

15,683. Your inspector of poor is almost the clerk to the board?—That is so. He often is. (*Dr. Marr*): He is clerk to the board.

Chairman: We are very much obliged to you.

(*The Witnesses withdrew.*)

(*Adjourned to to-morrow at 10.30 a.m.*)

5, OLD PALACE YARD,
WESTMINSTER, S.W.1.

TWENTY-EIGHTH DAY.

Saturday, 18th April, 1925.

MEMBERS PRESENT :

THE RT. HON. H. P. MACMILLAN, K.C. (*Chairman*).

THE EARL RUSSELL.

SIR ERNEST HILEY, K.B.E.

SIR DAVID DRUMMOND, C.B.E., M.D.

MR. NATHANIEL MICKLEM, K.C.

MR. H. SNELL, M.P.

MRS. C. J. MATHEW.

MISS MADELEINE SYMONS.

MR. P. BARTER (*Secretary*).

MR. W. FAIRLEY (*Assistant Secretary*).

Professor GEORGE M. ROBERTSON, M.D., F.R.C.P. (EDIN.), called and examined.

15,684. *Chairman*: We have with us this morning Dr. George M. Robertson, M.D., F.R.C.P. (Edin.), who is Professor of Psychiatry at the University of Edinburgh; Physician Superintendent of the Royal Hospital at Morningside, Edinburgh; and Physician-Consultant to the Royal Infirmary, Edinburgh.

Dr. Robertson, in addition to your present offices, were you formerly Lecturer on Mental Diseases at the Royal Colleges School of Medicine?—I was.

15,685. And you have been Medical Superintendent of the Stirling District Asylum, and Medical Superintendent of the Perth District Asylum in succession?—Yes.

18 April, 1925.]

Professor GEORGE M. ROERTSON, M.D., F.R.C.P.

[Continued.]

15,686. And at one time you were President of the Medico-Psychological Association of Great Britain and Ireland?—Yes.

15,687. Before we invite you to assist us upon some of the more detailed matters, I think it would be of interest to have from you a short account of the Royal Asylum of Morningside, as being a type of institution of which we have not heard much hitherto. I think that your institution is one of the seven public asylums, as they are called, in the statutory language in Scotland?—That is so.

15,688. Is it a hospital founded by Royal Charter and endowed with funds by philanthropic persons?—Yes, that is so.

15,689. It was founded, I think, so long ago as 1813?—It was opened in the year 1813.

15,690. At its present site?—No. The building that was opened at that time has been removed. It is practically the same site, the neighbouring site.

15,691. Then the leading feature from the financial point of view is that the institution is carried on not for the purposes of gain?—That is so.

15,692. And are you bound to receive persons who are directed to your institution?—I do not think we are bound to receive all persons. I think the managers have an option, but we are bound to receive the parochial patients from the district which we serve.

15,693. And in that way, therefore, you answer the statutory definition of a public asylum in the Scottish Acts?—Yes.

15,694. Then a few statistics about your population. You had, I think, at the 31st December, 1924, 829 patients in all on your register?—Yes.

15,695. Could you tell us how many of those were private patients, and how many were pauper patients, or rate-aided patients?—I can tell you, not for the present year—for the year before.

15,696. That will do equally well?—Yes, it is very nearly the same. There were 661 private patients, and the remainder were pauper patients.

15,697. What in that year was the total number?—The total number was 804.

15,698. So that the great bulk of your patients are private patients?—The great bulk of them, yes.

15,699. Have you a tariff for your patients, varying with the accommodation that you give them?—That is so.

15,700. I suppose the facilities for treatment are available to all alike?—The medical treatment is the same for every person.

15,701. But the tariff varies according to the accommodation afforded?—The accommodation, the food, and the number of nurses and attendants.

15,702. What is the lowest charge you make for a private patient?—£58 a year.

15,703. And I suppose it runs up to practically whatever the patient desires?—Yes, depending upon the accommodation, up to nearly £2,000.

15,704. Do the receipts from those private patients enable you, with the revenues from your endowments, to provide for the pauper patients?—No, the parishes are charged for the maintenance of the pauper patients.

15,705. The parishes will necessarily pay for their accommodation, but do they get something rather more than they would get as ordinary pauper patients?—No, I would not say that. I think the parochial patients in Scotland are all treated alike, but the parishes pay for the full amount, for the cost of the patient.

15,706. What is the figure paid?—£60 a year.

15,707. Then if you make any profit on the private patients where does the profit go?—The institution is divided into two portions, one for private patients paying higher rates of board, and another for lower rates of board. The division of the institution for those paying higher rates of board is in debt at the present time to the extent of about £30,000, and

any surplus that is over is placed towards the extinguishing of the debt. Then in the other division we wiped out our debt for the first time in 80 years last year. The money is available from the one to the other.

15,708. These are Craig House and West House?—Yes.

15,709. It is Craig House that is entirely used for private patients, is it not?—Yes.

15,710. Do you have any private patients in West House?—Yes, a large number of private patients in West House, about 400.

15,711. But no rate-aided patients in Craig House?—No.

15,712. Of course they are all within one enclosure?—No, separate enclosures. There is Craig House public road dividing the two, but they are under the same administration.

15,713. And Craig House and West House, of course, are quite distinct from those nursing homes of which we shall hear from you in a little?—The legal status is quite distinct, but they are under the same management.

15,714. Then, I think, an important feature of your institution has been its association throughout with the University of Edinburgh?—Yes, that is so.

15,715. Your last report, I see, at page 20, draws attention to that very close association; I see that for 46 years the institution has been connected with the University of Edinburgh?—That is so, yes.

15,716. Since the time when Sir Thomas Clouston was appointed Lecturer in Mental Diseases?—Yes.

15,717. And recently your relations have been drawn even closer with the University by the appointment of Dr. McAlister as Lecturer in Psychiatry by the University Court and by the selection of Dr. Susman, assistant to the Professor of Pathology, as part-time Pathologist to the institution?—Yes.

15,718. Are both those gentlemen, Dr. McAlister and Dr. Susman, on your staff?—Yes, they are on my staff. Then, of course, the institution founded the Chair of Psychiatry in the University of Edinburgh.

Earl Russell: To whom is this report made—to a body of trustees?

15,719. *Chairman:* The administration of the institution is in the hands of Governors?—Yes.

15,720. Who are appointed under the Charter?—Yes.

15,721. They are representative persons elected by various bodies in Edinburgh?—Yes.

15,722. And is your annual report made to the Governors of the Institution?—Yes. I did not wish to send too much literature, but I could send an annual report containing the names of all the Governors.

15,723. You perhaps might hand me in a copy of that, for my own information?—Yes.

15,724. Before we pass to other matters, I would like to know from you to what extent teaching is given in the University of Edinburgh in psychiatry, which is your own subject?—Yes. I give 30 lectures every year to the students.

15,725. Is that called a half-course?—No, that is a full course in psychiatry. I am only allowed by the arrangements of the University to give 20 lectures, but I manage to put in another 10.

15,726. Do all students for graduation have to attend those lectures?—All the students for graduation have to attend.

15,727. Is there a separate examination on your subject, or is it included among other subjects?—It is just included in the ordinary subjects in medicine. It does not have a special examination.

15,728. Do you see the papers, and set some questions in your own department?—I have the right to examine for the final examination in medicine. I do not do it, but I have the right to examine.

15,729. What we are interested in is to know to what extent the young medical man launched into the world from Edinburgh University has had both

18 April, 1925.]

Professor GEORGE M. ROBERTSON, M.D., F.R.C.P.

[Continued.]

theoretical and clinical teaching in insanity. To what extent do you think young doctors who leave Edinburgh University are equipped in this branch of their profession?—They have a knowledge of the principles of the subject. It is far too vast a subject for any student to grasp thoroughly, but they do have a knowledge of the principles, and have seen the most important types of cases; they have more tuition in Edinburgh than in any other medical school, I believe, in the world. They have these 30 lectures, of which half are clinical and the others systematic. Then there is an optional course of 20 lectures on medical psychology given by Dr. Drever, the Reader in psychology, and, in addition to that, the ward in the Royal Infirmary, Ward 3, over which Dr. Comrie has charge, is also available for teaching purposes, as well as the patients I have at the West House.

15,730. One quite recognises that in these days of specialisation it is not possible within the curriculum to make every student a specialist, but do you think the students get a good general grounding in the subject?—Yes, I think he gets a good general idea of the subject. With regard to the question of entering it as a subject for the final examination, I feel sorry for the medical student, as at the present time our curriculum is so overcrowded, that I always tell my class at the beginning of my course that so long as they attend regularly, and show that they are interested in the lectures, and do well in my class examination, then so long I will not press to have a professional examination on the subject, but if I thought there was any failure in attention or interest, then I would make it a professional subject.

15,731. *Sir David Drummond:* Dr. Robertson refers to Edinburgh as the leading University so far as this subject is concerned. I think there are others in this country where the same thing occurs?—Sir George Newman gave a description of a model medical course which was published about a couple of years ago, and the requirements there for instruction in this model course were less than what the students in Edinburgh University are receiving at the present time.

15,732. *Chairman:* Are there any facilities for post-graduate work in your subject?—There is a diploma in psychiatry, and a certain number of the graduates have taken that; but the diploma is such a severe one in Edinburgh that it entails full time work for 6 months. It is impossible to get the diploma without all that time being devoted to the subject, and so we have not attracted very many yet to it.

15,733. Is that a University diploma?—Yes.

15,734. Granted after six months' study and writing a thesis, or something of that sort?—No, attending courses of instruction, and passing two examinations.

15,735. *Earl Russell:* But it ought to have a high level in the eyes of the public?—Yes. We are between two policies: whether to have a very stiff examination and develop a higher value, or an easier examination and a larger number of candidates; up to now the medical faculty have said "We will make it an honours examination."

15,736. *Chairman:* I observed you were in the room yesterday, and therefore you will have heard the evidence that Sir Arthur Rose gave on behalf of the Scottish Board of Control. I do not propose to take you over the formal part of the evidence, but I want particularly to elicit from you your views on certain subjects which you are specially conversant with. Now, first of all, let us consider the question of certification in Scotland. Is the outstanding difference, as was brought out yesterday, between the English and the Scottish methods that in Scotland there is no distinction made between rate-aided and private patients in the matter of certification?—Practically no difference; there are minor differences.

15,737. But, broadly, one may say they are treated alike?—Treated exactly alike.

15,738. And a feature in Scotland is that the Sheriff is the person who pronounces the order for detention, unlike the Justice of the Peace in England?—That is so.

15,739. I mean he must be a trained lawyer, holding an important office?—Yes.

15,740. On the other hand, is there no provision in Scotland for the Sheriff seeing the patient?—None.

15,741. And in practice he does not see him, I understand?—No.

15,742. Now, on that subject have you any views as to whether this legal person who places the *imprimatur* upon the order of detention should or should not see the patient?—I do not see what object is served by him seeing the patient, because I do not consider that he is competent by examination to tell whether the person is sane or insane.

15,743. You regard him as a person proceeding upon the evidence, expert testimony, contained in the affidavits or certificates of the medical man?—That is so, yes.

15,744. On the other hand, do you attach importance to his position in this aspect, that as a trained person accustomed to deal with evidence he can scrutinise the affidavits to see whether they contain adequate facts to justify what one may call the verdict of the doctor?—That is the case.

15,745. And also to see that all the formalities of the law have been fulfilled?—Yes.

15,746. I know you have views about the judicial intervention in the matter generally, but it does seem important that there should be someone who should see that all the formalities are fulfilled and the evidence is such as would satisfy a trained mind that the conclusion reached is a sound one?—Yes, that is so.

15,747. But you do not attach importance to him seeing the patient, for the reason that you think he is not competent to form an independent judgment upon the medical problem?—That is what I think, yes; and I may say that is a view taken, I believe, by the majority of those who sign these orders. There have been Sheriffs who have signed orders to whom it has been pointed out that the facts indicating insanity were insufficient.

15,748. From a medical point of view?—Yes, and who have refused to withdraw their order, because they were quite willing to accept the statement in the certificate by the medical men that in their opinion the patient is of unsound mind and fit to be placed in an asylum. That was quite sufficient.

15,749. We have had quite a large body of evidence in England to this effect. Sometimes the justice of the peace interests himself very much in the case; I mean he practically makes a layman's examination of the case; whereas others treat the matter in the perfectly formal way which you have described. There is certainly a feeling in some quarters that the presence of an independent layman is valuable as affording the patient some opportunity of putting his case, so to speak, to an independent person outside the purely medical view of the case; and I ventured to put yesterday to one of the witnesses an example of what I had in mind. For example, something might have been stated as a fact communicated to a doctor, which, on the face of it, seemed quite insane, and yet, so odd is human life, was a perfectly true statement; and the patient might have said, "Oh, if you are going to certify me insane upon that matter, insane as it looks, it was a perfectly sane thing and did occur." Now where would the patient be under the view that you advance later on that there should be no legal person intervening; where would the patient have the chance of putting that aspect of his case?—What I thought, if I may venture to say so, gave a wrong suggestion in your question, was this, that the doctor may have founded his views on the insanity of the patient upon 20 different observations, but he happened to put down the wrong one, one that was erroneous, and the mere fact that he put down an erroneous observation does not mean that the patient

18 April, 1925.]

Professor GEORGE M. ROBERTSON, M.D., F.R.C.P.

[Continued.]

was sane, or that he had made a mistake in his diagnosis of the case.

15,750. No, but the person examining the affidavits to see whether the affidavits bear out the conclusion would certainly be entitled to say, "Your conclusion may be sound, but your premises are inadequate?"—Yes. That would mean, of course, that every premise would require to be tested by the person examining the affidavits. I may say that all these certificates are exceedingly carefully scrutinised by the Boards of Control both in England and Scotland, and they are constantly sending back certificates to us which they consider are inadequate, or in which they think some error has been made. We have 21 days within which to have these things rectified, and very often the Sheriffs themselves will refuse to sign a certificate, if there is some error in it, till it has been amended, or they ask us to amend the error after they have signed it.

15,751. *Earl Russell*: I want to put on this very point a case that actually happened in London only a few weeks ago—it came out in a trial at law: a doctor had certified a patient insane, and the observation which he had made of him consisted in twice watching him in his shop while he was standing in the public street on the pavement. Now you know if that came before a judicial authority he might surely say he did not consider that examination sufficient, no matter what the doctor had put in his certificate?—Yes. With regard to that, I should say that that doctor had no right to sign a certificate of that kind.

15,752. But how would that fact become known unless the patient had a chance of telling the judicial authority, or somebody, that the doctor never came to see him. In this case it was the wife who deliberately put him away?—As a matter of fact, the public are entirely dependent upon the honourable character of the medical profession, and their honesty in these matters. If a medical man wished to make totally false statements with regard to any person and put them into a certificate, well, of course, that person would appear to be insane, and the wrong man would be put into an asylum.

15,753. *Chairman*: But observe the safeguard that exists at present. Suppose there was a faked certificate such as you suggest, and the patient is seen by a justice of the peace who has before him the faked certificate, and the patient appears to be a comparatively sane person—we are taking a case of wrongful certification—he would say to the justice of the peace, "This is all a mistake; you must not sign that order"; and the justice of the peace would say, "But I have got a certificate in front of me which tells me this, that and the other." "Oh, yes," the man might say, "but I will demonstrate that is all untrue," and you would hold your hand. If he had no access to the justice of the peace or the Sheriff, then the faked certificate would be taken at its face value, and the man would be removed to custody, but at least he would be detained for a time unlawfully. That is the kind of thing one has in one's mind?—Yes. Of course I admit that in a case going before a third person it is much more likely to get justice than if it has only been before two, especially if that third person looks at it from a different angle. But then you must also bear this in mind, that if this third person is the person to decide the matter, and he is an inexperienced person, how many times is he going to make errors which are going to cause a great deal of trouble?

15,754. That is the debit side of the account, and we have heard instances of justices of the peace whose examination is so perfunctory as to be of no value at all?—Yes.

15,755. *Earl Russell*: In this case the doctor honestly believed the patient was insane, but anybody representing the public would say that is not a sufficient examination?—I do not think that that doctor was justified in giving a certificate under these conditions, any more than in writing out a faked certificate.

15,756. But the trouble is the conditions would never have come out unless the patient had a chance of making his protest?—I think you depended upon the doctor, and the doctor made an error of judgment in what he did.

Sir David Drummond: Dr. Robertson says he had constantly to send certificates back.

15,757. *Chairman*: I was rather struck with that. (To the Witness): Do you constantly have to send back certificates for completion, or amendment?—I asked the messenger who goes to the Sheriff's court, and he thought one per cent. of the certificates were sent back by the Sheriff as a meagre certificate.

15,758. I would not call one per cent. "constantly"?—Perhaps I was wrong in that. Then from the Board of Control we have many more returned; perhaps we will have six or seven in the course of the year.

15,759. Even that is not a very large number, and it depends a good deal upon what they are sent back for. If they are sent back merely for some trivial informality, then it is not of much consequence on the merits?—As a general rule it is a trivial informality.

15,760. I would not like the impression to go out that in Scotland certificates are constantly being sent back because they are inaccurate or insufficient.—No. The commonest inaccuracy in a certificate is with regard to defining the patient, you have to give his name, designation and residence, and that very often is not done by the doctor.

15,761. That does not affect the merits of the thing at all?—No, it does not affect the merits of the thing.

15,762. But I was struck with this, that evidently the Sheriff is not merely a formal functionary, because you tell us he sends them back to you sometimes because the certificate is too meagre?—It depends upon the Sheriff. A Sheriff has got great powers of discretion; he can do what he pleases. If it is put before them as legally correct they sign the document. He may sign the document simply because the doctor says the person is of unsound mind. Of course I agree that some person must sign the order and see that the thing is properly drawn out. My opinion is it should be the Board of Control.

15,763. We will come to that later?—Yes.

Sir David Drummond: Can Dr. Robertson tell us to what extent there are serious errors in the diagnosis?

15,764. *Chairman*: How often do you find there is an error affecting the merits of the certificate in your judgment, an error by the certifying doctor, or an insufficiency in the evidence which he adduces in the certificate, which really affects the merits of the case as distinguished from the mere points of formality?—I think it is always faulty expression. The facts observed are badly expressed, so they do not convey conviction to the mind of the third person who does not see the patient. For instance, I give a special lecture on certification to my students and, amongst many other things, there are a great many "Don'ts." For instance, a doctor writes, "He says he hears a voice." I suppose the whole lot of you here are hearing a voice at the present time, but what the doctor means is: he hears an imaginary voice, which is an hallucination of the senses.

15,765. After all, that is a criticism of literal accuracy rather than merits?—It is almost entirely that. I have not known of any case in which there has really been a wrong opinion expressed.

15,766. That is what we really want to get at.

15,767. *Sir David Drummond*: We heard yesterday that it was considered important that the second doctor should be an expert; do you agree with that?—I think that it would save a good many patients from going to an asylum who might be treated outside, if there were an expert.

15,768. That is to say, if such means were provided?—Yes. For instance, sending a patient into

18 April, 1925.]

Professor GEORGE M. ROBERTSON, M.D., F.R.C.P.

[Continued.]

an asylum with a temperature of 103 who is found to have pneumonia, and who is delirious. Such a case should never be sent to an asylum, but, of course, he is technically insane.

15,769. That would be the Professor of Medicine who was at fault in that case?—Yes.

15,770. *Earl Russell*: We are told these young doctors cannot have experience of insanity, but a newly-qualified doctor is supposed to be able to diagnose pneumonia, is he not?—Yes; but, unfortunately, when a case is complicated with mental symptoms very often that makes such an impression that he says, "I do not understand this," and he certifies the patient and sends the patient off. The same with typhoid, for example.

15,771. *Chairman*: Would you approve of the two certifying doctors being permitted to consult together?—Yes, certainly.

15,772. Both in England and in Scotland at present the requirement is that they shall see the patient independently and give their certificates independently, which seems to be possibly a relic of the time when it was thought that two doctors might be in collusion?—Yes, and in England the certificates are separate certificates, and on separate sheets of paper.

15,773. We have had evidence to this effect, and I would like to know whether you agree with it, that the opinion of two medical men given in consultation is more likely to be of value than the opinion of two medical men given separately?—Yes, that is quite true.

15,774. Do you think it better than one given separately, and that it is more likely to be accurate?—Most obviously, with the restrictions that are laid down in the English law against those who cannot give certificates, like a principal and his assistant.

15,775. But if you have two independent doctors do you regard the opinion which they arrive at in consultation as more likely to be accurate than the opinion they would arrive at separately?—Certainly.

15,776. Of course, in private practice the consultant doctor invariably confers with the doctor who calls him in?—Yes.

15,777. *Mr. Snell*: Suppose, doctor, there was any question at all of collusion: would not a second doctor, called in after a certificate had been signed by another doctor, be more likely to agree with the first on an expressed opinion than he would in consultation?—Well, I suppose one would say that is so. I mean to say, if you find your views are confirmed by another, or your observations are confirmed by another, it will strengthen them, but, as a matter of practice, I am perfectly certain it is not of the least importance.

15,778. *Chairman*: I think *Mr. Snell*'s point is that if there is tendered to you an opinion by a brother professional man, you are inclined to approach it from the point of view that it is right rather than to approach the subject *de novo*?—Yes.

15,779. *Mr. Snell*: Whereas if you are called in to help him to form a diagnosis he has not yet pronounced an opinion?—Yes.

15,780. I was presuming that would be a safeguard?—Yes.

15,781. *Chairman*: There is something in that, *Dr. Robertson*.—If two people come together the whole case is started fair?

15,782. Yes.—I agree.

15,783. Whereas if one gives his opinion first he is committed, and the man who is committed to an opinion has to be dislodged from it by his confrère?—Yes.

15,784. I think *Mr. Snell*'s point was really in fortification of that view?—Yes.

15,785. *Earl Russell*: Before we leave this question of some judicial officer seeing the patient, would you mind putting out of your head entirely the idea that he has to form an opinion as to his insanity or sanity. That is a technical question upon which the

best justice of the peace, as such, is incompetent to pronounce; but can he not find out circumstances attending the certification which may caution him or make further enquiry desirable? Suppose a man's wife has an intrigue with a lover and wants to put her husband away for that reason; if the patient sees a justice, may he not say, "There are reasons for this certificate quite apart from my conduct," and so put the justice on his enquiry?—Yes, that is quite true, but the doctor, you must remember, has been seeing this patient probably for some time, and knows the circumstances and the details and the surroundings far better than the justice of the peace can from one interview. I do not say that cases may not arise where he may discover something, and the doctor has been hoodwinked; but I think, in the vast majority of cases, that a justice of the peace will be misled by the patient.

15,786. But you must not treat the doctor as if he is the family adviser who has been attending the case for years. He may have been called in by the relieving officer to a pauper patient; he may have seen him just once, as the justice has, and heard the rest of the story from the wife. He has had no more information than that. He has formed a perfectly honest opinion that the man is insane, but he has not known all the circumstances, and the man has not had a chance of stating the circumstances to any authority?—Well, of course, a rate-aided patient of that kind has had the chance of speaking to two doctors.

15,787. Well, he has not in England?—We believe that is wrong, of course.

15,788. *Chairman*: But take even one doctor?—I agree that a second person is an additional safeguard.

15,789. It is a large topic, this. It is really a question of the intervention of some independent person in the process of the making of an order which results in the deprivation of liberty. It is the main problem which affects this branch of medicine as distinct from any other branch of medicine; and one is a little alarmed at the suggestion that the deprivation of liberty is to be left entirely in the hands of the doctor, or in the hands of an official body without the intervention of any independent person. Of course we shall have to discuss that with you a little later on, but it is just that general feeling which the public have in the matter which we must concern ourselves with, naturally.—Yes.

15,790. *Earl Russell*: I am not suggesting there is more than one case in 10,000 that will happen.—Yes, but you know hard cases make bad law.

15,791. *Chairman*: But, on the other hand, adequate safeguards prevent abuses.—Yes.

15,792. The abuses do not occur because the law is there in the background always.—But in Scotland no Sheriff has ever seen a patient and we seem to have been remarkably free from abuses.

15,793. I understand there has never been a case in Scotland in which a Court has found that a patient has been unlawfully detained. Is not that so?—Yes, I believe that is so.

Earl Russell: We cannot unfortunately say as much here.

15,794. *Chairman*: Do you remember the case of *Purvis* some time ago?—Yes.

15,795. I forget what happened about that case.—What happened there was this: it was a case something like the one *Lord Russell* refers to. A lady doctor was attending the wife of the patient; the husband became insane, and this lady doctor called in a specialist to see the husband; he found the husband to be insane, and he made every attempt to treat the patient outside of an asylum; I think he sent him away for a fortnight somewhere or other; but in the end it was found he could not be treated out of an asylum and so he was certified by the consultant and by the lady doctor who was the wife's doctor, and he was sent into the asylum. He was ultimately discharged, and he brought an action against the authorities for having detained him

18 April, 1925.]

Professor GEORGE M. ROBERTSON, M.D., F.R.C.P.

[Continued.]

there, and he lost his case because he was obviously insane. I believe that the medical profession protested against the case ever being brought into Court. It was one of these cases the Lord Advocate should have refused to allow to come into Court, there being no grounds to go upon. I think Mr. Ure was the Lord Advocate at the time, and the explanation he gave for allowing the case to proceed was that the patient's own doctor had not been called in to certify him.

15,796. But in the result it was found that the man had been properly certified and was insane?—Yes.

15,797. Then in Scotland, I think, the order which is made by the Sheriff has a three years' endurance?—It has a three years' endurance, with the exception of those cases under the last Act which are transferred to private care. There the order is kept alive.

15,798. Has a report to be made year by year on the condition of the patient?—No, one certificate stating that the patient requires attention in the asylum has to be drawn out every year.

15,799. But at the end of three years does the virtue of the Sheriff's order expire?—Unless you sign the annual certificate.

Chairman: Now I want to draw Lord Russell's special attention to this matter because I have been looking at the continuation certificate in Scotland. We have heard in England that some of the medical superintendents, while quite convinced that it was for the welfare of the patient who was convalescing that he should remain under care, have some conscientious difficulty in signing a certificate that the patient was still of unsound mind; and I notice the statutory form of certificate in Scotland is rather to our address in this matter. "I hereby certify on soul and conscience that I have within a period not exceeding one month preceding the date of this certificate, carefully reviewed and considered the cases of the patients whose names are subjoined, and I am of opinion that their continued detention in the asylum is necessary and proper for their own welfare or for the public safety, as the case may be. Signed by the medical superintendent." What strikes one at once is that it does not contain any statement that the patient is of unsound mind.

Earl Russell: It is far more desirable than our form in that way.

Chairman: That has struck me very much, because I quite appreciate the difficulty that some medical superintendents felt in certifying a person who was not, at the moment of the certificate, certifiable, that is to say, of unsound mind, while their real conviction was that this person was recovering from a state of unsoundness of mind, and would be better for remaining another month or two before discharge. Your form in Scotland seems to me to meet that case, by not requiring a medical superintendent to certify more than that he is of opinion that the continued detention of the patient in the asylum is proper for his own welfare or for the public safety.

15,800. *Sir David Drummond:* Does that not imply that he is of unsound mind?—Yes. My own opinion is that those doctors who refuse to give that certificate are carrying their scruples too far. If the patient, even though he cannot be certified, is the better for treatment in the asylum, I should say that patient should continue in the asylum.

15,801. *Earl Russell:* That is quite true, but you do not like to certify that a man is of unsound mind if you do not think he is?—That may be so.

15,802. *Chairman:* On the other hand, the certificate implies that the person is still of unsound mind, because if he is not of unsound mind he ought instantly to be liberated?—Yes.

15,803. *Mr. Snell:* It would be used for every case, for a chronic case and other cases?—Yes, that is used for all cases, but I object to that certificate on two grounds: one is, that it does not carry on the conditions under which the patient was sent into the asylum; it is a new form altogether.

15,804. *Chairman:* It is very striking?—Yes, it is. The second point is: to say that it is necessary for the patient to be in the asylum is also wrong, I think, if you take that in a broad way, because if a person has abundant means it does not matter how insane he is, it is not necessary that he should be in an asylum.

15,805. *Mr. Snell:* What would you think of a certificate which allowed the doctor to say that "while this patient is improved, it is advisable still for his own good to detain him"?—Well, I think that is all right.

15,806. *Chairman:* I do not like certificates to be in a form which requires the certifier to do any violence to his sincerity. I think the certificate should be such that the person could sign it with perfect candour and should not have even to brace himself to sign it with a certain effort contrary to what his conscience says. One would like the forms which are used in your work to be forms which can be conscientiously observed; and I can conceive the case of a person of whom it could not be predicated that he or she is of unsound mind at the moment, but that they are convalescent from unsoundness of mind. Now the worst thing you can do is to send out a convalescent patient, whatever the disease, until he is fully re-established in health. Therefore I should have thought that there must be many instances where, as a medical superintendent, if you are asked "Is A.B. still of unsound mind?" you would say "I think not, but I cannot say the precise moment when he passes from one zone to another. If he has another month, I think he will be all right." That would probably be your state of mind in the case of many of your patients?—Yes, that is so. In many of the certificates of probation we say the patient is convalescing; we do not require to say he has either recovered or is insane.

15,807. Would you welcome some form which is applicable to such cases, possibly intermediate between the Scottish form and the English form, which brings you up to the point of saying he is still of unsound mind?—Yes, most certainly I would. I have protested against that certificate myself to the Board of Control.

15,808. *Earl Russell:* It is all very well to talk about a tender conscience, but you do not want a professional man engaged in this business to sign a certificate and for it to be put to him in the witness box afterwards and for him to be asked, "Is that certificate literally true"?—I quite agree there should be a certificate such as you suggest.

15,809. *Chairman:* One has heard of formulæ in matters of religion being signed with reservations, but I do not see them being signed with reservations in matters of medicine?—For instance, in cases that are placed under curatory, if a patient suddenly recovers, there is no Judge who will take that patient out of curatory until he is certain that the recovery is going to be permanent; so the patients are detained under curatory, even although they are perfectly sane, till the Judges are satisfied that the recovery is a permanent recovery.

15,810. The Judge requires in that case that the doctor should certify that he is so re-established that he is able to take charge of, or to give instructions for taking charge of, his affairs. The test there is rather a test of capacity to manage your affairs than a test of pathological condition of mind?—The patient may have an attack of acute mania and suddenly get well, and the next day he could manage his affairs, but no one would remove a curatory.

15,811. *Earl Russell:* But even in the case I put to you, the Judge might very well not be shocked because he would quite understand what the doctor had meant; but you give the public an opportunity of saying, "Here is a doctor who told a lie," and that is most undesirable?—It is, yes.

15,812. *Chairman:* Now with regard to the methods of admission to your Institution, I see that something like 90 to 95 per cent. of your patients enter the

18 April, 1925.]

Professor GEORGE M. ROBERTSON, M.D., F.R.C.P.

[Continued.]

Edinburgh Royal Hospital at Morningside without any judicial order at all?—Yes, that is so.

15,813. But of those, I take it, quite a number come in upon the Scottish medical certificate of emergency?—That is so.

15,814. That is a certificate by a single doctor?—Yes.

15,815. And an application to you to receive the patient?—Yes.

15,816. But that order has only a three days' duration, has it not?—That is so.

15,817. And it has to be confirmed within three days by a Sheriff's order?—That is so.

15,818. So that in point of fact the only period during which that class are in your Institution without judicial authority is a maximum period of three days?—Yes.

15,819. After that the position is put upon a legal basis by the Sheriff's order —Yes.

15,820. On the other hand, there is quite a substantial proportion of your patients who are not brought in on an emergency certificate, and with regard to whom no Sheriff's order is ever pronounced—I mean a class of voluntary patients?—That is so, yes.

15,821. Of course in England there is also the urgency order, and therefore all patients who are taken into an asylum in England under an urgency order equally enter upon medical authority alone; but again it requires the legal confirmation within the short period prescribed?—Yes.

15,822. On this question of the judicial intervention I observe that you have views which are, if I may say so, vigorously entertained, and I should like to hear your criticism upon the judicial aspect of certification and detention. Will you just tell us in your own way how you approach the problem?—I approach this problem from the point of view of my patients and their friends. They come to me greatly distressed because a relative has gone out of his mind, and I say, "Well, the only place you can send this patient to is an asylum." They cannot afford anything else perhaps. "Before the patient can come in there he has to be certified, and you have to get a Sheriff's order to place him in an asylum." They all jib at this going before a Sheriff—going before a Judge. Then afterwards, if that patient comes in and recovers, the most bitter recollection he has is that he has been branded a lunatic and sent by a Judge into the asylum.

15,823. In your experience have you found that that episode is distasteful to both patients and relatives?—Most distasteful. Get rid of it, get out of it, in any way you possibly can.

15,824. Is that because of the stigma of certification, or because of the distaste for a judicial procedure of any kind?—I think it is both; that the procedure is judicial, I think certainly enters into it.

15,825. I suppose in the minds certainly of people of humble rank the Sheriff is associated with the person who hands out sentences of imprisonment and fines—I mean there is that idea, if one may put it in colloquial language, of "going before the beak"?—Yes.

15,826. Do you find that people who are in these distressing circumstances, both patients and relatives, resent this form of procedure?—Some resent it. Now, for example, we had a patient that Dr. Comrie treated in Ward 3 in the Royal Infirmary, a woman suffering from puerperal insanity; she was there a certain length of time; she became more excited, and it was necessary to remove her from Ward 3 to the West House at Morningside. When the husband heard that before she could get proper treatment in the West House she had to go through this formality, he was a most indignant man. He said, "My wife has been treated all this time in Ward 3 by Dr. Comrie; why cannot you treat her in West House in exactly the same way?"

15,827. And you say, "The law prevents me"?—The law prevents me, and, of course, one cannot help sympathising with these people.

15,828. Of course, it is a feature of this malady, unlike any other malady, that the doctor is debarred from giving the specialised treatment that you can give in an asylum, until the law has intervened?—Yes.

15,829. But observe that the intervention of the law is not meaningless; the intervention of the law is to preserve the liberty of the subject because your treatment, unlike any other medical treatment, includes an invasion of the liberty of the subject?—I know, but there is far too much made of that. Why should Dr. Comrie be able to treat the patient in Ward 3 in the Infirmary, and why should I not be allowed to treat the patient in the same way in West House? We are both doctors. I have more means available than he has.

15,830. *Earl Russell*: But Dr. Comrie's patient can leave him at her own option—that is the difference?—The patient is delirious.

15,831. The patient regards that as a considerable difference?—But the patient's most bitter recollection after is not that she has been insane, but that she has been certified.

15,832. *Mr. Mickle*: But, Dr. Robertson, you suggest that instead of being certified by the Sheriff she should be certified by the Board of Control.—No, I would wish ordinary certification to be done away with.

15,833. *Chairman*: Altogether?—Yes, altogether.

15,834. *Mr. Mickle*: In all cases?—But a form, some substitute, for the certificate introduced.

15,835. *Chairman*: I see that your view is that insanity should be treated as a notifiable disease?—Yes.

15,836. That a case of insanity should be notified to the proper authorities, so that the authorities have some responsibility with regard to it?—Yes.

15,837. And your suggestion is that, instead of having the judicial procedure, either the English or the Scottish form, the patient should be treated medically, but that the fact that the patient is being treated in an institution should be notified to the central authority?—Yes.

15,838. *Earl Russell*: You see, as against that, that section of public opinion which is represented by the Lunacy Reform Society regards the Board of Control here as being, as they call it, in league with the doctor, and no protection; it may be absurd but you have to allow for the feeling?—Yes, I know.

15,839. *Chairman*: You have to regard these things from the point of view of all sections of the community. If you were in a perfect world it would be quite easy?—Yes, but the majority of people who find fault with these procedures are those who have nothing whatever to do with the care and treatment of these patients; and all those who have to do with them, including the relatives and the patients, the vast majority of them, at any rate, object to these present procedures.

15,840. One can well conceive that the patient himself and his relatives, whose only concern is that the patient should get the best possible treatment, may resent exceedingly having to go through formalities of any kind; but it may be necessary that formalities should exist, to satisfy the public conscience, and also to prevent the possibility of abuses, because in every profession there is a liability to error, and the existence of safeguards is consolatory to the public mind?—I quite agree with you that there must be safeguards, and the matter must be reported to the authorities. I am not seeking to do away with all these things. I would increase the amount of inspection in the matter.

15,841. Then would you consider that the public interest in the matter is sufficiently safeguarded (a) by notification of every case which is detained, every case in which the liberty of the person has for that person's own good to be interfered with, and (b) in

18 April, 1925.]

Professor GEORGE M. ROBERTSON, M.D., F.R.C.P.

[Continued.]

spection and visitation on a more vigorous scale by the authority which has been notified?—Yes.

15,842. These two things together, in your mind, would give sufficient protection?—I think so.

15,843. *Sir David Drummond*: How would you deal with the question of compulsory detention? How would you compel the patients to remain in the asylum?—I would have authority for the patient who is notified. If two doctors certified that a patient needed the treatment in a special institution, that would be an authority for detaining the patient for a certain length of time.

15,844. That is the same as certification?—Yes, certification with a difference. I quite agree that two doctors have to come in, and the matter has to be reported to a third authority, but I would have everything different from what it is at the present time—the judicial authority, and the wording of the present certificates.

15,845. *Chairman*: Then the real authority for the detention of the patient on the system you figure would be two medical certificates that the patient is of unsound mind, and ought to be detained in your institution, coupled with the confirmation of that by the Board of Control after notification?—Yes.

15,846. *Earl Russell*: But you know what *Sir David* puts to you is quite right. The superintendent of any asylum would still have in his hands a document which would be an answer to a writ of *habeas corpus*. Whether you call it a certificate or anything else, it is something which deprives a man of his liberty?—Yes; I would call it something else.

15,847. *Mr. Micklem*: Do you not find in Scotland that a large number of patients think they have been wrongfully certified?—Yes.

15,848. And a great many think they are wrongfully detained?—Yes.

15,849. Do not you think it well that there should be some sort of public safeguard for them?—I quite think there should be a safeguard, and there are safeguards just now, and under the scheme I propose there are safeguards; but that will not convince them that they have not been wrongfully detained.

15,850. *Chairman*: But would not the warrant for detention have to be a statutory warrant of some sort, and would not that warrant be merely after all a certificate in another form?—Yes.

15,851. A rose by any other name, you know, would get as unpleasant an odour. Of course, I can see quite well that an enthusiast for the treatment of his patients who puts that, as he ought to do, in the very forefront, may feel embarrassed by legal formalities, but he may have to recognise that legal formalities must exist?—He has to recognise it, but every person is out to evade these formalities at the present time, and that in itself is an indication that the formalities are wrong. It is just like Prohibition in America; you introduce bootlegging. You have these formalities which people object to.

Earl Russell: You are entering on rather too large a subject there, Dr. Robertson.

15,852. *Chairman*: At the same time I think Dr. Robertson has this to say for himself, that when people, animated with a genuine desire to do good, find the straight waistcoat of the existing law too severe, and try to evade it, then the time has come when the law must be brought up to date, because the law always lags rather behind instructed public opinion, and the whole purpose of legislation is to bring the law up to date. Our function here is to survey the situation, and to hear from you in what respect the law is irksome to the patient and to the public. We have opportunities afforded us of making recommendations for bringing the law more into consonance with the general feeling upon the subject. It seems to be felt that the time has now come when the legislation ought to be reviewed again. Now your contribution to us, if I may say so, would be most useful in the direction of indicating where we may best ease the administration without the sacrifice of adequate safeguards. That is really the problem, as I conceive it?—That is so, and I

may say I do not expect judicial orders will be abolished at the present time. They will some day.

15,853. *Sir David Drummond*: Is it your opinion that a great many cases are certified now which need not be certified?—Yes, certainly.

15,854. And that certification could be done away with?—If you afford facilities for treatment.

15,855. *Earl Russell*: Do you think we could meet your point to some extent partly by the voluntary system, and partly by some method of provisional detention, waiting for certification until it becomes essential?—Yes—what I call notification.

15,856. *Chairman*: If the resort to the extreme measure of certification were only the last resort, then you would probably recognise that it would be quite appropriate in such cases, where you are really going to pronounce formally upon that patient's condition, if you were to postpone necessity for that until every other means had been explored in the patient's interests?—Yes.

15,857. The expedients therefore to be explored, as it appears to me, are, firstly, the voluntary system, which we shall now ask you about, as one method whereby the patient without certification gets the benefit of the treatment and is not subjected to any judicial process, and, secondly, the method whereby there is in Scotland an experimental six months treatment permitted by law at the present time, also without certification?—Yes.

15,858. There is the further suggestion that patients, or at any rate patients as to whose condition there is doubt, should be provisionally dealt with, as Lord Russell has put it, and placed under observation for a time with safeguards, and with certain modified powers of detention until it is seen whether you require to resort to the final and definite step of certification?—Yes.

15,859. Therefore these three ways seem to me to be all things that we might explore for a moment with you as obviating the necessity of certification until the last moment?—Yes; these are the very methods I recommend.

15,860. Let us take, first of all, the voluntary method. I have read with great interest your last report on your own institution on the subject of voluntary patients, and you go to the length of saying that that method under recent legislation has so developed in your experience as practically to have brought about a revolutionary practice?—That is so.

15,861. The procedure in Scotland for the admission of voluntary patients is now very simple?—Very simple.

15,862. What does it consist in?—It consists in the patient writing a letter, or signing a letter only, to the Superintendent desiring to be admitted as a voluntary patient: "I desire to be admitted as a voluntary patient to the Royal Edinburgh Asylum," and then he has to write an identical letter to the Secretary of the Board of Control. He comes in, and he is admitted on his request to the Superintendent, and the other letter is sent to the Board of Control, and within three days we get their sanction to keep the patient.

15,863. Is that all?—That is all.

15,864. *Sir David Drummond*: Then the system of the voluntary patient is only available in the case of people who are able to write that letter?—Yes, they all have to sign that letter.

15,865. *Chairman*: You see the point?—I know that point.

15,866. A voluntary patient connotes to my legal mind that the patient has volition and has sufficient intelligence to appreciate the nature of the act?—Yes; I have gone into that matter very fully in one of my reports. I have been dealing with these matters for many years. My view is the legal view, the same view as you have in connection with a crime: that a person is responsible if he understands the nature and quality of the act and the results of it. Now I should say however insane a man is, if he understands what

18 April, 1925.]

Professor GEORGE M. ROBERTSON, M.D., F.R.C.P.

[Continued.]

he is doing when he signs that letter, he should have the right to become a voluntary patient.

15,867. *Earl Russell*: Of course, he may perfectly well not understand that, even if he is full of delusions?—Yes.

15,868. *Chairman*: One must disabuse one's mind of the idea that every person who is mentally afflicted has no intelligence; a residue of intelligence may remain unaffected, of course?—Yes.

15,869. But the difficulty is this, that you have *ex hypothesi* a mind which is to some extent disordered, that is to say, it is pathological to a greater or less degree, and yet it is the act of that mind (and that mind *ex hypothesi* an affected mind) which is necessary, as a preliminary to admission?—Yes.

15,870. I could conceive it to be very difficult to say at what stage that person has passed beyond the zone in which he could give a really voluntary assent?—I quite agree with you that there would be a difficulty in the matter of perfect accuracy, but although a person is very insane I think he can sign an application to be admitted as a voluntary patient, providing he possesses the same state of mind as a person who makes a will. An insane person may make a will, provided the provisions of the will are not affected by his mental disorder; and in the case of crime, too, if he understands the nature and quality of the act, he is held responsible for it. Therefore, I say, under similar circumstances, these are the appropriate conditions in which a person should sign a letter for admission, if he understands the nature of the act and his delusions do not affect the writing of the letter.

15,871. We are all familiar with the class of case where a person says, "Well, I think I would be the better for going into retreat for a time; I feel I am upset, and I should like the shelter and the rest, and the regimen of an institution such as you have." There are many people in that position. That class of case seems to me the ideal voluntary case; but I have more difficulty with cases where the patient has less powers, and where the disease may have made further progress. I find it difficult to judge at what stage the power to give a voluntary consent is lost. What criterion can you apply? Would you take, for instance, a letter signed by anybody that professed to want to come to you as a voluntary patient, even although your own opinion was that that person had really signed the letter without the least appreciation of what it meant?—I do at the present time, owing to the state of the laws. The friends of the patient do not want him certified. Every person wants him to have the treatment in as simple a way as possible. They come up to me with these letters signed, and I admit the patient.

15,872. *Earl Russell*: Is the letter presented to the patient ready written, and does he merely sign it, or might he write it himself and sign it?—His signature is all that is required.

15,873. I want to know what the practice is?—Sometimes one and sometimes another.

15,874. *Chairman*: I can well imagine the case of a relative saying to the patient, "Now here is a nice letter, will you just sign it; that is addressed to a great friend of mine who has a charming place out in the neighbourhood of Edinburgh, and you are going to stay there. Just you sign down there." That may well happen in real life you know. The person in that state of mind, possibly very pliable, just says, "All right, where do I sign?" That is handed to you, and that is represented to you as being the act of volition of the patient. I should doubt very much whether that is an act of his at all.—So should I.

15,875. *Earl Russell*: If it had been a promissory note it would not do?—Yes, but I do not consider that in the slightest bit. Why should I? I have no responsibility in that. I have presented to me this letter signed by this patient, and after the patient comes he is a voluntary patient, and he can go by giving three days' notice.

15,876. *Chairman*: But I do not like the camouflage of suggesting that that is a voluntary patient. It is a patient who has gone in under the guise of being a voluntary patient, but in point of fact has had no volition in the matter at all?—That is being done at the present time, because of certification and orders which people are trying to evade. If you create laws which will enable a person to get this treatment simply and easily, there will not be any necessity to evade them.

15,877. That is just one of the things we wish to address ourselves to. I should like the true voluntary patient to be entitled, as hitherto, to have access to institutions. On the other hand, I should have liked the people who really are not capable of a voluntary act at all to have the benefit of escaping certification also, if their cases are fit for it; but I do not quite like the idea of their being described as voluntary patients when they have no adequate power of volition to appreciate what they are doing.—Neither do I. I think it is very wrong.

15,878. *Sir David Drummond*: Has it often come to your knowledge that people have declined to sign the letter?—Yes. For instance, many melancholic patients will refuse to do anything, even to take food; they will not sign a letter; and they would be very suitable patients to be voluntary patients. These people have to be certified then.

15,879. *Chairman*: How are we to avoid certification in their case?—By having what Lord Russell suggested just now, and what I suggest—that they should be notified. These are recoverable cases, and will probably get better within six months. Have them put in by some sort of modified doctor's certificate and notified to the Board of Control, and have them inspected, to see that there is nothing wrong going on.

15,880. An intermediate form of order?—Yes—what I call notification.

15,881. *Earl Russell*: It is still an observation certificate or a provisional certificate, but I dare say it may make a difference if you call it something else?—Yes, it will.

15,882. *Chairman*: And it would, of course, still necessitate detention against the will of the patient?—Yes.

15,883. Take the voluntary patient: of course the true voluntary patient, quite a large class of them, as we know, present really no difficulty, because they are all able to co-operate in their own treatment; they are like other persons who are in a general hospital?—Yes.

15,884. But do you find that the patients whom you have as voluntary patients appreciate that they are there subject to their own right to go away if they wish?—The vast majority of them do; there are some who are quite indifferent. As long as they are kindly treated and so on, they do not bother their heads about it. But the vast majority of them do know; and they are all told they are voluntary patients and that they have privileges; and the Commissioners, as they are going round ticking off the patients, very, very frequently say to the patient, "You know you are a voluntary patient?"

15,885. It has been suggested that a safeguard of some value might take this form: that the Commissioners on their visitation should see each voluntary patient and should make a return saying they have seen A.B., and they are satisfied they are there still of their own wish?—Well, of course, a test of some kind as to the volitional powers of the patient certainly would be the right procedure.

15,886. That would have the advantage of requiring the Commissioner actually to attend to the case, because if he has got to make a return about it, then he will have to consider it; and if he saw the patient and informed the patient again of what you have already informed him, and was able to assess whether he was still really in the category of a voluntary inmate in your Institution or not, it might be rather

18 April, 1925.]

Professor GEORGE M. ROBERTSON, M.D., F.R.C.P.

[Continued.]

a useful safeguard, I think?—It would. You would have to increase the number of Commissioners of course.

Chairman: We will come to that in a little.

15,887. *Earl Russell:* In this country the Board of Control have a way of saying to a superintendent of an asylum sometimes with regard to a voluntary patient: "We do not think that patient is a voluntary patient. If you keep him you must certify him." That is what they do say now?—Yes.

15,888. It is unfortunate they have to, but they rather feel they have to?—Yes. We have used every possible means in Scotland to avoid certification. For instance, you have strengthened us very greatly by your opinion that the Act of 1913 expresses that it is not only those who cannot be certified that may be voluntary patients. At the present time it is no one's business to see that the patient should be certified. The patient comes in to me; I receive a sanction from the Board of Control; I accept that; why should I go out of my way to certify the patient and earn the ill-will of the patient afterwards if he recovers? Then a voluntary patient very often pays for his own board, signs his cheques, and so on. He is not going to pay a doctor to certify him a lunatic when he does not want to be certified. The relations do not want him certified. If you call in any doctor, the important person to call in is the family doctor. You say: "This person is a voluntary patient, but he can be certified now." He says: "I will not certify him." They have great objection to certifying their patients at the present time. Two years ago a doctor came to me, to find another to certify his patient, because he said: "This is the first patient I ever had, and I do not like to certify him."

15,889. *Chairman:* Detention in the sense of interference with the liberty of the subject is just the other peril?—Yes. I do not think there is any medical certificate that can certify a voluntary patient, supposing he is insane but knows what he is doing, because every certificate under the Lunacy law is for a particular purpose. You talk generally about the lunacy certificate, but the person has to be not only of unsound mind but a fit and proper person to be detained in an asylum. You have the two conditions there. You ask the family doctor to go up and certify the patient. He says: "He is insane all right enough, but I will not say he is a fit and proper person to be detained in an asylum under a Sheriff's order." So, you see, even an insane person may not necessarily be certified by the family doctor.

15,890. Possibly the case might be met in this way: the voluntary patient might be admissible not merely on his own application, but with the accompaniment of a certificate from his usual medical attendant, because he has presumably had one in the great bulk of cases, or from a medical man, to the effect that he is satisfied that the patient is desirous of entering the institution and capable of forming an opinion upon it. I mean, one could devise a formula which would proceed upon a criterion such as you have in your mind?—Yes. A certificate of that kind was given when voluntary patients were first of all introduced into this country; that was in the Act of 1862.

15,891. It is a formality again, and you want rather to strip the thing of formalities; but a formality of that kind would not be a very rigorous one?—No. I think it is a very proper proceeding.

15,892. There are certain features in Lord Onslow's Bill which are open to criticism. It proposes to deal with people who are non-volitional; simply to be dealt with as parrels, so to speak. That is not my conception of a voluntary patient at all, to tell you the truth?—No.

15,893. I think that class of case, which for the time being has an absence of will-power, would be much better treated as a provisional case.—Yes.

15,894. *Sir David Drummond:* In your experience are a certain number of these voluntary patients certified eventually?—Yes.

15,895. On what ground?—Usually on the ground that they have given three days' notice to go.

15,896. *Earl Russell:* Do you agree with the view that Dr. Yellowlees took, that anybody who wished to leave the asylum must be insane?—No, I do not go quite so far as that. Another feature about voluntary patients is this: a patient comes in in the incipient stage of mental disorder; he has probably been ill before; and he says: "I want to come in as a voluntary patient; look after me." That patient at the end of a week becomes deliriously excited. What is to be done? That man has come to you as a voluntary patient. Are you to go and certify him? I think that would be hard on him. I have had a patient under my care for several years with recurring attacks; he resided in Craig House; he used to say to me when he was well: "Do not certify me however ill I get." I have got a melancholic lady just now whose great horror is that she will become so ill that I will certify her. These people have decided voluntarily to come for treatment, and then you go and certify them!

15,897. In recoverable cases, I wonder whether you could get over the difficulty of the three days notice by having some sort of provisional order for detention for three months, in the hope that at the end of that time the patient would be willing to be a voluntary patient again?—Yes; that comes in the group of cases the Chairman has suggested.

Chairman: I think the case you put just now is a very interesting one. A patient, who is quite able to appreciate that he has from time to time accessions of insanity, but has quite completely lucid intervals, and recognises that the onset of the disease is at hand, goes to you as his medical adviser and friend, and says: "Now I want to come into your institution for a time." That is a perfectly voluntary act on his part. His mind has not in the least passed beyond the zone of appreciating what he is doing. You say: "Certainly, come along." He has been there before, and he knows the place and all the rest of it; he is very glad to come to you, and you afford him all the means of treatment you have. Quite true, in about a week the illness is reaching its crisis, and he does become, if you please, acutely maniacal. At that moment, of course, he is not a voluntary patient, because the unhappy man is not able to have any will at that time. What are we to do with him? He has ceased in law to be a voluntary patient.

15,898. *Earl Russell:* Why cannot we regard his sane will as continuing over the crisis?—I think that is a most important thing. It was mentioned yesterday, for instance, that when they have to become certified, it has been recommended that they should go to another asylum.

15,899. *Chairman:* So that there should be no atmosphere of certification as a sequel to a voluntary entry?—Yes; if a man who is presumably sane selects a particular asylum because he prefers to go there, then after he has become insane and certifiable, why should he be removed from it? I do think that this continuing will is a most important matter. You see you are dealing with a patient personally; you have to look at these things from the personal, human point of view, and not from the point of view of the cold law. The next case is this: supposing a person has not gone to the asylum and applied to be a voluntary patient during the two or three days he had it in his power to do so, and he becomes maniacally excited; he has exactly the same symptoms as the other person who has taken the precaution—must you certify this man? Cannot you provide for him under this sort of temporary measure of notification?

15,900. Of course, the voluntary patient, who was capable of appreciating the situation and recognised for himself that for the next three months he would be unfit for ordinary life, might quite well agree to submit himself to treatment for three months. You might know the probable duration of the illness, and he might say: "I am pre-

18 April, 1925.]

Professor GEORGE M. ROBERTSON, M.D., F.R.C.P.

[Continued.]

pared for three months" (or six months, as the case might be) "to submit myself to treatment in your institution, with the result that my liberty will be restrained whether I like it or not, because I recognise that there is a time coming when I shall not be able to express my will."

15,901. *Earl Russell*: I think I am right in saying that we allow an inebriate to do it now for 12 months?—Yes. That is a very different thing; he is sane the whole time.

Mr. Snell: What do we do when we go into a general hospital, when we have to pass through an anæsthetic? We express our will for the coming event.

Chairman: We certainly do.

Sir Ernest Hiley: But the doctrine of the continuation of the sane will has a very limited duration. It is rather a difficult one.

15,902. *Chairman*: I think the problem is extremely difficult, because my sympathy is very largely with Dr. Robertson, that the main concern is the patient. No doubt you must surround the patient with the necessary legal safeguards, but the treatment of the patient is the main thing; of course, it ought to be?—Yes.

15,903. If you can get the patient treated and cured without certification, so much the better, but then even if the treatment of the patient involves interference with his liberty, what are you to do? That is just the difficulty; it is very complex.—It is very complicated. If a person in this condition determines to go, and expresses himself very strongly—the best test of that is, supposing he takes to his heels: that patient has to be certified, because we cannot keep him if he has expressed his intention to go. I may say another thing about these very excited patients: they lose their will altogether; they do not want either to go or to stay; they are quite indifferent.

15,904. They are neutral?—Yes. You leave the door open, and they have not the sense to go away.

15,905. *Sir David Drummond*: All through this discussion, not only to-day, but at earlier meetings, I have always had it in my mind that the great difficulty would be the very large proportion of patients who would decline to enter an asylum as voluntary patients?—Yes; many of them do.

15,906. We have been dealing with it as if the majority of them would present themselves voluntarily, if volition allowed it; but my impression is that there is a very large proportion of people who, although able to decide the question, would decline to do so?—No doubt a considerable number do decline; but a very large number, by far the majority, are quite prepared to do it.

15,907. *Earl Russell*: As a rule, when we certify them here, they are past the voluntary stage?—Yes.

15,908. *Chairman*: We should bring out at this stage this feature, which is very important. Dr. Robertson tells us that he finds that 40 per cent. of all the private patients entering the hospitals of Scotland do so as voluntary patients?—Yes.

15,909. *Mr. Micklem*: With regard to the voluntary patients in Scotland, suppose they want to leave, can you detain them for a single minute?—Yes, for three days.

15,910. Under what?—Under the law of voluntary admission.

15,911. Could you refer me to the law on the subject?—Yes. It is Section 15 of the Act of 1866.

15,912. *Chairman*: The voluntary system in Scotland has had full statutory recognition?—Yes, since 1866; and it introduced the system into the country. Prior to that, there existed what were called the voluntary boarders in England, but they were not really patients.

15,913. Then it has been reconsidered by the Legislature at intervals, and has been simplified from time to time, and is now in the very simple form which you described to start with, under the 1913 Act?—Yes.

15,914. And it has always been accompanied with this, that you might detain a person who came in as a voluntary patient for three days against the wishes of that patient after receipt of notice that the patient desired to leave?—Yes.

15,915. And those three days give you the opportunity of having the patient detained against his will by certification, if you conceive that it is necessary that that should be done in the interest of the patient, or in the interest of the public?—Yes. His friends at once, of course, are communicated with.

15,916. After all, the system is perfectly intelligible. One's only difficulty is how to judge if he is a voluntary patient or not?—He is a voluntary patient at present if he signs these forms.

Mr. Micklem: The Act of Parliament says "whose mental condition is not such as to render it legal to grant certificates of insanity."

Chairman: The 1913 Act has altered that, I think.

15,917. *Sir Ernest Hiley*: Both Acts speak of a written application. It is not a question of signing a form prepared by somebody else?—It usually is an application. There is no stress laid on that point one way or the other.

15,918. *Chairman*: I think the system is extremely valuable, because it achieves the treatment of the patient and it avoids the stigma of certification. In your experience, have you found that it has been liable to any abuse?—I think the friends have induced patients to sign the voluntary form rather than be certified. I think that has happened.

15,919. *Earl Russell*: When the patients have recovered, they do not regret having done so, do they?—No, they do not object; and, of course, they can leave at any time; it only lasts for three days.

15,920. *Sir David Drummond*: Has it crossed your mind that, instead of treating these patients in asylums, special hospitals might possibly be provided, apart from the asylums?—The well-managed asylums are by far the best places for the treatment of mental disorders; they have got far more wealth and far more facilities—far better surroundings.

15,921. But I am thinking of an institution which does not exist at all at present, apart entirely from public asylums?—A certain number of patients like to go into small houses and not to see other patients.

15,922. *Chairman*: At present you do not regard it as essential to the admission of a person as a voluntary patient that that patient should not be susceptible of certification at the moment?—I am not compelled by law to take any action in that matter at all, and if the person comes to me I admit him, if he has the sanction of the Board.

15,923. But in its inception the voluntary system in Scotland quite clearly was intended for cases which were not certifiable cases.—Possibly.

15,924. I think, historically, under the Act of 1866, it says so. It may be altered now; but the inception of the idea at any rate was that it was an expedient for persons who were not certifiable. It was assumed that all persons who were certifiable would be certified.—I think there is another way of looking at it, too. There has been a great deal of discussion over that word "but." It was possible that a person who was sane, but who required treatment and observation of some kind, might wish to go into an asylum. In the old days that person could not get treatment in an asylum.

15,925. If one may look at it historically, it strikes me in this way. First of all, the only ticket of admission to an asylum was a certificate. Then it was recognised that there were many people who would benefit by asylum treatment, but who were not qualified to get that ticket of admission. Therefore, the law provided that such persons could go in voluntarily without a certificate of admission. Then I think, the law, having got that length, is rather developing in this direction: that persons who, although they might be certified, are still capable of entering as voluntary patients should be permitted

18 April, 1925.]

Professor GEORGE M. ROBERTSON, M.D., F.R.C.P.

[Continued.]

to do so, and so get the benefit of treatment, although certifiable, without certification?—Yes.

15,926. One can trace it through three stages?—Yes.

15,927. The discussion has been very useful, but I think we are still left in some difficulty?—Yes. Before the stages you describe, the original voluntary patients had to be certified.

15,928. *Sir Ernest Hiley*: Do you find that this voluntary system you have been describing is in advance of public opinion in Scotland or is it abreast of public opinion?—I do not think it is in advance of public opinion.

15,929. It is supported?—It is supported, most decidedly.

15,930. *Chairman*: I think one may say this, that, so far as one is aware, there has been comparatively little agitation in Scotland with regard to the administration of the lunacy laws?—Practically none.

15,931. There is a general satisfaction with their administration?—Yes.

15,932. And there have been practically no cases in Court, so far as I know. I am probably as good a judge of that as you are, Doctor, but one knows that litigation relating to cases of insanity is exceedingly rare in Scotland.—Exceedingly rare.

15,933. Just as a matter of curiosity, have you yourself ever been sued in a case?—Never. I have been lucky perhaps.

15,934. I do not know about that. In the course of a somewhat extended experience I do not think I have ever had a case, or ever been consulted about a case involving a medical superintendent or a certifying doctor; I cannot recall one at the moment. I have had to deal with one or two questions about curatory, of course, where estates were involved.—Yes. One of the points is the case with which any mistake can be rectified by calling in two doctors from outside.

15,935. That is a very important safeguard which exists in Scotland, and it is taken advantage of, I understand?—Yes, greatly.

15,936. Now we have dealt with the voluntary patient at some length. Then the next question was the question of the provisional certificate which we have dealt with really incidentally. You think that some method of provisional certification would be an alleviation of the present system, and might be utilised for cases which were really likely to recover in a short time?—Yes.

15,937. Then may we have a word from you about the special provision (I think it is in Section 13 of the 1866 Act) under which there may be treatment of patients for six months without certification? I have used the word "treatment" advisedly to avoid the question of detention, as to which there is some little doubt. That is under Section 13, is it not, and the whole of that hangs upon a proviso in the section?—Yes.

15,938. Has the system of treating patients in houses without certification really been based upon that provision of the law?—Yes.

15,939. Now tell us a little bit about the development on those lines, because you have been, if I may say so, a pioneer in this work.—I found that insane persons were being kept in private houses, proprietary private houses, and I was not altogether satisfied with the treatment they received in these houses. Further, my Board permit me to do consulting practice and private work, and I did not like sending patients to private houses that were not under the Board; so on these two grounds I recommended that the Board should start private houses of their own which were nursing homes. I persuaded the Board they would be a good thing, that they would be a benefit to the public.

15,940. *Mr. Micklem*: You mean the Board of your hospital?—Yes, the Board of Managers. We bought two or three small houses. During the course of the war the War Office heard of this, and

they got hold of these houses for insane officers, they sent insane officers to them in the first place. Then at the end of the war when the officers were removed, we received into these places private patients, and converted them into ordinary nursing homes where the patient could be treated without being sent to an asylum.

15,941. *Chairman*: And where they could be kept for six months, was it?—And where they could be kept for six months, yes.

15,942. *Sir David Drummond*: Had you nothing of the kind before the war?—We bought these houses during the war, but during the war we could not make use of them.

15,943. When did you commence this system?—I think we opened it for ordinary patients in 1918 or 1919.

15,944. Before the war how did you deal with those patients?—Before the war these patients were put into the nursing homes kept by any person, usually lodgings.

15,945. Outside your jurisdiction?—Yes.

15,946. *Chairman*: Let us follow the idea. In ordinary ailments the use of the nursing home, as we know, has become more and more common because of the advantage of the treatment and the observation that can be obtained?—Yes.

15,947. Your conception is that mental ailments should also have the advantage of treatment in nursing homes on analogous lines?—Yes.

15,948. In pursuance of your general idea that mental ailments ought to be treated like other ailments, so far as possible?—Yes.

15,949. Then you were confronted with a difficulty that such persons from time to time require restraint or require detention against their own wishes?—Yes.

15,950. Was it in that state of matters that you resorted to Section 41 of the Act, 20 and 21 Victoria, which, while preventing the reception of lunatics in private houses, has this important qualification that "the prohibition shall not apply to any case where the party so received and kept has been sent to any such house for the purpose of temporary residence only not exceeding six months, and under the certificate of a medical person, which certificate shall be in the form of Schedule G hereunto annexed."?—That section has been repealed, and there is a new section to take its place, 29 and 30 Victoria, Section 13.

15,951. By Section 13 of the Act, 29 & 30 Victoria, the section which I have just been quoting was repealed, and in lieu thereof it is provided that "no person shall receive or keep any person as a lunatic for gain without the order of the Sheriff, or the sanction of the Board." Then "any person who shall receive into or keep in his house any such person, or any person alleged to be a lunatic, shall, within 14 clear days thereafter make application for such order or sanction; provided always that when the lunatic is a pauper lunatic, such application shall be made by the Inspector of the Poor, and it shall be lawful in such case for the Sheriff to grant his order on one medical certificate." Then it goes on to provide for visitation, and then the proviso, which is very important is: "Provided that the enactments of this section shall not apply to any case where the person so received and kept has been sent to such house for the purpose of temporary residence only, not exceeding six months, and under the certificate of a medical person, which certificate shall be in the form of Schedule G to the first recited Act annexed."

Earl Russell: That is how the earlier Act gets incorporated?

Chairman: Yes.

15,952. *Mr. Micklem*: But it leaves it very much where it was under the proviso?—Yes.

15,953. *Chairman*: Now the result of this was, I take it, that being desirous of having nursing homes for mental patients, you have taken advantage of

18 April, 1925.]

Professor GEORGE M. ROBERTSON, M.D., F.R.C.P.

[Continued.]

that proviso which provides that patients on one medical certificate in Form G may be kept (whatever that means) for six months' temporary residence in a private house?—Yes.

15,954. Then you have established such private houses, and you house your patients there for six months on one medical certificate in Form G?—Yes.

15,955. Let us look at Form G for a moment, which you have quoted, I think, in your *précis* on page 5. The certificate is to the effect "That C.D. is afflicted (state the nature of the disease), but that the malady is not confirmed, and that I consider it expedient, with a view to his recovery that he should be placed (specify the House in which Patient is to be kept) for a temporary Residence of (Specify a time, not exceeding six months)." Now the pre-supposition of all that is this, that the case is not a confirmed case, and that there is a prospect of recovery if there is temporary residence in a home?—That is so.

15,956. *Sir David Drummond*: What is meant by "confirmed"?—I suppose it means it is not a chronic case.

15,957. *Chairman*: Not established?—Yes.

15,958. *Sir David Drummond*: Then all acute cases could be taken in?—Yes.

15,959. Is that not a confirmed case of its kind?—I think "confirmed" means irrecoverable in contrast to cases that can recover; I think it means the chronic case.

15,960. *Chairman*: The words rather suggest that the contrast is between "not confirmed" and "with a view to his recovery"?—Yes.

15,961. Now this method of treatment has worked out, has it not, very well in your experience?—Exceedingly well.

15,962. And do you find that the six months' patient does recover in your houses within that period?—The majority of the patients recover within that time.

15,963. What happens if the six months elapse and the patient has not recovered?—Then if he remains in the home he has to be put under the previous portion of that section; he has to be certified, and he is treated as a boarded-out patient in the house.

15,964. *Earl Russell*: You can do that without going to the Sheriff, simply by the sanction of the Board of Control, without a judicial order?—Yes, I have given a form showing how it can be done. To prevent misconception, I may say that a great number of patients are also treated in those homes who come in voluntarily, not under Schedule G at all. Schedule G only applies in the case of those persons who do not come in voluntarily.

15,965. *Chairman*: Now do you conceive yourself, under that section with its proviso, and under Schedule G certificate, entitled to detain a person against his wish?—I do, yes. The purport of the opinion that we have taken has been to that effect,—that we have the power. But the Board of Managers of the Institution have instructed me that if I take in any patient under Schedule G, I have to get a letter of indemnification from the relatives of the patient against any action for damages against the matron or myself or the Board of Managers.

15,966. That is because of the possible doubt as to whether that section entitles you to detain the patient against his will?—Yes, just so.

15,967. It is noteworthy that that section is apart from the sections dealing with voluntary patients?—Yes.

15,968. And therefore seems rather to be upon a different basis?—Quite; there were no voluntary patients at the time Schedule G was passed.

15,969. In 1857?—Yes.

15,970. However, the fact is interesting to the lawyer, but the practice which you are pursuing is to treat patients in these homes, and to detain them if necessary against their will, for a period of six months?—Yes.

15,971. *Earl Russell*: Do such voluntary patients as come there come on the same terms as they come to an asylum?—No. It is not an asylum; it is a private house.

15,972. You have not got the three days power of detention?—No. They are strictly voluntary. As a matter of fact, legally there is no notification to the Board of Control of these patients at all, and there are no instructions given as to what is to be done with Schedule G.

15,973. You mean when the certificate is completed, nobody knows who is to have it?—No, but there ought to be notification, and, as a matter of fact, we do notify them.

15,974. *Chairman*: But that is a matter of practice rather than of regulation?—Yes.

15,975. *Sir Ernest Hiley*: But, in effect, on the certificate of one doctor you can detain one of these patients, in your view, for six months?—Yes.

15,976. Without any Sheriff's order, or any other procedure?—Yes.

15,977. *Earl Russell*: And without the Board of Control ever hearing about it?—Yes.

Sir David Drummond: What accommodation have you?

15,978. *Chairman*: There are four houses in all, I think, are there not?—There are four houses containing about 40 beds, and a country house containing about 15; that makes 55. Then we have got another big house which holds 20.

15,979. 60 or 70 altogether?—Yes; about 40 patients on an average we have. Of course, these cases should be notified to the Board of Control; every one realises it. It must be an error in the law.

15,980. *Earl Russell*: You have got everything you want there?—Yes.

15,981. No public authority?—No.

15,982. *Chairman*: I notice you say this in your last report: "In these homes the family physician can treat his own patients exactly as he does in nursing homes for other diseases"?—Yes.

15,983. So that the family doctor continues to attend the case, does he?—Yes. There are many patients in these homes that are sent in by their own doctor. For instance, Dr. Comrie puts a patient in one of these homes and treats him himself.

15,984. Then you go on to say: "The managers really provide the properly equipped home, and the necessary staff under the direction of an experienced matron, where early and mild cases of nervous breakdown may receive appropriate nursing and care. These homes are useful also for patients suffering from the mental breakdown that accompanies old age. Such cases are often very difficult to care for at home, yet no one likes to send an aged parent or relative in this condition to a mental hospital. There were 111 patients admitted into these homes during the year 1924, and the total number under treatment in them was 145"?—Yes.

15,985. *Sir David Drummond*: What view do the Board of Control take if one of these patients commits suicide?—That is just the whole point. These homes are created for the very purpose of treating these patients properly, who might possibly commit suicide.

15,986. *Mr. Snell*: Do you never have accidents of that kind?—There have not been any accidents of that kind so far, but we take the necessary precautions and know what to do, and everything is done properly.

15,987. *Miss Madeleine Symons*: They are all private patients, I suppose?—Yes, these are all private patients.

15,988. *Sir David Drummond*: Suicide may occur, of course, in the best conducted asylum in the country?—Yes.

15,989. *Mr. Snell*: Would it not be the fact that in proportion as patients were allowed liberty there would be danger of accidents of that kind?—Yes.

18 April, 1925.]

Professor GEORGE M. ROBERTSON, M.D., F.R.C.P.

[Continued.]

15,990. Is it not true, for instance, that at Maudsley they take those risks, and the rate of accidents is probably a little higher in consequence?—Yes. I quite agree with you that there is a danger of being too strict, but it is a very serious danger to be too lax. For instance, patients who commit suicide are almost invariably cases suffering from melancholia, and melancholia is almost always recovered from, if safeguarded.

15,991. *Earl Russell*: Would you have suicidal cases in these homes?—Yes, any kind of case.

15,992. *Mr. Micklem*: At the end of six months supposing the patient has not recovered, you get an order from the Board of Control?—Yes.

15,993. To what effect is that order?—A sanction.

15,994. A sanction to continue the treatment of the patient indefinitely?—Yes, till the patient's friends remove the patient, or the patient recovers. You have a sample of the order on one of the white sheets.

15,995. *Earl Russell*: Is this a case where the escape for 28 days would apply?—No.

15,996. I mean discharge by operation of law?—Yes; this is not an asylum.

15,997. And therefore it does not apply. They cannot escape from these places?—They can escape, yes.

15,998. *Chairman*: Are the houses really in a sense part of the system of boarding-out in Scotland?—Yes.

15,999. Are the patients in these places treated as boarded-out patients?—They are technically regarded as boarded-out patients under the law.

16,000. But one moment. The boarded-out patient is a patient who has been insane, but who may be with safety allowed to reside out of an institution?—Yes.

16,001. But the people you deal with in your nursing homes are people who have never been certified at all. Would they not fall into a different category from the boarded-out patients so-called?—They are under different sections of the law. A person can be boarded out without ever having been sent to an asylum. A person who becomes ill in a private house can be boarded out.

16,002. *Earl Russell*: Surely you are wrong in saying these are boarded-out cases?—They are described as boarded-out cases, under a separate section of the law.

16,003. *Sir Ernest Hiley*: I understood yesterday that boarded-out cases were registered by the Board of Control and periodically visited?—Yes.

16,004. *Chairman*: Surely this is different because you may have these patients there for six months; during that six months they are not registered, are not certified; they are merely private patients residing in a private nursing home, and they are not notified to the Board of Control. Now, on the other hand, when you proceed to obtain a sanction from the Board of Control, or an order from the Sheriff, you are then taking the first formal step with regard to these persons apart from the certificate, Schedule G, which you have got before. Then you go to the Board of Control, and you get from them a sanction, and that sanction does seem rather to correspond with an authority to board out a patient?—Although the patients are treated differently, and they are a different class of patients, they are described (Ninth Annual Report, 1866, page 25) under the heading of Boarded-out Patients, although, of course, they are not what we usually regard as boarded-out patients.

16,005. Now this method of treatment is, of course, not applicable to the pauper patients at all?—No.

16,006. These are all patients who pay for themselves?—Yes.

16,007. With regard to rate-aided patients, how far is the voluntary system available for them? The trouble arises in this way, that if the patient goes in voluntarily then there is no grant for that case?—That is so.

16,008. Therefore, if a local authority sends any of its afflicted rate-aided patients into an asylum on a voluntary basis, they must bear the whole cost themselves on their own assessment?—Yes.

16,009. Have some of the local authorities been doing that in Scotland?—Yes, they have, particularly the smaller parishes in Argyllshire; and that point is interesting because in these small country parishes everyone knows everyone else, and they co-operate to avoid certification, and the Sheriff's order; and so in these small parishes they allow them to go in as voluntary patients. In some of the big parishes, such as Edinburgh, and, of course, in Glasgow, they have adopted the principle of wards, which were originally started by Dr. Carswell, and afterwards extended; practically, these supply that provision for voluntary patients.

16,010. One of the curious things seems to be this, that the patients and relatives all seem not to want certification, while the public seem to insist upon it?—It is curious.

16,011. On the other hand, we are assured by very vigilant persons that there should be certification?—Yes. Someone wrote to the "Times" three weeks ago pointing out that the people of the country can be put into these two groups, and, as a matter of fact, those who want certification are the more vocal of the two, and you hear more about it.

16,012. *Mr. Micklem*: May I ask a further question about these nursing homes? Is it the fact that in Scotland any private person may, for gain, open a nursing home, and get lunatics on a medical certificate and detain them for six months without the Board of Control knowing anything about it?—Yes, that is so. With regard to that, of course, we have been trying to get the law altered for a long time.

16,013. *Earl Russell*: You do not think that desirable, of course?—It is most undesirable; we all think it is most undesirable.

16,014. *Chairman*: You desire disinterested management?—Yes. I want disinterested management, but I certainly think that any person who goes into a home of that kind should be notified at once to the Board of Control, and the home should be notified and inspected.

16,015. *Mr. Micklem*: At the present time there is no inspection?—The Board of Control is entitled to visit any place where a lunatic is being kept.

16,016. *Chairman*: If they know about it?—If they know about it.

16,017. But there is no method of notification?—No, there is not. The Board of Control have complained about the absence of facilities for knowing what is going on. We sadly need an Act to put that matter right, because now it is becoming so extensive.

16,018. *Mr. Micklem*: And yet there has been no complaint of illegal detention in Scotland in homes of this sort?—No, there has not been any complaint.

16,019. *Sir David Drummond*: Have any accidents occurred? Have they been brought under the notice of the Board of Control?—Accidents have occurred, and if they are fatal accidents they are investigated by the Procurator-Fiscal, and I suppose they are brought to the notice of the Board of Control.

16,020. *Mr. Snell*: In paragraph 1 of your précis you speak of there being only one proprietary asylum in Scotland?—Yes.

16,021. These homes are in a quite different category, presumably?—The homes I am talking about, Morningside, are in a different category. They are under the Board of Management of the Royal Asylum, but there are a great number of nursing homes in the country who will take in insane patients.

16,022. *Chairman*: Though they are not licensed?—No.

18 April, 1925.]

Professor GEORGE M. ROBERTSON, M.D., F.R.C.P.

[Continued]

Earl Russell: These homes of which Dr. Robertson is speaking correspond to our licensed houses, except that they are not licensed.

Chairman: And they are not carried on for gain.

16,023. *Earl Russell*: The ones he is speaking of are carried on for gain?—But they are not under the lunacy laws.

Earl Russell: I am speaking of the other homes, those run by private enterprise. They correspond really to our licensed houses without our licensed houses precautions.

16,024. *Chairman*: And the period is limited to six months?—Yes.

16,025. *Mrs. Mathew*: Are the numbers limited?—No. They are not lunatics in the eyes of the law during these six months.

16,026. *Chairman*: It is a curious position?—Most anomalous. This is the only form in the lunacy laws of England and Scotland, a copy of which has not to be sent to the Board of Control.

16,027. *Mr. Micklem*: It seems to have worked well?—It has worked very well.

16,028. *Chairman*: As we are reviewing the system, we are well advised to take hints from our witnesses if a system has worked well outside the law, or, at least, without, shall we say, rigid observance of the law; it might be desirable to institute such places and bring them within the law, if they supply a felt want?—Yes.

16,029. And it is quite manifest in your view that some form of nursing homes with notification and inspection supply a felt want?—Yes, undoubtedly.

16,030. And are beneficial both to the patient and the patient's relatives, and are sufficiently safe from the public point of view?—It is the only provision in the lunacy law for which I have known patients feel grateful; the others they complain about; but for a provision of this kind any number of patients have expressed their utmost gratitude to me.

16,031. *Miss Madeleine Symons*: You would prefer all such homes to be under disinterested management, would you?—I think it is much safer, and there is less possibility of many dangers; but the great Lord Shaftesbury expressed the opinion that proprietary institutions really did good because there was more personal interest taken in them, and therefore the management was improved by the personal interest taken.

Earl Russell: That may be true of the founder of such an institution but not necessarily of his successor.

16,032. *Chairman*: There is one thing you might just explain. In the forms you have been good enough to supply us with, I am struck with this, that in the case of the Form of Application to the General Board of Control to sanction to reception of a private patient into a private dwelling, apparently one medical certificate is required; that is Form F.2. I turn to Form D., which is the Form of Application to the General Board of Control for Scotland to grant sanction for the residence of a pauper lunatic in a private dwelling specially licensed or otherwise, and there I find that two medical certificates are required. So that a private patient may be received into a private dwelling with the sanction of one medical certificate, while a pauper patient can be received in private dwelling with the sanction of two medical certificates. What is the reason of that?—The reason is that there are three different ways in which a rate-aided patient may be boarded out. He may be boarded out on an order by the Sheriff with two certificates, or on the sanction by the Board of Control on two certificates, or else he can be transferred; that is a new arrangement under the 1913 Act; he can be transferred from an asylum to a private dwelling. There is, however, a fourth way, under this section which you have just referred to, by which one certificate only is required, in exactly the same form as is used for a private patient, but as a matter of practice they never do adopt that plan. There are three other ways of doing it, and the other ways are the ones that are always adopted; but there is nothing to prevent them print-

ing a form relating to pauper patients in exactly the same way as they printed a form relating to private patients; you will see it in the first portion of Section 13.

16,033. *Sir Ernest Hiley*: Is there any obligation at all to use Form F.1? The title indicates that it is an application to the Board for sanction, and, according to what Dr. Robertson says, there is no necessity to notify the Board, and presumably not to apply for sanction?—It is used after six months.

16,034. *Chairman*: This does not apply to the reception of people into these nursing homes for six months at all?—No, not at all. After six months you have to use one of those forms.

16,035. Or these may also be used for the initial reception of a patient into a private dwelling under the other provisions of the Act?—Yes.

16,036. Now there are one or two other matters on which I think you can make a contribution to our deliberations. I should like very much to have your views on the question of the employment of female nurses in institutions, because I know you have both experience and views upon that matter. Will you just tell us quite shortly in what the advantages in your view of the employment of female nurses consist and to what extent it has been adopted?—Yes. I have employed them now for nearly thirty years, and the system has been pretty generally employed in Scotland for about 20 to 25 years. In the first place, you are able to get trained hospital nurses, many of them educated women, who also take nursing certificates. You have these people to act as matrons of your asylums, and they introduce medical methods and hospital nursing of the best quality into the asylums.

16,037. Your policy has been to have women matrons at the head of the whole institution, male and female sides alike?—Yes. I first of all started with the female side; now it applies to the whole asylum.

16,038. Is she chief officer, so to speak, under you?—Yes; she is the head of the whole nursing staff, and the domestic staff.

16,039. Male and female?—Yes.

16,040. Is that the case in many of the asylums in Scotland?—Yes, in about half of them.

16,041. Half of them have a lady matron in charge of the whole nursing staff, male and female?—Yes.

16,042. Do you find it desirable also to have assistant matrons under her?—Yes. Then the next step, for the purposes of description, not chronologically, was to have a large number of educated women, with the hospital training and the mental training, in charge of the wards and groups of wards. This is entirely a new class that was not in vogue before at all. For instance, I have 15 of these at Morningside. I introduced them afresh and put them in charge of all these departments, to see that medical ideals and high nursing ideals were carried out.

16,043. These have all had medical training?—Yes.

16,044. *Earl Russell*: Is that too expensive for English rate-aided institutions?—No, because you are paying the nurses more than we are paying them. Hospital nurses are not paid so much as mental nurses are paid. It is the one reform in mental work which has not added to expense.

16,045. *Chairman*: Now what about the actual nurses themselves?—After that you have got the mental nurses, the ordinary probationers, and those with certificates; they get promoted to be in charge of wards.

16,046. They do not happen to have had general hospital training?—No.

16,047. They have begun in this career?—Yes. First of all, women were employed in the hospital wards, and, of course, there is no comparison between the nursing done by a woman and that done by a man, especially if the nursing is under skilled direction of a person who has been trained in the best voluntary hospitals. The nursing in our Scottish mental hospitals is just as good as it is in the voluntary hospitals. They were first all put into the hospital wards, and

18 April, 1925.]

Professor GEORGE M. ROBERTSON, M.D., F.R.C.P.

[Continued.]

then they were afterwards transferred into other wards, a certain number into other wards, because it was found that a woman had an extraordinary power even over excited patients. An excited man might be very pugnacious and combative with the male attendants; but, with a woman, he had a totally different attitude towards her altogether. An excited patient might be rushing about a room, taking off his coat and throwing it about, and if an attendant said to him, "Put on your coat," he would refuse, and then there might be an attempt to put it on, and there would be a struggle. On the other hand, the nurse would say in a quiet way, "Put on your coat," and the thing is done. It is found that in the case of very excited patients, women have a wonderful control over them, which means that although a man is deranged in mind, it does not necessarily mean that he loses all his faculties and all his intelligence. Then the presence of these women reduces the tendency to roughness. On the female side the female patient usually uses her tongue; but on the male side sometimes there is a tendency to strike, or something of that kind; but the presence of women has reduced this tendency, and it has introduced a totally different atmosphere in the place; and, what is more, a woman can decorate a ward and attend to the comforts of the patients in a way that a man cannot do. It has made asylums totally different places.

16,048. We heard yesterday that the Board of Control for Scotland was certainly in favour of women nurses in what they call the hospital side of institutions?—Yes.

16,049. You go much further. You would have them not only in the hospital department of asylums, but in charge of the ordinary day and night wards?—Yes, and other parts besides the hospital. As a matter of fact, the vast majority of asylums in Scotland carry out the same practice that I have. That was the one piece of evidence that Sir Arthur Rose gave with which I did not altogether agree. I think that the Board of Control approve of women being employed to the utmost extent.

16,050. *Earl Russell*: There was just one thing that struck me in the order you were giving us. Does not that system close the posts to the ward nurses, if these matrons and assistant matrons all have hospital experience?—No. She can go to a hospital and get her hospital training. The first point is that we are out to benefit our patients, not to benefit the staff.

16,051. That is perfectly true, but obviously if you prevent the opportunity of promotion arising, you do not get the best class of nurse?—That is so.

16,052. *Sir David Drummond*: Do you select the wards in which the women are nursing?—Every one of my wards has got a woman at the head of it. In the hospital ward they have almost sole charge, with one or two men perhaps to help them.

16,053. But there are certain wards which you would not put into the care of women alone, are there not?—There is no ward in the charge of women absolutely alone; there is always a man there, an attendant; one attendant is quite enough in most of the places.

16,054. *Mr. Snell*: There is no serious proportion of regrettable incidents?—No, very few.

16,055. It has its influence, even on that side?—It has its influence. Of course there are some patients you cannot possibly put under the charge of women.

(After a short adjournment.)

16,056. *Chairman*: On the subject of the employment of women, Dr. Robertson, as nurses in asylums, one knows that objections have been taken on various grounds to such employment, perhaps most prominently that much of the nursing is unsuitable to women. On that subject I think you hold the view that women who are doing their work as professional work approach their attendance on the patients from an

entirely professional point of view, and that these elements which the layman is apt to dwell upon do not really bulk in their minds?—That is so.

16,057. Do you find that the vocational aspect of it appeals very much to the women's minds?—It does, especially when they are supervised, and the system is originated under the superintendence of hospital nurses who have been accustomed to working amongst male patients.

16,058. Then the class of objection that the work may be unpleasant, or even indecent, does not really appeal to your mind?—No. Arrangements can be made by which that can be minimised in exactly the same way as in the nursing of male patients in a general hospital.

16,059. There are some cases, I suppose, particularly cases of sexual perversion and so on, which may be undesirable for women to handle?—There are undoubtedly cases of that kind, but there is no difficulty whatever in separating that class of case, and having them looked after in other wards.

16,060. And is the value of women's nursing in the case of the great majority of the patients conspicuous in its therapeutic value?—It is most conspicuous.

16,061. Then do you really advocate the introduction of nursing by women as what one might call the general system of nursing in all asylums, treating the nursing by male attendants as really a special provision for particular types of cases? Do you go so far as that?—No, I would not go quite so far as that.

16,062. I would just like to know where you pause in your extension of the system?—One group of cases that for convenience sake is very much better looked after by men—male attendants—are those patients who are able-bodied and able to work; it is much better that they should be looked after by the same attendants who go outside into the gardens and grounds and farm and work with them.

16,063. They are more like foremen in the work?—Yes.

16,064. *Earl Russell*: Working parties?—Yes; but that class of patient I think might be left to be looked after by male attendants; but in connection with their amusements and entertainments these can still be supervised by women. I think that a woman should be the head of a department that looks after that class. Then there are other wards where the patients are more uncertain, they may perhaps at times be excited, or perhaps impulsively do some act of violence; in these wards there should always be attendants; the majority of them should be male attendants; but even there I think that a woman should be the head of the ward, to see that there is no harshness or roughness of any kind. I think women should be present in every ward, but they are most suitable in the hospital wards, the wards where there are infirm patients, weak-minded patients, quiet patients, or melancholic patients, for instance.

16,065. Can you tell me how in practice men like having a woman over them; do they not resent it at all?—When the system is introduced for the first time the men do not take to it well, especially if they have not been accustomed to it, but after a time it works very successfully. The women who are placed in charge are selected women, and the men treat them with a remarkable degree of respect. I was very much afraid myself, when I first of all introduced a matron on the male side of an asylum, as to how the men would receive her, and I wrote to the Commissioners on the subject, asking whether they thought it was an experiment I might try, and they said, "Yes, try it," and there was no official I ever appointed who was better received than that particular woman, because of herself; she was a tactful woman, and they respected her. The men get accustomed to it in exactly the same way as a woman of means who has a house and has a chauffeur and other men under her.

18 April, 1925.]

Professor GEORGE M. ROBERTSON, M.D., F.R.C.P.

[Continued.]

16,066. They recognise her competence, too, I suppose?—Yes, they recognise her competence.

16,067. *Chairman*: Of course, during the war, and indeed I suppose in military hospitals generally, you had the nursing sisters and you had the male orderlies?—Yes.

16,068. And that system seems to work very well?—Yes.

16,069. *Earl Russell*: Do you allow your men and women patients to associate together for recreation?—There is a weekly dance in practically all asylums.

16,070. I mean in the evenings, to walk about the grounds, to play bridge, and so on?—We have bridge parties. They are allowed to invite patients to one another's wards.

16,071. And you find that has a good effect?—Yes, but they do not mix at large.

16,072. *Chairman*: It seems to be the consensus of opinion among the resident medical officers of asylums in Scotland that the employment of female nurses is beneficial, because appended to your article from the *Edinburgh Medical Journal* of March, 1916, of which you have favoured us with a reprint, there is a memorial sent on the 8th March, 1920, to the General Board of Control, which says this: "We, the undersigned, being members of the medical profession, engaged in the care and treatment of the insane in the asylums of Scotland, consider it our duty to bring to the notice of the General Board of Control, the District Boards of Control, and the Boards of the Royal Asylums, our opinion that the nursing and care of male patients, especially of those who are sick and infirm, by female nurses is primarily and essentially a medical question, and that the declared policy of the Union officials to get rid of nurses so employed and replace them by male attendants is a retrograde step against the best interests of the patients, and an interference with the discretionary powers of asylum medical officers. Should any action be taken by the Executive of the Union to give effect to above policy, as has already been done in England, it is our earnest hope that it will be firmly opposed by all authorities responsible under the lunacy laws for the care and treatment of the insane in Scotland." That memorial apparently was signed by 65 persons representing all the resident medical officers of asylums in Scotland?—That is so, yes.

16,073. This project of the increasing employment of women has been opposed, has it not, by the Union of Asylum Workers?—Yes, it is one of the planks in their programme.

16,074. One can appreciate why—because of course the introduction of women will ultimately mean the displacement of a considerable amount of male labour, will it not?—That is one of the reasons, yes.

16,075. *Earl Russell*: Is it not the only reason?—No. I think one of the reasons they stated was that women make bad trade unionists. Then, of course, they assert that it is improper work for a woman to do. It all depends how it is done. The attempt to introduce women on the male side for nursing purposes has been tried for about 80 years, and for many, many, years the attempt failed, owing to the difficulties; but then the mere fact that the attempt was made over and over again showed that there was some principle underlying it which forced people to attempt it, and in the end the happy solution as to how it should be done was found in Scotland.

16,076. *Chairman*: Of course, if the interest of the patients, in the opinion of the medical profession, is best subserved by female nursing rather than male nursing, I imagine that no interests of trade unions or anybody else should be permitted to stand in its way, if that be the true view?—That is so. The Board of Management of the Morningside Asylum offered to recognise the union. Our Board is a very strong legal board; there are three K.C.'s on it. We had Sir John Rankine, a professor of law, also a

member, and he said: "Trade unions are perfectly legal; in fact, they are encouraged by the Government, therefore we should recognise these trade unions," but the Union stated that they regarded this question not as a medical question, but as an economic one, and that we should put it down. My Board said that they would recognise the union if it did not interfere with female nursing, that that was to be put into the category of medical treatment, and that broke up the union. Then the Union also, I think, saw the District Boards of Control of all the district asylums that had recognised the Union, and put their case before them, but in Scotland the benefits of female nursing are so thoroughly recognised that the District Boards of Control refused to depart from their practice.

16,077. *Miss Madeleine Symons*: I suppose the women are paid considerably less than the men—which may be one cause for apprehension?—Yes, they are paid slightly less than the men, according to the proportion that the Asylum-Workers' Union recommends itself; but there is really no saving made by the introduction of these methods, because you have a larger number of women, and in Scotland we have introduced a much larger number of hospital nurses, and also a larger night staff. The whole hospital idea which accompanies the introduction of women has entailed a certain increase of expenditure.

16,078. *Earl Russell*: Is this also true with regard to rate-aided institutions?—Yes.

16,079. They also have larger staffs?—Yes, practically the same.

16,080. *Mrs. Mathew*: Might we know what is the proportion of nurses to patients?—That varies a very great deal. For instance, at Craig House, amongst private patients there are two nurses to every three patients; and in the nursing homes there are twice as many nurses as there are patients; but among the poorer class of patients there is about one nurse to every eight or so.

16,081. *Chairman*: Then as to the medical staff at Morningside, how many doctors have you altogether?—There are really altogether, including myself, seven doctors attached to the institution; one of these is a pathologist, and one of these is my deputy.

16,082. Then you have seven doctors there for 800 patients?—Yes.

16,083. It would appear then that both on the medical side and on the nursing side you are very much more amply staffed than the institutions we have been hearing about here?—Yes. Then, in addition to that, I have unpaid medical men who are gaining experience—whom we call clinical assistants; usually two qualified doctors and two unqualified doctors in addition.

16,084. *Earl Russell*: But they are not actually of much assistance in running the establishment, are they?—They are not much use for the first six weeks, but after that they are of use, and they can do a great many routine medical duties, such as the physical examination of patients, and so on.

16,085. *Chairman*: You have a couple of young residents, I suppose, just as the doctors in the general infirmary have?—Practically that is so. We have got two, and in recent years a considerable number of these have been women. Women have had great difficulty in getting posts, and they have begged to be taken on, and we have always had several qualified women remaining while they learn the work, and then that enables them to get appointments in other asylums. Of course, there is a great advantage in being so close to a University like Edinburgh.

16,086. Did you find you had actually to displace any of your male nurses who were earning wages with you?—I have never displaced a single person in an asylum to introduce a new method. For instance, just now only one half of the asylums have matrons over both sides; that is because they are waiting till the head attendants on the male side resign.

18 April, 1925.]

PROFESSOR GEORGE M. ROBERTSON, M.D., F.R.C.P.

[Continued.]

16,087. I could see, of course, that there would be very natural objection to the displacing of male attendants in favour of female attendants, but has the practice been to await resignations or deaths before substituting women?—Yes, the practice has been to await resignations.

16,088. So it has not been a case of individual hardship in any instance; but it is the general principle that you advocate?—Yes, that is so. I have not asked a single person to resign his post.

16,089. I suppose in the end of the day it just comes down to this, that the special qualities of women's natures suit them for the work of nursing in a way which occurs only rarely in a male?—Yes, they must have some fundamental advantage which enables them to do the work better than men.

16,090. And just as most women, I understand, prefer to be treated by male doctors—that has been rather one's experience—so on the other hand every man would rather be nursed by a woman?—Yes, of course that is quite true. Long before female nurses were introduced generally, it was found that occasionally male patients who refused to take their food would take their food from a woman, and a woman would be brought over from the female side to feed the particular patient; in the same way as a female patient will take her food from an assistant doctor when she will not take it from one of the nurses.

16,091. Now let us pass to another matter. You have favoured us also with a pamphlet which contains three papers by you: One on "The Hospitalisation of the Scottish Asylum System"; one on the "Treatment of Mental Excitement in Asylums"; and another on "The Use of Padded Rooms and the Practice of Locking-up Patients by Day in Single Rooms." The question of nursing by women, which you have been dealing with, is of course closely associated with the hospitalisation idea?—Very closely associated.

16,092. Your idea is as far as possible to remove the conception of a place of detention and to substitute the idea of a place of cure?—Yes, to try to introduce the hospital idea, like the great voluntary hospitals, and there is no better way of doing it than by introducing female nurses.

16,093. Not only by reason of the fact of their sympathetic attitude, but also because of the influence which they bring and which permeates the whole establishment?—Yes.

16,094. Which makes it seem less official, I suppose?—More domestic and homely, yes.

16,095. Then certain other features are alluded to by you as indicating progress in the hospitalisation idea. In Scotland I think what is known as an airing court—something like the prison yard in prisons—has been entirely abolished, has it not?—Practically abolished.

16,096. How has it been possible to do that?—Well, the ideal was to have the asylum as little like a prison as possible, and it was discovered first of all by Sir John Sibbald, when he was at the Argyll and Bute Asylum. When one of the walls of his airing court was being taken down for extension, his patients did not escape, and he thought how much better it would be if the patients were not confined in the airing court, but were allowed to walk about the estate in walking parties; and therefore he introduced that system, removed all his airing courts, and since then in practically all the asylums of Scotland there are no airing courts built, but the patients walk about the grounds.

16,097. Attended?—Always attended, except those on parole.

16,098. In that way again you give a greater sense of freedom, of course?—Yes.

16,099. Mr. Mickle: Have you not a number of refractory patients who must get some exercise, and yet cannot be kept in the general grounds?—That, of course, is a question one is asked constantly. I was

asked it a fortnight ago by a deputation from England.

16,100. Chairman: And what is the answer?—Well, we are able to take very nearly all the patients out into the grounds. These refractory patients seem to be fewer with us than they are elsewhere, and I attribute that in part to the treatment that they receive.

16,101. Earl Russell: A really refractory and noisy patient you keep in bed as a rule, do you not?—Yes, but we have them in bed usually in the open air, on verandahs.

16,102. Chairman: Does it come to this, that you can give exercise to all the patients in your establishment who require exercise in the grounds at large, with proper supervision and attendance?—Yes, but there are some very acute cases with whom it would be a perpetual struggle to take them round the grounds.

16,103. But you would not have taken these round the airing court either?—No.

16,104. Mr. Mickle: You would not have allowed them out in the airing court?—They are outside in bed, on a verandah. The verandah system, the open-air treatment of the insane, is adopted to a very, very large extent, and the first thing that is done to all our patients is to put them out in the open air. I think that very few people become insane, however strong their hereditary predisposition is, provided that their general health is good. The result is that even if they are subjected to very severe strains, if their general physical health is good they stand it, but if their general physical health is not good, then they break down mentally. They come to us, and we put them out in the open air, which is the best tonic you can have, and the cheapest tonic; and that is the first step to recovery.

16,105. Sir David Drummond: Have you many epileptics?—No, we have very few epileptics in Scotland.

16,106. Can you account for that?—As you go southwards the number of epileptics increases. You have not so many in the North of England as you have in the South.

Earl Russell: Is it a diet question, do you think?

16,107. Chairman: Or climatic?—I do not know what it is.

16,108. That point is important, because if you can do away with the feeling of constraint in the airing courts, and give the impression of liberty to go about in gardens and parks under attendants, you foster the idea of the place being a hospital rather than a place of detention?—Yes.

16,109. And it is a fact that all those patients who formerly would have been exercised in airing courts are now exercised in the open grounds of your institution?—Yes, practically all. There is some good in an airing court for particular cases, but the airing court system is a bad system.

16,110. As a system?—Yes.

16,111. Have you any airing court at all at Morningside?—I have one small piece of ground of about a quarter of an acre, which is enclosed, which might be regarded by some as an airing court.

16,112. Is it used to any extent by you?—It is very seldom used as an airing court. It has a verandah in it, and there are patients out in the air occasionally.

16,113. What type of patient do you put there?—They are restless and excited patients. For example, say it is a female patient; a patient who may suddenly denude herself and rush somewhere—this is a sort of enclosed space where no one would see that.

16,114. It really comes to this, then, that for the ordinary purposes of exercising patients there should not be airing courts at all?—That is so.

16,115. But you may need to have a part of your grounds set apart and enclosed for special cases which present difficulty?—Yes. The system is a bad one, although the individual airing court may be good.

18 April, 1925.]

Professor GEORGE M. ROBERTSON, M.D., F.R.C.P.

[Continued.]

16,116. Then I think, further, another step in the same direction has been achieved in the introduction of the open-door system?—Yes.

16,117. Is that to free people from the sense of constraint by locked doors and keys?—Yes. Of course there also have been people who have tried to work the whole asylum without locked doors, but now the majority of doors are locked. There are, however, a certain number of convalescent wards and villas and so on which have no locked doors at all.

16,118. And is there promotion, in your establishment, from places of greater to places of less restraint?—Yes, and the patients get parole—freedom to walk about the grounds as they please, and then afterwards parole to go into the town.

16,119. But you cannot altogether dispense with some locked rooms or locked wards?—I think you cannot altogether, without putting a tremendous strain upon the staff. The doors would require to be watched to see that the patients did not go out of them, and I consider that that is an unnecessary thing to do; so that a certain number of the wards have locked doors; but there is no patient in the asylum locked up in a single room.

16,120. We will come to that later; but the open door system generally is the system which favours as much freedom as possible, and as little closing and locking of doors?—Yes.

16,121. Then another point is the practical abolition of the padded room and the solitary confinement room?—Yes.

16,122. Upon that I think your experience in Scotland, and particularly in your own institution seems very remarkable. I gather that you have not got any padded rooms at Morningside?—No. There is one room which has not been dismantled, which is full of old furniture and things of that kind.

16,123. But it is not in any use?—There is no place in use, no.

16,124. Have you none of those rooms, which all of us have seen in asylums, either a padded room or a room with nothing but a mattress on the floor of it, and a high-up window and a door that can be locked?—There are no rooms of that kind. There are rooms which a patient can be put into, and a shutter put up, but every one of the rooms has got a handle on the door inside, and they are not locked up in the room.

16,125. By day or by night?—By day or by night, yes.

16,126. So that may I take it in your institution no patient is ever locked in a room himself alone, either by day or by night?—There is no locked seclusion at all.

16,127. *Earl Russell*: What would you do with a patient who is extremely violent, and trying to knock her head about and likely to do herself a serious injury?—There is no person I have seen for the last twenty years who has been trying to do that, except for five minutes. I had a melancholic patient who ran his head against a stone wall and tried to batter down the wall. That was done impulsively, but it was done and over. I have, however, never seen a patient carry the thing on for any length of time. There are patients, of course, who say that they will commit suicide. These are looked after by the staff, as they are in all places. We have in Scotland a very large night staff, and these patients are put under special observation at night, perhaps with a special attendant.

16,128. That is rather the point I was coming to. You have to watch them all the time?—Yes, we do.

16,129. I am thinking of a patient I saw the other day, in a padded room, who was prepared to commit suicide if given the opportunity then and there, by jumping out of the window; that means a considerable increase in the number of attendants?—I would not say considerable, but it certainly means an increase in the number of attendants. The whole method of progress consists in this, and 100 years ago all the restraint that was employed was used because

they had one attendant for from 30 to 50 patients; they had to tie up all the patients, use chains and lock them up; now we are gradually increasing the number of staff. Up till about 1837 very large numbers of patients were restrained in mechanical apparatus. They increased the staff and did away with the mechanical restraint, but Conolly, who was one of those who gave up restraint, introduced the secluded room. Now we have done away with the secluded room in Scotland by having some more staff, a still larger staff. Then we find that as you go on using these methods of care the patients gradually become quieter and quieter, and there is less and less of this sort of thing required.

16,130. Would you make the same objection to the use of hyoscine?—No. I would not. I would object to hyoscine being used continuously.

16,131. That is a form of chemical restraint, is it not?—Yes, it is. Hyoscine should never be used continuously, but it is exceedingly valuable in cases of emergency. Supposing a man has a tremendous outburst: you can give him an injection of hyoscine and control him, and then, if he is treated properly, two or three hours afterwards, when he begins to wake up, he is quite different. It overcomes an emergency.

16,132. You would not give him a daily dose or two doses a day for a week?—I would not say that in an exceptional case I would not do that, but I scarcely recollect having done it. I think that would be quite legitimate in certain cases.

16,133. *Chairman*: I think you put it in very well-considered language in one of the addresses I have here. It is on page 3 of the second paper, "Treatment of Mental Excitement." You say: "I intend, in the first place, to refer briefly to the treatment of mental excitement, which is a direct symptom of such diseases as acute mania, agitated melancholia, and delirious insanity. In these diseases sedative drugs are often employed, and as their use is condemned by some, the advantages and disadvantages of their employment may be mentioned. It is admitted by all that their employment is undesirable, and that when used for their sedative effects, it is on the principle of the choice of the lesser evil. It is also admitted that they are liable to abuse, that they should never be given at the will of nurses or attendants, and that their effects should always be supervised by medical men. They should never be administered in increasing doses with the object of completely controlling all signs of excitement, but they should be used merely to tone down the symptoms within manageable or safe limits, and they should only be administered for short periods to tide over a dangerous or acute exacerbation. With these precautions I have not hesitated to employ sedatives, but there are some who totally abstain from doing so. It appears to me that the toxic theory of the causation of insanity which is now being so widely accepted does not support a policy of abstention, for if there be a circulation in the blood of toxic agents acting injuriously on the brain, surely it is in accord with the fundamental principles and practice of medicine to administer an antidote, either chemical or pharmacological." I should think that that probably represents your considered opinion in the matter?—Yes.

16,134. *Earl Russell*: A sedative is not an antidote, surely, is it?—If the excitement is caused by poison in the blood, it is an antidote. For instance, if you have a person suffering from excitement caused by an overdose of strychnine, and has convulsions, you give him chloral.

16,135. What I expect you mean is that it is better to use even a strong sedative like hyoscine than to have anything like a physical wrestling with a patient?—Yes, but not to give that as a daily dose.

16,136. Not merely to give it in order to save trouble to the attendants?—No.

18 April, 1925.]

Professor GEORGE M. ROBERTSON, M.D., F.R.C.P.

[Continued.]

16,137. *Chairman*: That is the proper use of drugs in the treatment of excitement. Do you also commend the use of baths as a calnative?—Yes.

16,138. And also rest in bed?—Yes. There was a great discussion about the usefulness of rest in bed about 30 years ago. It was really introduced by the French—"alitement," they call it. There was great opposition shown to it at first, but it is shown now that when a patient is put into bed he naturally becomes restful and quietened; he is without his clothes; he is not irritated; there are not people interfering with him, nor can he disturb others, so that it is a very useful method of treating a patient.

16,139. But coming back to the hospitalisation conception, of course the padded room and the secluded room are features quite foreign to the idea of a general hospital; you do not have them there at all. It is all in the same line of development, that you have succeeded in eliminating them from your mental hospitals?—Yes.

16,140. And you have been able to do that, as far as I can see, for two reasons: first of all by substituting attendance for seclusion—that is the first thing?—Yes.

16,141. And then by finding that when you did away with the seclusion and the restraint the occasion for it seemed also, oddly enough, to diminish?—Yes.

16,142. So that it does not mean you have the same volume of restlessness and the violence to contend with, because the very abolition of the means taker to restrain them seems to have reduced the occurrence of such symptoms?—Yes.

16,143. *Earl Russell*: To some extent you treat them on the same principle that a man gentles a horse?—Yes. Once a German came round the asylum at Stirling, and he asked me if I used baths for excited patients. In Germany they have a great number of baths, and pictures painted on the ceilings, so that patients can look at them. I said, "No, we use them very seldom." He went round the place, and he said, "I see now why you do not have baths. You have not got any excited patients."

16,144. *Chairman*: There is one sentence which seems to me to sum up this position in a word or two. It is in the paper on the "Treatment of Mental Excitement in Asylums," page 2: "There is no doubt that the better treatment given nowadays to cases of acute mania, as compared with the past, is the chief reason why the disease now appears to be of a milder type than in the past." You have found, have you, in your experience, that there is less excitement and less violence and less noise among the inmates of your institution as time has gone on, and these methods which you have mentioned have been adopted?—That has been my experience, and the experience of everyone, that the amount of excitement—acute excitement—is less than it used to be.

16,145. Now on that, in the second and third papers included in this pamphlet, you deal with the causation of irritation in mental cases. Is a great deal of the violence, where it does occur, due to the fact that the patient is suffering from some form of irritation?—Undoubtedly a great deal of the excitement is due to some cause.

16,146. It may be antipathy to a particular attendant, or it may be difficult to find what is the exciting cause, but I suppose when you have accessions of rage or noise or excitement on the part of the patient it must be attributable to some cause, if you can find it?—Yes, that is so. If you take the trouble to investigate—and it is not very difficult to investigate—you will probably find it traced to some cause. For instance, a female patient may be excited and angry because another has a new dress, and she has not got one.

16,147. *Earl Russell*: That which is insane is not necessarily causeless, for that reason?—No.

16,148. *Chairman*: Will you just develop that point, Dr. Robertson?—I think that a failure on

the part of nurses and doctors as well in the past was that if a patient were excited they regarded that merely as a symptom of the disease, to be treated by drugs or in some such way. But after observation, I came to the conclusion that a great many of these cases of excitement were due to some form of irritation the patient had received—if one would only take the pains to find out what it was.

16,149. And they may be abnormally susceptible to trivial causes, which may cause excitement, just because they are in an abnormal condition?—Yes; many of these patients are excitable, and with quite innocent causes too,—things that any person might do without any intention of doing harm.

16,150. If you have sympathetic attendants and good medical men in charge, should it not be their business to try to find out in each case what is the cause of the disturbance, where disturbance takes place?—They do do it. Possibly they do not do it as much as they might, but certainly that should be a part of their duties, to try and find out and to remove all the causes of the excitement.

16,151. And in that way you would be able to eliminate the element of disturbance which you have at present in the asylums, or at least to modify it?—Yes.

16,152. I wish you would give us one or two illustrations within your experience of instances in which the cause of irritation has been discovered, and, when removed, the disturbance has ceased?—For example, one of my assistants found some three or four nurses holding a patient and struggling with her—struggling violently. He went up to find out exactly what was happening, and he was able to discover from the remarks the patient had made that she thought that the gas had been turned on—the gas taps in the house—and that there was a danger of an explosion.

16,153. That is what the patient imagined?—Yes, and the patient imagined that she was in her own house. The doctor very sensibly said, "I will take a look round and see the gas taps." He went away for a minute or two, and came back and told her the gas taps were all right; he had turned them all off. She at once got quiet and lay down, and there was no more trouble.

16,154. That was a method of humouring the case, whereas if you had simply contradicted her you might have got a further access of fury, I suppose?—Yes. Again there are persons who would say, "This is an insane idea which the woman has," or they might have gone on holding her, and she might have gone on struggling, and in some cases they might have put her in a padded room. That is a case where a little sympathy is better than using drugs and restraint.

16,155. *Earl Russell*: She was struggling for the perfectly rational reason that she thought she was going to be blown up?—Yes. It has been said, of course, that insanity is proper reasoning from false premises.

16,156. *Chairman*: Supposing a child said, there was a bogey coming in at the door: the mother would go and look; she probably would not smack the child; having looked, she would say, "It is all right," and the child would probably fall asleep?—Exactly. For instance, I remember that in the case of a demented patient it was discovered that her teeth were bad, and after investigation was made we found that the patient was excited and disturbed and irritable as a result of tooth-ache or neuralgia. The teeth were attended to, and this excited, troublesome patient, after that became perfectly quiet. I remember another instance in which a patient was very noisy at night, and the night superintendent went round one night—they usually go round with sweets and biscuits about them, to give to any patient—and she gave this patient a biscuit, and thought she ate it rather ravenously. She gave her some more, and the patient was quiet, and from that time onwards that patient got biscuits at night, and she was always

18 April, 1925.]

Professor GEORGE M. ROBERTSON, M.D., F.R.C.P.

[Continued.]

quiet after that. Apparently for some reason she was hungry at night and restless and could not sleep.

16,157. These are instances of the study of the idiosyncrasies of the particular patients, humouring them, and so avoiding these scenes which one hears of at times?—Yes.

16,158. Surely there must be room for the development and improvement of treatment along those lines?—I think there is no doubt about that.

16,159. And is it because you have been working along those lines that your happy experience has been a diminution of violence in your institution?—Yes, and because I have had such a well-trained staff under me, who are interested in these subjects.

16,160. Take the case you have been describing. If that case had not received sympathetic treatment, then I suppose there would have been more struggling, and then restraint, and restrained struggling produces still more violent efforts, and the case would have been a padded room case before the day was over?—Yes, and all regarded as due to the disease.

16,161. Whereas it would have been really due to unskilful or unwise treatment of the case, or at least unsympathetic treatment of the case—want of insight into the case?—Yes.

16,162. I see you refer to the phrase, which sometimes one hears, of "the asylum-made lunatic." It may well be that treatment along the lines which are lacking in insight and sympathy tends to exacerbate rather than cure a patient. May not that be so?—Yes, I think so. Of course, I think the phrase is abused.

16,163. After all, if one may use a homely simile; a dog that is always tied up by a chain is a much fiercer dog than one running about the place?—About 35 years ago there was an illustration of this in a comic paper, and I cut it out and sent it to the Commissioners in Lunacy.

16,164. The mere imposition of restraint is one of the things which is felt to be most galling by the patient?—Yes.

16,165. And in turn may produce the irritation which you find?—Yes. Of course, this must be remembered, that with regard to all these things, although evil in the bulk, there is something to be said for every one of them. I mean the airing court, for example, has certain advantages. The padded room, in a few cases, may have advantages. Restraint, in special cases, may have advantages, and it is used not uncommonly in what we call surgical restraint, where a person suffers from a surgical injury, and would injure himself if he got a chance.

16,166. *Mr. Micklem*: How did you deal with the lady who objected to the other one's dress?—It is very difficult, because if you had given a new dress to her, there would have been another two who wished new dresses.

16,167. *Chairman*: How did you deal with her? It might be useful for some of us to know how to deal with such a case.—The answer is that you must not deal with two cases alike. You have to think out the individual case, and how to deal with it, and act accordingly. No two people are dealt with alike.

16,168. I suppose you would deal with it on the principle of what Dr. Chalmers called "the expulsive power of new affection," and try to distract the attention of the person to some other interest?

16,169. *Earl Russell*: I should like to go back to the judicial authority. Just let me outline to you the procedure that takes place in the case of pauper patients in one of the London workhouses. The magistrate attends there and he sees the patient, either in bed, or the patient is brought in. He has a look at him, asks him if he wants to say anything, and then the patient is taken away again. There is no excitement, and no prolonged examination. He sees the certificate before him, he sees the relieving officer, and hears from him such particulars of the case as he has been able to get, and sees any of the relations who choose to turn up. Not until he has

gone into all those things does he sign the order. Do not you think that that affords some little protection and assistance, both to the patient and to the friends?—I think it is most excellent in these respects.

16,170. I mean it is neither upsetting to the patient, nor is it a farce.—No, I think it is a very thorough system, only I would wish it to be not a judicial authority.

16,171. You mean you would rather it was a person not a magistrate?—Yes.

16,172. But some outside person?—Yes, I certainly think there should be another person.

16,173. Is the reason you object to the magistrate the association with the police court?—Yes. Treatment should have as little to do with that sort of thing as possible.

16,174. What is your view about the administration of aperients in asylums, and particularly about croton oil?—Certainly it is absolutely necessary to attend to the state of the bowels; there is no doubt whatsoever about that; and great amelioration of the symptoms very often results from careful attention to the bowels and the liver. What aperients you use, of course, have to be determined by reference to the patient you are attending to, and usually one adopts what the patient himself or herself has been accustomed to.

16,175. You would not be in favour of a standardised weekly dose being administered to a whole ward in line?—No.

16,176. That is the practice in some places, you know?—I know it is done.

16,177. It is not really medical treatment?—No. Then with regard to croton oil, of course, croton oil has its use. One of the members of my Board was going round the asylum the other day, and we passed the dispensary, and the dispenser was in. Just by way of a joke, I asked her: "How often have you dispensed croton oil?" and she said, "Once; I have been here five years, and I have dispensed it once." I remember ordering it in one of the nursing homes in another case; and there are cases where croton oil is the best remedy to use. (When a person is unconscious, you can take a drop of croton oil and a drop of glycerine, put it in the back of the throat, and it will have effect when there is almost no other purgative that you can give. As a purgative used legitimately it has its uses.)

16,178. But you think once a year would be the sort of limit?—Yes, and it is in only one or two cases where it is required.

16,179. 5,000 doses in a year in any asylum of 2,000 patients you would think rather remarkable?—Yes.

16,180. There is only one other question I want to put to you, but it is a very big one. What is your view about the sterilization of lunatics, if you are going to let them out at large?—I think it is a horrible idea altogether.

16,181. You would be entirely opposed to it?—Most certainly.

16,182. Do not you believe that lunacy is hereditary?—Yes. I think too much is made of heredity. I would educate the public as regards marriage, by advising a person who has got nervous disease in the family to make a point of marrying into another family in which there is no nervous disease.

16,183. That is a long way to go in the education of the general public, is it not?—If you are not in too great a hurry, I think that some day or other that will be reached.

16,184. A generation or two, at least?—I have been consulted very frequently about the marriages of people—the better educated classes.

16,185. But what about 90 per cent. of the population?—With regard to them, of course, there may be a difficulty.

16,186. *Sir David Drummond*: Have they taken your advice, doctor?—No, they have not always taken my advice; that relieves the responsibility very greatly.

18 April, 1925.]

Professor GEORGE M. ROBERTSON, M.D., F.R.C.P.

[Continued.]

16,187. *Earl Russell*: In any case you would be completely opposed to compulsory sterilization?—I would.

16,188. Would you say on what ground?—You talk about interfering with the liberty of the subject; you are interfering with something just as important as the liberty of the subject; and I do not think any doctor would be justified in doing an action of that kind. I have known of it being done. I have known patients with religious scruples asking to have the thing done, and I have known it done, but I myself have dismissed it absolutely from my conception as a practical measure at all; and much of the harm that is done by heredity is cured by nature itself, because the vast majority of the persons who inherit a very strong tendency to insanity become insane before the ages at which they marry—before 25 years of age.

16,189. That does not apply so much to the feeble-minded cases, does it?—No; feeble-minded cases are a difficulty; I would segregate them.

16,190. *Chairman*: Just on that question, I know that in connection with the administration of the criminal law considerable difficulty arises in this way, that if you let out patients on parole or probation, or if they escape and are not followed up, you are very liable to have attempted suicides and so on taking place, which creates one of the difficulties in giving the freedom which it is so desirable to give at as early a moment as possible. The tendency to commit suicide?

16,191. On the one hand there is the desire to let the people regain their freedom as soon as possible, and on the other hand the risks attendant upon it, that they may do foolish things, or even criminal things?—Yes; well, of course, that has to be considered by the superintendent before he discharges a patient. If he thinks there is a strong probability that the patient will do these things, then he will not discharge him. On the other hand, if he thinks the possibility is a very remote one, then he just takes the risk.

16,192. Then apart altogether from anything criminal, if a patient is sent home on parole, not completely recovered yet, but if sent home, be it a man or a woman, it is very liable that sexual relations may be established?—Yes.

16,193. And not always with the most desirable results, I should imagine?—That is so.

16,194. You cannot ensure that such will not take place?—No, you cannot, and of course in such cases as these one has to do one's level best with the patient and with the wife and with both of them in the matter. We may avoid sending patients out on probation; it is within the discretion of the doctor—probation or pass—if there is a danger of that kind, but of course I have known of it being done.

16,195. *Earl Russell*: Are there not a considerable number of women detained in asylums, who need not be detained if you were sure they would not breed?—No, I do not think there are many detained for that reason—any more than a man is detained because he would go and get drunk.

16,196. *Chairman*: I really think we have covered all the ground that you have put before us in your *précis* and in your papers. If there is anything else you would like to bring before our notice, that we have not touched upon, we should be very glad to hear you upon it.—I do not think I have anything to add.

16,197. *Mr. Micklem*: If I understand you rightly, Dr. Robertson, you think that the padded room or seclusion, may in some very special instances be useful and possibly necessary, but, speaking generally, unnecessary in an asylum at all?—Yes.

16,198. What I want to put to you is this. In the little experience I have of asylums there are padded rooms to be found in all of them, and seclusion rooms. Do you find a substitute for those by putting the patient to bed and giving him a sedative?—Not necessarily. There are excitable patients who are put to

bed, and there are excitable patients who get sedatives; so there are also in these asylums which have padded rooms; as a matter of fact in my asylum, and in a great many other asylums—for instance, the Woodilee Asylum, one of the largest in Scotland, which has been established for more than 40 years—there is no padded room.

16,199. *Chairman*: What do you do, without it?—Probably put the patients to bed, have them out in the open air, and have an attendant in charge of them, and they might have sedatives.

16,200. *Mr. Micklem*: Usually it would be hospital treatment instead?—Yes, and personal attention—the patient would have a special attendant.

16,201. *Chairman*: And you would put them some times in a room by themselves?—Yes. If it were found to be unmanageable to have him outside, he might be put in a room by himself, with an attendant either there or at hand.

16,202. *Mr. Micklem*: As far as you could, you would treat those cases in the open air, I understand?—Yes, as far as possible, during the day time. No person would be locked up in a room with nobody near him; he might be put into a room and have some person keeping observation upon him.

16,203. *Chairman*: It would not be one of those rooms with merely a mattress on the floor?—No, the room would be an ordinary bedroom.

16,204. *Mr. Micklem*: It seems to me very largely a question of attendance; it is a question of expending money, really?—Yes, you have to increase the number of attendants, and also the number of the night staff. The greatest number of these people are put into these rooms because there is an inadequate night staff. They are well looked after during the day, and during the night time there is a small staff. How are they to be looked after? They are put into single rooms and locked up. That is not the best way of looking after them.

16,205. *Chairman*: You give a striking example on page 2 of your paper: "On one occasion I ordered an adolescent girl to be placed in the padded room. For several days afterwards when I visited her I received tales of her excitement and violence, and the number of nurses it took to control her when she was fed, washed, etc., so that any suggestion of mine for her removal from the padded room was instantly set aside as a demonstrated impossibility. One of the nurses, however, came to me privately, and under promise of secrecy told me I was being systematically deceived by exaggerated reports, and that there was nothing to prevent the girl leaving the padded room. This was a lesson on the weakness of human nature where selfish interests are involved that I have never forgotten. So fully realised, however, is the danger of abusing this form of treatment that the authorities most properly compel us to keep a written record of it in our registers." That was a case where it was much easier just to put the patient into the padded room, rather than to give the individual care and attention that the case should have got?—That was brought home to me very impressively. I went from one asylum to another where there was no padded room, and I found a totally different set of ideas among the staff. In the one asylum, when the patient became excited, the padded room was suggested; in the other asylum, all sorts of expedients were tried to get over the difficulty. You have got to use your brains, instead of simply putting the person into the padded room. Supposing you have a maniacal girl, very restless and excited, singing and shouting; if at night you put that person into a room and lock the door, it becomes dark, she rushes about, denudes herself, soils herself, sings and shouts and hammers on the wall, and you are undoing during the night time all that has been done during the day time—a sort of Penelope's web.

16,206. I am rather struck with this aspect of it: the patient goes into an institution for the first time, possibly an intelligent case, highly strung and unbalanced and upset. May it not often

18 April, 1925.]

Professor GEORGE M. ROBERTSON, M.D., F.R.C.P.

[Continued.]

happen that that patient, being brought for the first time into the atmosphere of an asylum, and seeing other cases afflicted in the same way, may find it very upsetting?—It might be upsetting if she is put amongst any class of patients, who are noisy and violent. In many of the hospitals that have been built in Scotland they have had a special set of receiving rooms provided, where a new patient is, as it were, broken in to the idea of being in the asylum, and is kept apart from the other patients; but as a general rule the condition of the patient is seen at first, and she is placed among a group of patients who are more or less in the same condition.

16,207. Then you would not allow the putting of a highly-strung, nervous person into a room or ward where she would hear unpleasant sounds, noises and shouts and so on, would you?—No.

16,208. I can imagine that that would be most detrimental?—Yes, it would upset the patient very greatly.

16,209. Do you in practice see that such cases are not exposed to those distressing circumstances?—Yes. Whenever a patient comes, it is always considered what part of the institution she should be placed in, and we have for the melancholic, sensible, quiet patients, for instance, a particular place.

16,210. Classification from the outset?—Yes. You have a very good idea, just by seeing the patient, and of course you have certain reports regarding the patient when she comes in, and we like to have a relative come, always, to give us a history of the case.

16,211. One has read of distressing cases of people who have gone in and who have been very much terrified and frightened at first, and had restless nights, because they heard in adjoining rooms people crying out and so on. Even to a sane person, that is depressing, but to a mentally afflicted person it may be the worst thing of all?—It may be upsetting at first, if precautions are not taken.

16,212. You agree that precautions ought to be taken to see that patients are not exposed to those surroundings?—Yes. There is no question that classification of patients in an asylum is a very important item, and the best classification can be had in the larger institutions. Where you have a small institution, with only about 12 or 14 patients, you have only one or two places to put the patients into. If you have a larger institution where you have 20 places, with the patients all classified, the result is you have a better opportunity of putting the person in the exact surroundings that suit him.

16,213. *Miss Symons*: On almost the same point, where you have to separate a noisy patient, not in seclusion, but in a private room, do you find that the institution is so constructed that the noise cannot be heard elsewhere?—As far as possible.

16,214. We have all noticed that in some cases.—Noise is one of the greatest difficulties in an asylum, after introducing all these hospital ideas. I mention it in this report; that is one of the greatest troubles. Most modern institutions have been built with quarters where a noisy patient can be placed so as not to disturb the others, and we have not reached finality in that ourselves. Only last week I was discussing with the matron and my deputy how we could provide a detached building where a noisy patient could be placed; but to separate a noisy person is a very important point.

16,215. *Sir David Drummond*: How can you obviate that in private homes?—We do not take any noisy patients in private homes. If a patient becomes very noisy in one of these private homes, then he is unsuitable for the homes, and we have him put into an asylum.

16,216. At once?—Oh, yes. Homes might be built where you could put in these noisy persons, but none of the homes we have can take in a very noisy patient.

16,217. In the case of a home that can accommodate 10 or 12 patients, even by raising the voice you would hear it all over the house; it is not necessarily

a very noisy patient that would disturb the others?—These 10 or 12 patients do not disturb each other. Then with regard to the poor people, these psychopathic hospitals should be substituted to take the place of these homes, and observation hospitals for the poor should be established, where voluntary patients could come in. At Morningside we have proposed to have a detached building where the rate-aided patients can come without coming into an asylum, *i.e.*, a psychopathic hospital.

16,218. *Miss Symons*: In the parishes where they do pay for voluntary rate-aided patients, how do they decide where they shall be sent—on a doctor's certificate?—Their own doctor—not the certificate.

16,219. The doctor's advice, I mean?—Their own parochial doctor recommends that the patient should have this treatment.

16,220. There is no difficulty about that? The patients who need it get it, in so far as the parish has voluntary boarders at all?—It has not developed very far, but the whole machinery is there. Supposing a patient becomes melancholic: the inspector of poor is informed; he calls a parochial doctor, who sees the patient and who says: "This is a suitable case for a voluntary patient," and he gets his voluntary treatment.

16,221. And that is developing all the time?—Yes.

16,222. Just one small point, following up a question Lord Russell asked about drugs. Do you ever find it necessary to administer drugs or aperients or sedatives in food?—That has been done occasionally. It is to be avoided as much as possible, but it has been done occasionally. Of course, you are faced with a practical difficulty. There is the patient, and the patient is in a state of great excitement, noisy, and so on, and requires a sedative. How is it going to be given? It is sometimes done.

16,223. In fact, you would say about it what you said about the airing courts and padded rooms?—Yes; in all things evil there is some good.

16,224. In Scotland do you get many, or any, children or young people in your asylums, or are the children who require treatment dealt with under the Mental Deficiency Act?—We do not have many at the present time. During the war we had a number, as they are only just now providing institutions for defectives in Scotland; we have a small number.

16,225. Would that cover all the children who might need treatment, or are there certain cases of abnormality in children which is not actually mental deficiency?—If there is something in addition to the mental deficiency, there is nothing to prevent them from being sent to an asylum, and they benefit very much by being sent to an asylum, because all the women there mother them; they like to see the small children; and they have a very good time when they come, but they only come in small numbers.

16,226. *Sir David Drummond*: I would like to hear you, Dr. Robertson, upon the question of the superintendent's duties, and the desirability of exercising both administrative and medical functions. What do you think about that?—I certainly think that the medical superintendent should be the head of the whole institution. If you have divided authority you almost invariably have friction, and what is more, as a general rule, the medical man plays second fiddle, because other persons have got the control of the material, furniture and food, and so on, and they can annoy the medical man in a great many different ways. It has been tried in this country, and has not been successful. It is adopted in France, and there the doctors object to it very decidedly. It was a most unpleasant experience to me to go to the asylum at Charenton and see the doctor describing some of the cases, and to have at his side the lay superintendent, who really was the "boss" of the place.

16,227. Can the superintendent of asylums such as we know here, of 2,000 patients, exercise his professional functions?—It is quite certain that, although

18 April, 1925.]

Professor GEORGE M. ROBERTSON, M.D., F.R.C.P.

[Continued.]

he is the head of the place, all these duties should be performed by competent heads of departments.

16,228. He delegates the work to other people?—I would not even say it is delegated. These persons are appointed to do these special duties, like a house steward. I do not say that I have delegated my duties of book-keeping and cashier work, or the farm work, to these people. These people are appointed to do the work of their department, but if any of them neglect the work of their department, then I would feel it my duty to report them to my Board.

16,229. Then you contend that you yourself are able to give sufficient time to your patients, and yet carry out your administrative duties?—I give sufficient time to my patients, but I have to look after these individuals and see that they are attending to their business.

16,230. *Sir Ernest Hiley*: Just following that up, doctor, can you give individual attention to each of the patients?—No, I cannot give individual attention to each of the patients.

16,231. *Sir David Drummond*: I thought you said you could?—I mean not in the fullest sense. With the development of psychiatry now, each patient requires a very great deal of personal attention, but that part of the work can be done with qualified assistants. All my assistants have made up their minds to go in for mental work as their life work. They come there with that promise or intention, and they are well trained, and they become ultimately superintendents of asylums; each one has his department, and he looks after the patients in that department, and I supervise the whole work and advise about the different patients. Any difficulties they have they bring to me, and I solve them as far as I can.

16,232. *Sir Ernest Hiley*: But even in your small and very well equipped institution you cannot give individual attention to each patient?—Why should I give individual attention to each patient, I mean in the way of ordering purgatives and things of that kind, when there are medical men looking after these individual patients?

16,233. I was not thinking so much about that. I want to go to the end. It is on your recommendation that a patient is discharged?—Yes.

16,234. Can you give enough attention to the patient to be able to make a proper recommendation at the end?—Yes. The majority of these cases are really very, very simple. In a difficult case one has to give more time to it, but in other cases, with the assistance of the medical officer, one does not have much difficulty in deciding.

16,235. Do you think it is possible in an institution such as we have here, of over 2,500 patients, and with even a smaller staff than you have for your 800, that the patients can get that individual attention which would ensure the medical superintendent being able to make a proper recommendation for discharge or for further detention?—Of course, it is quite certain that the smaller the place is the more individual attention you can give; and I should fancy that even in a large institution (we have no institutions larger than 1,000 in Scotland) a doctor, with expert assistants, could give an opinion, but certainly not such a good opinion or as reliable an opinion in all cases as he could if it were a smaller institution.

16,236. Just to leave that, and to go back to the point the Chairman mentioned in your paper on the padded room, was that an instance of bullying on the part of the attendant?—No, it was merely, I think, to escape having a troublesome duty to perform.

16,237. You have had a very wide experience: have you come across many cases of ill-treatment of patients?—I will not say many, but I have come across a certain number.

16,238. Do you consider they are a frequent occurrence?—To say frequent is very difficult if one is not to say the wrong thing; but every now and then there is an incident of the kind that may occur. I

found with regard to that a very important matter, and it is this: I have known of superintendents who dealt very severely with any case that occurred, dismissing the attendant, and so on; but I have found, just as has been found in penology, that the certainty of discovery is far more effective in preventing these things than occasional severity, when the majority of instances are not discovered. That is the reason why I have such a large supervisory staff; they are everywhere, and I can depend upon these people reporting things to me, but every now and again an incident of that kind occurs.

16,239. Then it is not wrong to attribute that sort of treatment to accident rather than to anything like habitual practice?—No, it is not, and in the vast majority of instances it is not done out of any wickedness at all, but it is just done out of irritability, or being out of sorts; it is just human nature. Many of these people enjoy a rough and tumble. Even sane people of that class very quickly use their fists and their hands, and think nothing about it. I remember one patient at the Stirling Asylum. There was a tremendous row and tussle, and he received a black eye and some bruises and so on. He had been a soldier; I made a long inquiry into the matter, and was rather distressed about it. The patient said to me it was the best day he had ever had in the asylum; the only complaint he had was that there were three of them to one man.

16,240. *Chairman*: There is one point I would like to bring out, doctor, on the questions recently addressed to you. I suppose one may take it that the great bulk of the population in the asylum consists of cases that do not require any special medical attention?—Yes.

16,241. The majority have been diagnosed and put in their proper category, and after that their treatment becomes more or less routine?—Yes, that is so.

16,242. And therefore you may safely relegate those cases to the matron and to your subordinates?—Yes.

16,243. But the cases that are recoverable, and which are recovering, and which merit, therefore, special attention, are at any given moment, I suppose, relatively few?—Yes.

16,244. Do you find that you have time to attend to those cases, and are they brought to your knowledge?—Yes.

16,245. You must be a very busy man, doctor, because you are not only Superintendent of this Institution, but you are also a University Professor, and you have, I know, other functions as well. You have these houses to attend to, and so on?—Yes.

16,246. Do you find that your mind is distracted or diverted from your purely medical work as the head of a great psychiatric institution by the cares of the household?—Not by the cares of the household; I delegate these to the matron; and as regards clothing and feeding and furnishings and other matters, to the house steward.

16,247. Is it only in matters of principle that you have to interfere?—Only in matters of principle.

16,248. Therefore when you have decided a question of principle, you can leave it to your subordinates to carry it out?—Yes. I do not care a twopenny bit what wallpaper they put up, for instance.

16,249. I am not so sure, doctor. The psychological effect of a wallpaper has some influence upon some people?—What we do is to put up another one.

16,250. What I mean is this. I am thinking of your day's work, so to speak, and the different proportions in which your fund of attention is occupied; we each have only a certain fund of attention, and the question is how it is occupied in the 24 hours. Do you find that you may safely relegate all these small matters of detail to others?—It has to be done with discretion, and I find I can with the staff that I have. I also find this, that the variety of interests that I have, I think, really are a stimulus, and broaden one's views on matters. For instance, all the different methods of dealing with insane persons

18 April, 1925.]

Professor GEORGE M. ROBERTSON, M.D., F.R.C.P.

[Continued.]

that I have had experience of, and in dealing with rich people and with poor people, have broadened my views very, very greatly, and given me many ideas.

16,251. Yes, but I mean the work of administration has not been pursued by you to the detriment of your proper medical work?—No. I think I have deputed more of that sort of work to these officials.

16,252. *Sir David Drummond*: As a matter of fact, how often do you see the patients?—Every day I go to the Institution; I do not see all the patients every day.

16,253. How often do you see all the patients?—Perhaps once in a week, most of them.

16,254. *Sir Ernest Hiley*: Do you have a daily report on each case?—No, not on each case.

16,255. Not a written report?—No. There are written reports for all the cases. Each individual doctor in charge of his ward has written reports of

all his cases, but he reports the principal cases to me.

16,256. Does he summarise that for you daily?—Yes.

16,257. Therefore by that means you can take a bird's eye view of the institution, as it were?—Yes.

16,258. *Chairman*: And do you see each of your assistant doctors every day?—Practically every day.

16,259. And if they have any difficulty about a case, or if they think any case is approaching the stage of discharge, do they discuss it with you?—Yes.

16,260. Do you have that patient then sent for, or do you see the patient?—I would see the patient at one of my visits.

16,261. So that when questions do come up that require your personal decision you see the patient?—Yes, I see the patient.

Chairman: I am sure we are much indebted to you, doctor, for your interesting contribution to our deliberations.

(The Witness withdrew.)

(Adjourned to Monday next at 10.30 a.m.)

5, OLD PALACE YARD,
WESTMINSTER, S.W.1.

TWENTY-NINTH DAY.

Monday, 20th April, 1925.

MEMBERS PRESENT:

THE RIGHT HON. H. P. MACMILLAN, K.C. (*Chairman*).

THE EARL RUSSELL.

SIR HUMPHRY ROLLESTON, BART., K.C.B., M.D.

SIR ERNEST HILEY, K.B.E.

SIR DAVID DRUMMOND, C.B.E., M.D.

MR. NATHANIEL MICKLEM, K.C.

MR. H. SNELL, M.P.

MRS. C. J. MATHEW.

MISS MADELEINE SYMONS.

MR. P. BARTER (*Secretary*).

MR. W. FAIRLEY (*Assistant Secretary*).

Dr. JOHN D. COMRIE, M.A., B.Sc., M.D., F.R.C.P., called and examined.

16,262. *Chairman*: This morning we have with us Dr. John D. Comrie, M.A., B.Sc., M.D., F.R.C.P. Dr. Comrie, you are Senior Assistant Physician to the Royal Infirmary at Edinburgh?—I am.

16,263. And Physician to the Deaconesses Hospital at Edinburgh; and some little time ago you were Consulting Physician to the Forces in North Russia?—Yes, I was.

16,264. You are good enough to attend this morning for the purpose of giving us some information as to the methods pursued in Edinburgh for the treatment of mental cases at the Royal Infirmary?—Yes.

16,265. And we propose, if you please, to confine your evidence to that particular topic, as we have

had a considerable volume of general evidence on the Scottish practice already. First of all, the Royal Infirmary in Edinburgh is a general hospital, is it not?—A general hospital, a voluntary hospital.

16,266. A large general hospital supported by contributions from the public and by endowments?—Yes.

16,267. It is not a rate-aided institution?—Not rate-aided.

16,268. It is a general hospital in the usual sense, for the treatment of all forms of surgical and medical cases?—Yes.

16,269. Then even from the earliest times has the Royal Infirmary in Edinburgh treated a certain number of mental cases?—Yes, almost for 200 years.

20 April, 1925.]

Dr. JOHN D. COMRIE, M.A., B.Sc., M.D., F.R.C.P.

[Continued.]

16,270. I gather from your *précis* that so far back as 1738 mental cases were treated at the Royal Infirmary?—Yes, they were.

16,271. I think it is rather interesting to place on our notes an extract from the Minutes of the meeting of the Managers of the Royal Infirmary on the 20th April, 1738, which reads: "As there is no proper place in Scotland for entertaining lunatics the Managers propose to prepare in this part of the house first to be built five cells to entertain such lunatics whose expense in the hospital their friends will defray." You find there an indication of the primitive and rather barbarous method which was employed for the treatment of lunatic cases at that period?—Yes.

16,272. And subsequently the number of cells, as they were called, was increased to twelve. But after the institution of the Royal Asylum at Morningside, of which Dr. Robertson has been telling us, in 1813, did the need for accommodating cases of chronic insanity in the Royal Infirmary pass away?—Yes.

16,273. And consequently those cells fell into disuse?—Yes.

16,274. Was it still found, however, that a considerable number of cases which reached the Royal Infirmary were suffering from mental derangement and required special treatment?—Yes, that was still found, and also that cases showed mental aberration in the wards of the Infirmary.

16,275. Sometimes, I suppose, as symptoms of the physical ailments from which they were suffering?—Very often arising out of the physical ailments.

16,276. And, as a matter of history, was a special ward set apart for the reception of these cases?—Yes. It is difficult to find out exactly when it was, but apparently it was immediately after 1813 when the Royal Asylum was founded at Morningside.

16,277. Then in 1881 the Royal Infirmary was transferred to its present buildings from the old Infirmary premises, and again was a ward set apart for the reception of cases of the type you have mentioned, and were rules drawn up for the regulation of that ward?—Yes. The practice had been found to be so useful to the public that it was decided in 1881 to set apart a special ward in the new building, and to improve its conditions, and definite rules were drawn up for its management.

16,278. And I think an assistant physician was put in charge of the ward, and perhaps we might have just a quotation from the rules defining its purpose: "This ward and the adjoining apartment shall be reserved for the reception of patients who, from nervous excitement or delirium, are likely to disturb the patients in the other wards of the house; and also for cases of poisoning, or other emergencies of a nature which might prove the cause of such disturbance." Consequently in the existing Royal Infirmary has it always been the practice to have a ward set apart for cases suffering from mental disorder of one kind or another, where special treatment was given to them?—Yes; that has ever since been the practice.

16,279. Has that ward been reserved for cases where the mental disturbance was incidental to other ailments?—No; that, no doubt, was its original purpose.

16,280. So it would appear historically?—But gradually more and more as time went on, the ward has been used for the admission of patients from the outside, private cases of doctors who are in difficulty as to the disposal of patients, and cases with regard to which the police or the magistrates were in difficulty; and more and more these cases have been admitted from outside.

16,281. So that while in its inception the idea was to have a special ward into which you could relegate patients who in the course of their illness became disordered in mind, it really has developed into a ward in which mental derangement is treated?—It has developed very much, and especially, I think, in comparatively recent years, the last 20 years or so,

during which cases of mental aberration due to alcoholism have very much diminished; that has left more room in the ward for cases due to other conditions, and so these other cases have been more and more admitted as the alcoholic cases fell out.

16,282. Before we go into the very interesting statistics of the cases handled in that ward, I would rather like to get from you a general account of the relation of this ward to the system of the treatment of insanity in Scotland—I mean its relation to the ordinary asylums, and what part this particular ward in the Infirmary plays in its relation to the general system. Could you tell us that?—First of all, with regard to the patients who were taken mentally ill in the Infirmary, of course it would be inconvenient to send them to an asylum, because they often have other conditions for which it is very undesirable that they should be removed from the Infirmary.

16,283. I suppose, in short, a state of mental derangement ensues on an attack of pneumonia, or uræmia?—Or in the case of a man with a fractured thigh bone, say.

16,284. That is a case already in the Infirmary for the treatment of the physical ailment; but, a mental derangement supervening, the case is removed to this ward, and is still in a general hospital, and has all the resources of the general hospital available for treating the physical side of the ailment, while the mental side is dealt with in the ward by special attendants, I suppose?—Yes, that is so.

16,285. And with a special physician in charge?—Yes.

16,286. Then these cases, of course, in their inception are not certified cases at all; they are simply cases of ordinary ailments in which mental symptoms have supervened?—Yes, either at the same time or subsequently. Then there is another group of cases. Doctors outside are often in great difficulty with regard to a case as to whether it should be sent to a mental hospital, to an asylum, or whether the case is likely to recover in a very short time; it may be a case which it is impossible to keep, say, in a private house on account of noisiness or family arrangements generally; and these cases are sent in for diagnosis in the first place, and in that sense the ward is, as it were, a clearing house either for getting patients better and sending them back home, getting them well enough to go for convalescence somewhere, or else sending them on to mental hospitals.

16,287. None of those cases which reach you are certified cases, are they?—None are certified.

16,288. In such cases what do you do in the matter of detention, because such cases must, in many instances, be disordered mentally? Are they all willing to receive your treatment?—They come in presumably voluntarily. They do come in voluntarily, or are brought in by their friends. They are not under any form of restraint when they come in, and, theoretically of course, they could get up and go out at any time. As a matter of fact, take a case of pneumonia, for example: if a patient insisted upon getting out of bed one would exercise one's discretion in acting for that patient's ultimate good. It would be extremely dangerous for him to get out of bed, probably fatal, and of course such a patient would not be allowed to get out of bed, or still less to leave the Infirmary.

16,289. But such a patient in private practice would not be allowed to get out of bed?—Exactly, except that with special attendants the patients are more easy to manage.

16,290. But it is a symptom, I suppose, of these ailments that whether in private practice, or in a hospital, for the patients' good they must be restrained?—They must be restrained, as necessary.

16,291. And although technically that may be an interference with the liberty of the subject, it is an interference which in ordinary practice takes place daily, I suppose?—It takes place daily, and it is quite recognised by law.

20 April, 1925.]

Dr. JOHN D. COMRIE, M.A., B.Sc., M.D., F.R.C.P.

[Continued.]

16,292. But theoretically these patients who come to your ward may leave at any time they please?—Theoretically, they may leave at any time they please.

16,293. They are under no legal restraint; they are merely under the restraint which any wise doctor imposes upon a suffering patient?—That is so.

Sir Humphry Rolleston: I wonder whether Dr. Comrie will just expand a little the statement that one has the right legally to restrain a delirious pneumonic patient. It is humanly so, but is it legally so?

16,294. *Chairman*: I do not think so, Dr. Comrie.—My understanding is that the doctor must in such a case act for the benefit of the patient to the best of his ability, and restrain the patient, if necessary, and take responsibility temporarily for doing so; and that the patient may subsequently bring an action against him under the common law, but that the law would undoubtedly exonerate the doctor.

16,295. Of course, you must remember we are dealing with practical problems. I suppose if a patient is brought into the general hospital suffering from some injury to the brain, let us say, a fracture of the skull, you may at once have to perform an operation on that patient?—Yes, that is so.

16,296. And technically that is an assault upon the patient, of course?—Yes.

16,297. But no Court of Law would regard that as otherwise than necessary, though technically it is an assault?—Technically it is an assault.

Sir Humphry Rolleston: It is not provided for in law.

Chairman: There is no provision that I know of in law for that case.

Sir David Drummond: On the other hand, if you allow the patient to get up, and he dies, the Coroner will inquire into it.

16,298. *Chairman*: You are between the devil and the deep sea?—Yes.

16,299. And also it might be said that you were guilty of professional negligence if you allowed a patient to get up when he ought to be kept in bed; you would be contributing to the patient's injury?—Yes, I think so.

16,300. However, these things fortunately settle themselves by commonsense, and the law is sometimes in consonance with commonsense; but we understand the legal position of these patients—they are like the other patients in a general hospital, they have come in, and the only specialty in their case is that their ailment is mental instead of physical, and you treat them as you would treat other patients in a general hospital. Legally they are free to get up, but they do not in practice do it; and the doctors exercise both moral, and, where necessary, I suppose, physical restraint, upon those patients?—As necessary, yes; and we really never have any trouble with patients.

16,301. We should bring out at once that these patients are not taken for gain in any sense?—They are not taken for gain.

16,302. They are treated gratuitously, like all other patients in general hospitals?—Yes.

16,303. Now, before coming to the detailed statistics, have you found that the facilities thus provided in the hospital in Edinburgh are advantageous in the public interest, and in the interest of the patients?—Very advantageous; I have found that over and over again. Cases are saved, for instance, from being certified and going to a mental hospital and having whatever stigma attaches from that. Then very often such patients are found to require medical or surgical treatment, which could be administered much more readily in a general hospital than it could be in a mental hospital.

16,304. Are many of the cases associated with some physical condition, the alleviation of which results in mental improvement?—Very often, yes. One finds, for example, in cases of melancholia that that is very often the case, that there is some physical underlying condition as a contributory cause.

16,305. On that being alleviated the mental symptoms disappear?—Yes, the mental symptoms gradually disappear.

16,306. We have heard some evidence in England of cases where delirium has supervened on pneumonia or uræmia, being taken to the mental wards in poorhouses, and there certified. I suppose you would regard that as an undesirable practice?—I think it is unnecessary, in the first place, and highly undesirable in the second.

16,307. Is it merely a transitory phase associated with the illness?—Yes, and passes off when the illness is recovered from.

16,308. But if certification is resorted to in order to impose restraint upon such persons, then they have the stigma of certification for life?—Yes.

16,309. While all that really they have suffered from has been some ordinary ailment with a transitory phase of mental disturbance?—Yes.

16,310. Now you succeed in obviating certification altogether in those cases by this method which you pursue in Edinburgh?—Yes, in a very large number of cases.

16,311. What is your relation to the Royal Asylum at Edinburgh—I mean what determines whether a case is sent to you or sent to the Royal Asylum?—That perhaps is largely a matter of opinion of the outside doctor, and his doubt about the case; and also probably cases tend to come to us because the doctor does not wish to take the personal responsibility of certification in some instances; so that the tendency is rather to send them in to us and leave to us the question of certification.

16,312. But I could conceive that among the patients reaching you some would be cases in which certification at the moment would be quite legal, I mean the cases would be in such a condition that certification could be quite conscientiously resorted to?—Yes. For instance, I notice in my statistics in 1923-24 that there were 17 cases of fixed delusional states. These were observed by us for a sufficiently long time to verify this condition, and then they were certified and sent to an asylum; that might have been done before they came in to us. There is a small number of these cases.

16,313. Then it really turns upon the discretion of the doctor who is attending the case whether he will recommend that the case should be sent to your ward, or should be certified at once and sent to an asylum?—It depends a good deal upon his discretion, yes, and the case is often difficult for him to diagnose.

16,314. And then, in addition to that, he may of course recommend that the patient should enter an institution voluntarily, as another expedient?—Yes.

16,315. Not applicable so much to rate-aided patients, of course?—No, the voluntary admission is not applicable to a great extent to rate-aided patients; only a few parishes in Scotland make provision for that.

16,316. I was thinking of the choice presented to the medical attendant. He is attending a poor person who is showing symptoms of mental derangement. What resources has he at his disposal? He seems to me, in Edinburgh, to be able to say, "This is a case where I think the symptoms will pass off; this is a case for Dr. Comrie in the Royal Infirmary"; or he may say, "This is a case of clearly pronounced insanity and it should be certified"; or, if the person had a little means, he might say "I think you should yourself voluntarily go into an institution, and we will see if arrangements can be made for you." That would be a possible alternative?—Yes.

16,317. Are there any other things that might be done?—No. Of course this ward to a large extent takes the place of the voluntary admission to an asylum; it really does that for pauper patients.

16,318. *Sir David Drummond*: What proportion of these cases attend your out-patient department

20 April, 1925.]

Dr. JOHN D. COMRIE, M.A., B.Sc., M.D., F.R.C.P.

[Continued.]

before they are admitted?—Quite a small proportion; I could not give you an exact figure.

16,319. You do not see many of them yourself before they are admitted?—If I might just give a figure at random I should say perhaps something like 5 per cent. may be seen.

16,320. *Chairman*: I have not brought out from you yet the full equipment of your institution. Have you an outdoor clinic as well?—Well, there is a general out-patients' department of the hospital, and a certain number of cases come through that. Then some cases are sent up, as Sir David Drummond asked, to see me personally at the ward, in a side room of the ward, and these come irregularly; I have not any definite day.

16,321. The out-patients' department is the general out-patient department of the hospital, and of course that would be in the hands of the junior physicians and surgeons of the institution?—Yes.

16,322. If they find a case which exhibits mental derangement they may pass on the case to you for consideration?—Yes; that is quite common. A large number of cases come in that way; they appear to be likely to cause disturbance in other wards, or are unsuitable for other wards, or are possibly cases of attempted suicide in other wards. These cases are sent up with a request that they would be admitted to ward 3.

16,323. Are some of the milder cases treated in the out-patients' department by visiting from time to time and getting advice, and possibly medicine?—Yes; a number of the slighter cases are treated in the out-patients' department.

16,324. *Sir Humphry Rolleston*: There is no special day for them?—No. Professor Robertson is, I understand, going some time to organise such a clinic, a regular psychopathic outside clinic.

16,325. *Chairman*: In association with the hospital?—In association with the hospital, to which he is consulting alienist, but that has not matured yet; at present they come with the ordinary out-patients.

16,326. *Sir Humphry Rolleston*: There is no social service associated with the infirmary—I suppose the after care would be associated with Morningside, and the other mental hospitals?—There is a social service gradually increasing its scope.

16,327. *Chairman*: But is it specially associated with that department? Is it not just the general social service that is given to all patients?—The general social service for out-patients, who form a pretty large part of the work; and it renders very valuable service in that way, visiting them both before admission, and following them up after admission. A social service among in-patients is being developed.

16,328. Who engages in that work—volunteers?—Several ladies. The Edinburgh University Settlement had a great deal to do with starting it; it is all worked by ladies, of whom there are now four paid workers and a varying number of volunteers.

16,329. Is this ward open just as all the other wards are open, or is it kept closed?—To the public—it is open under the same conditions, that is to say, anyone having a friend in this ward can get a visiting ticket and see the patient on four afternoons a week at certain hours, and visit his friends and visit any other patient.

16,330. One is familiar, of course, in connection with the Edinburgh Hospital with the visits that are paid by good-hearted people to mental patients, and Sunday morning visits, and so on, that take place there: is this ward treated in the same way as the other wards, or have you to take any special precautions?—No, we sometimes have ward concerts, for example, in the evening. Ladies organise concerts, and the patients appreciate them very much. It is a little bit awkward sometimes; if there is a patient requiring quietude in the ward, or a patient is very noisy, the concert has to be put off.

16,331. Have you any separate rooms for patients there?—No, that is one of the drawbacks of it. The

department consists of four rooms; there is the large male ward, there are two smaller rooms for female patients which are capable of holding four or five patients each, and then there is one room with one bed in it where a noisy case, or a case which is unsuitable to have in the ward, may be treated temporarily.

16,332. Then you have nothing in the nature of padded rooms there?—No padded room.

16,333. And if any patient becomes obstreperous how do you deal with the case?—If a patient becomes obstreperous there are several ways of dealing with the case. For example, there is, first of all, an attempt at moral suasion, by appealing to the patient, and this I think is more effective in the case of male patients than in the case of female patients; that is to say, I think the sister and nurses can exercise more restraint simply in that way over male patients than over female patients.

16,334. Is the ward staffed with female nurses?—Yes, female nurses in the main; there are three men who are called porters.

16,335. They have not the status of nurses?—They have not the status of nurses; they act under the directions of the sister.

16,336. You were telling us that the sister will use moral suasion with the patient?—Moral suasion in the first place, and attempt that as far as possible. Then, of course, secondly, there is the use of drugs.

16,337. Sedatives?—Sedatives such as paraldehyde, hyoscine, morphine, veronal, and so on. Then in other cases there is the question of restraint—in surgical cases, for instance. I have a patient in the ward just now, for example, with a compound fracture of the leg, and she resents the splints being on it, and takes them off at every possible opportunity and throws them out of bed, and then raises her leg in the air and has a look at it, which of course is very bad. In a case like that it is an absolute obvious necessity to fasten the splints down to the bed—surgical restraint. It is an obvious necessity that that splint should be fastened down on the bed, and the leg fastened down, so that is an example of surgical restraint. Then in such a case, too, the patient's hands would be fixed by bandages, fixed to the edge of the bed to prevent her from working at the splints. A somewhat similar procedure might be carried out in the case of pneumonia in which the patient was insisting on getting out of bed, which is a very dangerous procedure in a person with pneumonia with a failing heart. Human restraint which, of course, is rather desirable in many cases for mental patients, that is to say, by a nurse standing on each side, and holding the patient's hands, is here out of the question, because a patient suffering from acute delirium with pneumonia as a rule resents any human interference; and so it is found to be better that in such a case a screen should be put up round the patient's bed and the attendants should be on the far side of the screen ready to come to the patient's assistance, to give the patient a drink, or do anything for the patient should it be necessary, but that the patient in such a case should simply be restrained by a sheet pinned over the bed or by bandages. Then a somewhat similar procedure is found advantageous, and for the same reason, in heart cases; they often resent the presence of another person very much, such as a nurse at the bedside; they may have a delusion with regard to the personality of the nurse and resent it very much. Such measures of restraint are only carried out for a few hours at a time, that is all that is usually found to be necessary, and then the patient realises that it is useless to struggle against inanimate restraint, whereas the patient would go on struggling persistently against animate restraint; so he quietly drops off to sleep, and then the restraint can be removed. Of course such restraint is very much easier to carry out in a general hospital than in a mental hospital.

16,338. Why is that?—I think it is because of the greater access of the public—people see what is going

20 April, 1925.]

Dr. JOHN D. COMRIE, M.A., B.Sc., M.D., F.R.C.P.

[Continued.]

on all the time, and they have confidence; they see for themselves that this is the proper and obvious thing that should be done for this patient; and they see and approve of it, and there is never any complaint about it. In the mental hospital it is considered to be more open to criticism. And then, of course, the superintendent of an asylum has certain legal disabilities; every time restraint of that sort is used he has to enter it in a book for the inspection of the Commissioners.

16,339. Now you just deal with these patients apparently on ordinary lines, and adopt commonsense expedients in their interests?—I think that is how to put it, yes, that one adopts commonsense expedients, such as one might use in any ordinary medical case in private practice.

16,340. You are not subject, are you, to any inspection?—No. As a matter of fact, members of the Board of Control do come and inspect the ward unofficially by arrangement, but they make it quite clear that they do not come officially. They just come to keep in touch with what is going on in the ward.

16,341. But they have really no more status there than they have in the other wards of the hospital?—No, presumably not.

16,342. *Sir David Drummond*: What is the relation between that group of wards and the general hospital—I mean as to position?—It is simply one of the wards in a pavilion. In Edinburgh the wards are mostly arranged in tiers of three in pavilions, and this is simply a ward in a pavilion of three wards, the upper two being surgical wards.

16,343. Would noises arising in your ward be heard in the general hospital?—They are sometimes complained of in the ward above, but very seldom.

16,344. *Chairman*: I suppose there is this feature, too, that as the cases come to you after a process of selection, that is to say, on the advice of the medical attendant, you probably will not have the most violent and noisy type of case sent to you?—I should not say that; I think we do get very violent and noisy cases. For example, some of the alcoholic cases are excessively violent and noisy. Yes, I think that we have cases that probably are more violent and noisy than many cases in a mental hospital, but they are violent and noisy for a short period only.

16,345. The point that *Sir David* raised is of importance. In the accommodation which you have, are all the patients of different types together?—Yes. I have always realised that that is a defect. It would be very advantageous if there were more possibility of classification of patients; if a noisy patient could be kept quite away in a separate ward, and at some little distance from the quiet and timid patients. That is one drawback to this particular ward.

16,346. I can imagine a sensitive case. Take a woman who is overwrought and sensitive, and melancholy possibly, she might be much alarmed by the advent of an extreme alcoholic case, for example?—Yes. Of course, as much care is taken as possible to keep them as far apart as possible, and violent cases are put behind a light screen, and so on.

16,347. But the screen will not keep noises out?—No, it does not keep noises out, but it prevents the timid patient from seeing threatening looks and threatening movements.

16,348. It disturbs the sleep also?—Yes.

16,349. Do you find much difficulty arising from that cause in the actual work of your ward?—Only occasionally, but I do feel it would be a great advantage if there were more rooms in such a department, so that classification could be better carried out. I think that in any reconstruction or any development that should be borne in mind. I understand that at the present moment there is a scheme for actually adding an early mental department to the Royal Infirmary of Edinburgh, but it has not eventuated yet. It is, I understand, largely a matter of finance.

16,350. *Sir Humphry Rolleston*: Accidents, of course, occur in all mental hospitals—there must be

a certain number of suicides, and so on—how do your accidents, suicides and escapes, compare with those of an ordinary mental hospital?—I do not think we have suicides actually occurring in the ward. Of course we admit a great many people who have attempted to commit suicide. I think in one particular year the number I give is 58. This was about 60 per cent. of the melancholic cases, who had already attempted to commit suicide, but we do not have suicides after they come in.

Sir Humphry Rolleston: Really? That is most successful.

16,351. *Mrs. Mathew*: Would you be in favour of small rooms instead of large wards?—There are advantages in the patients being together; they derive something from one another. The worst patients derive a great deal of benefit from the admixture with sane, or almost sane patients, so that there is an advantage in having a large ward; but at the same time I would certainly recommend a number of small wards for the purpose of classification—that is to say, for accommodating very violent and noisy patients on the one hand, and on the other hand, very quiet and timid patients who prefer seclusion.

16,352. *Sir David Drummond*: Might we hear about your staff? I take it you have an exceptional staff?—There is a sister in charge, and then there are six female nurses under her, and three male orderlies or porters—ten.

16,353. For how many patients?—About 24 patients.

16,354. That is practically one attendant to two patients?—Yes. I should add that of course in the case of any patient where a special nurse is required, the special nurse is available from the general staff of the infirmary in addition. There is also a strict rule that under no condition may there be fewer than three attendants in the ward.

16,355. You have no difficulty in getting special help?—No difficulty in getting special nurses, or getting male porters.

16,356. *Chairman*: Then, just to complete the staff, have you a resident under you?—Yes, a resident who does duty in another ward as well, but I have a resident.

16,357. Is that a male or female doctor?—A male doctor.

16,358. Is he appointed to you in the usual way in Edinburgh, appointed as your resident?—He is appointed to another ward where I am senior assistant physician, in which I act as well. Then he comes to Ward 3, as a matter of practice.

16,359. You, as the senior physician will visit, I suppose, every day?—Yes, every day.

16,360. And you see all the cases each day?—I see each case each day. With regard to the staff I should add that I also have a doctor, who is non-resident, from outside, who acts as clinical assistant. And Professor Robertson, of the Mental Hospital at Morningside, has very kindly allowed his Deputy Superintendent, Dr. McAlister, to act in that capacity, so that I have the benefit of a trained alienist.

16,361. *Sir Humphry Rolleston*: I quite realise the benefit that a patient on the border-line may obtain from being in contact with patients who are perfectly sound mentally; on the other hand, is there not a little risk that it may react on patients who are sound in the same ward. For instance three children were admitted for gas poisoning—is it not possible that the effect of seeing a wild lunatic might produce some impression on their minds which eventually would be not entirely beneficial?—I think theoretically that is so, but I think practically it does not arise, because one would to a certain extent be able to classify the patients, and one would keep away such patients as you mention from the very wild patient.

16,362. I imagine the children being there was just an accident?—That was accidental gas poisoning.

16,363. Would you ever think of recommending that a woman who is mentally unstable should have

20 April, 1925.]

Dr. JOHN D. COMBIE, M.A., B.Sc., M.D., F.R.C.P.

[Continued.]

children put near her so as to awaken her maternal and better instincts?—It would not be possible to arrange it, of course, but when it does happen by accident it always does have a beneficial effect on a mental patient.

16,364. *Mr. Snell*: I want to know what effect it would have upon the health of the general ward. Will there not be another side to all that?—I think the sane patient can stand association with the insane patient without being deleteriously affected.

16,365. I should have thought in a hospital ward where a patient requires every ounce of his nervous and physical strength to fight his disease, the presence of noisy irritable patients would have been very bad?—Well, again, theoretically, yes, but you can to a certain extent keep them apart. You can, for instance, use the single room I mentioned for treating very bad cases of poisoning.

16,366. *Chairman*: But I think you are a little at cross purposes. One of the purposes of this ward, I understand, is to remove from the general hospital cases which are disturbing and noisy, and likely to affect injuriously the other patients. In the ward itself we shall not find general patients, that is to say, patients suffering from ordinary ailments?—No, they are suffering from a few conditions of which the most typical one is poisoning. The question is not asked whether they are cases of accident or suicide; they are all admitted to this ward, and a good many of them are cases of accident, and these are examples of the sane patients to whom I refer, not patients suffering from general diseases.

16,367. You speak of the benefit to the mentally afflicted cases of the association of ordinary patients, but I rather thought that this ward was for the purpose of segregating the mentally afflicted cases and treating them by themselves in this special department of the infirmary?—There are poisoning cases, and then, of course there are the cases who are ill with something else, who have been noisy at one time, and therefore removed from another ward.

16,368. That is temporary mental disorder?—Very temporary. Then, of course, there are the alcoholic cases who are also admitted to that ward, and they are noisy for a short time; but then for several days before they go out they are perfectly sane.

16,369. Take the type of person such as *Mr. Snell* has in mind, I think; a person who quite accidentally has been poisoned, a perfectly sane person, but through some domestic accident has taken poison.

16,370. *Sir David Drummond*: Pardon me, you do not take that case there?—Yes, they come in there.

16,371. I thought it was only mental cases?—That is one of the rules of the place. Given a case of poisoning arriving at the front door of the infirmary it would be impossible to start asking: "Is this a case of accident?" They must be taken in somewhere at once; they are all taken into Ward 3, and having come there they are all retained there.

16,372. *Sir Humphry Rolleston*: Is not the question of alcoholic and poisoned patients rather a historical survival of the functions of the ward?—Yes, it is.

16,373. It is not part of the scheme of the Edinburgh Infirmary?—The ward is, so to speak, a historic survival which has undergone development, and is undergoing development.

16,374. So that you might eventually shed the alcoholic cases without much loss to psychological medicine?—I think probably they will be shed ultimately.

16,375. I can imagine a case of accidental poisoning, where the patient was recovering, being very much disturbed by the presence of a very noisy and clearly mental case in the next bed. It would retard recovery, would it not?—It might, but then such a case would not be put in the next bed to a noisy patient.

16,376. *Chairman*: These things are managed with good sense, I have no doubt; but you do find yourself to some extent hampered in your treatment by the

physical circumstances of your accommodation?—Yes; undoubtedly it would be better to have several small rooms in addition.

16,377. The main topic which interests us is the type of institution, it is the system that is of interest to us, a system of treating mental cases as part of the ordinary work of a general hospital?—Yes.

16,378. That is in operation at the present moment in Edinburgh under the conditions you have mentioned?—Yes, and I think quite successfully—about 60 per cent. of recoveries.

16,379. And apparently provides a method of dealing with cases provisionally without certification?—Yes.

16,380. A sorting out place?—Yes.

16,381. *Sir David Drummond*: Is the accommodation which you have anything like adequate for a large district like that?—No, I do not think so, because we are limited to a large extent by the number of patients that have to be treated.

16,382. You often have to refuse cases?—We often do keep cases waiting which go to a mental hospital instead, or we keep slighter cases waiting a longer time at home.

16,383. *Sir Ernest Hiley*: Can you give us any idea as to the extent of your waiting list?—I think it is not a very large waiting list in this particular ward. I should think of the mild mental cases waiting to come in there are usually about half a dozen or so all the time.

16,384. *Mr. Micklem*: How many beds have you got in the male ward?—Sixteen, and eight female, with a possibility of taking an extra two beds in either case.

16,385. *Sir Ernest Hiley*: If you were given a free hand to extend, what provision would you make in addition to what you have now?—In the first place, I think it is very important, and it is a great advantage, to have such a ward under the same roof, at all events, as the general hospital. I mean it would be quite a different type of ward if it were at some distance. I think it must be really under the same roof. Then I think it should have some grounds for the exercise of the patients; I think that is very important. Then I think that there should be a considerable possibility of the classification of patients, that is to say, a number of rooms in addition to the wards, and then the possibility of fresh air treatment.

16,386. But how many beds would you provide?—I think, that in Edinburgh, with a population of 50,000, and a large surrounding district, as far as present needs go 50 beds would do very well.

16,387. *Sir David Drummond*: Can you tell us about the costs of your department as compared with any other portion with a similar number of beds?—No, I am sorry I have no statistics.

16,388. *Chairman*: The staff is larger, is it not?—The staff is somewhat larger than it is in an ordinary medical or surgical ward.

16,389. But you think the cost does not vary very much?—I do not think the cost is very greatly higher. The increased staff is practically the only increased item of cost, and per patient I should say the cost is not larger, because the patients go out fairly quickly.

16,390. *Chairman*: On that point, first of all, what proportion of your cases are bed cases?—They are all regarded as bed cases. Of course some of them are up for part of the day, but they are all regarded as bed cases all the time.

16,391. Then you do not propose to cater really for a resident population of insane people in the ward?—We cannot do that meantime with the present facilities.

16,392. I am not sure that it would be appropriate that you should, because you do not want to convert yourselves into an asylum?—No; I think it would be better to keep to the bed cases.

16,393. *Sir David Drummond*: Curable cases?—Yes.

16,394. *Mr. Micklem*: You will have some in there for three months or so?—Virtually we are limited by

20 April, 1925.]

Dr. JOHN D. COMRIE, M.A., B.Sc., M.D., F.R.C.P.

[Continued.]

the number of beds multiplied by the number of days in the year and divided by the total number of patients who pass through in the year. That gives us the number of days we can keep the average patient, but that is only two or three weeks, and the maximum time that we can keep cases is six weeks. Of course occasionally they go on longer than that, but it is only very occasionally.

16,395. *Chairman*: If there is some prospect of getting a complete recovery I suppose you may keep a case a little longer?—Yes, but if a case is not well in six weeks we regard it as not likely to be well under six months, and then further steps are taken for disposal by sending the case to an asylum.

16,396. It is a prominent feature of this system that you do not cater for a resident population of confirmed lunatics; it is a place where you deal with the transitory cases, and the cases which have not been completely diagnosed?—Yes.

16,397. But you do not propose to equip yourself for ordinary prolonged residence of patients?—No; the managers of the infirmary do not encourage that at all.

16,398. I think we might take from you the statistics. We have heard how you run your wards.

16,399. *Sir Humphry Rolleston*: Might I ask one question about construction. I do not know when you said "under the same roof" whether you were speaking literally or whether you meant in the same ring; because I should have thought it was rather an advantage to have the block separately surrounded by a park, such as at Phipps' Institution at Baltimore, where it is in the same ring, but not absolutely under the same roof. I should have thought the advantages to patients in that way would more than counterbalance the advantage of immediate surgical help that might be available under the same roof. When you say "under the same roof" do you really mean that, or do you mean an annexe?—I used the term "under the same roof" with the idea of being emphatic. I was actually thinking of the Phipps' Institute in Baltimore when I said it. The Phipps' Institute is connected by wide corridors with all the other departments of the hospital. It is in a ring with the other blocks of the hospital. The great point is this, that the other specialists can be got at once. It is not a question of arranging by letter with the specialist to come and examine the patient; he can be actually got in the course of two or three minutes to come and see a patient at once.

16,400. *Chairman*: You mean really as part of the same establishment?—Yes.

16,401. *Sir Humphry Rolleston*: You would be quite content to take charge of the Phipps' Institute if it were transferred to Edinburgh?—I should be quite delighted.

16,402. *Chairman*: Now I propose, with your permission, to take the table which you have furnished us with on the second page of your *précis*, regarding the classes of case admitted to these wards, and put it on our notes as it stands?—If you please. (The Table is as follows:)

	1852-53	1883.	1913.	1923-24.
Drunkenness	6	210	209	119
Delirium Tremens	60	91	48	14
Confusional States associated with other diseases.	40	48	60	102
Melancholia (non-suicidal) ...	—	12	30	29
Poisoning and attempted suicide	6	25	35	58
Dementia	—	—	30	52
Psycho-neurosis (Hysteria, &c.)	5	11	12	35
Post-epileptic States	9	19	16	29
Mania	11	21	13	20
Gross Brain Disease	8	30	24	16
Fixed Delusional States	—	4	24	17
Primary Mental Defect	—	—	3	9
Total Admissions	145	471	504	500

16,403. That table shows the very interesting history of the cases which have been dealt with in these wards at various periods during the past 70 years; and the statistics point to interesting changes in the social habits of the people, particularly in the cases of drunkenness. You have there a history which shows an increasing use of these facilities, reaching apparently in 1913 a maximum of 504 cases, while for the year 1923-24 you have 500 cases in all?—Yes, virtually the same.

16,404. This table shows us the classification of the cases, which seems to cover pretty well most of the ordinary forms of insanity?—Yes.

16,405. You do not have cases of dementia præcox or general paralysis of the insane among them?—Oh yes, we have a number of cases of both these; the dementia præcox are included under the word "Dementia."

16,406. So we may take it that all types are represented in your ward at some time or another?—I think a few cases of almost every type of insanity.

16,407. *Sir David Drummond*: When you speak of "Gross brain disease" we are not to assume that all cases of gross cerebral disease go to your ward?—No. These were cases in which there had been some mental condition, and a cerebral tumour or meningitis had been found to be the cause of it.

16,408. There is a mental side to the cerebral condition?—Yes.

16,409. *Chairman*: Now these being the number of admissions in 1923-24, namely, 500, it will be interesting to hear from you the results of your treatment—I think you can give us some figures. You say: "With regard to results, the proportion of cases discharged sufficiently well to return home was 72 per cent. of the total."?—Yes, or perhaps it is fairer from the point of view of mental disease to leave out the alcoholic cases altogether.

16,410. If we leave them out, is the number of cases sufficiently well to be returned 64 per cent. of the total admissions?—No, of the total mental cases.

16,411. Putting aside the alcoholic cases?—Yes.

16,412. If we take 1923-24 the alcoholic cases apparently are 133 in number, because I am including drunkenness and delirium tremens?—133.

16,413. Then if we take 133 from 500 we get 367 other cases?—Yes.

16,414. And of the 367 other cases 64 per cent. I gather were after treatment sufficiently well to return home?—Yes, that is what I mean.

16,415. Then with regard to the disposal of the other cases, I think you passed on to mental hospitals 17 per cent. of the total, or, again excluding the alcoholic cases, 22 per cent. of the total?—Yes.

16,416. Does that mean that these cases were found not to yield to the treatment in your ward, and to exhibit a more or less permanent state of mental aberration?—Yes; that includes either those cases which were found, after an interval had elapsed for diagnosis, to be cases of chronic mental disease which were not early cases, and which need not be retained at all—

16,417. Proper asylum cases?—Proper asylum cases or cases which we could not keep for a sufficient length of time for recovery.

16,418. In these cases did you resort to certification?—In these cases we did resort to certification as a rule. In five cases only, the patients entered mental hospitals as voluntary patients.

16,419. Then these must be people who have some means?—These were people who had some means, or whose friends had some means. But there is no doubt that this would have been taken more advantage of, if the pauper patients could have gone as voluntary patients, and we are often asked by them whether they can go as voluntary patients, and we have to explain to them that they cannot.

16,420. Now I would like to know how you deal with cases which have to be certified. Does the certification take place in your own institution?—Yes.

20 April, 1925.]

Dr. JOHN D. COMRIE, M.A., B.Sc., M.D., F.R.C.P.

[Continued.]

16,421. Who does the certification?—The actual certifying doctors are, in the case of the private patients, always the resident physician and the clinical assistant; in the case of the pauper patients the parish council sends two of its own medical officers from outside.

16,422. Do you yourself ever certify?—I never certify.

16,423. Then the two certificates are given and transmitted to the Sheriff?—Yes.

16,424. And an order is pronounced by him, and the patient is taken from your ward to the asylum to which he is directed?—Direct to the asylum, yes.

16,425. But apparently that happens in a relatively small number of your cases?—Yes, only 22 per cent.

16,426. Then I may take it that if a provision of this sort were made general throughout the country a very large proportion of cases would escape certification altogether?—Yes. I think one might assume that the similar proportion of cases might be treated with a similar result in other places.

16,427. Of course we must not assume that all those who are in your ward would be necessarily certifiable cases?—No; of course some of them might have recovered at home.

16,428. We must not assume these are all cases which would otherwise have been certified, but in consequence of your facilities escape certification; some of them would never have been certified anyhow?—No doubt. There is one point with regard to that, and that is on the question of the seriousness of the illness. It might be said that these cases were all very slight cases which would never have been certified; but I think it is sufficient answer to that to point in the case of melancholia to the number of those which at all events have been sufficiently severe to attempt to commit suicide before they came in; that is to say, out of 87 cases of melancholia, 58 had already attempted to commit suicide. That shows of itself that they were serious cases, and the same applies to the other diseases.

16,429. *Sir David Drummond*: Is there any compulsion upon the other physicians to send you cases that become mental?—There is no compulsion, but they prefer to do it.

16,430. They leave them in the ward as long as they can do so without disturbing the other patients?—Yes, and then of course there is always, in the case of the high wards three flights up, the risk of suicide.

16,431. The physician may use his discretion whether he transfers a patient from his own ward to yours?—Yes, but he is generally rather anxious to do so.

16,432. Some of these hysterical cases are very interesting for students, and they are not dangerous cases?—But they are still available for students in Ward 3.

16,433. *Miss Symons*: Do you get many re-admissions, doctor?—Not many; occasionally a person comes back. That applies particularly to cases of epilepsy in which a man has a post-epileptic state, and is in for a short time and gets better, and then has another attack in the course of a few months and comes in again.

16,434. Really recurrent cases?—Yes, recurrent cases, and the same applies to some recurrent types of mild insanity.

Mr. Micklem: Take the case of a pauper patient whom you have to certify for the asylum; I suppose the cost of maintaining him in the asylum is exactly the same whether he is certified or uncertified. How is it in Scotland where you seem to admit the voluntary patients—these people are not allowed to go in as voluntary patients?

16,435. *Chairman*: They do not get the grant—is not that the trouble?—The point is this: there is a Government grant in aid; I cannot give you the exact figure, it is roughly between £5 and £6, but this grant in aid is available for pauper patients who are certified, but it is not available for anyone

else, so that if a pauper patient goes in as a voluntary patient then his parish council loses his grant in aid.

16,436. We have still to deal with one or two of the residue of your cases. I see that a small percentage is transferred to other non-mental hospitals, chiefly poor law hospitals?—Yes; that for example includes cases of senile dementia; that is the most typical kind of case coming under this heading.

16,437. You have told us about the length of stay. You have already alluded to the great advantage which many of the cases derive from being in a general hospital; that, their ailments being associated with physical disease, they have at hand all the resources of surgery for their treatment, as well as the fact that there are pathological and bacteriological laboratories available and specialists at hand. All these are available to your cases there, which of course cannot be available to the same extent in an asylum properly so-called?—No, unless it happens, as in the case of Edinburgh, to be close to us, and to be very well provided with a laboratory of its own.

16,438. Quite so. Then you regard it as advantageous that these wards of yours, being part of the general hospital, are open to public visitation, and in that way public opinion has an opportunity of satisfying itself that everything is all right?—Yes; one feels that that is a great safeguard, that public opinion can satisfy itself at once, or, if there is anything unsatisfactory, then a complaint can be lodged at once, which is a very important thing.

16,439. Have you formed any opinion as to the type of cases which are best suited for treatment in this way?—Well, I think the types which give the best results are, first of all, confusional insanity due to exhaustion, or due to a toxic state following, for example, infectious fevers. These recover very well. Then the same thing applies to cases of mental derangement occurring in the course of syphilis too, in which a correct diagnosis means a cure. It is very important in this particular disease that the diagnosis should be made at once, and one feels that if they come into a general hospital this is more certain to take place than if they went perhaps to a district asylum where the matter might be delayed longer.

16,440. That brings one to a very important feature, that to get the benefits of an asylum the patient has to be so far advanced in his ailment as to require to be certified?—Yes.

16,441. Whereas in your case, certification not being a necessary prerequisite to treatment, I suppose patients will come at an earlier stage?—Yes. Of course, they sometimes are very severely affected mentally. A patient may be quite stuporous or quite violent, and show all the symptoms of general paralysis of the insane. The case presumably would be one just at the beginning of that disease, and then by getting the diagnosis made at a very early stage, one can apply the treatment at once, and many of these patients become perfectly well again. For example, I had a case quite recently of a man who had been very violent, who was in a stuporous condition, was found to be suffering from this condition, received treatment, and in three months was again perfectly normal mentally and back at work.

16,442. *Sir Ernest Hiley*: He would not have got the same treatment in the public dispensary provided by the town?—Yes.

16,443. He would have got the same treatment?—Yes, he would have got the same physical treatment, but he needed also in-patient treatment, owing to his mental state. Of course, such a patient is passed on afterwards to that department as an out-patient, to continue as an out-patient. Then, to continue these cases, melancholia gives very good results, despite the fact that many of these melancholics were very much depressed indeed, so depressed as to have attempted suicide. About 60 per cent. of these cases became sufficiently well to return home, and about 40 per cent., on the other hand, were passed on to mental hospitals. Then with regard to the violent cases of psycho-neuroses,

20 April, 1925.]

Dr. JOHN D. COMRIE, M.A., B.Sc., M.D., F.R.C.P.,

[Continued.]

hysteria, neurasthenia, and so on, with very marked mental symptoms, the benefit of the hospital treatment again appears in this, that in 50 per cent. of these cases it was possible to find a definite physical cause for the condition. Some of these cases were operated upon. Some had various forms of treatment; and in all the cases except one, the patient left hospital to go home again; one case went to a mental hospital.

16,444. *Chairman*: That is a very good record of that type of case?—Yes, and, as a matter of fact, this one case went to the mental hospital as a voluntary patient, because arrangements had been made for her doing so before she had come into the ward.

16,445. Then, on the other hand, have you found that cases of chronic manic-depressive insanity are not so suitable for you?—They are not so suitable; that is largely on account of the question of time; they require a long time, and a longer time than we can afford to give them.

16,446. And consequently do your records show that some 60 per cent. of these cases have to be passed on to mental hospitals?—Yes, whereas 40 per cent. recover sufficiently to go home.

16,447. Then in cases of fixed delusion, were these cases passed on to mental hospitals after the condition had been diagnosed and found to be established?—There it is a question of diagnosis.

16,448. These are not cases appropriate for treatment in your wards?—No, the treatment there would have no special benefit.

16,449. You focus your conclusions in three propositions which we might just put on our note. You say that you draw the following conclusions with regard to the treatment of early mental cases in general hospitals. Will you just read out your three propositions?—"Firstly, slight and undiagnosed cases of mental disorder admitted to a general hospital may in about 60 per cent. of cases be expected to recover sufficiently to return home within a period of six weeks." That means, of course, not returning home for full work, but very often going to live with relatives in the country for a time afterwards, but, at all events, to live in an ordinary house under ordinary domestic conditions. Then secondly: "Treatment in a general hospital is particularly valuable in expediting recovery because of the relative ease with which physical conditions (infective, exhaustive, or reflex) as partial causes can be discovered in a large proportion of the cases of confusional mental states, melancholia, and psycho-neuroses." Then thirdly: "The association of mental cases with patients who are normal mentally, and the greater freedom of access by the public in a general hospital are important factors in expediting recovery and in establishing public confidence."

Chairman: I think we have had a very complete and useful account from you of your work, for which we are obliged. If any of my colleagues have questions to ask they will do so.

16,450. *Mr. Snell*: I would like to ask Dr. Comrie about the great diminution of cases due to alcohol in one form or another, these figures are extraordinarily striking. To what do you attribute that great falling off since 1913 to 1924?—There is no doubt that less whisky is being drunk in Scotland; less spirit, less alcohol generally is being drunk in Scotland, and there is no doubt there are fewer drunken people. Then I would point out, that not only is the number of cases less, but I have divided alcoholism into two types, first of all, drunkenness, and secondly, delirium tremens; and one notices particularly with regard to delirium tremens that there has been a very marked fall since 1883, from 91 to 14, whereas ordinary drunkenness has fallen from 210 to 119—that is practically half.

16,451. Do you attribute that to what we call voluntary abstinence from alcohol?—I think it is voluntary abstinence. It is difficult to say why people are more abstinent. In my own mind, although I

have no particular reason for saying it, I have rather associated it with the increased price.

16,452. That is what I am wanting to find out, whether it really does mean a change in social habit, or whether there are economic influences operating?—I think that perhaps general influences may have a good deal to do with it. The army, for instance, had a good deal to do with it; there was a very striking drop (although the process had begun before 1914) between 1914 and 1924. I think the military discipline of the army had a good deal to do with it.

16,453. *Chairman*: In Edinburgh, as far as I remember, prohibition is not in operation in any of the wards?—No.

Chairman: Of course, as you know, Mr. Snell, we have local prohibition, but, as far as I know, Edinburgh has not prohibition.

16,454. *Mr. Snell*: Yes. If you look at the figures as between 1913 and last year they fall from between 50 and 60 per cent. in 1883, to 50 per cent. in 1913, and then they drop to 26 per cent.; so it is extremely interesting.—Extremely interesting, and there is no doubt that the type of alcoholism, the severity rather of the alcoholic cases, is very, very much less.

16,455. Put quite bluntly, what I want to find out is whether the amount of unemployment which exists on the Clyde and all round that southern part of Scotland has to be taken into account in considering these figures.—Of course I am only considering Edinburgh, but I think probably there are somewhat similar figures in the west, and I think probably unemployment has something to do with it.

16,456. That would fit in with your ideas as to price?—Yes.

Mr. Snell: That is not so pleasing as it might have been.

16,457. *Chairman*: Is the whisky still of the same potency in Scotland?—No, I think not—much less.

Chairman: That would be another element to take into account.

Mr. Snell: One notices in connection with that that there is an increase in the cases due to poisoning and attempted suicide.

Chairman: Methylated spirit has become a beverage, I am afraid, nowadays.

16,458. *Sir Humphry Rolleston*: With regard to the early treatment in hospitals, I suppose perhaps the greatest of the several advantages is the much greater facility for correcting any physical infective causes, and that the psycho-therapeutic aspect is perhaps not so marked, although it is a tremendous advantage from the environmental point of view to remove the patient from the depressing conditions?—Yes.

16,459. You, no doubt, go in for psycho-therapy, but the real great advantage in a general hospital is perhaps first the great facilities for skilled examination?—Yes, I think so, both as regards the question of laboratories, and then perhaps even to a greater extent the possibility of getting physicians, surgeons, gynaecologists and so on so readily.

16,460. Psycho-therapy is carried out?—Yes.

16,461. But you lay more stress on the team work, so to speak, than on the specialised treatment?—Yes, I am, in this report, laying more stress upon the team work.

16,462. *Sir David Drummond*: Have you discussed your methods in Edinburgh with alienists in this country? Have you gone into the question with any of them?—I have discussed it a good deal with Professor Robertson.

16,463. I meant in England?—Occasionally. I know a number of alienists, and I have spoken to them.

16,464. Do you know the views they entertain about this, the possibility of introducing mental cases into general hospital wards such as you have?—Some of them, I think, are very much in favour, as I have heard it expressed, of having a less cloistered form of treatment, than that at present in vogue.

16,465. As far as you have gathered, your methods in Edinburgh would be acceptable in this country?—I think they would be acceptable and feasible.

20 April, 1925.]

Dr. JOHN D. COMRIE, M.A., B.Sc., M.D., F.R.C.P.

[Continued.]

16,466. *Sir Ernest Hiley*: Would it be possible to extract from the accounts of the Royal Infirmary the cost of running this ward of yours?—Yes, I think it would be. I would be very happy to forward it.

16,467. Could you let us have that without much difficulty?—Yes, I will forward it to the Secretary.

16,468. *Chairman*: Then perhaps we should just add that you have been good enough to furnish us with a report, from the British Medical Journal for September 27th, 1924, of an article which you con-

tributed on "Early Mental Disease treated at a General Hospital." You refer us to that article for more elaborate detailed examination of the cases which you have had through your hands?—Yes, the *précis* is really to a large extent taken from this.

16,469. But we have here in this pamphlet the more elaborate examination of these cases to which you refer us, if we wish further detail.—Yes, fuller statistics.

Chairman: We are very much indebted to you.

(*The Witness withdrew.*)

Dr. JOHN CARSWELL, F.R.C.P. (Glasgow) L.R.C.P. (Edinburgh) called and examined.

16,470. *Chairman*: Our next witness is Dr. John Carswell, a Fellow of the Royal College of Physicians of Glasgow and a Licentiate of the Royal College of Physicians of Edinburgh. (To the witness) Dr. Carswell, I think you have been engaged in medical practice, and in lunacy administration since 1878?—That is so, yes.

16,471. You began your career in the Woodilee Asylum, Lenzie, to which you were appointed as Assistant Physician in that year?—I was.

16,472. Then just to take your experience, you were certifying physician in Lunacy for the Glasgow parish from 1889 to 1914, and Lecturer on Mental Diseases at Anderson's College Medical School, and Extra-mural Lecturer in Glasgow University. Then you were engaged in consulting practice, and were Medical Officer for mentally defective children to the Glasgow School Board, and then you were a Commissioner of the General Board of Control for Scotland from 1914 to 1921?—I was.

16,473. On retiring from that office you have been since attached to the London region of the Ministry of Pensions as Neurological and Mental Specialist, and in 1924 you delivered the fifth Maudsley Lecture?—That is so.

16,474. Now we should like very much to have from you an account of your pioneer work in Glasgow. It is alluded to in your lecture, but perhaps you will tell us in a little more detail of the inception of that scheme, and how it has worked in practice. I think it started so long ago as 1889, with a suggestion which you then made to the local authority in Glasgow?—That is so.

16,475. What was your motive in making the suggestion that you then made to the local authority?—The primary motive was that, in common with others, I was impressed with the fact that mental disorders were entirely neglected, so far as the study and systematised knowledge of them were concerned, until the patient appeared as a certified lunatic at the door of an asylum. No provision existed anywhere at that time for meeting the needs of the patient while the patient was still in the condition which he, as well as his relatives and friends and medical men, recognised to be of a serious import in relation to the question of his mental state. Arising out of that conviction was the feeling, not my own, but it was general and had been expressed by others in medical journals before that, that some provision ought to be made to meet the case of patients in that state. It happened that the Barony Parish of Glasgow, as it then was known, with which I was connected, found that its asylum at Woodilee was getting overcrowded, and the question arose therefore in a very practical form: What can be done? And it was with an open mind that my suggestion was received, that what might be done provisionally was to have some investigation made that could be systematically recorded as to the nature of the kind of cases that applied to the inspector of poor for relief in respect of insanity, and that provision should be made for placing certain of the cases under care and treatment without going to the asylum. These were the motives.

16,476. I follow. You were really impressed with the fact that the only passport to treatment was a certificate of lunacy?—Not only was it in law but in

fact; there was no early treatment of lunacy. I am speaking of public insanity, the rate-supported insane. Of course the well-to-do people were always at some advantage in that respect.

16,477. But so far as the rate-aided patient was concerned, until he was certified he could not get the benefit of any of the recognised forms of treatment?—Nothing.

16,478. And was it in view of that fact which had impressed itself on you that you made your suggestions to the local authority?—That is so.

16,479. I think your suggestions took two main lines: first of all, that the certification of all cases reported to the local authority as in need of asylum care should be placed in the hands of one responsible and experienced medical officer?—That was one recommendation.

16,480. And, secondly, that the medical officer should be provided with hospital facilities for the temporary treatment of patients who, in his view, might be treated without recourse to legal certification?—That is so.

16,481. So first of all we may say it was preventive, in the sense that certification was to be avoided if it could be?—That is so.

16,482. And, secondly, if and when certification had to be resorted to, it should be in the hands of a responsible medical officer conversant with this particular form of malady?—Yes. I have prepared a supplementary *précis* which I do not propose to read, unless you desire it, but if you would allow me to put it in, on the evolution of lunacy administration in Glasgow, I would like to read relevant to your question now one portion relating to the appointment of a certifying physician.

16,483. If you please?—I think it is so important that I thought it wise to put it definitely in writing. "The idea of having a special medical officer to examine and where necessary to certify all cases arose out of the obvious necessity for a policy of the nature proposed"—that is to say, the policy of having observation wards and sorting out cases without certification; it arose out of the necessity for the success of such a policy that it should be "carried out by one responsible official who would inform himself of the views of the Council and of the General Board of Lunacy, as well as the limits of responsibility which the inspector of poor would undertake on the advice of his medical officer; because it must not be forgotten that the responsibility for the steps taken to certify or otherwise dispose of a case of lunacy reported to him rests by statute upon the inspector of poor. Clearly, in a new movement, highly experimental, and not free from legal and other pitfalls, the statutory official had to have the assistance of a medical officer who would be disposed to carry out his duties along the lines indicated. I make this observation because the appointment of a certifying physician has been sometimes represented as arising out of the necessity for having an expert opinion. I make no comment upon that aspect, but in the interests of historical accuracy, and for a better understanding of the position, I think it necessary to make this clear." Perhaps I may be allowed to say, notwithstanding that out of the many thousands of cases that passed through my hands during the years I held that office,

20 April, 1925.]

Dr. JOHN CARSWELL, F.R.C.P. (Glasgow), L.R.C.P. (Edinburgh).

[Continued.]

the Parish Council had not to answer a single letter of complaint relating to all these things. The main thing was that you could not embark upon an experiment of this sort and just leave it haphazard, and get this man or another man to come in and certify. It was a policy clearly thought out, submitted to the General Board of Control, and it involved the official responsibility of an official who was trusting to the medical officer to advise him correctly.

16,484. Then would you say it is an indispensable feature of the scheme of having the provisional treatment of mental cases in hospitals that the certifying doctor should be a specially selected official?—I think so.

16,485. That makes it more difficult, of course, to deal with cases occurring in rural districts, because you may not always be able to get the services of an expert in such parts of the country?—I do not think that difficulty is so serious as it appears. In any case, in England the law provides for the removal of a patient without being visited and certified, a simple ordinary urgency order removes a patient, and he can immediately be examined by a man of experience and expert knowledge, and with the full knowledge of the policy that is being followed by the responsible authorities. I do not know that I make that point quite clear. What I mean is this, that it is easy to illustrate it by the position of a medical officer of health, not only does he know about drains, and other matters connected with that, but he knows the general lines of policy within which he must act.

16,486. *Earl Russell*: You would remove the patient to a centre anyhow?—That is being done now in England.

16,487. Before he was certified?—In Scotland, and in my practice I always visited the patient at his own home, but in England patients are removed pretty summarily.

16,488. But only on emergency orders?—Only on an emergency order, which is not a real certificate of insanity at all; it is an emergency order, and, as I understand, it is nearly always acted upon in the case of a reported insane person.

16,489. Would you suggest that the emergency order should be applied to all cases to enable them to reach this centre for examination?—I think the public mind in England seems to be so habituated to that procedure, that it would not shock any sensibility in the English mind that a patient should be removed on an urgency order on the certificate of the nearest medical man available.

16,490. Of course there is always the shock to the alleged lunatic himself?—That is so, but as I understand that is pretty well generally the universal practice here. I am open to correction in the matter.

16,491. *Chairman*: In some parts of the country undoubtedly the urgency order is taken advantage of to a large extent; we have had evidence to that effect?—But in London I think almost all cases are removed to a Poor Law infirmary, and there seems to be no objection to it.

16,492. They are taken there by a relieving officer without a medical certificate at all?—That is so.

16,493. Then they must be brought before a magistrate within three days?—Precisely. There is ample time. If a relieving officer has that power, as I understand he has, to remove a patient reported to him as requiring care on account of the state of his mind, then the difficulty of the rural districts, it seems to me, disappears.

16,494. Except this, that he removes him naturally to the local poor-house. The local poor-house will not, of course, have so complete an equipment, and the patient would not get the advantage of being certified by a specialist, unless he were taken much further away—taken into some centre?—I presume that you are coming to a scheme for the substitution for the Poor Law infirmary arrangement of some kind of reception house; so that when I made the suggestion that

the patient could be removed there, I had in mind that it would be not to a Poor Law infirmary, but to a reception house where an experienced man was available.

16,495. Your view seems to be that the task of medical certification should not be in the hands of the ordinary medical attendant, but should, in all cases, be in the hands of some special functionary?—For the reasons I have taken some trouble to state. More on the ground of public policy than on the ground of the more efficient medical skill available, I agree; and would so recommend a scheme of that sort.

16,496. Only in the case of rate-aided patients?—I am speaking entirely of rate-aided patients; and I think the question of the certification of the person who is to be provided for on the direct and sole initiative of his own relatives or other person interested is another problem entirely.

16,497. *Earl Russell*: Another difficulty that presents itself to our minds necessarily is that in this country you do not deprive the patient of his liberty without a medical order, unless he is dangerous to himself or to others, or is being ill-treated. Now under your system everybody would be in the first instance deprived of liberty without even the sanction or protection of a local doctor?—I am afraid, if I may say so, your Lordship has misunderstood my position; I do not suggest such a system. I was meeting the case of the rural districts. I think that every person who is stated to be insane ought to be visited in his own home, if possible, by a responsible medical officer.

16,498. By your special official, do you mean?—I do not know. If you cannot have a special man you must have the other. But the rural district difficulty has been so frequently stated (I mean outside) that I do not think it is such a serious difficulty as at first it appears; but in any case I would like very firmly and strongly to say that I know of nothing (again I am speaking of rate-aided patients) that would justify even a remote suggestion that the general practitioner has on the whole not been a successful official in the discharge of his duties under the Lunacy Acts towards rate-aided patients, and all other classes of patients. I think the general practitioner in this country has discharged his duties excellently well, and they are disagreeable, responsible and unsought-for duties.

16,499. *Chairman*: I think that what we should specially like to have from you is your actual experience. I am afraid it will be our task to judge how far the same expedients can be adopted elsewhere. We would like to have the practical evidence of what yourself devised and did in Glasgow. That will be most useful to us?—Yes. In practice it came to this: we had a population round about 600,000; very largely, to the extent of roughly 80 per cent., people who when mental illness afflicted any member of the family, required public assistance. When a medical man became aware of an illness of that character he intimated, or he asked the relatives to intimate, to the inspector of poor. The inspector of poor, or his assistant immediately telephoned to me, and, within a very short time, I visited the patient. Speaking almost in strict accuracy, every case reported every day was seen and disposed of that day. There might be two cases in a day, there might be six or eight cases in a day, occurring all over a fairly widely scattered area. These cases were all visited, examined, reported upon, and disposed of the same day.

16,500. They were brought to your knowledge by the inspector of poor, and was he under an obligation to notify you?—He notified to me during 24 hours of 365 days.

16,501. But I want to know under what authority he notified you. You were the medical officer. You must have held some appointment which had been given to you?—As Certifying Physician in Lunacy to the Parish.

16,502. That is a novelty?—Yes.

16,503. What one wants to get at is how you came to hold that office. Did the local authority institute that office in Glasgow?—Yes.

16,504. And appointed you to hold it?—Yes, they appointed me to hold it.

16,505. What statutory authority or other authority had they for starting such an office?—No statutory authority was necessary beyond this, that they had statutory powers to appoint medical officers to carry on the medical duties of the parish.

16,506. And availing themselves of those general powers, they decided to have a certifying physician for their lunacy cases?—That is so.

16,507. Did they provide a salary and establishment for that office?—They provided a salary—of sorts.

16,508. *Sir David Drummond*: Did they pay according to the number of cases?—No, I was paid a salary. There was no inducement to certify patients.

16,509. *Earl Russell*: No fees at all?—No fees at all.

16,510. Had you an office, Dr. Carswell?—I had an office—that is to say, I had a room at the chambers of the parish council.

16,511. And that was the place where you received those notifications from the inspector of poor?—No. I received them in bed sometimes by 'phone in the middle of the night—at any time, and at all times.

16,512. Were any rules or regulations framed by the parish council requiring the inspector of poor to notify you?—Yes.

16,513. And it was in pursuance of those regulations that every case occurring in this large population of 600,000 persons was at once notified to you, and visited by you?—Yes.

16,514. *Sir David Drummond*: Only the 80 per cent.—only the pauper patients?—Only the pauper patients; 80 per cent. of the whole population came under that category; that is to say, they required public assistance.

16,515. *Chairman*: We have got an idea in our minds of the system that was inaugurated by you. Then when the case had been visited by you, what was the next stage in the patient's history?—The patient was examined and a responsible decision come to in his own house, and his relatives were seen; the matter was discussed, and it was decided either to remove the patients to the observation wards, or to certify the patient and remove him to the asylum. The removal of the patient either to the one place or to the other was carried out by the assistants, the removing officers appointed by the inspector of poor.

16,516. Then it was really in your discretion whether the patient was sent to those observation wards, or was regarded as a case suitable for immediate certification and removal to an asylum?—Entirely within my discretion.

16,517. Then that class of case visited by you in its home I can understand; but there must be a considerable number of cases, I should think, in Glasgow, of persons wandering in the streets insane?—A considerable number.

16,518. What happened to that class of person?—They were also notified by the police to the inspector of poor, and then the rest of the process is the same.

16,519. But where was the person taken to? He is, *ex hypothesi*, a person with no home. Where is that taken to in the meantime detained?—He was detained at the police office.

16,520. Is that where you saw him?—That is where I saw him. Perhaps it might be useful to interpose here that supposing a man or a woman were taken out of the river, having attempted suicide, by the police and taken to the police office: there was no intervention of court proceedings or police charges, or anything of that sort. The case was seen immediately by the medical officer of the police, who said "This man is insane, or he is in need of observation," and the police lieutenant, acting on the opinion of the medical officer of the police intimated to the inspector of poor, and I was told by the inspector of poor; and perhaps within a couple of

hours the patient was safely in bed in the observation wards, or safely removed to the asylum. No charge of attempted suicide, or anything of that sort was made.

16,521. *Earl Russell*: Would such a charge get entered on the charge sheet in the police court?—No, it is not a crime in Scotland to commit suicide. In order to regularise sometimes the necessary detention of a patient overnight in the police court, they might enter on the charge sheet a charge of disorderly conduct.

16,522. *Chairman*: You must not take me as assenting to the view that *felo-de-se* is not a crime in Scotland. I see how the thing worked. You have not told us yet of the institution of those observation wards, which is a very necessary part of this system. How did they come into being?—I thought I had already mentioned that, owing to the urgency that arose from the needs of the parish by their own asylum reaching a state of overcrowding, they considered what could be done to avoid building a new asylum. Therefore there was a very open mind when, in answer to that enquiry, I suggested the establishment of observation wards, and the sorting out and dealing with patients who might not need to go to the asylum at all.

16,523. Where did you get provision of that accommodation?—To begin with we had to be content with a very small amount of provision in one of the poorhouses of the city. That continued for some years until two parishes amalgamated. You understand the scheme began with the Parish of the Barony. The Parish of the Barony and the Parish of Glasgow in 1889 united, and then we had the 600,000. Prior to that we were dealing with a population in the Barony Parish of 300,000, but in 1889 the amalgamation of the parishes afforded a larger basis, and then the united parish set out on a large scheme of hospital building. They built three large hospitals entirely removed from poorhouses, Stobhill, the Western District Hospital and the Eastern District Hospital.

16,524. These were Poor Law infirmaries?—These were what is known in England as Poor Law infirmaries. We transpose the terms in Scotland. Our big general hospitals (like St. Thomas's) would be called infirmaries, whereas in England you call them hospitals. We call the Poor Law hospitals, hospitals, not infirmaries; so that when you use the term "infirmary," for example, the Royal Infirmary of Edinburgh, is the important General Hospital of Edinburgh.

16,525. *Earl Russell*: Can you give us any idea, however rough, of the capital cost of these three new hospitals?—At the moment I would not like to trust my memory, but they were regarded as not inexpensive for the provision made.

16,526. £100,000, or half a million, or what?—I think nearer half a million for the three hospitals. Stobhill is a very large hospital. They have 1,200 beds there, or more, and it is on a large village system with wards scattered over a considerable area. The other two hospitals were in the city proper and meant to meet the cases of people just immediately at the doors.

16,527. *Chairman*: You have told us that they were quite apart physically from any poorhouse, and were infirmaries, as we call them in Scotland, in everything except that they were rate-aided.—They were rate-aided.

16,528. But they had the features, so far as laymen visiting them would observe, resembling those of the general hospital, I take it?—They resembled exactly a general hospital of London.

16,529. And the only difference between them and, let us say, the Western Infirmary in Glasgow, was that the one was dependent upon voluntary contributions, whilst the other was dependent upon rates?—That is so.

16,530. In treatment and in character and in staffing, did they compare with each other on a more or less equal footing?—In these respects they do. Of

20 April, 1925.]

Dr. JOHN CARSWELL, F.R.C.P. (Glasgow), L.R.C.P. (Edinburgh).

[Continued.]

course, naturally the Western and the Royal Infirmarys of Glasgow get men who have reached the top of the tree professionally as the visiting physicians and surgeons. The others have men of experience, but who are either past the top of the tree or are climbing to the top of the tree; but in medical status they stand very high. The mental patients were provided for in the Eastern District Hospital there in a separate pavilion, not at any of the other hospitals at all.

16,531. *Sir David Drummond*: Not at Stobhill?—Now they are. I shall develop that in a moment. At the outset we had a pavilion for 50 beds, 25 women and 25 men, at the Eastern District Hospital.

16,532. *Chairman*: Now was that the first ward or block of the type which had been instituted in Scotland?—It was; that was opened in 1904. We were really carrying on one way and another for some years before 1889, before the amalgamation of the two parishes, until the whole scheme could be completed, and this new hospital opened in 1904.

16,533. Then, when the other two hospitals came into existence were they also equipped with special accommodation for mental cases?—No. I have explained that only at the Eastern District Hospital had we the pavilion for 50 patients.

16,534. What is the position now?—The position, as I understand, now is that they still have 50 beds in the Eastern District Hospital, and I think they have 120 beds (I speak from hearsay only) at Stobhill Hospital, and they have now two medical officers, one the certifying physician in lunacy, Dr. Mackenzie, who continues the work at the Eastern District Hospital, and Dr. Anderson, who acts as a visiting physician to the wards at Stobhill.

16,535. Now, after 1904, and so long as you continued certifying physician, was the only provision available to you for observation and treatment this block in the Eastern District Hospital?—That was all.

16,536. Because you had only 50 beds, and I was wondering how far you found those resources adequate?—They were adequate for the purposes we had in view during that period, consistent with the state of opinion in relation to lunacy administration then. The fact that the observation wards proved so successful has given rise to larger views and more open-mindedness, and therefore it was only to be expected that a larger extension of provision would be made. But during the ten years that I controlled these wards I think the 50 beds were adequate for the purpose we had in view at that time, as I have said, consistently with the state of medical and public opinion on the question.

16,537. The purpose you had in view was that in cases which were not immediately declared cases, and therefore not appropriate for immediate certification, the patients should be under observation for a time and treatment in this block; and from there either discharged recovered or, if necessary, sent on to a mental asylum under certification?—That is so.

16,538. It gave you a period for more complete and accurate diagnosis and more observation of the case and deliberate judgment as to its disposal?—That is so, and did more, a very important matter: it gave the relatives and, in some aspects of the case, even the patient, time to realise the situation. The great difficulty in dealing with a mental case is that relatives need time to realise the situation. In well-to-do circles that is more or less easily secured; they can go abroad, they can take the patient to the seaside, they can do lots of things. When it occurs in a working man's home, and the woman who carries the whole domestic burden of the daily routine breaks down, it becomes a matter of urgency, and her husband and others are not keen that the patient should go to an asylum, and the patient is very willing to go somewhere, but would dread going to an asylum. That would be her feeling; I call it dread, it is her dread; and if unfortunately after a month or six weeks' treatment in hospital it becomes obvious that not six weeks but six months, or even 12 months, would be necessary, the patient and her friends have realised

then the need for it; and you have met a great public want there in giving these people time to realise the situation and satisfying them that they have got everything done that can be done for them in a preliminary way before they are sent to an asylum.

16,539. *Earl Russell*: At what stage before certification do the relatives come in touch with anybody, and who is it they come in touch with? Is it the inspector of poor, or is it the certifying physician in this case?—They come in touch with their own medical attendant, and their own medical attendant refers them to the inspector of poor.

16,540. Yes, but I mean before a certificate is made is information present to the mind of somebody connected with the certification as to what the relatives wish, and what the conditions of the home are, and so on?—Yes. The certifying physician has seen the home, he has been there. He sees the patient, of course, regularly, as a matter of treatment, every day, and he sees the relatives, the husband or the wife and others frequently on their visits to the hospital.

16,541. I do not understand that. I thought they were brought to you, and I thought you were the person who saw them in the observation ward?—No, I visit the patients at their own homes.

16,542. You first saw them, not when they were in the observation ward, but in their own homes?—That practice has been somewhat relaxed in Glasgow, and they do now, I understand, remove patients fairly freely in the way that your Lordship suggests. Personally I regard it as of the utmost importance that the certifying physician in lunacy should visit the patients at their own homes. The patient should not be disturbed at all until he is seen by a responsible medical official with all the possible appliances in his hand for the adequate determination of what is best for the patient. That I regard as important.

16,543. *Chairman*: We have been much interested in the suggestions that we have received that there should be some intervening period between the first discovery of the mental aberration and the ultimate judgment upon the case by way of certification. Various expedients have been suggested for doing that, and we have heard from Dr. Comrie this morning an interesting account of how it is done to some extent in connection with the Royal Infirmary in Edinburgh, which is not a rate-aided institution at all. In Glasgow the problem seems to a large extent to have been solved along the lines that you promoted, which were to have in the rate-aided hospitals observation wards to which patients could be taken for this intermediate period, and there dealt with in one way or another. It does seem to be necessary to get some kind of house, either a reception house or an observation ward, in which patients can be kept for the time being, until they are properly diagnosed and disposed of ultimately?—I thought that was the proposition I was putting before you.

16,544. Yes, that is exactly what you have exhibited to us. That system is still in operation since you left?—It is still in operation and very successful, and I understand that instead of the limit of six weeks, which was considered a great concession to my views, the Board of Health and the Board of Control have consented to a period of six months.

16,545. Tell me how you faced and dealt with one difficulty that of course occurs to one. Many of those cases which you sent to the observation ward must have been fractious and obstreperous, I should imagine?—Yes.

16,546. What authority had you to detain them against their wishes?—No more than you have already heard from Dr. Comrie to-day.

16,547. You did what was considered best from the medical point of view for the patient?—No more and no less; and I think personally it is very little authority that is contained in Schedule G, of which you heard from Dr. Robertson the other day.

16,548. *Earl Russell*: Were these all dealt with under Schedule G?—No; I presented that to the Board of Lunacy at the time, and they would not

20 April, 1925.] Dr. JOHN CARSWELL, F.R.C.P. (Glasgow), L.R.C.P. (Edinburgh).

[Continued.]

listen to it. It was a special arrangement made with the Local Government Board.

16,549. Before certification what is the provision with regard to the maintenance—are they maintained by the rates just as any other sick poor person would be?

Chairman: If they are in a rate-aided hospital they must be, I suppose.

16,550. *Earl Russell*: Is a contribution made from the parish, or is it all part of the same thing?—It is all part of the same thing. I have prepared this little statement on the evolution of Lunacy Administration in Glasgow. The Glasgow Parish Council is also the Glasgow District Board of Control. It acts like your Asylums Committee of the London County Council. It sits as one body with its own officials, the same officials as the other, and then it sits as another body, the Parish Council.

16,551. Rather as it would be here if the guardians ran their own mental hospital?—Yes, and if they were constituted as the lunacy authority. The parishes in Glasgow did run their own asylums, but they were not the lunacy authority. That is a complicated question.

16,552. *Chairman*: In law these persons in these wards could not be detained?—In law they could not be detained.

16,553. Yet in their interests in many instances it would be proper that they should be detained, would it not?—In their own interests it was proper that they should be detained.

16,554. And, in fact, were they detained?—In fact they were no more detained than any of you gentlemen would be detained in a nursing home, if unfortunately you found yourselves under the necessity of going there.

16,555. *Earl Russell*: Is that quite so, Dr. Carswell?—That is quite so.

16,556. *Chairman*: Suppose one of these patients in an observation ward at Stobhill, or in the Eastern District Hospital, had announced that he was going out, and was going to throw himself in front of the first train, what would you do?—Certify him and remove him to the asylum.

16,557. Or suppose that he was in bed, and in a state when it would be exceedingly dangerous for him to be allowed out, would you not keep him down in bed?—I would if he was to be well to-morrow or next week. I would not send him to the asylum if I knew that, with a little restraint or treatment, in the course of a week he would be all right. He would thank me for doing it.

16,558. What we are considering is this, whether it may not be necessary as an accompaniment of this method of treatment that there should be compulsory powers of detention as well, because otherwise you will find yourself open to the criticism that you are breaking the law by detaining persons without any authority?—I am very conscious of that. At the same time I am very conscious of the need for keeping such hospitals free from any form of legal interposition in restraint of the patient. I do not think the difficulty is so great as it appears. I would rather take the risk, as I took it in the hospital wards, of having to certify a patient and remove him to an asylum, although I was very unwilling to do it, believing he would be well if he stayed there for a month or so. But if he insisted on going out, I would rather take the risk of doing that than have the other nine patients out of ten feel that they were in a place where they were detained. I think the atmosphere of the hospital is so easily engendered in these cases, and was successfully engendered, so much so that we almost never had the difficulty of having to consider whether I should remove the patient under a certificate to an asylum, solely for the reason that he wanted to go away—very rarely.

16,559. *Earl Russell*: And you would run the risk of actions by half-recovered patients, who had been discharged, against the managers for unlawful im-

prisonment?—We have run that risk. We ran that risk for ten years under my care, and the responsible authorities have never even had to answer a letter of complaint all the time.

Earl Russell: But this was Scotland?

16,560. *Chairman*: I am afraid we might have actions in England, judging from the experience in the Law Courts?—I fancy you have to put these matters a bit more to the test before you can be sure that is really the position. My experience is such that I am satisfied that 70 per cent. at least (I do not think I am putting it too high) of the patients who require treatment—again I am speaking of rate-aided patients, and it makes an important difference whether you live in a room in a licensed house or in a villa—70 per cent. of them are quite willing to remain in a hospital provided the accommodation is good and the attention is skilled and sympathetic.

16,561. I think one would recognise that on all hands the great bulk of the patients are both willing and grateful, but the question is with regard to those who are not; and it is the recalcitrant and difficult person who gives all the legal trouble afterwards?—Then I think he must be certified. Then you are running risks also; but I do not think the risk of establishing a hospital on the lines suggested need be complicated with the other risk that arises out of certification.

16,562. You would eliminate as far as possible all the legal element from it, and emphasise the medical element?—Yes.

16,563. And you think this transitional period ought to be as free as possible from the idea of compulsion?—It ought to be entirely free. I give that as a very deliberate opinion. If it is complicated with a legal position or the restraint on the patient, you will introduce elements into the general administration of that hospital that will adversely affect it.

16,564. To complete the thing logically you suggest that in this period of observation the patient should be under no legal compulsion to remain, but, if occasion arises for compulsion, then that should be dealt with by obtaining certification?—Compulsory detention.

16,565. Yes. I will make my point again. The patients in this institution are not to be compulsorily detained. They have been recommended to this place by the certifying officer; they have gone there, and if occasion should arise for their compulsory detention there against their declared wishes then you would say the expedient is to have them certified?—That was my expedient, and I know of no other. I hope I understand you, that you are excluding the question of any possible restraint as meaning the same thing as detention.

16,566. It is very difficult to know at what point the patient is being, in point of fact, made the victim of a breach of law in his own interests either in private practice or in an institution. But your conception of the system is that the patient who goes there should be under no legal form of restraint or compulsion whatever?—That is my view.

16,567. Should be an inmate of the institution exactly as the ordinary inmates of the institution are situated?—That is my view.

16,568. Then if occasion should arise for detaining a patient against his or her wish, you would propose at that stage to invoke certification?—I would.

16,569. *Sir David Drummond*: Only if they are certifiable cases?—Clearly, I am assuming that.

16,570. There are many people who elect to leave the hospital although they are not certifiable?—Oh yes, I am assuming that. The instance it arose out of was the man who says, "I am going away and shall throw myself in front of the first train."

16,571. *Chairman*: The other alternative method was the suggestion that there should be a period of observation in an institution without certification, but accompanied by some modified form of control which would be placed in the hands of the head of that institution, so as to obviate risks that might

20 April, 1925.] Dr. JOHN CARSWELL, F.R.C.P. (Glasgow), L.R.C.P. (Edinburgh).

[Continued.]

arise through patients exercising their freewill and deciding to go away without any notice, when it was bad for them to go away, escaping, and possibly committing suicide. It was suggested that during the transitional period there might be some modified power of control, but that, I gather, is not in concert with your view?—These considerations do not appeal to me when I keep in view my own personal experience.

16,572. *Earl Russell*: You do not want the patient to feel under duress—that is the prominent feeling in your mind?—I do not wish them to feel under duress of any kind. I think it is bad for the conception of the hospital idea, bad for the nurses and the doctors—bad all round. It will deteriorate the whole idea.

16,573. *Chairman*: Then would you give us some very instructive figures that you have?—Might I, Sir, before getting to that, emphasise the importance of paragraph 4?

16,574. About getting the cases at the early stages?—Yes, and also a most neglected class of case, namely, the depressed patient, and the confused and bewildered patient, due mainly to bodily exhaustion conditions, who are regarded as “not bad enough” for an asylum—(a horrible phrase that has crept into modern language, as bad as “the borderline case”)—“not bad enough” for an asylum, but who nevertheless constitute a large body of suffering people many of whom commit suicide while in a state manifestly requiring skilled treatment. That I consider is a most important consideration. Every medical man in practice among the poorer classes knows the kind of case. A woman marries at 18 or 20; by 35 she has had perhaps eight or nine children and, as they used to say in Glasgow, buried six of them. She has carried on all her social, physiological; and financial functions, under very poor conditions, and she breaks down; she gets dull, apathetic, bewildered; her house becomes neglected; her man comes home at night and there is nothing prepared for him; the fire is out. The doctor sees her, he does not know what to do with her; she is “not bad enough,” they say, for an asylum, neither is she in a literal sense. The existence of the observation wards in Glasgow had the effect of educating the medical mind into the knowledge that a woman of that sort could be reported to the inspector of poor just as though she were insane, knowing that she would be taken into the observation ward and treated there, but not certified insane; and that constituted a considerable number of the cases. And when you come to consider the statistics I would like to stress the fact that we reached the class of case that was urgently in need of care, and was never provided for, not even in asylums; and therefore with that remark on that, I think, very human element, a very necessary element from the medical view, I wish to look at the figures to which you refer.

16,575. *Earl Russell*: How does your percentage of certified cases compare, say, with the London figures?—That I cannot tell you. I have never been able to understand the London figures.

16,576. It ought to be a good deal less?—It ought to be a good deal less, and is.

16,577. *Chairman*: Your figures are rather instructive. Using the round numbers, I think the cases intimated numbered over 1,000 per annum in Glasgow. (I am taking page 2 of your *précis*.) Of these there were admitted to hospital during the ten years 1904 to 1914 an annual average of 640?—Yes.

16,578. Then of the cases treated in the hospital an annual average of 261 were discharged recovered and 111 were discharged improved—an average annual total of 372 cases, out of 640, who were treated without recourse to asylum care. That is the record of the work?—That is so.

16,579. And from that one can infer that, through the provision of probationary hospital wards, more than half of the cases there treated for mental disturbance succeeded in escaping certification altogether?—That is so.

16,580. And in addition you are enabled to treat, as you have just explained, a class of case for which at the moment there is no provision at all elsewhere?—Yes.

16,581. Included in those statistics are the class of case you have been describing?—That is so.

16,582. Then may we take it that the result of your experience in Glasgow has been that the system you then inaugurated in association with the Poor Law authority, the special wards for the probationary treatment of the mentally disordered, has succeeded there in solving this problem of treating persons who are mentally disordered, without certification and so as to avoid certification?—In so far as it is possible to do that.

16,583. Yes; you think that is the practical solution which you devised, which commended itself to the authorities in the West of Scotland, and which in practice seems to have worked very successfully?—That is so.

16,584. *Earl Russell*: Out of your 1,000 cases there were 360, I see, who were not admitted to hospital. Could you tell us a little about those cases? I take it none of them would have been certified in the ordinary course under the English practice?—They were either sent direct to the asylum or not certified at all.

16,585. That 360 may include some sent direct to the asylum?—Yes. That brings out the point that a sorting out did occur in the patient's home. The patient might go direct to the asylum.

16,586. *Chairman*: That is when you used your discretion in the first instance?—In the first instance I said, “This patient must go to the asylum direct.” But 640 of the 1,000 came into the hospital. For the rest nothing was done at all. That is to say: Sometimes it happened a man and his wife quarrelled and it depended upon who got first to the inspector of poor to report the other insane. Nothing was done there.

Chairman: Then you will refer us for further discussion of the matter to the copy of the lecture which you have been good enough to send us, the fifth Maudsley Lecture, which is in the hands of the Commission. We are very much obliged to you for telling us about your experience in Glasgow; I think it is most instructive for our purpose, if I may say so.

16,587. *Miss Symons*: Did you find that you could not keep many of the cases long enough; I think you said you could only keep them six weeks when you were there?—That was the understanding. We could, if a patient was recovering, by application to the Local Government Board get that period extended for another six weeks in any particular case, where we showed that further treatment would be advisable.

16,588. But where a longer period was necessary, did you find that many of those patients availed themselves of it—I suppose you did not, because they were all rate-aided patients, and they could not go as voluntary patients—or did you have voluntary rate-aided patients in Glasgow?—We had no voluntary rate-aided cases.

16,589. I think you heard Dr. Comrie's evidence, and he said he believed a great many more patients would have availed themselves of the voluntary provisions if they had been extended to rate-aided patients. I wondered if you had experienced the same difficulty in Glasgow?—I think a considerable number of patients of the rate-aided class would go to asylums voluntarily.

16,590. Take, for instance, the woman you gave us as an instance. Supposing that she was found to require a much longer period than six weeks or six months, it would seem rather hard if she could not go as a voluntary patient, though she might be willing to do so, and would have to be certified?—We would admit that difficulty if she is going to get

20 April, 1925.] Dr. JOHN CARSWELL, F.R.C.P. (Glasgow), L.R.C.P. (Edinburgh).

[Continued.]

well. It is only bad workmen who complain of their tools; you can always use your tool. Sometimes we meet a difficulty like that, I do not mind telling you, by getting the husband to take the wife home for a week, and bring her back again as a new admission. You have got to have resources; you cannot do a big thing like this with such a variety of circumstances to consider without having a little elbow room and a little common sense.

16,591. *Earl Russell*: Quite; you made the law your servant instead of your master?—That is so, as far as it was possible to do it in reason, but manifestly we could not lay ourselves open to risks. But a case such as you instanced just now we would neither send to an asylum nor turn out except in that sort of way.

16,592. *Mrs. Mathew*: I was sorry when you said that such a case would have to be reported to the inspector of poor. Is there no way out of that?—I expected to have been taken over points like this at some detail, and I would be very glad to offer the Commission my opinion upon that question. I have a very strong conviction indeed. I have indicated in my *précis* very briefly that in my view the proper authority for receiving intimation of the occurrence of insanity is the Public Health authority, and not the Poor Law authority at all. That opens a very large question. I had devoted a great amount of thought and consideration to it. I find little support from medical men in asylums, because they do not want the medical officer of health to get his nose into asylums; I find no support from medical officers of health because they do not want to be bothered with it. In Glasgow the Poor Law authority has discharged its duty magnificently, and I think, speaking generally, that can be said in Scotland as a whole. Take, for example, a woman who turns ill from an infectious disease: she is taken into an infectious diseases hospital run by the municipality, simply by the doctor attending the patient intimating to the medical officer of health that the patient is ill, and requires to go to an infectious hospital. When she develops mental trouble in that hospital, the doctor has to send for the husband and tell the husband that he must go to the inspector of poor and get his wife removed to an asylum at the instance of the inspector of poor. Well, I think that is a hardship, and I do not see that the admission of patients, or the treatment of patients, should be complicated by a Poor Law qualification, a poverty qualification; and I know no way out of the necessity that presently exists for the first executive official connected with the case being a Poor Law official. I know no way out, unless you turn to the other constituted authority, namely, the Public Health authority. That might be worked along with the suggestions made by the Medico-Psychological Association in favour of a mental board of health. The mental board of health would practically be the county council for functioning in respect of mental health as they function in respect of general questions of public health; and I would favour that. Therefore my answer to your question is, that there is no legal way just now of getting the necessary public assistance otherwise than through the Poor Law. I would suggest that that might be altered, but I put in this consideration that personally I have no complaint, but rather the reverse, to make of anything in my experience of the Poor Law authorities in Scotland, except in that legal and technical sense in which it is undesirable that a man should have to go and apply to the inspector of poor for assistance for his wife, or vice versa.

16,593. Would you favour a regional mental medical officer of health, one for a region or a district, or a town, as the numbers permitted?—I think local authorities should be empowered to take a step of that sort if they thought proper. I have no great belief in compelling local authorities to do certain things. They must be compelled to do some

things, but I have a very great belief in allowing local authorities a considerable amount of discretion and initiative in their own servants; and if you qualify your question whether I am in favour of the appointment of a regional medical officer for mental health, with the consideration that local bodies should be empowered to do that if they think proper, I would agree.

16,594. Then about the mentally defective children—do you have them mixed up with the older mental defectives or lunatics in hospitals?—No. In the case of mentally defective children the provision is varied and efficient in Glasgow. The education authority runs special schools very successfully, so far as special schools can be called a success at all. The Parish Council, or the District Board, provides for uneducable children in a special home at one of the asylums—idiot children. They also provide, by payment to an institution at Larbert, an educational institution. The Catholic Church found some conscientious difficulties in allowing children to be sent to imbecile institutions that were not run by the Catholic Church, and the Board of Control, when I was a member of the Board of Control, suggested that they should run some for themselves. They instituted one in Glasgow, and they have now, I think, a very much larger one, and it is also successful. Then there is a voluntary body as well. We favour the idea that every possible means should be put in the way of the public to provide facilities for the care of these children, because the human element enters so largely that you have to provide a great variety of facilities, and that is the policy that is run in the west of Scotland.

Sir Humphry Rolleston: Dr. Carswell has raised with Mrs. Mathew a very important point about the relation of the Public Health authority to mental disease, and he says in his *précis*, "I consider that the questions connected with the causes and prevention of insanity are in substance the same as those which arise in the course of public health administration." Now I was wondering whether on a subject which is rather difficult it would not be helpful if perhaps Dr. Carswell would be so kind as to submit a memorandum on what that means, and what it implies, so that we may have it in writing and study it at our leisure.

16,595. *Chairman*: I should welcome that myself. I think you have some of the material there?—I have some of the material, and may I put in this note on the evolution of lunacy administration in Glasgow? I shall be delighted to prepare a memorandum on that question alone.

Chairman: Thank you.

16,596. *Sir David Drummond*: Just one point. I do not know whether you can offer an opinion, but can you conceive it possible, Dr. Carswell, that such a scheme as you have worked in Glasgow could be introduced in this country, a comprehensive and adequate system dealing with these cases, without enormous capital outlay?—Considerable—I would not like to say enormous.

16,597. But it would entail that—new buildings?—It would entail, I am afraid, new buildings in most instances. Personally I think London could be divided into five or six different districts, each with a properly equipped hospital of 200 or 300 beds, and provide for all the cases occurring in that area, out of which might be sent the patients who required to go to the asylum. With regard to the country, I am constantly met with the country difficulty. I have been over the whole of the south of England and the Home Counties, and I have looked at these conditions. The facilities for getting from one place to another are so great, and the idea of travelling about is so familiar to the people that personally I do not think in practice the rural district difficulty would be so serious as it appears to be. Take, for instance, a place like Ipswich. At Ipswich they have a borough mental hospital. Now I am treading on delicate

20 April, 1925.] Dr. JOHN CARSWELL, F.R.C.P. (Glasgow), L.R.C.P. (Edinburgh).

[Continued.]

ground. They have also a county mental hospital not far away. I do not see any difficulty in utilising the borough mental hospital entirely for the whole rural district.

16,598. *Chairman*: We have only to thank you very much for your assistance, and we shall expect the advantage of this memorandum which you are going to prepare at Sir Humphry's suggestion?—If you please.

(*The Witness withdrew.*)

(*Adjourned to Monday, May 4th.*)

5, OLD PALACE YARD,
WESTMINSTER, S.W.1.

Monday, 4th May, 1925.

THIRTIETH DAY.

MEMBERS PRESENT :

THE RIGHT HON. H. P. MACMILLAN, K.C. (*Chairman*).

THE EARL RUSSELL.

SIR HUMPHRY ROLLESTON, BART., K.C.B., M.D.

SIR ERNEST HILEY, K.B.E.

SIR DAVID DRUMMOND, C.B.E., M.D.

MR. NATHANIEL MICKLEM, K.C.

MR. SNELL, M.P.

MRS. C. J. MATHEW.

MISS MADELEINE SYMONS.

MR. P. BARTER (*Secretary*).

MR. W. FAIRLEY (*Assistant Secretary*).

Evidence (on behalf of the Medico-Psychological Association of Great Britain and Ireland) of: Dr. R. H. COLE, M.D., F.R.C.P., Physician for and Lecturer on Mental Diseases, St. Mary's Hospital, London; Examiner in Mental Diseases and Psychology, University of London; Chairman of the Parliamentary Committee of the Association. Dr. M. A. COLLINS, O.B.E., M.D., Medical Superintendent, Kent County Mental Hospital, Chatham; former General Secretary of the Association. Dr. E. GOODALL, C.B.E., M.D., F.R.C.P., Physician for Out-Patients in Psychiatry, Cardiff Royal Infirmary; Lecturer on Mental Disorders, Welsh National School of Medicine; Medical Superintendent, Cardiff Mental Hospital, Whitchurch; Ex-President of the Association. Dr. J. R. LORD, C.B.E., M.B., Medical Superintendent, Horton Mental Hospital, Epsom. Dr. W. F. MENZIES, B.Sc., M.D., F.R.C.P., Medical Superintendent, Stafford County Mental Hospital, Cheddleton; former President of the Association. Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S., Consulting Physician, Charing Cross Hospital; Lecturer on Morbid Psychology and Hon. Director of Research, University and City of Birmingham; Examiner in Neurology, University of London; late Pathologist, London County Mental Hospitals; President-Elect of the Association. Dr. R. WORTH, O.B.E., M.B., Medical Superintendent, Springfield Mental Hospital, Tooting, London; General Secretary of the Association.

Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. E. GOODALL, C.B.E., M.D., F.R.C.P., Dr. J. R. LORD, C.B.E., M.B., Dr. W. F. MENZIES, B.Sc., M.D., F.R.C.P., Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S., and Dr. R. WORTH, O.B.E., M.B., called and examined.

16,599. *Chairman*: This morning we are to have the evidence of the Medico-Psychological Association of Great Britain and Ireland, which is to be tendered to us by certain representatives of the Association who have been appointed for the purpose. Gentlemen, we have all read with great interest the memorandum which has been prepared on behalf of your Association, and it has occurred to me that we should take

the same course with regard to this memorandum as we did with regard to the memorandum of the British Medical Association, that is to say, that we should incorporate in our minutes the text of your *memorandum, at least the first 18 pages of it, in order that we may have a record of your considered opinion upon the matters which we have before us. I think

* See Appendix XXIV.

4 May, 1925.] Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. [Continued.
E. GOODALL, C.B.E., M.D., F.R.C.P., Dr. J. R. LORD, C.B.E., M.B., Dr. W. F. MENZIES, B.Sc.,
M.D., F.R.C.P., Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S.,
and Dr. R. WORTH, O.B.E., M.B.

it is desirable, where an Association of your responsibility has formulated its views in a document of this sort, that we should have on record your recommendations in the actual words which the Association has chosen, rather than that we should have a more or less detailed examination upon all the points. We should I think reprint the actual memorandum for reference, and it should be also available to the public. That will be without prejudice to our discussing with you this morning certain points in some detail. I should like to know if that course commends itself to the representatives of the Association?—(Dr. Cole): Quite. We esteem it a great honour to have the memorandum printed. Personally, I should like to have the views put forward by Dr. Goodall also incorporated.

16,600. There are, as you know, considerations of economy in the matter of printing, and I thought we might print the recommendations dealt with specially in the memorandum; but we may consider putting in the whole of it. The first 18 pages contain the official memorandum of the Association, as I understand?—That is so.

16,601. Which are formal recommendations?—That is so.

16,602. First of all, I think we might have from you a short account of the history of the Association. I see it dates back as far as 1841?—That is so. It was formed, first of all, in Oxford by a certain number of medical superintendents of asylums, as mental institutions were called then, one of whom was Sir Charles Hastings, who was also one of the founders of the British Medical Association. It was felt that the time had come in which psychological medicine might be advanced by having an Association of Medical Officers of asylums, for the exchange of ideas, and soon afterwards a Journal was founded for the publication of professional papers and discussions, which Journal was first of all called the "Asylum Journal," and afterwards became the "Journal of Mental Science." This Journal has existed since the year 1853 as a quarterly periodical. The original object of the Association was in no way analogous to a trades union, but purely to promote the care, treatment, and recovery of patients suffering from mental disorders and to encourage research into the causes of insanity and its prevention. Dr. Bucknill, afterwards Sir John Bucknill, was a shining light in those days, and he insisted that our work should be a department of mental science, that we should take up the scientific aspects of insanity as well as purely administrative problems. In later years our activities have been extended in promoting the education and examination of medical men and women and nurses engaged in the practice of psychiatry. We have altogether between 700 and 800 medical practitioners, some of them women, who are actively interested in psychiatry. Each member pays an annual subscription of a guinea and a half, and this includes the current number of the "Journal of Mental Science." We have medical officers of both public and private institutions, and also men from the prison service, men and women employed under the educational authorities, professors and lecturers in psychiatry, and men and women in consulting practice, and also in general practice.

16,603. Then your activities, as far as I can gather, fall into two compartments. You have first of all, the practice of the art of psychiatry, and then you are concerned with education and research?—Certainly.

16,604. These are the two main divisions of your work?—Yes.

16,605. And associated with the latter is your important work in the training of nurses?—Yes.

16,606. Perhaps at the outset I might ask a question which interests me. You have since 1891 conducted examinations for a certificate in mental nursing, and have, I see, awarded your certificate to more than 18,000 male and female nurses?—Yes.

16,607. Would you tell me how your system of examination and certification correlates with the system which is set up under the recent statute—I mean the Nurses Registration Act of 1919?—Would you mind if Dr. Collins answered that?

16,608. If you please. What struck me was that there would appear to be some overlapping between the two certifying bodies. Are they related in any way?—(Dr. Collins): The syllabus for the two examinations is practically the same, with the exception that in the case of the Nursing Council the preliminary examination is an examination common to all nurses. It is an entrance examination, and the qualifying period, which in their case is 18 months, can be taken at any hospital where nurses are taught.

16,609. For the purposes of your certificate is it not necessary that the nurse should have had any general hospital experience?—No, it is not necessary, but she must have had three years in the same mental hospital. The General Nursing Council do not require that three years to be spent in the same place, neither do they require candidates to have been three years in a mental hospital at all.

16,610. It is perhaps rather an embarrassing question to ask you, but how do the two certifying bodies rank?—The certificate of the General Nursing Council has never yet been given. The first examination is to be held in June this year.

16,611. It strikes one as rather unfortunate that there should be two systems of certification for nurses, and that some of the nurses might take the one method, and others take the other. It would have been very desirable, if possible, to have one recognised qualification for the nursing profession in mental science?—Considerable effort has been made in that direction. One of the difficulties is money. We can conduct an examination for the cost of 15s. to the candidate; in the case of the General Nursing Council eight guineas is required. That is a very great difference which the nursing side feel very deeply.

16,612. Of course your examinations have been organised by your own Association, and are less perhaps encumbered with difficulties?—We do the work of examining for practically nothing, particularly the *viva voce* examination. The General Nursing Council are not willing to accept voluntary service; they want to have the control over their people that they have by paying them.

16,613. It did strike one as rather unfortunate that there should be two recognised certificates. Competition, of course, may be desirable between two bodies who grant diplomas, but, on the other hand, the overlapping seems perhaps a little unfortunate; but you say efforts have been made in the direction of bringing the two together?—There was a meeting called by the Ministry of Health between the General Nursing Council and the Medico-Psychological Association; the Association was given certain rights with regard to the General Nursing Council. An Advisory Committee was formed, half of whose members belonged to the Nursing Council, and half to our Association, and their recommendations are recommendations to the General Nursing Council with regard to the final examination in mental nursing only.

16,614. Sir Humphry Rolleston: When Dr. Collins said that the Nursing Council charged eight guineas, partly because they wished to have control of their own people, did that mean their examiners, or what?—Yes. I mean they did not care for the principle of voluntary examiners, I think. We examine them *viva voce* without fee. If you have to travel you get a small sum for expenses, but beyond that we examine without fees. But that is what I believe is not feasible under a public body like the General Nursing Council.

4 May, 1925.] Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. E. GOODALL, C.B.E., M.D., F.R.C.P., Dr. J. R. LORD, C.B.E., M.B., Dr. W. F. MENZIES, B.Sc., M.D., F.R.C.P., Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S., and Dr. R. WORTH, O.B.E., M.B. [Continued.]

16,615. I was wondering whether the expression you used was quite happy?—They are a public body, and I think the feeling is—mind you, I am only speaking of the feeling I have gathered from conferences which I have been to—that they ought not to have examiners who were not paid; but that is only the feeling I have gathered. At any rate, they are not able to reduce the fee.

16,616. *Chairman*: The contrast really between the two is that the Nursing Council is a statutory body which, of course, is bound to administer the Act which Parliament has handed to it. I understand your system of examination has been constituted by your own body and is therefore a voluntary arrangement; and there may be some difficulty in bringing into relationship two bodies whose origin is so entirely different, yours being purely a voluntary organisation, and the Council under the Act of 1919 being a statutory authority; but it is satisfactory to know that relations have already been established between the two bodies in this matter?—There is another point I might make, namely, that we nominate the examiners for the final examination for the Nursing Council to appoint. I mean there is a good deal of working together, and, of course, this is the first examination.

16,617. Quite. The thing is merely in its inception just now, and possibly in the course of time it may be possible to assimilate the two?—Up to the end of June this year our certificate is registerable by the General Nursing Council, but it will cease to be so, and one must wait and see what effect that will have.

16,618. The whole thing is really at the present moment merely at its initial stages. You were in the field no doubt, first of all, with the qualification. Then the question arises as to what should be the relationship between the voluntary system and the statutory system. That seems to be the practical problem to which you will be addressing yourself no doubt later on?—We propose to continue our examination for the present.

16,619. I quite understand that.—(*Dr. Cole*): There may be fusion in time, we feel.

16,620. It was merely the practical point that in a profession like mental nursing it seems desirable that there should be one standard of certification that should be recognised as the universal standard in the profession, and that may ultimately come to be so?—Yes.

16,621. I understand, gentlemen, that the preparation of the evidence which you are to give us to-day was entrusted by the Association to a Committee, the names of whom are set out in this print before us, and that the gentlemen who are here this morning are those who have been deputed expressly to give the evidence before us?—Yes. Amongst these names you will see there are some men connected with public, and some with private institutions, and some in practice.

16,622. We fully recognise the representative character of the Committee, and of the gentlemen here this morning, and we also fully recognise the very representative character of your Association in all matters connected with psychiatry in this country?—And you will notice we also take into our fold mental deficiency, which we have always regarded as part of psychiatry, although strictly, it is not within the Reference of this enquiry, I understand.

16,623. It is sometimes a little difficult to keep the compartments distinct, as you can imagine, but technically it is not within our purview?—You notice we grant a certificate for mental deficiency.

16,624. So I notice. Now our Reference, as you are aware, falls into two parts. The first part relates to the amendment of the existing law relating to the certification, detention and care of patients, while

the second part relates to the very important question of the treatment of mental disorder without certification. On the first part of our Reference, namely, the state of the existing lunacy laws in those matters to which I have referred, might I ask you, as persons conversant with the working of the code, how you have found it in practice?—I think some of us feel that there is an unnecessary amount of records to be kept, and unnecessary searching enquiry into certain things. We quite recognise that safeguards, as they are called, are necessary, but we almost feel they are a burden in the carrying out of the Lunacy Act—that they really interfere with the treatment of mental disorder. That is our point. Our principal point is that the Act, such as it is now, prevents us from treating mental disorders in the way we consider medical science at the present day dictates; that the Act actually prevents the treatment of insanity in the proper way.

16,625. Of course you will realise that the law as it stands at present is a compromise between the purely medical aspect of mental disorder and the legal aspect of it. It is a balanced statute which endeavours to reconcile those two not always very easily reconcilable aspects of the same problem. On the question of the machinery of the Act, that is the actual machinery for certification, detention and discharge, what have you to say as to its adequacy in providing safeguards against abuse?—We think that they cannot be improved upon except in one or two minor respects. One is that we feel that probably a second certificate in doubtful cases is a proper safeguard. At the present time the majority of pauper patients, rate-aided patients, are received on only one certificate of a doctor, whereas of course for private patients, or paying patients, two are necessary. We feel that is a safeguard.

16,626. We will develop that a little later. But have you found that under the existing code, the methods, the avenues by which patients may reach mental hospitals, are rather difficult and complicated—the different methods which you know obtain with regard to the lunatic found wandering at large and the lunatic who comes through the workhouse and the different classes which are provided for under the statute? Have you found in practice that those different methods of dealing with cases cause any embarrassment?—We, who are conversant with the Lunacy Law, do not mind that very much. It seems to work fairly well.

16,627. We have had a good deal of evidence to this effect, that the persons who actually have to carry out the executive part of the Act, people like relieving officers, and so on, have found themselves embarrassed by the complexity of the programme of certification, and the selection of the particular method to be applied in a particular case. There is a considerable choice of methods of procedure, as you know?—Quite so.

16,628. Do you think that the preservation of those various methods serves any particular purpose, or would you be in favour of a simpler programme of certification?—Perhaps Dr. Collins will answer that question. (*Dr. Collins*): We do, under our Recommendation 28, recommend the same procedure for all patients.

16,629. Yes, I have noted that, but I thought that that was probably referring rather to the assimilation of the rate-aided patient to the private patient?—But you are referring now to the rate-aided patients?

16,630. I am really referring to this, that there are so many different methods provided under the statute, and in the case of rate-aided patients particularly there are several methods under the Act of 1890; it seems to present a rather embarrassing choice to the medical man?—Under our recommendations from No. 28 onwards, by the provisional order or the two certificates we should cover, I think, every case by either of those methods.

4 May, 1925.] Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. [Continued.
E. GOODALL, C.B.E., M.D., F.R.C.P., Dr. J. R. LORD, C.B.E., M.B., Dr. W. F. MENZIES, B.Sc.,
M.D., F.R.C.P., Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S.,
and Dr. R. WORTH, O.B.E., M.B.

16,631. That is really a general answer to my question. We are considering the simplification of the code; at the same time, we wish to preserve every necessary safeguard.

16,632. With the provisional order which is reviewed at the end of three days, or the two certificates, you will not need any special provision for people wandering at large, because they would be dealt with under the provisional order?—Yes.

16,633. Then you recommend as an Association one method for dealing with all classes of patients, private and rate-aided alike?—(Dr. Cole): A simplified procedure.

16,634. It did occur to one that the Act of 1890 contains the survival of a good many previous legislative efforts, some of which are really unnecessary at the present day; and if one could get an adequate code, but a simpler code of certification, it might facilitate the working of the statute very much, particularly in the hands of those subordinate persons who have to do the actual executive work, before the cases reach your hands at all. I am impressed with that very much and relieving officers have told us of their difficulties in administering the Act?—(Dr. Collins): Perhaps these figures will help you as to how the Act works now. These figures refer to 244 patients admitted to Chatham in 1924; 196 were admitted under one certificate, either as paupers in receipt of relief, or in such circumstances as to require relief for their proper maintenance; 7 were admitted as lunatics wandering at large, and 29 as not under proper care and control with two certificates. So that you may take it that the Act works so that the majority of people are brought in under one certificate; although as I read the Act, I do not think personally that that was the intention.

16,635. That really supports the suggestion I am making, that the Act is a little ambiguous in some of its provisions. It is very undesirable that there should be any ambiguity, or that people should be at a loss to know what is the proper procedure to adopt. Things have to be done quickly, and it is desirable that the system should be as simple as possible. I am sure that will have your support as an Association?—Yes.

16,636. Now returning to your memorandum, I understand that your Association has from time to time taken up the different aspects of the problems with which you are concerned and has reported upon them; and that the present recommendations are the outcome partly of those previous reports, and partly of a general revision of the whole position in anticipation of our meeting to-day?—(Dr. Cole): That is so. When it was announced that a Royal Commission was to be appointed, we formed our Committee, and we looked up the work we had hitherto done. There is a very important report on the status of the British Psychiatry Committee, of which there is a short resumé on page 4. Then in 1918 after the War—and during the War—there was such a revival of feeling in the matter that the medical profession and the public seemed to realise that lunacy in many cases could be managed without certification, although of course the bulk of the cases in the Army could be managed under military law which is more drastic than the civil law. Still it gave us an opportunity to press what we have been urging for many many years, that there should be some revision of the lunacy law for the initial stages of mental disorder.

16,637. I observe on page 5 in your comment on the lunacy law you express this view: "The Association is of opinion that the vast majority of the community, including patients, is grateful for the protection afforded by the existing Lunacy Acts, and that the safeguards they provide against abuses and illegal detention have on the whole proved satisfactory"?—Yes.

16,638. But, on the other hand, in your opinion the statutes have "failed to keep pace with medical

progress, especially in regard to the treatment of the initial and most curable stage of mental disorders." I may take it, I think, generally, that the subject in which you are most anxious to assist us is that second topic, namely, the introduction of new legislation to deal with incipient cases without certification?—That is so.

16,639. That is really the province in which you are specially fitted to assist us?—Yes. We would like to make the statement that with regard to a compromise between the legal and medical professions, we do really feel that the lawyers have had the greater share in regarding a person as possibly shut up unnecessarily, and the public needing protection, rather than regarding the patient as a sick person who requires treatment. It is very rarely in the Lunacy Act that any reference is made to the person being ill and requiring treatment and what is the best thing to cure the person. The chief concern seems to be whether he is a proper person to be there, in a place that is under suspicion as it were; and the whole Act reads in that way, as if it were an undesirable place, in which a person should not be unless he is qualified to be there as a person either dangerous to himself or to others, not as a person who is ill and requires treatment to get him well again. That is our point about the Act really and truly, that it is too legal and too little medical. I merely mention this in connection with your remark, Sir, when you suggested a compromise between the medical and the legal professions.

16,640. You mean the compromise has all been one way?—Yes.

16,641. On the other hand, you have to recognise this, that we are dealing with a subject upon which the public are very sensitive. The question of the liberty of the person is naturally a topic where the legal element has to come in. In the case of other ailments, where the patient is a willing co-operator in his own care and treatment, the position is easier. The difficulty here is that you must, in the interest of the patient himself, use certain methods of restraint which, if not authorised, would be illegal. That is where the difficulty arises?—We quite realise that.

16,642. And therefore the tendency of the code may be more prominently towards dealing with the safeguards against improper detention than looking at it from the medical point of view, with which the Legislature would naturally not interfere. The Legislature would not interfere with the treatment of patients, because that is a matter for the medical profession; but it is naturally concerned with the safeguards for the liberty of the person. Probably that is the reason why it has, as you say, a more legal atmosphere?—Yes.

16,643. Now on page 6 you formulate certain leading views which we shall find worked out in detail in your recommendations, and the very first matter to which you refer is the desirability of the establishment of clinics for mental disorders?—Yes.

16,644. On that subject what is the practical view of yourself and of your colleagues as to how the thing should be started?—I will ask Dr. Goodall to answer that.

16,645. Dr. Goodall has, I know, had considerable experience already in developing this method. Perhaps he will be good enough to give us his views? We are practical people, Dr. Goodall, and wondering how we can best follow out your idea into actual practice?—(Dr. Goodall): Of course, we want these clinics (I believe I am speaking for my colleagues) in association with the general hospitals.

16,646. That is the first proposition; let us examine it for a moment?—Where there is a medical school, of course, *a fortiori*.

16,647. That assumes the existence of a general hospital?—Yes.

4 May, 1925.] Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. E. GOODALL, C.B.E., M.D., F.R.C.P., Dr. J. R. LORD, C.B.E., M.B., Dr. W. F. MENZIES, B.Sc., M.D., F.R.C.P., Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S., and Dr. R. WORTH, O.B.E., M.B. [Continued.]

16,648. And the association with it of a clinic for mental treatment?—Yes.

16,649. One difficulty that occurs to one at once, of course, is that general hospitals are not to be found everywhere; they are to be found at the larger centres of population. How would you propose to deal with the cases in the more remote parts of the country. Would you have them sent in to towns, just as they are sent in at the present moment for other ailments?—In the appendix which deals with my evidence I draw attention on page 28 to Lord Dawson's scheme: "How these maladies could be brought into the comprehensive scheme for the hospital treatment of disease in general, which was described in the Interim Report of the Consultative Council on Medical and Allied Services." That Report envisaged a whole network of hospitals, great and small, from the main one in connection with the medical school through lesser ones in towns where there was no medical school away to outlying districts where there was a cottage hospital. All these were to be linked up by a motor system, and disease was to be treated from the periphery to the centre, and vice versa; and the scheme, which that Committee proposed, is illustrated best in Gloucestershire; so I would treat them everywhere.

16,650. *Sir David Drummond*: Do you think a clinic apart from an indoor department would be of much service?—I have had five years' experience of an out-patients' clinic in psychiatry at the Cardiff Royal Infirmary, which was set up in the hope that an indoor clinic would be established when the Early Mental Treatment Bill (as I hoped) would pass. If it had not been for that hope, I would not have advised it or worked it, because I consider it entirely a one-horse show. I can say that seven-tenths of my patients want to come in immediately.

16,651. That was our experience in Newcastle. We established an outdoor clinic without any in-patients department?—I keep it up in the hope that it is the thin edge of the wedge, and I do not want to withdraw it. There is a large After-Care Association in connection with it now.

16,652. *Chairman*: There are certain precedents in connection with the treatment of tuberculosis and venereal diseases which have now been taken over by the public health department in most of the large towns; I suppose, you have separate institutions with out-patient departments as well as in-patient departments, and patients resort to these places for treatment. If you take any large general hospital in a town, both the in-patients and the out-patients are generally drawn from a considerable area round about. Out-patients come in and stay for a time to get the benefit of the treatment. Is it your view that these clinics should be established in separate institutions comparable with the tuberculosis institutions, or that they should be more closely associated with the general hospital and become simply a department of the out-patient and in-patient administration?—Yes; I would have them part of the administration, but not contiguous; I would have them as they have on the continent, as at Munich, for instance, with which I am familiar. That place is in a separate pavilion, like the gynaecological pavilion and that for children's diseases, with a certain amount of ground around it; it is part of the University system, but it is separate in that way and not contiguous. You must have arrangements for mental cases which you cannot have in the general wards of a general hospital.

16,653. Do you think the general hospitals throughout the country would be disposed to co-operate?—I have been informed that that is very doubtful, whether they would be so disposed; I do not know why. I believe in time that opposition would break down. I may tell you that at Cardiff the City Corporation gives £2,000 a year to the Cardiff Royal Infirmary, and has five representatives on the Board.

I asked the Secretary particularly, and he says, "Yes, they are there, and they are welcome there." They are practically helping to support the place already, and I fail to see why a local authority should not co-operate with the committee of an infirmary—I do not think there is anything in it—in time.

16,654. When you speak of the general hospital, are you thinking of the hospital that is supported by voluntary contributions?—Yes, as at present.

16,655. You are not thinking of the Poor Law infirmary at all?—No; I would rather it had nothing to do with the Poor Law.

16,656. I would like to follow that idea out with you. We find the general hospitals which are supported by voluntary contributions and endowments scattered throughout the country in large centres of population. One trouble of course is that they are generally very full up already, and their accommodation is pretty well taxed?—Yes.

16,657. If a mental clinic were to be associated with them, that would mean more building, of course?—Yes.

16,658. And further expenditure?—Yes. The Early Mental Treatment Bill provided for the co-operation of local authorities in that matter, and it will not be done, I think, without their co-operation. Abroad, as you know, it is the State; here, I take it, it would be the local authority.

16,659. If grants of money were made either from Imperial sources, or from local sources, do you think that that might encourage the general hospitals to undertake this branch of the work?—Yes, I presume so; I think it would.

16,660. We have had some evidence as to the association in Edinburgh of mental treatment in the Royal Infirmary with the general hospital work, and very remarkable results were communicated to us by Dr. Comrie?—Yes, I have read them.

16,661. Is it on those lines that your Association think a solution of the problem might be found?—I say on page 29 of this appendix: "These patients"—these were Dr. Comrie's patients—"were treated in wards of the infirmary which are reserved for early mental cases and cases of incidental delirium. Such an arrangement is not the equivalent of a separate neuro-psychiatric department *ad hoc*; it is by no means the ideal." The ideal to my mind is what is found on the Continent, especially in Germany, and also in the United States, at such an institution as the Boston Psychopathic Hospital. As we know, you must have arrangements for exercising and occupation which cannot obtain (so far as I can see) in the general hospital; there is not enough scope for fresh air and exercise.

16,662. The treatment, in short, of mental disorder requires a different type of equipment?—Yes.

16,663. Do you not think that that difference in equipment points to the desirability of separate institutions rather than to the association of the treatment with the general hospital treatment?—Yes, as I said, separate pavilions of the same administration.

16,664. If you take, for instance, any of the well known hospitals here in London, some of which are right in the town with no ground round them at all; such places would not be suitable for the treatment of mental cases?—No. London is a problem in itself, I think. The same applies to Berlin. They had a clinic at Charlottenburg, in Berlin. They work a neuro-psychiatric clinic right in the middle of Berlin.

16,665. But they would not have the facilities for gardens and exercise grounds?—They have a certain amount, like Bethlem have, for instance, here, but of course the problem is easier of solution in the big provincial centres.

16,666. Is your primary conception that these clinics should, if possible, be associated with the

4 May, 1925.] Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. [Continued.
E. GOODALL, C.B.E., M.D., F.R.C.P., Dr. J. R. LORD, C.B.E., M.B., Dr. W. F. MENZIES, B.Sc.,
M.D., F.R.C.P., Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S.,
and Dr. R. WORTH, O.B.E., M.B.

general hospitals in administration but that they should be conducted in separate buildings?—Yes.

16,667. With separate equipment?—Yes.

16,668. Then, I suppose, on the staff of the general hospital, just as at present you have the surgical staff and the medical staff, you would also have some person specially conversant with this branch of medicine, who would have his own residence, and so on, as a department of the hospital?—Neurology ought to be worked with psychiatry in my opinion as it is done abroad, and there would be a professor of psychiatry and neurology; he would be on the University staff, one of the ordinary professors, and all the medical staff of the hospital would be available for the clinic, and *vice versa*; and the same would apply to the nurses.

16,669. The other idea of having separate institutions has already been developed to some extent, has it not, in connection with tuberculosis?—Yes, I believe so.

16,670. It appears to present a choice of methods as to whether it is better to have it in association with the general hospital or to have it as a separate institution by itself, separately run?—Anything that tends to promote a differentiation between the neuro-psychiatric clinic and the general medical clinics is greatly to be deplored in my opinion; they should be recognised as one organisation; there is nothing peculiar about the mental cases. That is the trouble we are suffering from.

16,671. You find an assimilation in the public mind of mental disease to other forms of disease?—Certainly.

16,672. You do not want even a geographical discrimination in the treatment?—No. Might I just read this note to you: "If recent and curable cases of disease, now known as mental disease, because they chiefly manifest themselves as disorders of conduct, are isolated from the main mass and dealt with under special conditions, they will be looked upon as something apart and fail to enlist the live interest of the medical and nursing professions; the resources of medicine will not be brought to bear on them. The combined experience of men skilled in different branches of medicine must be available and regularly applied, as in the case of other kinds of disease in the same social class, in connection with the general infirmaries."

16,673. You wish to eliminate as much as possible the deterrent that at present exists which is associated with asylums?—Yes. I would have no recent or curable cases of mental disorder at the asylums except such as were an overflow, because the clinics could not accommodate them.

16,674. Let us turn for a moment to the other side. I was looking at the clinic from the point of view of its association with the general hospital, not as a separate entity by itself; what is to be its relation to the existing asylum system of this country?—There would be no relation except when cases got incurable or dangerous or violent; they would be transferred to the so-called mental hospital.

16,675. Do I understand that you would exercise some selection of the cases presented to you at your clinic, some of them you would regard as appropriate for remission to the mental hospital at once?—All early and recent mental disorder cases would be available for a clinic in my opinion.

16,676. Would this stage of the clinic be interposed, so to speak, between the first onset of the ailment and its ultimate disposal either by cure, as it might be in your clinic, or by remission to a mental hospital, if it were a case where permanent treatment was required?—Yes, that is my view; the detention would take place at the asylum, and then the lawyers can reign supreme.

16,677. I do not know that that is desirable, I hope not, but one likes to figure all these things out practically. Let us just consider what you have in

mind: an unfortunate citizen is attacked with a certain amount of mental disorder; he himself is possibly still quite capable of realising his condition, or his friends are. You would figure that case being brought, in the first instance, to a clinic in a centre?—Yes.

16,678. A clinic associated with a general hospital or an independent institution; the case would arrive there in the first place. Then do I understand the case would be in the hands of the doctor in that clinic for a period?—Yes.

16,679. Would you receive all classes of cases, including dangerous cases, right away into this clinic?—You might have to restrain a dangerous case, of course.

16,680. We will come to the question of the legal difficulties in a moment; but from a doctor's point of view would your first aspiration be to have the handling, as a doctor, of all cases before they were ultimately transferred to asylums?—Certainly, acute manias and acute melancholic cases ought to come in.

16,681. But would not you need in this clinic to have practically a duplication of the equipment of the asylum, because you would have to have provision for seclusion and restraint and treatment which, although devoted to the earlier stages of the disease, would be a duplication of what you would find in the asylum?—The staff would be so much more heavy, both medical and nursing, that you would not want in practice any restraint or seclusion.

16,682. You contemplate in the clinic a much more intensive treatment of the cases, because you would have a larger nursing staff and a larger medical staff?—Much larger medical and nursing personnel.

16,683. There is one aspect which rather commends itself even to a layman like myself, that is that so many cases of mental disorder are associated with physical ailments, and in a general hospital you are able to call in the consultant in any department to advise upon the case at once. Is that one of the features that commends this to you?—That is a very strong point indeed. The Boston Psychopathic Hospital is one of the finest things there is.

16,684. We are indebted to you for sending us a copy of their report?—If you look at their staff there are only 110 beds there. That is really a psychopathic clinic.

16,685. It is a very elaborate one?—There is the chief medical officer; two medical officers; four assistant medical officers; only 110 beds. Then in the Psychology Department there is a chief psychologist, one psychologist and two assistant psychologists. In the Bio-chemical Laboratory there are the chief of the laboratory, two laboratory technicians and four student internes. In the Pathological Laboratory there are one assistant pathologist and one laboratory technician. In the Department of Therapeutic Research there are a chief of department and one assistant physician. In the Out-Patient Department there are the chief of the department; two assistant physicians and one clinic manager. Then there is the Social Service Department, with a head social worker and four social workers. In the Occupational Department there are the head occupational therapist and one occupational therapist. In the X-Ray Department one roentgenologist and one technician. A Dental Department. The Consulting Staff is composed of specialists in the major branches of medicine and surgery. The Nursing Department consists of the superintendent of nurses, assistant superintendent of nurses, one chief supervisor (male); three supervisors (2 male, 1 female); 12 head nurses (male and female); 28 attendant nurses; and two hydrotherapists (1 male, 1 female). Of course, we know what there is in asylums here.

16,686. I was certainly impressed with the completeness of the staff for the treatment at Boston Institution. I think we can hardly hope to have institutions of that sort all through this country for

4 May, 1925.] Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. E. GOODALL, C.B.E., M.D., F.R.C.P., Dr. J. R. LORD, C.B.E., M.B., Dr. W. F. MENZIES, B.Sc., M.D., F.R.C.P., Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S., and Dr. R. WORTH, O.B.E., M.B. [Continued.]

some time, Dr. Goodall.—I think the Maudsley Hospital is very well equipped. Sir Frederick Mott would know.

16,687. That is one?—That is one, but that is the way to staff these places.

16,688. *Sir David Drummond*: Might we hear Dr. Goodall upon the preliminary steps of introducing these patients into the clinic? Would they come to the clinic entirely in a voluntary way, sent by the doctor as ordinary patients—is that your idea?—Yes. We agree, I think, with the Early Mental Treatment Bill in the main, with certain modifications; the patient would come with one medical recommendation, and in the case of the non-volitional patient there would be a notification to the Board of Control within 24 hours. We did not even think the minister of religion or the justice was necessary in the non-volitional case, as the Early Mental Treatment Bill had it.

Chairman: But following out Sir David's point, I can understand the case of the patient who is at home, who is afflicted with an incipient mental disorder, coming to the out-patient department and getting advice, and possibly being alleviated and not requiring to become an in-patient. Then I can conceive also the class of case where the onset is of a much more violent and sudden character, when something has to be done at once; that person is not capable of forming any judgment at all of what is right for him. How would that case reach you? It obviously could not be treated as an out-patient case; it plainly must be dealt with at once in some place where there are facilities for detention. Would you figure that case also being brought to you by the medical attendant and relatives?—Yes, I do not see why not, and notified to the Board of Control within 24 hours.

16,689. Be it so. That person would be brought by the relatives or the doctor called in. Then take the case of the wandering lunatic: that person would be brought to you by the police, I suppose?—Yes. These things are all done at Utrecht, as you may know; they are done every day there.

16,690. Then your conception really of this clinic is in one of its aspects a clearing house?—No; I think that is a mistake. As far as possible I would avoid that, if by that is meant that cases are to be sent on to the asylum from there; it ought to be an institution for the treatment and cure of the patient.

16,691. But cure, unfortunately, does not always happen?—No; you would have them there for six months, and renewable for other periods of six months as we recommend.

16,692. Let us assume that the patient has reached you through one or other of the avenues which you have described, that the case is regarded as one suitable for out-patient treatment: then I suppose the patient would attend at regular hours, and get advice, and possibly medicine, and so on, and be treated like any other out-patient case. If, on the other hand, the case was one for in-patient treatment, I suppose the patient would be taken in and assigned a bed in one of your wards?—Yes.

16,693. And in that way you would assimilate the treatment of mental disease to what happens with regard to patients coming to an infirmary, as we call it in Scotland, or a general hospital, for any other ordinary ailment?—Yes.

16,694. And people would be sent in from the country districts to the centre to get the benefit of either the out-patient or the in-patient treatment as required?—Yes.

16,695. Would it be necessary to have institutions all over the country? Because at the present moment the centres, the general hospitals, cater not merely for people from their own towns, but they take in people from a wide area. I know the Edinburgh Infirmary has patients from Orkney and Shetland. Is that what you conceive should be done, or do you rather propose a network system all over the country?

—The main clinic would be where the medical school was and the University. I start with that, certainly, then radiate out from that.

16,696. Let me put a practical difficulty that appeals to one: supposing in some remote part of Wales a person suddenly becomes maniacal: there is no University town and no clinic within, let us say, 100 miles of that place, and the transport facilities are difficult. How are we to deal with that case. Something has got to be done at once, observe?—Yes. Under the Dawson scheme there would be a district hospital there on the cottage hospital lines, and my idea is set out in the "Lancet," which is quoted here, that there should be sufficient psychiatric facilities at that place to deal with the patient until he could be got by ambulance to the next town.

16,697. It would be fairly primitive in a cottage hospital, would it not?—What else could be done with him?

16,698. Take the Poor Law infirmary?—I consider that would be the periphery of the system. Even there he could be reached by practitioners (that plan allows a practitioner to attend his own cases), even there he could be reached by experts from the main clinics sent out to advise.

16,699. *Mr. Micklem*: What would you do in the case of a patient under treatment who wanted to go home from one of these clinics?—Let him go. If he is not fit we could do other things.

16,700. *Sir Humphry Rolleston*: With regard to the admission to the in-patients department of the mental clinic of really violent cases, non-volitional cases, who really are very maniacal, would it not be better for a patient in that condition to be sent for the time being to a secluded portion of a mental hospital? Would that be desirable for the sake of the other patients who, although you do classify them in an ideal in-patients department of a mental clinic, would to a certain extent be influenced by the knowledge that these violent cases were there?—Yes, that has been urged, I know; it is urged by the National Council of Mental Hygiene that people are put off from going to the clinic because they know that the real insane are there. But I wrote to Professor Winkler at Utrecht, and he said there is nothing in it at all, in his experience. I do not see why that case should not be treated in a clinic. It is a matter of opinion. I know he would be taken into the Munich clinic and treated, and by proper treatment he would be effectively calmed down, by hydrotherapy and things of that sort.

16,701. *Sir David Drummond*: The same objection would apply to acute pneumonia and many other cases which we admit to general hospitals?—With that, of course, goes the question of trusting the medical profession. In Munich, when I asked them what they would do as to restraining a patient or secluding him, or putting him in a bath with a lid on, if necessary, the medical officer only stared at me and said "That is a matter for the medical director." But I am afraid in this country things are not sufficiently advanced to trust the medical profession to that extent. There is not that respect for learning that there is abroad.

16,702. *Mr. Micklem*: Supposing you were satisfied that the patient was of unsound mind, would you let him go?—Then provision of course exists in the Early Mental Treatment Bill for notification to his relatives to remove him; the relations usually act; if they will not, some authority can be called in.

16,703. *Chairman*: For the moment I want to have in my mind a clear conception of your programme. It is that all cases of mental disorder, whether merely incipient or pronounced, which at the present moment are dealt with under the existing law, should, in the first instance, reach your clinic? Is that right?—You might get a case of paranoia, systematised delusional insanity, pronounced, it might be lasting

4 May, 1925.] Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. [Continued.
E. GOODALL, C.B.E., M.D., F.R.C.P., Dr. J. R. LORD, C.B.E., M.B., Dr. W. F. MENZIES, B.Sc.,
M.D., F.R.C.P., Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S.,
and Dr. R. WORTH, O.B.E., M.B.

for months, it would not do to take him there; we know he is incurable at present.

16,704. If you are going to have classification there must be some person at the portal of this clinic; is there to be a preliminary sorting out of cases, or is there to be a reception of all types of cases in the first instance, subject to disposal later?—I think the experience of the Maudsley Hospital comes in there. I do not know whether you have examined Dr Mapother yet?

16,705. Not yet?—But they do select their cases. Most cases are sent to them by medical men, as a matter of fact in practice; others they have themselves to determine upon, as you say, in an emergency.

16,706. From the point of view of the simplification of working, the reception initially of all cases would probably be much easier to work. All cases pass through your hands, and upon some of them an early judgment could be pronounced to the effect that the cases were not suitable for treatment in your clinic; these would leave your clinic and pass into the ordinary type of institution. But is it your conception that there should be a preliminary classification such as takes place at Maudsley, and a rejection of some cases, or that all cases should, first of all, reach the clinic?—I think it would be going too far to say all, but the great majority undoubtedly. Some cases would have to be rejected as soon as they are brought. There would have to be a staff there to decide it, as in the case of the Boston Psychopathic Hospital.

16,707. Some person of authority would require to pronounce that judgment?—Yes; you could do it with sufficient medical staff.

16,708. And what would happen to the case rejected as unsuitable for treatment in your clinic? What would be the criterion of rejection, and what would happen to the case?—Of course we do not want cases to be dealt with under the Poor Law, so that the present methods of disposing of the case would not apply; but he could be certified in some suitable place, which we hope would be under the local authority, and taken charge of by the officer of the local authority, and removed to the mental hospital.

16,709. But that would necessitate the institution of yet another place. We would then have not only the asylum at the one end of the system and the clinic at the other, but also some intermediate place where persons could be kept awaiting certification, because rejected by the clinic. Is not that an over elaboration?—I do not see why they could not be certified at the clinic, but I believe at Maudsley they do object to it.

16,710. We have heard evidence to the effect that it brings an unhappy association to the institution; the patients say, "We come here voluntarily, and find ourselves detained involuntarily," and that the association is unfortunate and operates as a deterrent. Have you any view on that?—Of course the population of this country seems to be so frightfully sensitive on these matters. I cannot understand why these things work in other countries.

16,711. You know, Dr. Goodall, we have got to take our country as we find it and, after all, if I may say so, in this matter there is a good deal in sentiment, you know?—Yes.

16,712. In fact, I should have thought that persons conversant with mental disorder would know that sentiment is often one of the determining factors in the treatment of the disease; and you have to conciliate the feelings of patients in these matters if you wish to attract them?—Yes. That presents a difficulty as to where that certificate is to be signed, I admit; but that in itself is not enough to invalidate a principle of such importance.

16,713. Not for a moment, but then you appreciate that, sitting as we are here and envisaging the possible recommendations we may make, we have to produce something that is more or less complete, and

we must not leave ragged ends; we must have something in our minds which deals with the whole position.

16,714. *Sir Humphry Rolleston*: I cannot help feeling that if so many patients are going to pass through, and have their case decided there, that may eventually rather prejudice the reputation of a mental clinic. From what you say, in spite of the slight protest you make, do you not make it rather into a clearing house?—I do not think many cases would be rejected from there. (*Dr. Lord*): There is a paragraph in our report, on page 10, which deals with Dr. Goodall's difficulty. That is a paragraph unanimously agreed by the Association.

16,715. *Chairman*: "Special clinics to act as 'clearing houses' may be necessary in large districts, but it is hoped that if the bulk of the occurring mental disorder were overtaken while in its early stages, such 'clearing houses' would be a disappearing factor in the mental health service of the country. Admission of suitable cases direct to mental hospitals is part of the policy of the Association." You see, Dr. Goodall, one can appreciate the desirability of a clinic where hopeful cases and early cases are treated; but if it is to be a place where all cases are received, it seems to me you get into a different region altogether, and have some difficulty in relating such an institution to a mental hospital. What would be the effect on the mental hospital if it was known as a place to which only persons went who had passed through a clinic and were regarded as practically hopeless cases? You would have a very depressed population in your mental hospital, would you not?—(*Dr. Goodall*): I do not think clinics, however abundant, would be able to deal with all these early and recent cases. Abroad, undoubtedly, cases are admitted into the German and Italian asylums direct, because there are not enough clinics to deal with them, so that they will always have interesting cases; and it is certain they do, because the amount of scientific literature produced from those institutions is very considerable, although it will not compare with what is produced from the clinics. They must be having the cases, but as regards the ultimate reputation of the asylum, I must admit I am not concerned greatly about that; we cannot help that with the march of progress.

16,716. The principle was that there should be the mental hospital for the treatment of the cases which are properly certifiable and certified, on the one hand; and, on the other hand, a system of clinics where cases may be treated of a different type, or at least of a recoverable type or an incipient type, with a view to the avoidance of certification. I could imagine two types of institutions of that sort working together with goodwill quite satisfactorily; but that would involve that into the one class of institution there should go only the cases which were selected because they would benefit by the clinic and might escape certification; whereas a case, which an alienist was able to say at once would not recover in a clinic, ought to be disposed of without going through the clinic, unless you are going to use it as a clearing house. Which is the principle in your mind?—That last case you referred to should go to the mental hospital at once.

16,717. Direct?—Yes.

16,718. That does involve then, as I say, some criterion to be applied at the outset, a criterion which will enable you to discriminate between cases suitable for clinic treatment, and cases suitable for mental hospital treatment?—In our memorandum we advocate that patients be voluntarily admitted to mental hospitals as well, as in Scotland.

16,719. Suppose we take it that way. Certain cases are asylum cases, and certain cases are appropriate for the clinic. The asylum would be the proper place for the established case of mental disorder?—Yes.

4 May, 1925.] Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. E. GOODALL, O.B.E., M.D., F.R.C.P., Dr. J. R. LORD, O.B.E., M.B., Dr. W. F. MENZIES, B.Sc., M.D., F.R.C.P., Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S., and Dr. R. WORTH, O.B.E., M.B.

16,720. It would also have a certain number of voluntary persons, as you recommend?—Yes.

16,721. The clinic, on the other hand, I gather, is to contain only persons who are there voluntarily?—No, non-volitional cases as well.

16,722. Non-volitional cases because they are possibly recoverable cases?—Yes, people who cannot, for instance, sign a paper, although we do not want the volitional case to sign any paper. These non-volitional cases would not be able to sign, but still they should be admitted.

16,723. You might, of course, have a case of acute mania of a very transitory type where certification would be a most unfortunate stigma, because recovery was indicated at a very early stage: such a case would benefit by treatment in a clinic?—Or a case of stupor.

16,724. Then you get at once into this region, that such persons are not capable of co-operating in their treatment, and they must be detained, whether they like it or not?—Yes.

16,725. It is at that point that Mr. Micklem's observation applies. Do you contemplate in your clinics possessing a certain amount of legal power of restraint?—Yes, such as was given under the Early Mental Treatment Bill—six months.

16,726. Lord Onslow's Bill?—Yes, we want to continue those periods of six months, if necessary.

16,727. These persons then who enter your clinic, because they are themselves capable of appreciating the benefits they are to get there and wish to come in, or those who are not non-volitional cases but are recognised by their medical attendant and relatives as suitable persons for your clinic and are admitted by you on that footing, would all be there subject to this, that if they wished they could leave, but would require to give you 72 hours' notice—that is Lord Onslow's Bill?—Yes.

16,728. Is that your contemplation?—Yes.

16,729. Now just follow that out a moment. Here is a general difficulty on which I should like to have the collective opinion of you gentlemen. It puzzles me a good deal as a layman, to be quite frank: the existence of mental disorder connotes a certain amount of mental disturbance affecting the will power and the intelligence; one must assume some disturbance. Is a patient who is in that condition capable of an act of will in the same sense as an ordinary sane person is capable of an act of will, that is to say, appreciative of the circumstances and appreciative of what he is doing? I should have thought that you must have found that many of the cases which purported to be voluntary or were represented as being voluntary were not really voluntary in the sense of being expressive of a full will, an appreciative will. What do you say about that, Dr. Goodall? The difficulty of it, as you see, is that the intelligence is to some extent upset. I do not suppose the judgment of any of us is so good when we have even a bad headache as it is when we are perfectly fit?—Although we do not want them to sign documents, if they have sufficient so-called volition to sign a paper, let them sign a paper. If not, then this Mental Treatment Bill provides for a minister of religion, or a justice, to give a recommendation; but we say a medical recommendation and notification to the Board of Control would be sufficient.

16,730. What I have in my mind is a very large topic, and that is whether you can have a voluntary patient at all in the full sense of the term?—As I say again, it is a matter of trusting men who, in our judgment, of course, I need hardly tell you, should be trusted. They are trusted abroad for this very work every day.

16,731. Yes, but I am not very fond of phrases which are colourable phrases; and a voluntary patient, it always seems to me (to some extent at least, and it must be so in some cases), is rather a contradiction in terms, because, first of all, he is a person whose will

is to some extent abated.—Many of them have full volition, of course; others are betwixt and between.

16,732. It does not commend itself much to my mind (this is, perhaps you will say, a lawyer's point) to take an assent from a person who is in a pathological condition. As a lawyer one would not ask a person who is in a state of mental disturbance to perform any of the usual acts. You would not think it fair to take from him a contract giving up his property if he was in a state of mental disorder; but you propose to take from him a contract to give up his liberty when he is in a state of mental disorder, and one rather has the feeling that the voluntary system may be apt to become rather a system of camouflage, that it professes to be voluntary, whereas the case is not really voluntary, and that it might be more frank to say the case is to be treated, whether voluntary or involuntary, in the clinic?—Yes, but I think in practice the mass of the insane are seeking protection, and they are only too glad to have protection, advice and prompting. You can do things by advising them and gently guiding them, and they like it; they feel in need of sympathy and support. A person may come and say "I resent that, and I resent this," and in the end walk in quite easily, with very tactful nurses and doctors. Very few people offer real resistance. I suppose then it would be against the liberty of the subject, but they could be dealt with on the ground that they need support, and are glad to have it.

16,733. But I would like to have the comment of you eminent gentlemen before me upon that problem which has been in my mind, as to whether the description of these persons as voluntary patients is really not a misnomer? What do you say to that?—(Dr. Cole): As a matter of experience I have admitted many voluntary boarders. The vast majority of them have, in a common sense way, what we call volition. Of course it raises a large metaphysical problem, the problem of will; after all it is a matter of susceptibility to suggestion in different individuals who are regarded as normal, but there are a great many people walking about with but little will power; some of them may almost be said to be automatons and a good many insane patients have volition well marked.

16,734. Of course a great many cases are quite able to recognise their position and the desirability of treatment; but there are cases when you get into the borderland, where I should have thought it must have been rather a matter of conscience with a medical man as to whether it was fair to take an assent from such a person, because really his state of mind was not such as to enable him to appreciate one way or the other, and to take an assent which is not a real assent but really a formality is undesirable.—(Dr. Lord): An assent to what?

16,735. An assent to treatment and detention.—He comes and offers himself voluntarily for treatment and he is not refused. The treatment is there for him, if he wants it.

16,736. Suppose the person is brought by relatives and the patient is observed by you not to be able to express any will at all. What would you do?—He is brought for treatment in the same way as a patient suffering from fever. If he expresses any opposition then of course he must be taken away and dealt with under the Lunacy Acts.

16,737. Mr. Snell: I would like to ask Dr. Cole if he finds that a person has an all round volition, or whether the volition in these cases of which he speaks is restricted to certain departments of the mind?—(Dr. Cole): No, I mean an all round volition in the vast majority of cases. We want particularly to provide for people in whom the will is to some extent obscured, delirious cases, which may be regarded as people who have no choice; they give no expression of volition when given a choice to do one thing or

4 May, 1925.] Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. E. GOODALL, C.B.E., M.D., F.R.C.P., Dr. J. R. LORD, C.B.E., M.B., Dr. W. F. MENZIES, B.Sc., M.D., F.R.C.P., Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S., and Dr. R. WORTH, O.B.E., M.B. [Continued.]

another; those cases ought to have special machinery to enable them to be regarded as voluntary patients, or at any rate as not needing full certification.

16,738. *Chairman*: That is quite clear. One can quite see that cases may be treated, and ought to be treated, short of certification, if they are recoverable cases, but one is thinking of the régime under which they are to be there. The suggestion is that they should be there first as voluntary patients—that is to say, persons who recognise their state sufficiently to desire treatment. Then there should be another class, involuntary persons who will benefit by treatment and may recover, but in whose case the detention is involuntary. How are you to deal with that class of case, where there is a necessity for restraint in a clinic which contains persons who are not certified? There must, must there not, be some form of power over those persons in their own interest? I mean, must not the doctor have some power of control over such patients? Take the case we figure of an attack of mania, acute but recoverable, a case eminently suited for treatment in a clinic, and a case which will probably, after a very short time, recover—that person must at the moment be subjected to restraint, and possibly severe restraint?—(*Dr. Lord*): Are you thinking of mechanical restraint?

16,739. Yes.—It is practically never used now. If you search the English hospitals through you will find practically none of it in the last 10 or 15 years.

16,740. *Sir David Drummond*: That is not quite what we have heard?—(*Dr. Goodall*): *A fortiori* in a clinic with a strong personnel you would not want any mechanical restraint.

16,741. *Chairman*: Supposing that person wants to throw himself out of a window?—(*Dr. Lord*): He would be taken care of by nurses or treated by the doctor.

16,742. You are referring to mechanical restraint in the technical sense of the Rule?—Yes.

16,743. I should have imagined that you must exercise a very considerable degree of physical restraint upon patients just as you would in the case of pneumonic delirium; you would hold your patient down?—I wanted the position to be clear as to what sense you are using it in. If you are using it in the sense of medical restraint by means of baths, nurses, appropriate remedies by means of diet and other methods, restraining excitement, well and good; but if you mean by mechanical restraint tying up or trussing up a person, or something of that sort, that is gone in nearly all asylums.

16,744. Let me put it in another form: the right to detain. It is perfectly obvious that the case I figure of an acute mania ought to be detained. Call that "detention." Now "detention" is illegal without authority of some sort. I think your view would go so far as this, that there should not be certification, or that certification is unnecessary because a patient is merely going to be treated for his illness by a doctor?—My view is the view of the Association, that perhaps for some trifling period, which the public officials and others concerned could not very well object to, the case for detention ought to be decided upon, whether it is recovering from an acute mania, or beginning an acute mania. After a certain period of enquiry, which we put at three days, and in America is put at ten days, you have to decide one of three things: (1) Will the patient stay in hospital voluntarily on the advice of his friends and the hospital? (2) You may put him that question, but he may not be able to understand the question, or to answer it. What are you to do?

16,745. What could you do with the second case?—You have got to consider him as a child in the eye of the law; you have got to do what is good for him. But (3) he may say, "No, I will not stop, I am perfectly sane." Then you hand that case over to the legal authority. They say, "This man shall be

restrained or detained," and hand him back to the medical authorities. It is quite clear. There is no ambiguity in our minds on the subject.

16,746. Then it comes to this, that all the persons who are in such places of provisional observation and treatment as you figure are theoretically there voluntarily?—That is right.

16,747. There is no legal interposition with regard to their case at all?—When a person is admitted for acute mania in America, for instance, there are ten days for that person to make up his mind to remain voluntarily, or if he will not make up his mind or objects to detention, then the legal authority is communicated with, and they come in and decide what has to be done.

16,748. Again let us be clear. The inmates of this clinic, I take it, in your view are persons who are to be for the time entirely in the hands of the medical profession, that is to say, there is to be no legal interposition at all?—Yes.

16,749. The legal interposition may come in later if required?—Yes, immediately you have got to act in opposition to the patient's will.

16,750. Or without the patient's will?—His active will; then the doctor's province ceases, and the lawyer comes in and says to the medical man "Well now, he must clear out; this is a case no longer for you," and the doctor discharges him.

16,751. Again it looks to me as if the clinic were, to some extent at least, a clearing house?—A clinic must be a clearing house on discharge at least, whatever it is on admission.

16,752. But you do not desire any form of qualified legal power during this period in the clinic? Some witnesses have suggested to us that, short of certification, it might be desirable possibly for the protection of the doctor, possibly for the protection of the patient, that in the clinic stage there should be some legal power accorded to the medical man in charge to restrain or to detain?—Yes. (*Dr. Goodall*): The Early Mental Treatment Bill gave power to detain for six months.

16,753. On the person contracting to do so?—(*Dr. Lord*): On notification, and the authority can come of course at any time and see the case. (*Dr. Collins*): There is no detention in this Bill at all.

16,754. *Chairman*: Except the 72 hours?—There is no detention. It really means the patient who is not unwilling can be allowed to remain in an institution for six months. It is Clause 4 of the Mental Treatment Bill; there is no detention except the 72 hours.

16,755. And the obvious purpose of that is, that if the case is one that ought to be detained but does not want to be detained, the 72 hours gives you an opportunity of communicating with the authorities?—Yes. (*Dr. Lord*): Our recommendation 3, if you will look at it, is "That voluntary patients should be received, and also that provision be made for the reception of non-volitional patients for a limited time without certification."

16,756. And without any legal powers?—Except such as will be given us.

16,757. The question is whether you think as an Association that it would be desirable that while the patient is in the clinic he should be dissociated from the law altogether, or whether you would regard it as desirable to have some modified power of detention short of those powers which you obtain on full certification?—(*Dr. Cole*): I might inform you that originally in 1911 we thought of asking Parliament for powers for detaining patients in clinics, but since that time we have come to the conclusion that it is useless to ask Parliament to give the medical profession power to detain patients except under a legal authority, and we do not want that for the establishment of clinics. Therefore all we want in these clinics is to have voluntary patients and the delirious patients, the patients who have no will power, that

4 May, 1925.] Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. E. GOODALL, C.B.E., M.D., F.R.C.P., Dr. J. R. LORD, C.B.E., M.B., Dr. W. F. MENZIES, B.Sc., M.D., F.R.C.P., Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S., and Dr. R. WORTH, O.B.E., M.B. [Continued.]

is to say, they would not want to leave, and can easily be induced to stay; and any patients who object to be there should be discharged at the end of 72 hours.

16,758. I follow your principle?—We think it is useless to ask Parliament to give the medical profession the power. (Dr. Lord): The important point is that we do urge that with regard to all cases of the non-volitional type, it should be necessary for the clinic or the doctor at the head of the establishment to notify the central authority.

16,759. That is the precaution you suggest?—That is the precaution we suggest.

16,760. Of course we have had from Dr. Comrie his experience in Edinburgh. The patients who are treated in the Royal Infirmary at Edinburgh are none of them certified, although I gather some of them might be certifiable. It is rather striking, if one looks at this very interesting paper on the Utrecht Institution, to see that Dr. Winkler, at page 18 of the pamphlet, says: "One may ask if I have the right to retain such patients against their will. The measure is so salutary for the patient and his family that I never discuss it. Without doubt I have the right to declare these patients momentarily insane, and to ask legal authorisation to send them to an asylum, which never is refused. But I ordinarily do not. In this way nearly all transient psychoses recover in the clinic, without the stigma of having been insane." That is, I will not say an evasion of the law, but just giving the go-by to the legal side of it, by saying: "The patient's interest is the main thing, and I treat my patients there without bothering about the law"?—(Dr. Lord): We should not propose to repeat that in England; that might do for the Dutch mentality, but it would not do in this country. (Dr. Menzies): I think there is a class of case you are losing sight of which in my opinion should be admissible to a clinic, and that is a certified case which has to go there for some physical disorder, say for an operation for appendicitis.

16,761. Such a case might be sent to the clinic from a mental hospital?—What I should like to see is that the committal order is not broken by transference to the clinic for a week or two.

16,762. That is a piece of machinery that would be very desirable: that a patient in a mental hospital, if you please, a certified case developing appendicitis, where the facilities for an operation did not exist in the mental hospital, should be sent for the time being for treatment in a general hospital and then taken back?—Taken back quite freely. I am afraid I have been doing it myself without due regard to the law; it has now been brought to my notice that I have been acting illegally.

16,763. Your paper is most helpful to us, but I always like to think out the proposal in its practical aspects, and I want to get really down to the bed rock of the thing?—I have a complete scheme for North Staffordshire which would work satisfactorily, and it is one of the most barren districts as regards population in the whole of England. There is not a general hospital within 10 miles.

16,764. Is this in being, or is it in project?—It cannot be in being until the local authority have control of all cases of mental illness, and until they have power to contribute towards the voluntary hospital for the support of beds for an indoor clinic.

16,765. You have also been good enough to hand us a paper, but have you confronted the problem which I have been putting in regard to the voluntary patients?—Yes, I have.

16,766. What is your view as to whether voluntary patients can exist in the case of mental disease?—I think that they can for practical purposes. I am constantly having patients coming up to the door and asking for re-admission, and I cannot re-admit them

at the present time at all. That is a cruel thing to a patient; it may perhaps be unusual in North Staffordshire, but I have got the whole of the medical profession on my side, and they are all willing to establish a clinic as far as they can do it, if it were not a question of money.

16,767. Then is it your view that the clinic should contain all cases initially, or selected cases?—No; I think that is a narrow view to take of clinics. I should have the local authority in power over all mental cases. I would have a principal officer of mental health, who would have a central office. The relieving officers, who would then be officers of the mental health committee, whether full time or part time, would bring under the notice of the medical officer of mental health for the county all cases; and he, being in intimate touch, not only with the clinics, but with the mental hospitals and with the outdoor clinics in the small towns, would know, after consultation with all the specialists in the county, exactly what was to be the disposal of every patient.

16,768. You have supplied exactly the link I was looking for in supplement of what Dr. Goodall has been telling us. I wanted to get at the criterion for disposal. That test should take place, according to you, in the hands of some specially appointed officer?—Yes.

16,769. Curiously enough again we had evidence from Dr. Carswell that he had in Glasgow, while he was there, practically the post you contemplate. He told us that every case in Glasgow reached him first; he saw the patient personally himself in every instance, and he said: "That is a case that ought to go to the infirmary," or "That is a case that ought to go to the mental hospital," and he relegated to one or the other as he thought right. Of course there were no clinics, and therefore the case you would have sent to the clinic he sent to the Poor Law infirmary; but that institution in Glasgow was specially equipped to deal with mental cases, and he in effect provided the advantages of a clinic in that way; but the key of that whole system seemed to me to be the existence of a person who was a certifying authority, or at least the representative in the district of the local authority?—There cannot be delay; in many cases there must be freedom of admission to the county mental hospital, for instance. The relieving officer, or whoever is the official concerned—we hope the officials of the mental health committee—cannot wait while a delirious case cuts its throat, or while a homicidal case commits a murder; but in the course of the next day or two, and before the patient is to be finally dealt with, whether by voluntary means or by certificates, the mental officer will have had an opportunity of seeing and examining that patient and consulting with other heads of departments as to what is the best disposal of that patient in his own interests. It might be that he would go to the county mental hospital, it might be to the indoor clinic; he might, if it were only a case of delirium tremens, be allowed to go home. He might then attend the outdoor clinic for a short time.

16,770. Of course one knows that the actual violent cases are relatively much fewer than the public imagine?—That is so.

16,771. But take the instance you have put of the suicidal case arising in a town. Do you contemplate that that case would be disposed of by this medical officer of mental health sending it to the mental hospital, or to the clinic?—He might dispose of it, yes, but we must not envisage only patients in a town; we must envisage my district, say, amongst others, where there are isolated farms where there are actually people who have never been in a railway train.

16,772. But that is a better case, because we test it in its most difficult circumstances. Take a violent case suddenly arising in some isolated farm—as you

4 May, 1925.] Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. [Continued.
E. GOODALL, C.B.E., M.D., F.R.C.P., Dr. J. R. LOED, C.B.E., M.B., Dr. W. F. MENZIES, B.Sc.,
M.D., F.R.C.P., Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S.,
and Dr. R. WORTH, O.B.E., M.B.

say, some immediate step is required. Is the immediate step that you contemplate this, that the official whom you have described, the medical officer of mental health, would be called in?—No, there is not time for it.

16,773. What do you do with such a case?—The officer who is present, a relieving officer, and the local doctor, would take him to the mental hospital straight away.

16,774. That is unfortunate, if I may say so, because he is taken to the mental hospital, and there at once the asylum stigma, of which we have heard so much, seems to attach; whereas, although it is a very violent case, it may be a recoverable case?—We do not believe that stigma will last indefinitely. We believe that if there is early treatment of cases the stigma will, in the course of 25 to 30 years, be entirely absent.

16,775. One would hope so, but it is an aspiration at present?—I do not know. I undertake to say, if I live long enough, that in ten years time, if this Bill passes, 50 per cent. of my cases will be voluntary.

16,776. We have had remarkable statistics on that subject already, but I still want to pursue that topic a little further with you, Dr. Menzies. Such a case as you have figured may be eminently recoverable?—Yes.

16,777. Is not that a typical case for clinic treatment?—Yes. We do not want to limit the immediate committal, the immediate destination of a patient. We want that patient to have the destination which is immediately nearest him if it is an urgent case.

16,778. Of course you have figured an eminently recoverable case, but nevertheless one that must be detained?—Yes.

16,779. Now are you going to leave that detention, which will be only temporary, and I agree will be in the interest of the patient himself—are you going to leave that without any legal sanction in the clinic?—No, notification.

16,780. Notification and sanction?—And treated after three days by a provisional order, and after a month, if it still continues, then the magistrate must decide what the destination is to be.

16,781. We are now introducing the lawyer into the clinic?—We cannot help it; if you are going to curtail liberty, you must introduce the lawyer.

16,782. Even into the clinic?—Even into the clinic—that is my view.

16,783. I rather thought the ideal was that the clinic should be dissociated from the legal element altogether, and that the legal element should only come in when you got the length of sending the case to a mental hospital?—I can tell you that is possible in large centres of population, but it is not practicable from the financial point of view in sparsely populated districts of England. (Dr. Lord): Might I say we have got a good practical example in America. In Albany, and in the City of New York, a health officer, a similar official to the one Dr. Menzies has been mentioning, has the power to take up a person of that sort, or he acts in the case of information by the friends and relatives and so on; and he takes him to the clinic where he can be kept for 30 days. In other places he can be taken to the State hospital and be kept for 10 days, but at the end of 10 days, should he himself or his friends demand his discharge, and he is not a suitable case for discharge, then the lawyer is brought in to decide the question.

16,784. Let us again revert to the case put, the violent case which has to be taken to the mental hospital; there is no other provision for it, there is not a clinic available, and it is taken direct to a mental hospital. The medical superintendent at present, of course, could not receive such a case without a certification order. You contemplate that the case could be received without certification?—Yes.

16,785. Then that would be followed by notification. What would be the warrant of the medical superintendent to continue to detain that case? You do not want to have certification because the case is *ex hypothesi* a recoverable case; you must therefore have some alteration of the law which would enable the medical superintendent to detain that involuntary case (because *ex hypothesi* it is not a voluntary case) against his wish, for a period that would allow of the recovery?—(Dr. Menzies): Not necessarily the recovery, no.

16,786. A chance of recovery?—A chance of recovery. We say that when the provisional order, which must not last longer than 31 days, and even then has to be renewed from seven to seven—when that is about to expire, then the medical expert must decide about the patient, provided he is a man who is able to give an opinion.

16,787. At present it evidently would be to some extent a matter of circumstances whether the case reached a clinic or a mental hospital?—It must be a matter of circumstances; we want freedom.

16,788. In either of those two places, do you contemplate that there should be a certain amount of intervention of the law to protect, on the one hand, the person who is at the head of the clinic, and, on the other hand, the medical superintendent of the mental hospital, but that the legal intervention should be short of certification?—I do not think you need to introduce it in a clinic, because they would not keep in a clinic a patient who objected.

16,789. We are taking the non-voluntary case, the very case you figure.—Well, I say there is provision in the Mental Treatment Bill to detain him in the clinic for a period of six months, renewable, I understand, under certain circumstances, up to a year.

16,790. You see there is a broad discrimination here; there are two ways of looking at it. You may say that the clinic treatment shall be dissociated altogether from the law,—that is the medical province, and there shall be the period during which the doctor shall be supreme and the lawyer shall be absent. On the other hand, there is the view that even in the provisional period, because some interference with liberty may be necessary, there should be some legal power short of the powers which result from certification. I want to know very much whether the view of the Association is that the provisional period should be in the hands of the doctor alone, so that he should be able to deal with his case as he pleases, or whether during that period he should have certain legal powers confided in him, but that those powers should be short of the powers which result from full certification.—(Dr. Lord): Are you contemplating Section 4 of this Bill? That gives a similar thing; it gives power to house a voluntary patient.

16,791. The six months is only the maximum period during which this treatment may be accorded. Some cases are not voluntary, but transitory, and it is desirable that such cases should escape certification if possible, if such cases must be detained.—(Dr. Cole): Why not "retained," not "detained"?

16,792. That is mere language.—I do not know. A person is detained against his will; but a person who has no will is retained. The view of the Association is that if the person will not accept treatment, if he objects, he must be certified, and then there is the legal intervention.

16,793. May I suggest for your consideration that that is a little unfortunate, because I could imagine a case eminently recoverable, who was both violent and difficult to deal with, who said "I am going out of your place at once and am going to fling myself in front of the first train that comes along," and yet so transitory was the ailment that possibly in a week or ten days it is almost certain that he would be all

4 May, 1925.] Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. E. GOODALL, C.B.E., M.D., F.R.C.P., Dr. J. R. LORD, C.B.E., M.B., Dr. W. F. MENZIES, B.Sc., M.D., F.R.C.P., Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S., and Dr. R. WORTH, O.B.E., M.B. [Continued.]

right again; but, on this view, he has got to be certified.—(Dr. Lord): That is a case you have created in your own mind. I have never met one. (Dr. Menzies): We have 31 days for the provisional order; and then it is for the magistrate to decide whether the patient is to be detained altogether or not.

16,794. Then you would import into this provisional treatment some legal power?—A provisional order in the case of a patient who says: "No, I am not going to be treated."

16,795. Then the resisting case would not necessarily be immediately certified?—Only after the three days.

16,796. What about a provisional order for him?—The provisional order is a modified form which we do not think would have the stigma attaching to it.

16,797. If you had a provisional order which would entitle you to deal with a resisting case for such a period as would give you a chance of effecting a cure, would not that be a desirable thing?—(Dr. Goodall): I believe there is a confusion. I never thought the provisional order was intended to apply to clinics at all, only to mental hospitals. (Dr. Cole): Only in exceptional cases. (Dr. Goodall): In the Boston Psychopathic Hospital they have a ten-day temporary admission; a patient must be discharged to the asylum, or if not legally insane, put on a voluntary status at the end of ten days. (Dr. Menzies): Probably all the clinics would refuse to have a patient who would not stay there; but there are a certain few cases which I would not like to see the clinics forbidden to receive, as for instance, the one I quoted, the appendicitis case. (Dr. Goodall): The Boston Institution is allowed to receive anything and keep it for ten days. (Dr. Lord): That applies to all the mental hospitals in the United States anyhow, if the case is an urgent one.

16,798. Sir Humphry Rolleston: Is it not probable at the present time, Dr. Goodall, that if you had any legal power of restraint in these mental clinics, it would really damage their reputation, and prevent people coming to them who otherwise might come?—(Dr. Goodall): You must have a period in which to make up your mind as to whether you can continue on a voluntary basis, or have the patient "committed," as they say in America—certified.

16,799. 72 hours is not sufficient, is it?—They do not think that, evidently. (Dr. Lord): I must say that any patient who goes into a clinic and promptly wants his discharge would be very awkward to deal with in a clinic; the chances are that they would send for his friends, put him in a cab, and send him away. (Dr. Cole): In voicing the opinion of the Association I ought to say that the provisional order is not intended to be applied to clinics. Supposing at the Maudsley Hospital a patient was homicidal and suicidal and so on, even although it is against the rules of the Maudsley Hospital, they might have to sign an urgency certificate for his admission to Bethlem; they might have to break their rules. Where the Maudsley Hospital fails, in the opinion of the Association, is that they are unable to take the delirious cases at the present time, because the patients are not in a position to have volition to sign a paper to go there. That, to our mind, is a pity; that the Maudsley Hospital does not provide for that class of case, which does not require certification, has no will-power, would stop there, but is not a voluntary patient and therefore is not admitted.

16,800. I follow. Of course, you will see what is in my mind. I am endeavouring, with your assistance, to formulate a system of working, and I want to see, so to speak, the programme of it. It involves certain types of institutions and certain relations between them, and certain different stages, certain periods at which the law intervenes. One must envisage the whole thing as a system; one wants it to be as simple

and at the same time as effective as possible, always keeping in view the benefit of the patient and also his protection. That is the sort of general consideration one has in one's mind. I have a little difficulty in envisaging exactly the system which you have in view. Of course, I see the importance of a clinic; I see the desirability of a person being treated without certification; I see the importance of having facilities for dealing with recoverable cases. All these things, if I may say so, are things that we recognise almost as obvious things. It is much more the machinery of it that is puzzling us; as to how you are to work it out on the lines of the existing system, as remodelled, or what practical recommendations we can make. As far as we have got, the practical recommendation is this: (a) that there should be a system of clinics established, preferably in association with general hospitals, or, alternatively, independently of the general hospitals, but in dissociation from the mental hospitals; (b) that there should continue to exist the mental hospitals throughout this country, and that those mental hospitals should work to some extent in parallel with the clinic system, because they also would be available in future for the admission of voluntary patients; and you seem further to contemplate that the relegation of a case to the one type of institution or the other, the clinic or the mental hospital, should be in the hands of some responsible local official, appointed by the local authority, who would deal with all the cases and relegate them to one or other of these institutions, according as he thought best from his experience.

16,801. Mr. Micklem: Could that apply in the case of private patients, do you think?—(Dr. Menzies): No; this applies to rate-aided patients. (Dr. Cole): I have some experience of the London hospitals. At St. Mary's Hospital I have a right to three beds; I never use them, and refuse to use them, because I consider it is not wise for me to take in mental patients to the ordinary wards of the hospital without properly trained staff and without proper arrangements being made. I have frequently seen mental patients in the hospital, of course. We have an out-patient department, and many doctors in the district send me incipient cases of insanity; and I am the officer of the district who decides where these patients are to go to very largely. They come to my out-patient department, and I may decide that this is a patient that must go to the infirmary, and herein I have experience of what the stigma of pauperism is. The Paddington Hospital has been allocated to St. Mary's Hospital, and the staff are paid for attending Paddington Hospital by the Guardians, and the students go there for clinical instruction; also they see the mental cases in the observation wards there. I am consulting psychiatrist to the place, and I am called in now for all the doubtful cases, to decide what is to be done with them. They have a paid medical officer, and he certifies the ordinary cases. Any doubtful cases I am asked to visit and to report upon; but I have the power to send patients to the Maudsley Hospital, that is to say, a clinic. I send them to the Maida Vale Hospital and other places; but I do consider that the private practitioner should have some voice in the matter; he would call in the relieving officer, and the relieving officer would deal with a case as best he can; he very frequently sends them to my out-patient department, and, in other cases, to the infirmary.

16,802. Chairman: Have you considered the effect upon the mental hospital atmosphere of so many of the recoverable cases being withdrawn from it?—Yes. I think a large number of the members of the Association regret it very much. What we feel is that it should be mostly in the hands of the public. Many people prefer the mental hospital, undoubtedly; patients who have been there before may not look at the clinic; others will go at once to the clinic. (Dr.

4 May, 1925.] Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. [Continued.
E. GOODALL, C.B.E., M.D., F.R.C.P., Dr. J. R. LORD, C.B.E., M.B., Dr. W. F. MENZIES, B.Sc.,
M.D., F.R.C.P., Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S.,
and Dr. R. WORTH, O.B.E., M.B.

Lord): Of course, our clinics reach a class of case that is not reached by the other institutions.

16,803. You reach the incipient cases?—Yes, quite a range of cases, neurological cases, functional nervous cases, and so on. These cases, when they are allowed to get worse, when they are untreated, of course, may come into the asylums ultimately incurable. We are spreading out the net to gather them in these clinics, and we also want to use the clinics as mental health centres.

16,804. Of course, one of the functions they would perform in the public interest would be by attracting the cases at their early stages, and you might obviate the increase of the asylum population?—If a clinic is successful, there is no question about it; it will take many years, of course. Ultimately, your mental hospital will become superfluous, to some extent.

16,805. I am a little distressed at the thought of the mental hospital, instead of as at present containing a population of various types of cases, becoming practically a place in which there were nothing but hopeless cases?—By that time, if that ever comes about, of course, naturally you would have to change your personnel and change the name of the institution and the authority it is under. (*Dr. Goodall*): I can say that has not come about in Germany for 35 years; and, as I have said, very excellent scientific work is turned out of the German mental hospitals. (*Dr. Lord*): There are many cases of mental disorder which we cannot reasonably expect to cure under two to three years. Are you going to lodge them in a clinic all that time? No; you must have mental hospitals.

16,806. But that would be the voluntary case?—It might be a voluntary case. It might develop after a period strong objections to remaining, in which case it has to be certified; as it got better, being under certificates, we should say: "Well, you are very much better. If you like to take your future in your own hands, you can go out, we do not advise it, or you can remain voluntarily." We want freedom in these matters.

16,807. I should like Sir Frederick Mott's view on this matter?—(*Sir Frederick Mott*): My idea is that it is largely an economic question. If we could establish all over the country hospitals like the Maudsley hospital, which in my opinion is almost ideal, that would be the very best thing, but at the present time it is quite impossible. The great idea, I think is to attract the patient as soon as possible to come under treatment, because as Dr. Maudsley who gave this money to the hospital said: "That there are crowds of incurable cases of insanity congregated in large asylums is undoubtedly owing in some measure to the common neglect of early treatment when the malady is most curable." For that reason he gave this money, but it was thought at first that the Maudsley Hospital would only be able to receive certifiable cases. As I had a great deal to do with the Maudsley Hospital and its building, I advised Dr. Maudsley (because of my experience during the war with regard to cases of insanity), to adopt the system of having non-certifiable cases there, because I said: "I am perfectly sure the great number of people will not come to the hospital, and will not be brought to the hospital, if it is felt that it is a half-way house to an asylum." He quite agreed to that, and it has worked extremely well, I think. But there are a certain number of cases that one feels perfectly sure will get well; even very bad cases I have known get perfectly well if they are properly treated for a short time; and we want powers somehow to retain those cases for a time, so that they will not be discharged and sent to an asylum, because if that happens people will not come. You were speaking about volition just now. I had two cases, they were quite insane, but I

felt sure that if I could send them to the Maudsley hospital they would get well. Their great fear was that they were going to be sent to an asylum. I persuaded them both, I said, "This is a hospital; you will not be certified and sent to an asylum; you will be cured." I saw one of them about a week later, he was quite sane, and in about a month he went out; but most of the cases have to remain there from three to six months. Dr. Mapother will tell you about that.

16,808. Yes, we are hoping to see him.—We want really an extension of time, and, as Dr. Goodall said, if you were to trust the doctors to do their very best, having regard to the excellent staff they have there, I think that would be desirable; but if that is not possible there are other methods. I do not think that a clinic at a general hospital is advisable unless they can provide a condition of things like we have at the Maudsley hospital, namely, extensive grounds and occupation for the patients; because to put a good many of the cases into a ward is not desirable, I think. Of course a certain number of cases can be so treated, but not the general run of cases that I have seen at the Maudsley Hospital.

16,809. Might I, Sir Frederick, ask a question there? Does not it really come to this, that the institution you figure is just another mental hospital? It is to have wards and staff, and grounds, and so on. It is just to be a mental hospital, but a mental hospital in which cases are to be treated without certification?—Yes, but excuse me, Sir, there are four highly qualified medical officers, and a number of clinical assistants, and a very experienced staff, and it is associated with the general hospital, King's College Hospital opposite, so that a specialist can be called in to see the cases, and so it is run on hospital lines. Of course I think there is a great improvement now in our mental hospitals generally throughout the country, especially in the London county mental hospitals, as regards those provisions.

16,809A. What I mean is this, that so far as outward semblance is concerned, the institution would to all intents and purposes be an asylum, but an asylum which contained no certified cases?—No, a mental hospital.

16,810. A mental hospital, but one which contained no certified cases, and no cases which were going to be certified there; but in outward semblance, and in equipment, it would only be a better mental hospital than the existing ones?—The wards are small, there are not more than 28 patients in a ward, whereas in the mental hospitals they are very large wards; I know some with 100 patients.

16,811. It does not quite meet my point that it is a mental hospital still, but a mental hospital where there is no compulsion, and where the equipment is better and the staff is more elaborate?—There is much more individual treatment.

16,812. We ought to have that in the mental hospitals also?—I quite agree with you, but can you do it? It is a question of finance. I would like to see Dr. Goodall's system adopted but it is impracticable at the present time.

16,813. Where you cannot have a Maudsley institution what is your solution?—I should like to see a scheme such as Birmingham might establish. I say here "Birmingham might establish such a mental hospital in association with either of the two great general hospitals in that city, and affiliated as a school of the University; or a group of authorities representing boroughs and county councils in the Midlands might combine with Birmingham for this purpose." I believe that would fulfil Dr. Goodall's idea. It is a question of finance mainly. I know that one hospital that was approached with regard to having a clinic and proper wards said, "Yes, we would be very glad to do this, but we have not the money."

4 May, 1925.] Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. E. GOODALL, O.B.E., M.D., F.R.C.P., Dr. J. R. LORD, O.B.E., M.B., Dr. W. F. MENZIES, B.Sc., M.D., F.R.C.P., Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S., and Dr. R. WORTH, O.B.E., M.B. [Continued.]

Then I suggested that possibly it might be financed, as Dr. Cole says it is likely to be at St. Mary's, on the same basis as the tuberculosis, or the venereal disease clinics. Then, thirdly, I suggest "The establishment of hospitals associated with, but outside the grounds of existing asylums, provided with properly equipped and staffed clinical laboratories under borough or county councils, and, where possible, affiliated with a general hospital of a medical school or university." For example, Portsmouth might have a clinic outside the mental hospital; I think it would be a great thing to have it outside. You would have an efficient staff. What is done in the mental hospitals, which is much better than it used to be, is to have separate villas within the grounds, so that acute cases never go into the general hospital among the chronic cases at all. I believe that is so, Dr. Lord, is it not? (Dr. Lord): Except perhaps to attend the cinema entertainments; they live outside as in a village. (Sir Frederick Mott): I think a good deal must be taken into account from the point of view of the district. (Dr. Lord): The great point is that we cannot as an Association recommend things we think impracticable economically.

16,814. And we cannot, as a Commission, do so either?—We suggest that you put an authority in each area, and that authority have wide influence, not only have on it representatives of the county council, but all sorts of authorities who are interested in mental health, and let them settle what the area should be—give them freedom on these points that we have suggested. If an area wants to have a clinic why should not it have it? If in another area they can do best with some special institution affiliated with several general infirmaries, or the Birmingham scheme, for instance, or the Cheddleton scheme—all these schemes are practical for districts, but they may be impracticable as general measures.

16,815. Then you do not think a uniform system is capable of construction for the country?—At the moment that is quite obvious from the practical point that Sir Frederick Mott has raised: Parliament could not suddenly order every general hospital in this country to build a clinic. The general hospital would say "All right, take over the general hospital; we cannot do such things." You can make schemes legally possible. (Dr. Goodall): That is what the Early Mental Treatment Bill did. (Dr. Lord): At present the authorities can do nothing. Whenever they try to advance early treatment they come up against the law somewhere.

16,816. Would you tell us exactly how you work at Cardiff, because I do not think we have got it as yet? I mean your method of procedure at Cardiff. Several of the witnesses who have preceded you have told us that at Cardiff there is a system in actual operation which works very satisfactorily?—(Dr. Goodall): I have only got an out-patients' department at Cardiff; there is no indoor provision.

16,817. You have the University College of Wales?—Yes, the Welsh National School of Medicine is there.

16,818. Then with regard to yourself what is your position?—I am Lecturer on Mental Disorders there and Physician to the out-patient department.

16,819. That out-patient department is an out-patient department of the general hospital at Cardiff?—Yes, one of the departments of it.

16,820. A voluntary hospital?—Yes.

16,821. Have you a ward?—No, but I have several cases in, in co-operation with the physicians.

16,822. Mixed with the ordinary cases?—Yes, we take that risk, but I have already said that that is not what I recommend.

16,823. Quite. I am anxious to know what you are doing. You have an out-patient department?—Yes.

16,824. Is it largely resorted to?—Not largely, because there is no indoor department. It would be

about five or six times bigger if it was well known there was an indoor department. They will not go to the mental hospital; it may have a good name, it does not matter; they want to go to some place away from the mental hospital.

16,825. You offer them an out-patient department in the first instance? Is that known to the people in Cardiff?—Yes, and all round. There are two million people round Cardiff and they come from all parts.

16,826. Is the out-patient department separate from the ordinary out-patient department for ordinary patients?—No. I share a room with the gynaecologist.

16,827. Have you an assistant doctor there?—No, I have a clinical assistant if I want one, and a nurse I take down with me.

16,828. Do you attend there so many hours a week?—Every Tuesday afternoon at present.

16,829. Is it posted up that that is the time you will attend there?—Yes, and the doctors round the district know it.

16,830. Can you give us any statistics of the number of people who come to you there?—I do not have more than 90 to 100 a year at present.

16,831. What sort of person comes to your outdoor clinic? Do you get the incipient case we are in search of?—Yes, a great number of them. Of course I get defectives and epileptics, and all sorts of neuro-psychiatric cases and borderland cases.

16,832. You cannot take them in, I understand?—No, but I have very many early cases. As I say I am at my wit's end very often to know what to do with them.

16,833. What do you do with them?—You can only treat them in their homes.

16,834. Some you get in by hook or by crook?—Yes, and there are some there who ought to be certified; but we take the risk, because, of course, they will not take these people in if they know they are insane. The best I can do is to advise the doctor what to do with them, but it is a deplorable thing, because no case of mental disorder can be treated properly in a private house.

16,835. I am interested in the incipient case. Sometimes they arrive at your out-patient department, and you observe that the case is one of mental disorder, is one of delusion, at any rate, and you interview the case, I suppose?—Yes.

16,836. What facilities for treatment have you? Do you advise a régime of any sort, or what do you do?—There is nearly always a relative with them. We take a very full history to start with, family and personal; then I have always had a diet sheet typed ready, and one about exercise and hydrotherapy, and that sort of thing.

16,837. You really prescribe for the case?—Yes; they get their medicine out of a bottle the same as the others at the infirmary.

16,838. But you prescribe a mode of life as far as possible?—Yes, and I write to the doctor in every case.

16,839. And do you find that in consequence of the advice you are able to benefit those patients, many of them?—I am afraid I cannot say that, because seven-tenths of them want to come inside; it is a one-horse show.

16,840. Earl Russell: Do you ever recommend any of them to go to the asylum?—No; I always say "Do not send them there," but they drift there in the present circumstances.

16,841. What happens to them if they get really bad and you cannot take them in?—They have to come to the asylum, of course, many cases that should not come at all. I have set out here the cases that came during the last six months. I say they ought not to have gone there at all.

16,842. Chairman: You are, of course, Superintendent of the Cardiff Mental Hospital yourself?—Yes.

4 May, 1925.] Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. [Continued.
E. GOODALL, C.B.E., M.D., F.R.C.P., Dr. J. R. LORD, O.B.E., M.B., Dr. W. F. MENZIES, B.Sc.,
M.D., F.R.C.P., Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S.,
and Dr. R. WORTH, O.B.E., M.B.

16,843. But so fixed is your idea of the dissociation from the clinic that you do not recommend the patients to go from your outdoor department to your mental hospital?—No. I think most of us engaged in psychiatry will delay certification.

16,844. Do you never get a case of the type we have been talking about where immediate steps are required?—Yes.

16,845. What do you do with that class of case. Supposing an advanced case is brought to you, what do you do with that?—I get them into communication with the chief relieving officer. There is nothing else to do at present.

16,846. That case does become certified and is sent to your mental hospital?—Yes. It would not be if there were a clinic. I have heaps and heaps of non-volitional cases come in.

16,847. In Cardiff, suppose the matter were legalised, do you think there would be any difficulty in working wards for indoor patients in connection with your clinic?—No, I do not believe so, because as I have already said Cardiff cannot be unique, but the fact is that they are subscribing £2,000 a year to the Infirmary and have five representatives on it, and the local authority has worked excellently with the Infirmary people. I think if facilities were given to establish clinics, Cardiff would be one of the first places to have them.

16,848. It might, as Dr. Lord suggests, be one of the places to show the way how this could be done. It would be an example of actual working?—Yes. I may say that the facilities at the Cardiff Mental Hospital are only three miles from the Cardiff Infirmary; you could not have a closer association. It is about as good an instance of a halfway hospital between the ordinary mental hospital and clinic that you could get, but it is not sufficient, it is not what we want. We want nothing other than such clinics as they have in Germany and in America.

16,849. What is the view of the Association on Lord Onslow's Bill generally?—(Dr. Cole): We have put it down here in our report on page 18. First of all, we feel that the whole Bill is permissive. Unless local authorities are asked to do things and establish these places they will simply mark time, and do nothing. Under the provisions of the Mental Deficiency Act little has been done for a long time in consequence of the war; and here everything is merely permissive. It does not even encourage them in these things. For Clause 2 we suggest, "It shall be the duty of any local authority to arrange for the provision and maintenance of an institution or clinic for the treatment of incipient mental disorders." The view of the Association is that it shall be the duty of the local authority. If we make it merely permissive they will not do anything. That is our experience, at least when it comes to psychiatry; unless they are forced to do things local authorities will not do things—that is one of our objections. (Dr. Lord): Of course, it is recognised that we could not coerce the local authority, but they would have a choice of schemes.

16,850. *Earl Russell*: They have a statutory obligation?—They have a statutory obligation, but you would have some difficulty in coercing them. (Dr. Cole): On that page you will see some of the criticisms which our Association has made. We would rather it went through as it is than have no Bill at all. I know that the County Councils Association objects to co-option, but there we feel ourselves that Clause 1 is a very important one. We should rather like to see good people and well-informed people co-opted who are not members of a local authority.

16,851. *Chairman*: You have the advantage of getting women also on?—Quite so. Then the other criticisms, if you look at the Bill, subsection (3) "Receive and lodge as a boarder"—

16,852. If you do not mind, I would rather reserve that for the minute, because I want your views on that separately. It is the treating of incipient cases, and the voluntary boarder, that one is concerned with?—We object to the word "boarder." It is Clause 2, subsection (3), "receive and lodge as a boarder." We would like this word always used, "a voluntary patient."

16,853. There is a distinction taken throughout the Bill between the voluntary patient and the boarder?—Yes; we think that is unfortunate.

16,854. They are treated as two different kinds of people?—We do not like the word "boarder" in the Lunacy Act, we think it ought to be "a voluntary patient." We think the voluntary patients would be quite as numerous as the certified patients in the course of time, when the principle spreads in rate-aided hospitals.

16,855. The distinction taken in the Bill as far as I can gather is a little obscure; it is that a "boarder" may be a person who is not necessarily suffering from mental disorder, whereas a "patient" is a person who is suffering from mental disorder and is considered likely to benefit from temporary treatment; but the boarder is a person who may be received even although he will not admit he is suffering from mental disorder?—It says a boarder who is desirous of submitting himself for treatment.

16,856. I do not think I admire the distinction myself at all, but I was trying to see what was in the mind of the draftsman. I think, to do the draftsman justice, what he was thinking of when he used the word "boarder" is the person under Clause 2 of the Bill. When he talks of the "patient" he is thinking of the person under Clause 4?—Would anyone want to be a boarder in a clinic or a mental hospital unless he is mentally disordered? The word "boarder" is a mistake, both in the present Act and in this Bill. It savours rather of the commercial boarding house than of a clinic.

16,857. I do not say I admire it, but I find it there?—Where we maintain this Bill does not fulfil its purpose, is that it does not provide at all for private patients. As a matter of fact there is threatened opposition to the Bill under the aegis of the Board of Control if the private patient were introduced into it, but I understand that even so certain clauses are ready to be inserted in it.

16,858. Are you quite sure, because Clause 4, subsection 2 says: "For the purposes of this section the expression 'approved institution' means any institution, being either an institution under the control of the visiting committee, a registered hospital, or a licensed house." The licensed house is a typical place where the private patient is received?—I am referring to the patient in single care; that is not mentioned here. A very important modification of the law we consider ought to be brought about for the proper supervision of these people. A good many of them are not in recognised places, and they suffer from mental disorder. It really means another section, notwithstanding Section 315 of the Lunacy Act.

16,859. That is a different topic. That is a question of the amendment of the existing law for the better protection of single care patients. This is a question of what is the proper machinery to introduce to enable voluntary and incipient cases to be dealt with?—That is exactly what we want for nursing homes and for single care patients as well, which is not mentioned in this Bill.

16,860. You mean that single care might be approved, that is to say, that a particular house might be approved by the Board of Control as an appropriate place to receive a single voluntary patient?—Yes. We do not ask to approve of the place, so long as the medical man recommends the place.

4 May, 1925.] Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. E. GOODALL, C.B.E., M.D., F.R.C.P., Dr. J. R. LORD, C.B.E., M.B., Dr. W. F. MENZIES, B.Sc., M.D., F.R.C.P., Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S., and Dr. R. WORTH, O.B.E., M.B. [Continued.]

16,861. I see the hiatus you are pointing to. Among the institutions that may be approved there does not occur the home of a single patient?—It would be impossible to approve all the houses where single patients go to-day.

16,862. But at the same time you want some machinery devised whereby cases may be received without certification and kept?—Yes; our point is this that every certifiable patient does not require detention, and at present it is illegal for such a patient to be kept; we think it should not be illegal for a certifiable patient who desires treatment in a single house to be allowed to live there. That is what this Bill does not provide for. (Dr. Lord): Clause 4 you see we limit to non-volitional cases. It is a fault of the machinery that voluntary patients were included in both sections. For instance, the voluntary patient may go to any hospital, whether it is suited for the purpose or not, and offer himself as a voluntary boarder, whereas if he offers himself under Clause 4 they might say: "No, you must go to a place approved of by the Board of Control." (Dr. Cole): We object to the recommendation by two medical practitioners; we think one ought to be sufficient. (Dr. Lord): That is under Clause 4. (Dr. Cole): Yes. (Dr. Lord): Clause 4 would merely apply to clinics and similar hospitals, and the rest of the Bill would apply primarily to mental hospitals and also clinics in certain cases.

16,863. It is a little difficult to follow the scheme in the draftsman's mind in this Bill. I personally have some difficulty in following the distinction between the boarder and the voluntary patient?—(Dr. Cole): I think "boarder" was really copied from the Lunacy Act.

16,864. In Clause 5 it recognises two classes of persons?—(Dr. Cole): But "patient" really refers to a delirious patient, in which case the relatives act for him.

16,865. But it does not say so. Is not the distinction this, that the one person comes in with a recommendation, and the other without? The voluntary patient who presents himself at the door of the mental hospital and is received has not any recommendation. He is a "boarder" in the language of the Bill; but the "patient" in the language of the Bill is a person who has been recommended?—(Dr. Lord): We have had, of course, many meetings on this Bill, and that is a new explanation. Clause 2 deals with an Act of Parliament already in force, and therefore it uses the same term, it is merely extending the present clause of the Lunacy Act regarding boarders to asylums which exist under the Lunacy Act; while Clause 4 does appear to involve a new type of institution, places like the Maudsley hospital, and hospital clinics, and also possibly nursing homes; and possibly a new type of patient, and he is to be a provisional patient. Originally I should think Clause 4 was drawn up with a view to some form of detention. At the last minute courage failed and they left out the detention, but left the machinery there under a voluntary guise.

16,866. I dislike ambiguous legislation. I like to know where I am, and it does seem to me that the Bill, however excellent its motives, is not so clear as it ought to be?—(Dr. Lord): We have put it all right; it is all clear and logical in our notes. (Dr. Cole): The notice should be in writing. You will see our amendment on page 18. We think it is very important, because a patient may say he is leaving and the notification may never reach the proper authority. Also we would like to say "provided he does not give notice, afterwards withdrawing it." Some of these voluntary patients want to go one day and do not want to go the next day.

16,867. I have difficulty in calling that a voluntary patient at all?—But that is so.

16,868. Earl Russell: You have to make sure he has access to writing material?—Quite so, and the patient may be paralysed or have no right arm.

16,869. Chairman: It is uncommonly difficult to legislate for every type of case if you have to legislate in general language?—There is a provision that a patient may be discharged by a relative. Then there is sub-section (5) (b), a patient may be discharged by the superintendent or other person.

16,870. That is on the analogy of the present private patient who may be withdrawn, but the barring certificate is always available in that case?—Yes, I only point it out. We do not object to it particularly, but it is so.

16,871. Earl Russell: Sub-section (b) does not prevent his remaining as a voluntary boarder?—(Dr. Cole): I was mentioning (5) (b) "may at any time be discharged from the institution by the said superintendent or other person, or by order of a commissioner or on the direction in writing."

16,872. Earl Russell: Still that would not prevent his saying "I want to be a voluntary boarder on my own"?—He would have to go out and come in again. He is discharged. It is rather ambiguous. (Dr. Menzies): I think discharge means being taken off the benches, and not issuing from the front door. (Dr. Cole): That may be the explanation.

16,873. Chairman: At any rate these are matters that should not be left obscure in an Act of this sort?—(Dr. Lord): Nothing should be obscure in a Lunacy Act.

16,874. In any Act I may venture to add?—(Dr. Cole): I daresay you notice the principle of two medical men acting together. We recommend for treatment one medical man. This is a new principle introduced which we want to foster. We object very much that two medical men should have to examine a patient apart; we think it is a pity. We notice that under the Bill the two medical men are to certify together.

16,875. Yes, and I am rather interested in noticing that in America, in one of the forms, certification follows after consultation between the two doctors?—(Dr. Lord): I shall probably have an opportunity of telling you about that.

16,876. With regard to what Dr. Cole was saying, I see at page 48 where you have collected together a considerable amount of information of other places, you give the form which is in use in the State of New York, and I notice that the doctors certify "As a result of such joint examination," so that there the examination is a joint examination?—Yes. (Dr. Cole): That is so in Ireland now; two medical men sign one certificate for a private patient.

After a short adjournment.

16,877. Chairman: Dr. Cole, may I draw your attention to recommendation 30 on page 14, "That it should be made possible for rate-aided patients to be admitted to mental hospitals under a 'provisional order'." You then give a reference to recommendations 31 to 35. What exactly has the Association in mind as a provisional order, in contradistinction to a certificate?—(Dr. Cole): In the first place it was to take the place of the urgency order, such as we have now for private patients only.

16,878. On one medical certificate?—On one medical certificate. Another thing is that on that certificate we do not wish the patient to be styled as a person of unsound mind. What we wish to say is: "This is a patient who requires temporary care, observation and treatment," without specifying that he is a person of unsound mind, or even specifying that he requires detention. I know from the legal aspect no doubt you consider he is detained, and so he is, but we thought we would not mention the words, "person of unsound mind," and we would not mention the word "detention"; and this form should be used not only

4 May, 1925.] Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. E. GOODALL, C.B.E., M.D., F.R.C.P., Dr. J. R. LORD, C.B.E., M.B., Dr. W. F. MENZIES, B.Sc., M.D., F.R.C.P., Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S., and Dr. R. WORTH, O.B.E., M.B. [Continued.]

for urgency, but for practically all cases in the initial stage, for their reception into a mental hospital or anywhere else.

16,879. What power do you contemplate it would give? It would be addressed to somebody, of course; it would be addressed to the medical superintendent of the mental hospital where the patient is to be housed? — It would give him all the powers for three days such as would apply in the case of any other patient if he had a complete reception order on admission.

16,880. Only for three days?—Such as we have now for the urgency order, which lasts one week.

16,881. Do not you think that three days may be too short a period?—We think that in a number of cases at the end of three days, when the patient is once in a mental hospital, he will perhaps be content to remain, and might be a voluntary patient; but if he is not fit for that we might then call in a justice or two members of the visiting committee of the public mental hospital to sanction the prolongation of this provisional order for a further period of twenty-eight days. Then again he might be a voluntary patient; the acute symptoms might have passed off.

16,882. Then it is not a certificate of insanity?—No.

16,883. But it is a certificate which carries with it certain powers short of the powers which are given under a certificate?—We think that the powers would be exactly the same; it would require an order and a certificate; an order of a relative or public officer, and the certificate of a doctor.

16,884. Now you say that it should not authorise in terms detention, although it should have the effect of authorising detention. Do you think it is desirable to beat about the bush in that way? If it is going to give the power to detain, is it not better to say so frankly?—We leave the legal profession to decide that point.

16,885. *Earl Russell*: It is not altogether a legal question, but I understand from you that you are very much impressed by the effect upon the patient's mind? —Yes. A provisional order means that a patient is capable of detention, as he is now under the urgency order. It does not follow that every person who is certified at present is detained. He may be willing to remain now. There are plenty of patients quite willing to go to an asylum, although they are detained legally; and possibly every case under provisional order may not require detention, although, as you know, we want very much to foster the system of voluntary treatment for all cases, when possible.

16,886. *Chairman*: You see it would need actually to confer some power. Merely to say: "This is a case which ought to be treated," which is really what you propose, would not carry you very far. It would be no authority to the medical superintendent if that person said: "I am just going away." There would be no authority in terms to detain him?—We have not drafted the order and certificate, but we notice that it has been drafted by the British Medical Association, and with that we are in agreement. (*Dr Lord*): The urgency order orders the detention.

16,887. It does, but I rather gather from Dr. Cole that he wishes to evade the unpleasantness of detention. One can be too mealy-mouthed about things, you know?—(*Dr. Cole*): Yes.

16,888. *Mr. Micklem*: In those cases, supposing the patient ultimately has to be certified, do you propose, after the provisional order, that a petition should be presented?—If necessary, certainly, after 28 days.

16,889. Do you want all the formalities of a petition?—(*Dr. Lord*): They will be very much less. You would have all the particulars there in front of you. (*Dr. Cole*): We say: "That when a provisional order and certificate is about to expire, the following three courses should be considered, according to the exigencies of the case, namely: (a) that the patient be discharged; (b) that the patient may remain volun-

tarily, or be dealt with, if a non-volitional case, under some such treatment as that projected in Clause 4 of the Mental Treatment Bill, 1923; (c) that a judicial reception order for detention be obtained on petition, with two medical certificates." (*Dr. Menzies*): What was in our mind was to give the patient who objects altogether to detention the widest possible means of putting his views before his own legal adviser, to give a chronic delusional case every chance.

16,890. *Earl Russell*: And before the judicial authority?—Before the judicial authority.

16,891. You know, we have been told by so many doctors that all that would be very bad for the patient?—Not for the class of patient we are dealing with. These cases are those of chronic delusional insanity, and nothing would make them any worse. We think that they should be satisfied to the full.

16,892. *Chairman*: I think, Dr. Menzies, we are not going to face up to the question of classifying different types. In certain cases which you figure, a more or less forensic debate between the justice and the patient would be most detrimental, I should imagine? —I do not see that it does any harm to the patient; it does not apply to acute toxic insanities; it is the chronic delusional person that wants to argue the question of his detention.

16,893. *Earl Russell*: And he will not be the least bit more satisfied when he has argued it?—No, but he will have had his chance. (*Dr. Cole*): In the majority of cases it is merely formal. The petition is signed and presented to a magistrate, and the magistrate, if satisfied, signs it.

16,894. *Mr. Micklem*: Who presents the petition in these rate-aided cases?—We hope when the Poor Law goes, as it seems to be going, the officer of the local authority will take the place of the present relieving officer; in many cases the relatives of the patient will. (*Dr. Lord*): Police authorities might take action in criminal cases.

16,895. *Chairman*: The practical purpose of this provisional order is to interpose a period for observation, treatment, and possibly recovery, without certification, but under a minor form, and a form possibly less injurious to the reputation of the patient?—(*Dr. Cole*): A good many patients would recover in a month, and they would be willing to remain afterwards for two or three months.

16,896. You do not contemplate that the provisional order is to apply to people in clinics, do you?—Possibly, and single care cases and nursing homes.

16,897. *Earl Russell*: What is the objection to turning it the other way, to starting the whole thing just as if you were going to certify, and then arresting the process without certifying, or suspending the order?—(*Dr. Lord*): That is what happens at present.

16,898. But you cannot suspend it long enough?—You can suspend it for 28 days now. (*Dr. Cole*): In the first place we label the person as a person of unsound mind. (*Dr. Lord*): And you make him a pauper. (*Dr. Cole*): Secondly there is an order for his reception, although it is postponed.

16,899. But that might be modified so that the order was something to the effect that, without proceeding to adjudicate upon the case, none the less the patient should be detained for observation?—In that case it means that the judicial authority should sign the paper. In our recommendation we think it advisable that the judicial authority should always see the patient.

16,900. As against that you have got to remember that you are asking the public to agree to your detaining the patient without any representative of the public seeing him?—For three days; the same as is done by the Poor Law—the relieving officer.

4 May, 1925.] Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. E. GOODALL, C.B.E., M.D., F.R.C.P., Dr. J. R. LORD, C.B.E., M.B., Dr. W. F. MENZIES, B.Sc., M.D., F.R.C.P., Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S., and Dr. R. WORTH, O.B.E., M.B. [Continued.]

Chairman: I think if it is to be extended to 28 days there is to be an interposition of the judicial authority.

16,901. *Earl Russell*: That is not much help, is it?—(*Dr. Menzies*): Yes, a great help. (*Dr. Cole*): We thought then that a man would not be stigmatised as a lunatic or of unsound mind for one month. That is why we should not like to use the words "person of unsound mind." It is quite true that the urgency order at present does call the person a person of unsound mind, and does use the word "detention."

16,902. *Chairman*: I think the urgency order is intended not for the purpose of dealing with the case provisionally, as you are looking at it, but rather from the point of view that you must get the case, just because of its severity, at once under control. Your provisional order is aimed at something quite different. It is rather aimed at the case which is not a very pronounced case, and which may recover rapidly?—(*Dr. Cole*): Yes.

16,903. The urgency order is to get a grip on a person who may be a very violent case, and must be dealt with by urgent measures?—We do not know whether that was the intention of the Act or not, but in many institutions 60 or 70 per cent. of the cases are urgency order cases; it is a very important and very useful provision. (*Dr. Lord*): In the Lunacy Act it was provided so as not to postpone treatment until the legal formalities in a reception order were completed. That was a recommendation of a House of Commons Committee sitting, I think, in 1876.

16,904. *Mr. Micklem*: The urgency order under the Act does not apply to the rate-aided patients, does it?—(*Dr. Cole*): No, but there we have the relieving officer's three days' order, which is without medical formality at all.

16,905. But will you not be very much increasing the expense in these cases? You will want a certificate at the beginning of the month and two at the end?—That original certificate might be allowed to rank as one of the certificates afterwards.

16,906. *Chairman*: But it will not be a certificate of unsoundness of mind?—No, that is perfectly true. (*Dr. Menzies*): There are many of us who think that a medical certificate should not express, at any rate in the first place, whether a patient is of unsound mind or not. It should confine itself entirely to medical facts.

16,907. *Mr. Micklem*: You will want a double appearance of the justice?—(*Dr. Lord*): We want the lawyer to pronounce him insane.

16,908. *Earl Russell*: You do not mean to say you want to throw upon the justice the obligation of saying whether the man is sane or insane?—We do. They are all suffering from mental disorders, which may not be insanity.

16,909. *Chairman*: Are the lawyers to define insanity?—(*Dr. Cole*): The doctors cannot.

16,910. If the doctors cannot, and the lawyers will not, where are we?—(*Dr. Menzies*): We want to get away from any medical man expressing an opinion as to insanity. Our field is to express the fact that he is suffering from a mental disorder.

16,911. *Earl Russell*: What you will say is: "He does such-and-such things, and thinks such-and-such things," and it is up to the lawyer to say whether it is insanity?—That is so. (*Dr. Cole*): Insanity is entirely a legal expression. (*Dr. Menzies*): The medical profession has stuck to that for many years. (*Dr. Collins*): It is suggested under recommendation 38 that there should be an additional statement by the doctor of the reasons for the necessity of detention, where he thinks detention is necessary.

16,912. *Chairman*: I have sometimes thought that the really critical thing is this, that the doctor should say that his patient, owing to his mental condition, requires, either in the interest of himself or in the interests of the public safety, to be controlled. That

is a test, so to speak, from his conduct. I quite agree that no one can say whether a person is sane or insane; in one sense you cannot say that, because it is not a matter of precise definition. But the real thing that justifies the detention is that it is not safe for that particular person, having regard to that particular person's state, to be a free agent; that is the real thing. It is to safeguard him or others from injury that the detention is authorised. It is really an inference from his conduct. His conduct renders him a person unsafe to be a free agent?—(*Dr. Cole*): There is one further point: Would you limit insanity merely to those cases? If a person is suffering from mental disorder, say drinking and leading a riotous life, without injury to himself or the public particularly, but you feel that under control you would be able to cure him, surely then he ought to be certified, although he is not a danger to himself or to the public.

16,913. Ethically that might be very desirable, but again we are getting into this region: if it is a question of pathology, it is a question for you doctors to say whether that pathological condition renders him a citizen whose conduct is abnormal, a citizen to whom measures have to be applied which are not applied to an ordinary citizen. Are you not the best judges of the abnormality?—(*Dr. Cole*): We admit that. The point is that we want to dissociate psychiatry from the position, as it were, of being the governor of a prison; in other words, we want to state what the patient is suffering from, and treat that, and if it is necessary for the patient to be detained for that purpose, then we think some person other than the medical authority ought to step in and say: "This person ought to be detained."

16,914. *Earl Russell*: I understood you to say, Dr. Cole, that if the patient was of no danger either to himself or to other people, but none the less wanted restraint for his treatment, he ought to be restrained. You mean a man ought to be cured against his will?—I think so, in the interests of the State.

16,915. It may be sound, but it is new?—In the interests of the State these people ought to be cured. If we want to prevent insanity, we must treat it at the early stages.

16,916. You mean that every man who takes a glass too much should be prevented?—I think so.

16,917. I am inclined to agree with you, only it is a new view of legislation?—(*Dr. Lord*): It is only Dr. Cole's personal view. (*Dr. Cole*): I am glad to see that Lord Russell agrees with me. (*Dr. Lord*): Of course, Parliament did try to deal with them under the Inebriates Act.

16,918. *Chairman*: The whole purpose of certification is to authorise detention against the wish of the person. As long as the person is willing to be treated, you do not require those compulsory powers. A person's resistance is due to his own mental disturbance, and the doctor, who is the judge of his abnormality, says, "This person, to my knowledge, is abnormal." Your diagnosis may not be complete, but you are able to say that this person is abnormal, and you are further able to say that this person ought to be treated compulsorily, whether he likes it or not, and therefore that he is a fit and proper person to be admitted to an asylum and there detained. Is not that a proper thing for a doctor to certify? No layman can certify it?—(*Dr. Cole*): He has the most experience, undoubtedly. I think it is quite right that the State should expect him to express his opinion; it is his own opinion.

16,919. Then you object to attaching the label, "This is a person of unsound mind"?—For one month.

16,920. You would rather say, "This is a person who ought to be detained under observation and treatment. From the facts of the case I deduce from my knowledge that this is a person who for the

4 May, 1925.] Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. [Continued.
E. GOODALL, C.B.E., M.D., F.R.C.P., Dr. J. R. LORD, C.B.E., M.B., Dr. W. F. MENZIES, B.Sc.,
M.D., F.R.C.P., Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S.,
and Dr. R. WORTH, O.B.E., M.B.

moment is so abnormal that he ought to be subjected to detention, whether he likes it or not." All you object to is the categorising of him?—(Dr. Menzies): That is so. (Dr. Lord): The public strongly objects.

16,921. Mr. Micklem: Do you suggest that the justice of the peace should necessarily act upon that single certificate of the doctor for this temporary order?—He does now, practically.

16,922. Or should he exercise any judicial view about the case?—(Dr. Cole): If he is not satisfied we suggest that he can call in another medical man.

Chairman: Yes, but why should the justice say he is of unsound mind, if he says, "I agree"?

16,923. Earl Russell: That seems to be enough, if the justice says, "I agree"?—That is the term we use—"should have the sanction of the judicial authority."

16,924. Chairman: That is to say, neither the justice of the peace nor the doctor is to commit himself to the view that this is a person of unsound mind. All that either is to commit himself to is that this is a person whose condition justifies his temporary detention?—(Dr. Menzies): That is the position.

16,925. On the expiry of the period of treatment a conclusive judgment would have to be pronounced, and it would have to be pronounced, notwithstanding the period he has gone through, that he is now a person of declared unsound mind?—(Dr. Lord): That is right, unless he has recovered or has become a voluntary boarder.

16,926. But if he requires to be detained do you then contemplate that the doctor should pronounce upon the case?—As now.

16,927. Earl Russell: I am anxious that you should have more than 28 days. Do not you think that a longer period might be useful, and that more people would escape certification if you took a longer period?—(Dr. Cole): That is so, but what would Parliament say?

16,928. I know, but if you tell us 28 days is enough, obviously we cannot recommend more?—(Dr. Lord): Under Clause 4 of the Mental Treatment Bill that was extended to six months.

16,929. I should have thought a longer period was better to give you a better chance of discharging some people without certification?—(Dr. Cole): I really do think that if a person is mentally unbalanced and requires detention for three months, in spite of the stigma, it is justified by the facts. If a person is so ill, it seems to me it is only honest to regard that person as of unsound mind, and you cannot get away from it. Personally I should think three months would be too long.

16,930. It may be three months in an alcoholic case?—Yes. (Dr. Lord): I do not think we should raise any objection to the extension of the period. We put that period because it was hopeless for us to ask for more.

16,931. Chairman: Are you not apprehensive that this provisional certificate, which authorises detention in a mental hospital for 28 days, may not attract just the same stigma, if there is any stigma about certification? If a person is known to be a person who has been subjected to one of these provisional orders, and has been an inmate for 28 days in a well-known asylum, do you think people would draw a fine distinction and say, "Mr. So-and-so was a certified lunatic, and Mr. So-and-so was a person under a provisional certificate."?—(Dr. Cole): I think that is a matter of education. There are people in institutions who go to their business daily. 50 per cent. of these cases will be voluntary patients.

Earl Russell: I think the public do attach importance to the term "certified lunatic." They think it means something terrible.

16,932. Chairman: Undoubtedly?—I do not think they regard it so at the present moment in the case of an urgency order. There are cases admitted on

an urgency order, and they become voluntary boarders, at the end of one week, and go away after a time; those people feel they have never been certified.

16,933. I was wondering whether it was not the actual residence in the institutions?—(Dr. Menzies): That is so at present, but we hope that with a larger percentage of recoveries it will not be so; we hope that with 50 per cent. of admissions of voluntary patients that distinction between asylum and general hospital will gradually fade away.

16,934. Do you think we shall ever be able to abolish what, after all, is a fact of nature: that there is a social difference between mental disease and other diseases which must be recognised?—We shall never obliterate it, but we shall diminish in the public view the stigma that attaches to it.

Sir David Drummond: As a matter of fact, amongst rate-aided patients the whole thing is "taken to an asylum." They never speak of certification at all; with the poor people that really is the stigma.

16,935. Chairman: Yes. One would like to analyse what the stigma really is. The stigma means this, that this person has, owing to his misfortune, or his fault sometimes, ceased for a time to be a normal, rational human being. No amount of beating about the bush, or calling things by different names, no amount even of humane treatment will obliterate the fact that in that person's life there has been an episode, a pathological episode, if you please, which to some extent will place him apart from others. Is not that almost inevitable?—(Dr. Cole): Yes. (Dr. Menzies): It may be, but the practical point of view of the poorer classes is that at present if a person has been certified he is unemployable. (Dr. Lord): I think the point is that once he has been a certified lunatic, wherever he goes everybody thinks: "Is this man going to go off again?" They have no surety about him; they feel an uncertainty.

16,936. But is it not a fact that a certificated person—?—That increases it.

16,937. Of course, it is a pronouncement upon the case, and therefore may, like a conviction in a police court, be brought up against you again?—That is just the point we are making. As soon as it is generally known that cases of "run-down" nervous debility and so on, are freely admitted and go in and out of mental hospitals, nobody will know, when a person comes out, whether he has been there as a certified person or not.

16,938. I think you are a little optimistic in imagining that the presence of those uncertified persons will permeate the atmosphere of the asylum. I should have thought rather that the real cases of insanity in the asylum would be more liable to spread their influence to those uncertified cases?—(Dr. Cole): That is not our experience. (Dr. Lord): I think after 26 years' experience that if permission were given to admit these people voluntarily, I should have at least 50 per cent. of my patients voluntary boarders, in the course of ten years or so.

16,939. You see, you gentlemen are able to appreciate this matter with a balanced judgment, but we are dealing with the public, and it is much more difficult to educate the public. Some people, for example, dislike the atmosphere of a law court; I enjoy nothing better. You probably enjoy the atmosphere of a mental hospital, but the members of the public may have a great distaste for it?—(Dr. Cole): Because they are not allowed to go there; they ought to be allowed to go there. (Dr. Lord): We do not want them shut up; it is you people who shut them up. You avoid the patients and the institutions. (Dr. Cole): Believe me, they are not such bad places as some people really think. It really is because they are so sequestered, and people are put on one side, that wrong impressions are allowed to be spread about as to what goes on in these institutions.

4 May, 1925.] Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. [Continued.
E. GOODALL, C.B.E., M.D., F.R.C.P., Dr. J. R. LORD, C.B.E., M.B., Dr. W. F. MENZIES, B.Sc.,
M.D., F.R.C.P., Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S.,
and Dr. R. WORTH, O.B.E., M.B.

16,940. At any rate we meet on common ground, and that is that it is desirable that there should be removed from the mental hospitals as far as possible all those elements, the prison element and the detention element, and so on, and that they should be so far as possible assimilated in character to a general hospital as a place of hopefulness and cure?—Yes.

Chairman: How is it to be done?

Sir Ernest Hiley: I do not quite see how they are going to achieve anything even by taking a man to one of these clinics. The man will become stigmatised among his neighbours if he is taken away by a sanitary inspector.

16,941. *Chairman:* That is a difficulty I have felt a good deal. People are a little merciless in their judgment of their fellows?—(*Dr. Collins:*) But he is moved to a fever hospital now.

16,942. But nobody thinks the worse of you for having scarlet fever? — Why should not the same person do it?

16,943. His destination would become known, because probably he has become eccentric first of all?—(*Dr. Lord:*) Unless we change these things we shall simply stick as we are. (*Dr. Cole:*) We feel it is a step in the right direction. It is perfectly true that at Maudsley Hospital patients have come back to me and said, "The place is only an asylum," and they feel it is a stigma in the same way as if they had been certified and gone to an asylum.

16,944. It may be an alleviation, but I do not think you would be able to eliminate it. I know that personally I should feel differently according to whether a relative of mine had gone to the Maudsley Hospital or the Royal Infirmary; that is the view merely of the man in the street, of course?—(*Dr. Cole:*) You are talking of a mental patient going to the Edinburgh Royal Infirmary or to the Maudsley Hospital. I must admit that the man in the street would think less of it than going to the Royal Infirmary, because he would think the person was less afflicted.

16,945. It would be no reflection upon his rationality anyhow. Suppose one is told of a friend of one's own, "He has gone into the Edinburgh Royal Infirmary"; I would say, "I am very sorry." If, on the other hand, I am told, "He has gone to the Maudsley Hospital," I would say, "Oh, that is that very interesting place in London."

Earl Russell: I should say he had got that fashionable disease—a nervous breakdown.

16,946. *Chairman:* The question is whether you can bring those types of public institutions on a level in the public estimation?—(*Dr. Menzies:*) We want you to help us. (*Dr. Goodall:*) Maudsley clinic, after all, is under the London County Council. If it were not under the local authority at all, if it were like Professor Winkler's clinic at Utrecht, or a pavilion in connection with the Cardiff Infirmary, what would be the difference? Only that he had an unfortunate disease that affects his highest organ. That would be the only difference then.

16,947. *Sir Ernest Hiley:* We have already had the objection put to us that even a ward in a general hospital becomes known as the "balmy ward." We had that from a doctor the other day?—(*Dr. Cole:*) Yes; we cannot obviate that. (*Dr. Goodall:*) That is no reason why all the benefits of treatment should be denied to a mental case; that is the only place where he is going to get it.

16,948. *Chairman:* We are on a different topic for the moment. The question we were considering was whether you can at any rate mitigate this stigma by opening the doors of mental hospitals to voluntary cases, to provisional cases, and also opening them more to public visitation. All those things would go in the direction of assimilating the mental hospitals to the other hospitals. Whether it would achieve your ideal of getting rid altogether of the stigma is a

different matter. All that you can suggest and all that we can recommend are steps in that direction: the removal of features which are at the present moment objectionable and unnecessary from the point of view of the treatment of mental disease. Is not that what we are after?—(*Dr. Cole:*) That is so. (*Sir Frederick Mott:*) But where it is not possible to have a clinic, surely it is possible to have an acute block, preferably outside the asylum grounds, so that some distinction should be made, and those people admitted there would never mix with the chronic lunatics at all.

16,949. Yes, Sir Frederick, that is part of the general question, really, of classification, is it not?—It is more or less, but a great many of the mental hospitals have not that provision at all; they have put it up inside the grounds. I am of opinion that it would be very much better if it were outside, because the public would then differentiate at once. They would say: "He never went into the chronic hospital at all; he went to the clinic."

16,950. *Earl Russell:* Will not the public on the other hand say, "It is where the raving lunatics go"?—No; they are curable. Then if you had in addition a convalescent block, the patients would go from that acute block to the convalescent block, and would never mix with the chronic lunatics at all.

16,951. *Chairman:* I see you put it thus at page 20: "This mixing of acute and possibly recoverable cases with the chronic incurable is now being recognised as a thoroughly bad system, for it tends to a prevailing idea of hopelessness in recent admissions, and not infrequently of helpless despair of returning to their homes." A segregation of this type of case is what you recommend?—Yes.

16,952. I think that is really a branch of the general topic of classification: that the cases, as received, should be relegated to different sections of the mental hospitals?—It is more than that, because they might do that in the old asylums, but the new asylums have now been constructed with special blocks for acute cases; that has been so in the London County Asylums. (*Dr. Lord:*) Sir Frederick would like to see that particular acute block situated not on that portion of the estate on which the main hospital is, but at some distance away, yet in touch with the mental hospital, so that a patient might go to that particular block (it might be given a fancy name) and not be counted as having been to the chronic insane asylum. We are adopting that in London a good deal.

16,953. *Earl Russell:* You want the patient to say, "I have never been in the asylum at all"?—(*Dr. Lord:*) Practically no recoverable patients with me are transferred to the main mental hospital; they only come into contact with the better class of chronic patients in connection with such things as cinema entertainments and so on. (*Sir Frederick Mott:*) Would it not be much better if the building were outside the grounds? (*Dr. Cole:*) That is a further modification in principle, putting those buildings outside the mental hospital grounds entirely, half a mile away. (*Sir Frederick Mott:*) If there were a general hospital in the town, that block could be correlated with the general hospital. (*Dr. Lord:*) Between the two.

16,954. *Chairman:* I should have thought the acute recoverable case would have been the best case for your clinic?—(*Dr. Cole:*) It comes to having a clinic in connection with the mental hospital or with the general hospital.

16,955. *Sir David Drummond:* Is that the considered opinion of your Association, because we have heard from that chair the opposite opinion—that they should be associated with the general hospital?—Whenever possible, we think it should be in connection with the general hospital. (*Dr. Lord:*) We have put it quite clearly that wherever it is possible it should

4 May, 1925.] Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. [Continued.
E. GOODALL, C.B.E., M.D., F.R.C.P., Dr. J. R. LORD, C.B.E., M.B., Dr. W. F. MENZIES, B.Sc.,
M.D., F.R.C.P., Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S.,
and Dr. R. WORTH, O.B.E., M.B.

be in connection with the general hospital; but if not in connection with the general hospital, it should be a separate building, and that building you could link up with the mental hospital, or be affiliated with the general hospital at some distance. You have got that under recommendations 4 and 5. (Dr. Cole): On page 9, in the middle, we say: "They should therefore be established all over the country in large centres of population, preferably in connection with general hospitals."

16,956. *Chairman*: Recommendation 4, Dr. Cole, is "That such a clinic should be where possible an annexe to a general hospital, or housed in a special building."—Yes. That special building in some instances might be near the mental hospital.

16,957. But where there was not a general hospital, or where arrangements could not be made with a general hospital, then the next best thing would be to have it in association with a mental hospital?—Yes.

16,958. I mean we must take things as we find them, to some extent, and as Dr. Lord points out, the idea should be in the first instance permissive, by authorising the adoption locally, as circumstances dictated, of one or other expedient?—(Dr. Lord): It must be, from the money point of view. (Dr. Cole): Undoubtedly. If some of the Poor Law buildings were transferred to the local authorities, they could be made use of.

16,959. That is a very practical suggestion: that some of these reforms might lead to the releasing of premises which are at present utilised for the permanent detention of lunatics, and thus enable some of these institutions to be set up. For instance, some of the Poor Law infirmaries are not full, as we know, just now?—No, and some of the newer ones have excellent accommodation.

16,960. They are indistinguishable from general hospitals. That is an instance where the stigma has disappeared. The Poor Law is resorted to by all and sundry now, without any sense of stigma?—(Dr. Cole): Well, there is some stigma. (Sir Frederick Mott): Are they not pauperised?

16,961. They are not pauperised; we have heard evidence to the effect that the stigma is rapidly evaporating?—(Dr. Cole): In the case of the Paddington Infirmary, when it was labelled "Paddington Hospital" patients rushed to it to such an extent that they were obliged to put the name of "Paddington Infirmary" back again.

16,962. It is very curious that the name should have that effect. Of course, as you know, we reverse it in Scotland?—Yes. Here an infirmary denotes the Poor Law. (Sir Frederick Mott): I think these hospitals outside the grounds would be really valuable as clinics too, because the practitioners could bring their cases there for an opinion as to what was the best kind of treatment.

16,963. I want next to take you to your views on the question of rate-aided patients and private patients. Do I understand that the view of the Association is that the two classes should be assimilated as regards legal procedure?—(Dr. Cole): That is so, entirely.

16,964. And do you recommend that in every case there should be two medical certificates granted after consultation, and not as at present in isolation?—We can have consultation now. There is nothing to prevent two medical men talking about whether a person should be certified, so long as their examinations are separate.

16,965. But there again you recommend two medical certificates by medical men, who should be entitled to give their joint certificate?—Yes.

16,966. And again you propose the assimilation of the rate-aided patient to the private case in this respect, that there should be a petition in the case of the pauper patient, as there is in the case of the private patient, and that petition should be at the

instance of a relative or official, or whoever it may be who has to deal with the case?—Yes.

16,967. All that one understands, because it is pretty simple. You equally object to the element of pauperisation which is associated with the lunacy administration?—That is so. Of course, a good many of these people would never be paupers. (Dr. Lord): You have got to become a pauper to be treated, at present.

16,968. What is your view as to that? How do you propose to eliminate that aspect of the treatment of the insane?—Much the same as happens now in our public mental hospitals; immediately the patient pays the full maintenance rate, he is transferred to the private class, and the county council recover the maintenance. On the other hand, if he does not pay up to that maintenance rate, the maintenance is recovered by the Poor Law.

16,969. May I put two cases to you: first of all, the case of a pauper who is a pauper, that is to say, an inmate of a workhouse; that person may become insane and may go to an asylum; he would go as a pauper, because he is a pauper; that is to say, he is a person in receipt of rate aid. For that class of case one might not have the same sympathy, because there would be no alteration in status in that instance; it would be merely a person who, being a pauper, has developed a mental ailment. The class of case that has appealed most to myself and to my colleagues is the case of a well-doing artisan, who has never had any association with the Poor Law, but who, by reason of this particular affliction besetting him, finds himself converted into a pauper, because the machinery of the law passes him through a pauper stage; and even if the efforts of his family are able to provide the necessary means of paying for him in the asylum, he has nevertheless passed through a stage of pauperisation, which to many people, I should think, would be an unpleasant feature of the whole episode. Have you discriminated in your minds between those two classes of cases?—The discrimination is this: of course, naturally, if the inmate of a workhouse had to go to a mental hospital, he would become a mental hospital patient, and the Poor Law authorities then would be the "friend" who would have to take out the petition, and they would pay for him; but he would be, from our point of view, the same as the other patients, even if he was paid for by the local authority.

16,970. His case would be really rate aided through the Poor Law?—Yes. I had a case the other day of a man occupying a high military position who had to go to all the trouble, a ridiculous farce, of a near relative having to go to the workhouse and become a pauper, and the day after she entered my institution she was made a private patient. She ought to have been able to come to me direct and pay the maintenance.

16,971. *Earl Russell*: What happens to a person who is taken to a fever hospital and treated at public expense?—They recover from the friends.

16,972. Supposing they do not recover from the friends: what is the authority that pays in a fever hospital?—The county authority.

16,973. So that they do not become paupers at any stage?—No.

16,974. *Chairman*: As far as I remember, in Edinburgh there is a well-known fever hospital; lots of people go there; it is supported out of the rates, but not out of the poor rates?—No.

16,975. They recover what they can?—Yes; and a great many well-to-do people go there.

16,976. And they pay?—Yes.

Earl Russell: You have not got our Poor Law system.

Chairman: We have the Poor Law system in Scotland for lunatics as well.

4 May, 1925.] Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. E. GOODALL, C.B.E., M.D., F.R.C.P., Dr. J. R. LORD, C.B.E., M.B., Dr. W. F. MENZIES, B.Sc., M.D., F.R.C.P., Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S., and Dr. R. WORTH, O.B.E., M.B. [Continued.]

16,977. *Earl Russell*: Now the maternity case is paid for by the guardians, and there is some special provision that that shall not pauperise?—I cannot say about that.

16,978. *Chairman*: Is there so very much difference whether the rate out of which your case is paid for is the poor rate or the county rate?—(*Dr. Cole*): All the difference in the world, from the point of view of stigma. What really pauperises the artisan you are speaking about is that, say, the artisan's wife goes to the relieving officer and says: "My husband has gone off his head. Will you make arrangements; something must be done," and he goes to a mental hospital or an infirmary, he is certified by the Poor Law medical officer, and he is paid for by the Poor Law. There is nothing to prevent the wife of the artisan consulting her medical attendant and using an urgency order for direct admission to Hanwell Asylum as a private patient; that is perfectly permissible under the present law, but it is not generally known and is not often done.

16,979. *Mr. Micklem*: At present where a person is visited by a medical officer of a union he is deemed to be in receipt of relief, and becomes a pauper?—That is so.

16,980. Supposing this were altered so that the provision was that the mere visitation by a medical officer should not constitute pauperisation?—That would make a lot of difference; that is really at the bottom of the whole thing.

16,981. *Earl Russell*: They would remain paupers afterwards if they did not pay the full maintenance rate?—Yes.

16,982. *Chairman*: Let me put the two cases: the husband, in the case you have figured, has become mentally afflicted, and the programme is as you have described it. The Poor Law doctor certifies, and the man becomes a pauper in an institution supported out of the poor rates. If on the other hand the same artisan had taken scarlet fever; he has taken a notifiable disease in that case also. The medical officer will go to see the case, and will arrange for its removal to an infectious diseases hospital. The man will recover, one would hope, in that institution, and would emerge, would resume his work, and would never have been a pauper at all. Is not that so?—Yes, that is so.

16,983. *Earl Russell*: I am not quite sure that the medical officer who sees him is not paid by the county and not by the guardians?—He is paid by the county.

Earl Russell: That is a difference, again.

16,984. *Chairman*: This is all on the lines of the assimilation of the two forms of illness, mental illness and physical illness. Why should the case of the mentally afflicted have to go through this process of pauperisation, while the person who is compulsorily removed in the case of an infectious disease to an infectious diseases hospital, and emerges, never has been pauperised at all, and yet has public service rendered to him at the public cost?—(*Dr. Lord*): Lord Shaftesbury fought that years and years ago, and it was incorporated in the second Bill of 1845. There were two Lunacy Acts passed in 1845, but in the second Act the mental hospital was to be divided into two: one for chronics and one for dangerous or new cases; so that they would not go, as the witnesses bitterly complained before the House of Commons Committee, to a Poor Law institution; they would go to a mental hospital. That demand on the part of the medical profession is as old as the hills.

16,985. Is there any inherent reason in the nature of this malady that should render it appropriate for treatment through the machinery of the Poor Law?—(*Dr. Cole*): None whatever.

16,986. *Mr. Micklem*: There is this, that at the present time under the Poor Law you have poor houses to which they can be removed, and until you have your clinics you have no other places for them?—They can and ought to go direct to the mental

hospital. (*Dr. Menzies*): We are trying to get them to go direct; the Board of Control are doing their best to get them to go direct.

16,987. It is a great advantage to get them into the workhouse from time to time, because very often they come out discharged without having been certified?—(*Dr. Lord*): I think it is a historical legacy. The poor insane used to be housed in poor houses, in prisons and lock-ups, and they became the property of the guardians, and they remained the property of the guardians.

16,988. *Earl Russell*: The asylum was built as a clearing house for the wards of the poor houses?—Yes, and every Committee of the House of Commons that has met, and many have met since the Act of 1845, have all complained of the same thing, that a poor man must become a pauper before he can be treated for mental disorder.

16,989. I was in Sussex on Saturday, and I was informed that nearly the whole of them came direct to the asylum?—Yes, and in Cambridgeshire it is so, too.

16,990. *Chairman*: Now Mr. Micklem's difficulty, as I apprehend, may be solved in this way: it is true that at the present time, as between the patient's home and the asylum, the Poor Law institution has been interposed as the place where the patient is kept *faute de mieux* for certification; but is not that due to the circumstance that no one can enter the portals of a mental hospital unless certified? If you can take your patient under a provisional order direct to the mental hospital, you can avoid the Poor Law institution altogether. If you can provide, along with the present system, a system of provisional treatment, then it seems to me that you can take your patient direct from his home to the mental hospital, where he will be dealt with under this provisional system, and probably not become a fully certified patient?—(*Dr. Lord*): Certainly. It is quite open now under certain sections of the Lunacy Act for mental hospital committees to make contracts with guardians. Supposing they entered into a contract with Paddington to keep patients, we could say, "You keep these patients, but you must have so many trained nurses, and so much equipment, and so on." (*Dr. Cole*): All this is under recommendations 21, 22 and 23. As you know, the hospitals are supported by the local authority, but patients are paid for by the guardians; it is dual control. From the general public point of view it does not matter where the money comes from.

16,991. *Earl Russell*: You will destroy a number of very profitable actions as to pauper settlement?—That is a thing which the medical profession thinks most unfortunate. (*Dr. Lord*): The Legislature has always had in mind that Poor Law authorities were not the right people to have charge of the insane; the Poor Law had them originally by legacy; the next thing was to put them into the hands of magistrates, and then they were taken over by the county councils for care and treatment. So we think that the county should take over the whole of the duties in connection with those patients. We think it would be better for the patients, better for administration, and economic in the long run.

Chairman: Now, further, on this question of certification, you recommend, I see, that the justice of the peace, when invoked either for the 28 days' provisional order or for a permanent certificate, should be a specially appointed justice.

16,992. *Mr. Micklem*: You do not want that with a provisional order?—(*Dr. Menzies*): I think we do not say so with a provisional order; only for the permanent order.

16,993. *Chairman*: Then I see you want a special justice for that?—(*Dr. Cole*): If possible. (*Dr. Menzies*): It is possible always. (*Dr. Lord*): I think there ought to be a special justice.

4 May, 1925.] Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. E. GOODALL, C.B.E., M.D., F.R.C.P., Dr. J. R. LORD, C.B.E., M.B., Dr. W. F. MENZIES, B.Sc., M.D., F.R.C.P., Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S., and Dr. R. WORTH, O.B.E., M.B. [Continued.]

16,994. What do you mean exactly by a "special justice"? Do you mean one selected for the purpose by his brethren?—(Dr. Menzies): That is the way the appointment is made at present. (Dr. Cole): One who is capable of doing the duty, and has some experience. A man once a justice is always a justice, and will be entitled to act; such a man may be inefficient; there is a difference between justices.

16,995. And between medical men?—I think in Quarter Sessions they are very careful about it; in some instances they are merely taken in rota. Whether it is always so or not I do not know, but I think approved justices are better than justices who are not approved, as a general rule.

16,996. Mr. Micklem: In most counties all the justices are approved?—(Dr. Menzies): That is unfortunate, because we think if a certain justice is interested in this question, he will do his work well, and we think that by specially appointing them they will be able to select enough justices whose interests lie in this work.

16,997. Chairman: And who will gain experience?—Yes. (Dr. Cole): For instance, justices in connection with licensed houses in the provinces are men who take an interest in the matter.

16,998. Then, next, I understand you are in favour of the justice, be he specially appointed or not, seeing the case?—Yes. (Dr. Collins): He does or should see the patient in the case of a pauper lunatic; he is directed to do so. In the case of a private patient he need not.

16,999. The patient has to be told after admission of his right to see a judicial authority?—Yes.

17,000. Again, that seems rather a futile way of dealing with it, does it not?—It is better that he should see him originally, before he makes the order.

17,001. I cannot see any reason why in the case of the pauper the patient should be seen, and in the case of the private patient the patient should not be seen?—I presume it is because there is only one certificate. (Dr. Cole): Telling a patient that he has the right of seeing a magistrate is very upsetting to some patients.

17,002. You do not want to have patients badgered about their legal rights and the filling up of forms?—(Dr. Lord): And such a form, too.

17,003. At any rate your view is that every patient should be seen on certification by the justice who is to pronounce the order?—(Dr. Collins): Yes.

17,004. I suppose in many cases the seeing of the patient would be a mere formality?—I think it is for the justice to see the patient and judge for himself. (Dr. Menzies): There is a fundamental principle underlying our recommendations. It is to make the treatment of a patient as a sick man as easy as possible, and to make his improper detention as difficult as possible; all our recommendations are framed to that end.

17,005. Earl Russell: Why two medical certificates?—At the end of 28 days a justice steps in and signs a permanent order of detention.

17,006. In how many cases do you think the second medical certificate would be of any effect in preventing improper detention? You are adding a large sum to the rates for the extra certification?—But we hope that half our cases are going to be voluntary, and another quarter will be kept under the Mental Treatment Bill and will get better before they are certified; so we are going, in ten years time, we hope, to cut our permanent certificates down to one quarter.

17,007. Chairman: This assimilates itself to what we discussed earlier in our deliberations, that one medical certificate will be sufficient for perfectly obvious cases; but that, in cases that were at all difficult, the justice or the doctor certifying should be entitled to call in a second opinion, and in that

way get better assurance. But if you are going to have a provisional period of detention on one doctor's certificate, then you achieve exactly the same result, because that person is observed for a time, and it is only after a period of observation has expired that you bring in two doctors, in cases which are really pronounced cases, because the other cases in the meantime would have all eliminated themselves?—Yes. (Dr. Lord): I think our feeling was that the general public will be much more assured if in all cases there are two certificates. (Dr. Menzies): I should have gone further—but this is my personal opinion—that the patient about to be certified should choose the second medical man.

Sir David Drummond: If the function of the doctor is alone to state the symptoms, as it were, not to offer an opinion as to whether the person is sane or not, surely one man could make that statement?

17,008. Chairman: But I understand the certifying doctor at the expiry of the 28 days has to certify unsoundness of mind?—Yes.

17,009. In the first place, as Sir David points out, he has only to certify that this is a proper case for care, observation and treatment. Do you need two doctors to say that?—(Dr. Cole): No; one.

Sir David Drummond: That is what I mean.

Chairman: That gives us some relief, Lord Russell.

17,010. Earl Russell: I still do not understand what the second one is for?—As you know, I am an expert, and a general practitioner calls me in, and he has made up his mind that this patient has got to be certified and got away; but he will not act alone. He can act alone by sending a patient away on an urgency order. He calls in an expert, and says: "Am I doing right or doing wrong?" Then he feels assured, if told one way or the other, and the patient is dealt with. It is difficult enough to get some men to certify at all at the moment, and they are calling in experts, even amongst paupers, very much more than they did before the recent law case.

17,011. I should have thought that you could get all that by leaving the power to the justice to call in a second opinion, if there were any doubt about the case, because surely there are 50 per cent. of the cases in which there is no doubt?—More than that.

17,012. Do not you get all you want by leaving it to the justice to take a second opinion if he thinks it necessary, or if the other doctor thinks it necessary?—We are perfectly willing to do it, but we thought that in the present state of public feeling people would be more assured if there were two certificates. The original intention of the Act was that most patients were to go under Section 13, with two certificates.

17,013. Mr. Micklem: Not in the case of rate aided patients?—Yes.

17,014. Sir David Drummond: Is it your proposal that the second doctor should be an expert?—No. We really have thought this out, and at our special committee meeting we thought that an approved doctor might be a good thing; we have thrashed the whole thing out since, and we have come to the conclusion that we should not take from any medical man the right to give a certificate. We feel that every medical man should be proficient in certification of mental diseases.

17,015. Earl Russell: That a little gets away from the medical practitioner calling in the expert?—I am talking now of the person of means. In a country district it is impossible to get an expert there. (Dr. Lord): I think permanent certification is a serious matter. I am quite certain from my dealings with the general public in these matters that they would feel it was a safeguard, and much more satisfactory, to have two medical certificates, when it becomes a question not of temporary treatment but possibly of retaining a patient for many years.

4 May, 1925.] Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. E. GOODALL, C.B.E., M.D., F.R.C.P., Dr. J. R. LORD, C.B.E., M.B., Dr. W. F. MENZIES, B.Sc., M.D., F.R.C.P., Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S., and Dr. R. WORTH, O.B.E., M.B. [Continued.]

17,016. *Chairman*: We have your view on that. I want also to hear your views upon the question of the central authority. Dr. Menzies has been good enough to send us a supplementary memorandum on this subject. I do not know whether your views, Dr. Menzies, have the assent of all your colleagues, or not?—(*Dr. Menzies*): They have the assent of these witnesses—not of the Medico-Psychological Association.

17,017. We will take it with that note, but we are most interested in the question of the part the Board of Control or any other central authority is to play in any reformed system. Will you tell us what is your view of the function it should perform, on the outline of your memorandum?—It is in the summary on page 5 of my memorandum. "Paid Commissioners in ordinary to include at least four or five medical and two legal members, the former of whom shall have been medical officers of mental hospitals. One should have special experience in mental deficiency, another experience of private patients mainly. These commissioners may visit institutions once in two years" (I suggest two years, but that does not matter) "the legal members need not go on circuit."—I understand that is the position in Scotland to-day?

17,018. *Chairman*: Yes?—"The medical members to be paid at least £2,000 per annum and to count towards pension the years served under a local authority."—we look upon that as very important—"which would contribute proportionately towards pension."

17,019. That is a recommendation that the Board should be strengthened numerically?—Yes, as regards its medical members.

17,020. Is it your view, and the view of your colleagues, that the Board is under-staffed at present?—It is from the medical point of view. One knows of questions being held over at the Board for an undue time, two or three weeks or more, simply because the few medical members who had actual experience of mental hospital administration were on circuit and could not attend to them.

17,021. Have you considered the system of having district commissioners?—I mention it here—district inspectors.

17,022. You call them inspectors. It sounds as if it were rather a more subordinate person than I had in mind. I was wondering whether, in consequence of the large institutions in this country, and the large number of cases, instead of sending your medical Commissioners from headquarters *en voyage* all through the country, which is rather a disturbing thing in a way, you could not have a system of district commissioners?—I think not; not high commissioners; they will savour too much of provincial administration.

17,023. I was assuming that you would have a central authority on top as the co-ordinating authority to whom they would report, and who would send down in special circumstances one of their members.

17,024. *Earl Russell*: And also that they should be changed about on a sort of Wesleyan circuit?—Then they would not be district commissioners.

17,025. *Chairman*: Why not? Three years in Lancashire and then three years in Essex?—Yes, you could divide the country into a certain number of districts, but they would have to be very few. I get over the difficulty of the number by saying that these central commissioners need only visit once in two years, provided that the local inspector visited oftener.

17,026. But, after all, the gentleman coming down from London and going to the institutions once or twice in a year has not a great deal of time, and probably may not have a great deal of knowledge of the local conditions. I should have thought it would have been very valuable to have had responsible, highly-placed officials who would act as district commissioners, and who would have a comparatively

limited area within which they could be not merely visiting once or twice a year, but moving about the institutions regularly; that the commissioners should be looking in and out more or less frequently, and keeping an eye on things?—I think there would be a tendency there to fall in with the views of the local authority.

17,027. It becomes subservient?—In sentiment only, of course. (*Dr. Lord*): You could not put up a man big enough; they would have to be men probably inferior in professional status to the staff of the mental hospitals, unless you pay enough.

17,028. Pay seems to be the criterion?—If you are going to put in a man who cannot teach me anything, for instance, what is the use?

17,029. *Earl Russell*: It is not necessary that a district inspector should be able to teach?—No, but he is to exercise authority over me.

17,030. *Chairman*: Take the gentleman who is to be local inspector in head (b) of your recommendations, Dr. Menzies: "Local inspectors to be appointed by the Minister of Health and be subject to the direction of the Board, one medical and one legal inspector together to visit each patient twice a year and oftener if required in individual cases." In a sense, you know, that is the same idea. It is that there should be on the spot persons who have official duties to perform—duties of inspection; to visit each patient. It is very difficult to keep the two distinct. Suppose the inspector goes and sees a patient, and the patient says, "I would be all right here if I could only get a decent dinner; the food is abominable." Is the inspector to say, "That is a matter of administration"?—(*Dr. Menzies*): I say somewhere that he should report to the Board on each occasion.

17,031. Then the third suggestion is: "Associate medical commissioners to visit institutions once in two years to advise medical officers as to treatment." These are intended to be high experts?—High experts. That is a recommendation of the Association—recommendation 20: "That the remuneration of the medical members of the Board of Mental Health should be increased. The State should require the medical members of the Board to be of the highest standard of scientific and professional attainments."

17,032. These are consultants, really, who are to advise the Board of Control or the medical superintendent on general medicine and so on?—Yes. You cannot expect them to be sufficiently highly paid to be permanent members of the Board of Control, I think, because the Treasury would never face the expenditure.

17,033. You suggest that they should be paid by fee?—Yes, by fee.

17,034. But can you get as consultants more qualified experts than you already possess at the head of the best mental institutions in this country?—We do not want necessarily experts in mental disorders; we want men eminent in the profession.

17,035. To be sent round?—Yes. I know of no more pleasant visits than when Sir Clifford Allbutt used to come and discuss advanced questions of higher medicine with the medical officers; I remember it quite well. (*Dr. Goodall*): That is the sort of man you want, of course.

17,036. Then the idea is that there should be a panel of these people; I mean half a dozen selected men because of their great eminence in their profession?—(*Dr. Lord*): And their interest in psychiatry.

17,037. And you say it would be an encouragement to the medical superintendent to be visited by such gentlemen?—Yes.

17,038. This is quite a novel suggestion, is it not, Dr. Cole?—(*Dr. Cole*): It is. Of course, the alternative to this is that a good many institutions have visiting physicians now, and visiting surgeons—Wandsworth, for instance, and several other institu-

4 May, 1925.] Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. [Continued.
E. GOODALL, C.B.E., M.D., F.R.C.P., Dr. J. R. LORD, C.B.E., M.B., Dr. W. F. MENZIES, B.Sc.,
M.D., F.R.C.P., Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S.,
and Dr. R. WORTH, O.B.E., M.B.

tions; but that does not quite meet this point of Dr. Menzies, with which all the witnesses are sympathetic, that we recognise that the Board of Control require for their ordinary work people who have had training in mental hospital administration.

17,039. Do not you think the public might apprehend, if you had too many medical superintendents at the Board of Control, that they might carry with them too much of the atmosphere of their training?—Originally there was always one general physician appointed, before Sir Clifford Allbutt; in my time, Dr. Southey, the last being Dr. Coupland. The present Board has not a member who originally was a general physician, but I put it down to this cry for economy. There must be at the moment at least three administrators, but the fourth should be a general physician, unless this scheme of Dr. Menzies is carried out.

17,040. Do you think the Board of Control should have enlarged powers? At present, as you know, its powers are largely advisory. Do you think it should have more executive powers?—I do not know if the Association has expressed any opinion upon that. (Dr. Menzies): Yes, the Association expresses the opinion that a grant should be in the hands of the Board of Control, and that gives sufficient lever. We do not see why it should be any worse than the main roads grant or the education grant.

17,041. *Earl Russell*: What grant are you speaking of?—The 4s. grant. (Dr. Lord): At present that 4s. goes to the guardians, but under our scheme the county authorities will become the rating authority. I believe at the time that 4s. was granted, it only cost 8s. to maintain a patient.

17,042. *Chairman*: I think what Dr. Menzies means is this: he is contemplating a State 50 per cent. grant similar to the Child Welfare grant, and if that were instituted then the power of withholding the grant would give sufficient lever to the central authority to enforce its wishes?—(Dr. Menzies): Yes. I cannot see why, for instance, some associations (the County Councils Association, I understand, is one) object to the suggestion of a grant; yet none of them as county councillors and as members of the main roads committee object to a grant towards main roads, and very few of them object to the education grant. I fail to see why they object to having a grant for mental health.

17,043. Is it not because it involves an element of control over them, which the other grants do not?—The other grants do demand efficiency; for the education grant they have to pass a standard.

17,044. Have the Association any views to offer us on the subject of licensed houses as a class of institution?—(Dr. Cole): We feel that in 1890, when the Act came into force stopping the growth of licensed houses, it was on the whole a mistake. We feel that the general public here in England want their relatives to go to places that they select; some people like private institutions and some people like public institutions.

17,045. In your professional practice do you find that there are a considerable number of people who prefer that type of institution?—Undoubtedly; and private doctors do, too, in influencing their patients.

17,046. Is the existing number of licensed houses, and the accommodation available, inadequate for the requirements of that class of patient?—They are all pretty full, I understand. There has been no great cry about this matter, but there is a tendency when they are rather full to an evasion of the Lunacy Act, that is to say, that people are managed outside and without certificates who ought to be notified to the Board of Control.

17,047. It is rather odd that with an increasing population and increasing means in the country, there has been a decreasing number of licensed houses?—The decrease in the accommodation has been rather anomalous; that is to say, large houses like

Bethnal and Hoxton House have taken pauper patients. There have been several small houses containing three or four patients closed, by reason of the owners not being interested enough. The number of beds in licensed houses just about meets the present requirements. But you are quite right—it is an extraordinary thing that in thirty years the accommodation in licensed houses should be sufficient, whereas the number of private patients in the public institutions has increased very much.

17,048. There is another feature of it, too, and that is that their distribution throughout the country seems to be quite accidental?—Yes, quite unsatisfactory. (Dr. Lord): Another point is the increasing number of voluntary patients in licensed houses; the increase is 50 per cent., almost, in some cases. (Dr. Cole): We think that the licensing methods are unfortunate. I am thinking of one or two houses, one at Bedford and one at Rotherham; they are all built round with houses, and there is no means of moving a house. At present a house cannot be moved out of the licensing authority's area. They want to go ten miles away, into the country, and at present that cannot be done.

17,049. No; the licence is lost then?—It would be very satisfactory if it could be altered.

17,050. That is a minor matter; but the continuance of the licensed house system is, of course, one of the matters we have to consider. We heard that in Scotland there is only one, a very small house, of about 50 patients. Apparently it does not seem to be required in Scotland?—But the Scots people have been brought up with the Royal Asylums having excellent private patient accommodation; for years and years—I am speaking now of my experience of 30 years—although many Scotsmen come south for the treatment of mental disorders, a good many English people also go to Scotland. What I want to say is that Sir John Batty Tuke's place at Saughton Hall is the only one there, and Scotland does not require another; and yet I think there would be a great outcry if our present private institutions were interfered with. It surely comes to this, that if you interfere with private asylums you ought to interfere with single private patients, and to carry the thing out logically to interfere with private practice as a whole.

17,051. I think perhaps there is this difference: there has been a certain amount of public feeling with regard to licensed houses in this respect, that there may be a conflict between interest and duty in such institutions. You see, after all, it is not merely like private practice; of course it may be that there is a conflict of duty and interest even in ordinary practice, that the doctor may pay more visits than are necessary for the patient's welfare; but in the conduct of a licensed house there may be special temptations which do not arise in ordinary practice at all, and a conflict between duty and interest?—The only one I can think of at the moment is a dishonest collusion between the medical officer of an institution and the relative of a patient. However, the safeguards are such that it is impossible for anybody to be detained unnecessarily in any mental hospital, private or public.

17,052. Of course, you are associated with one yourself, and it is not perhaps quite fair to ask you the question, but you do not think there is any risk of an exploitation of a patient?—Not the slightest; I am absolutely certain myself it is not so.

17,053. *Earl Russell*: As to the time of discharge, there may be a permissible margin of two or three months, may there not?—But fewer cases are discharged recovered. The recovery rate would be very much larger in licensed houses if the patients were not discharged earlier by their friends.

17,054. *Chairman*: In short, when convalescence is established?—Yes, because patients in licensed houses

4 May, 1925.] Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. E. GOODALL, C.B.E., M.D., F.R.C.P., Dr. J. R. LORD, C.B.E., M.B., Dr. W. F. MENZIES, B.Sc., M.D., F.R.C.P., Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S., and Dr. R. WORTH, O.B.E., M.B. [Continued.]

have means of completing the convalescence elsewhere, which is not so in the case of a public hospital.

17,055. *Earl Russell*: I was only putting it to you on the Chairman's point of the conflict between interest and duty. There is another possible effect: that where the margin of discharge might be either this week or this time three months, there might be a temptation to extend it unnecessarily sometimes?—I do not think so.

17,056. I do not say it operates, but obviously there may be a temptation to do so, if there is a highly paying patient?—I do not think so, because people do not pay longer than they can help.

17,057. People pay up to £2,000 a year sometimes?—Possibly, and more, but then the point is this: that money is being paid, and the relatives would like to save it. Why should they pay for their relatives more than they need?

17,058. The Master in Lunacy has something to say as to the amount?—Quite so, but I do not see why you think a patient can be detained on account of the money he is paying to an institution.

17,059. *Chairman*: Surely that is quite obvious?—A man has a rich wife, and the wife is in an asylum—

17,060. You have not quite got the point that the public look at. I do not say for a moment it is a sound point, but one must appreciate the public point of view. It is this: there is in a home a patient paying £2,000 a year; he has really recovered, and might quite well be discharged. Is there not a certain temptation to the medical superintendent to say: "Well, if we lose Mr. So-and-so and his £2,000 a year it is going to be rather hard to make our accounts balance next year"?—I do really say, reputation is at stake: it is absolutely impossible. I do not say that some recovered patients do not remain on as voluntary boarders, paying large sums of money; they do; but why should not they?

17,061. There is no harm in it at all?—There is no reason why they should not. But to say that any medical man is so unworthy as to detain a patient for the sake of the money being paid, I really repudiate that notion on behalf of people who have to deal with private asylums.

Earl Russell: I was putting it to you as an instance of the conflict between duty and interest which makes the public suspicious of these places.

Chairman: A trustee in law is not entitled to do certain things, although he does them in perfect propriety and honesty, simply for this reason, that the doing of such things may put a temptation in his way. The law will not allow people to be put into such a position that there may be that taint, even although on all hands it is admitted there is none.

17,062. *Earl Russell*: It is a question of "Lead us not into temptation"?—I think it is largely theoretical, and practically it is not possible.

17,063. *Chairman*: There is one matter I want to elicit from Dr. Goodall. You are anxious, Dr. Goodall, to put before us your views with regard to the employment of female nurses in mental institutions. We have heard a certain amount of evidence on that subject already, and of course we also have before us the 7th Annual Report of the Board of Control, 1920, from which you quote in the letter you addressed to our Secretary. We also have the report of the Departmental Committee of the Board of Control which inquired into the matter; but we should like very much to have your own personal view upon that question. First of all, when you recommend, as you do, the increased employment of women in the treatment of male cases, are you speaking for the Association, or are you speaking individually?—(*Dr. Goodall*): Individually.

17,064. Is it a topic on which there is a difference of opinion in the Association?—(*Dr. Lord*): It has not been thought to come within its purview.

17,065. It arises in this way, Dr. Lord, that one of the topics remitted to us is the care of patients; not merely the detention and the discharge, but also care, and of course "care" involves the question of the nursing, does it not?—Yes.

17,066. Whether it is precisely within our purview or not, I do not know. At any rate we have had some evidence upon it, and Dr. Goodall has sent us a letter in which he expresses, I gather, his own personal views on the matter, but it has not been thrashed out by the Association?—Not as a whole. Any member of the Association here is prepared to give his experience.

17,067. We have had Scottish evidence very favourable to it. Would you tell us, Dr. Goodall, what your own view is on the matter?—(*Dr. Goodall*): I have had, out of nine wards occupied by male patients (the other is shut for the present, or that would be under female nurses) six under female nurses, and in two of those wards there are no men attendants at all. Since 1920 and during the war I have had about seven years' experience of the treatment of mental diseases, some of them very severe, amongst the troops; half of our hospital was occupied for mental diseases amongst troops, and they were all under female nurses, trained, certificated mental nurses, a sister and a staff nurse in each ward, and men subordinate to them. 2,000 cases were nursed in that way. For seven years I have seen the male wards in charge of female nurses, under the matron, with female subordinate officers and no male officer of any kind.

17,068. There are two points: one is the disciplinary point, and the other is the therapeutic aspect. As far as the maintenance of discipline is concerned, do you find that women are able to exercise sufficient control over male patients?—Yes, there is no trouble in that. The only thing they may be lacking in is a small detail, like exercising in the gardens, and soon they do all that. But I do not think a woman has all the time the attention of a man; they are apt to fail in small things, but those are too minor to put against the value of their services.

17,069. From the therapeutic point of view, do you think women are able to deal with the cases?—I think they are far superior to men from that point of view.

17,070. Is it recognised that a woman's ability in these matters elicits the better side of the men, and is soothing?—That psychological matter is part of the sex distinction, and then when the patient is in any way ill she is so much better from a nursing point of view, especially when supervised by a trained nurse, like the matron and her assistants would be; and the trained nurses are going round the whole of the hospital.

17,071. The ministering angel has always been of the female sex, I understand; at least, the poet said so; but that is founded upon a real psychological basis, is it not?—Certainly, I think so.

17,072. I notice with interest that Dr. Winkler, in his account of the Utrecht Hospital, said: "No male attendants are admitted to the female wards. Male patients are nursed partly by women and partly by men, but the first nurse in every division is a woman. The administrative staff is responsible to the professor, but its chief, the adjunct-director, on principle not a medical man, is independent in all technical, financial and administrative affairs." The second sentence relates to another topic, but apparently in Dr. Winkler's establishment, which you hold up to us for admiration, there also women are employed for nursing male patients?—Yes. In the psychiatric clinics abroad you do not find men, except in a subordinate position, the same as they are at the institution where I am. I think you will hear from Dr. Mapother that they have trained general nurses all over the Maudsley Hospital; no men at all, except for very subordinate things.

4 May, 1925.] Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. [Continued.
E. GOODALL, C.B.E., M.D., F.R.C.P., Dr. J. R. LORD, C.B.E., M.B., Dr. W. F. MENZIES, B.Sc.,
M.D., F.R.C.P., Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S.,
and Dr. R. WORTH, O.B.E., M.B.

17,073. We have had evidence from the Asylum Workers' Union that it is undesirable to have male patients attended by female nurses?—Yes, I know. We have had a considerable amount of difficulty in Cardiff with the Cardiff Trades and Labour Council and the Municipal Employees' Association, who represent the National Asylum-Workers' Union in the boroughs—a very great amount of trouble and odium.

17,074. On this question?—Yes, from the trade union point of view. In fact the committee of visitors brought an action for libel against the secretary, but fortunately that was settled.

17,075. What was the view of the trade unions with which you found yourselves confronted?—They said it was not moral and proper for girls to be looking after these people. That was one point. The other was that it was ousting male labour. Both of those were entirely false, but on those they went.

17,076. The first point seems to be not tenable, but on the second point, have you in the employment of women actually displaced male employees?—Undoubtedly, we have to. There are 75 per cent. of women about the place, whereas before—

17,077. But I am thinking of displacing actual persons. Substituting is one thing, but displacing is another. Have you actually dismissed employees in order to take on women, or have you waited till a vacancy occurred?—We never dismissed anybody. In the three remaining wards the men are there, because they have had such long service.

17,078. That is a point one must distinguish. It is one thing to make a clean sweep of your staff, which I can quite understand would be resented; it is another thing, as and when vacancies occur, to employ women to take the place of men who have died or who have retired?—Of course that was done. The hospital was all cleared out after the War Office occupation was finished, and we had to start with a new staff. That gave us the opportunity to start with women.

Mr. Snell: It would be true that if the vast majority of attendants were to be female, the male attendants would be proportionately less; so that the trade union, from that point of view, were on safe ground.

17,079. Chairman: Whether on the other hand you would retain men always because of that reason is a different matter?—I deny that that was a fair argument at all. They said that the committee of visitors did this on grounds of economy. That was false. They did it for the benefit of patients.

17,080. Miss Symons: Were the rates of pay in fact different?—Of course the women get a little less, but there are more employed.

17,081. Chairman: The actual outlay for the attendants is about the same?—The men get more money, but the women are more numerous.

17,082. However, these complications are a little beside the general question as to whether it is desirable in the interests of male patients that they should be nursed by women, because if it is desirable for their cure, it is essential, I am quite sure, that no economic considerations should be allowed to stand in its way?—It is most desirable.

17,083. One would have to be assured first of all that for the care of male patients women can do the work better?—Certainly.

17,084. And that is your considered view?—Certainly, after seven years.

17,085. It would be rather interesting to know how far that view is shared by the representatives before us of your profession. What do you feel, gentlemen, about that?—(Dr. Menzies): I have had them for 25 years in certain cases in the infirmary with children, and to a less extent with fresh admissions. My personal view is that you must cut up your admissions into two classes. There are some fresh admissions which I have not found at any rate can be nursed advantageously by women; they are altogether too violent and delirious.

17,086. Apparently the matter has reached this stage, that there is a general feeling, as far as we can gather from the information before us, in favour at any rate of the increased employment of women in attendance on males?—Yes, I think my experience supports that.

17,087. Because of their greater therapeutic capacities and also their greater powers of sympathy?—Yes. (Dr. Lord): I have had experience since about 1900, and I have heard a good deal about it since. I must say there is a good deal of nonsense talked on both sides. I think the medical superintendent ought always to have at his command a nursing staff, in the same sense as he has medicine. In other words, he selects the nurse, whether it is male or female, like he selects his medicine. I mean, to have any hard and fast rule about the matter is against all principles of the doctors' treatment of cases. Certainly I should object to anybody else dictating to me as to whether I should employ a man or a woman on any particular case. Therefore my ideal is to have in a public mental hospital certainly a considerable number of women on the male side, so that I can treat by female nursing such male cases as are recommended by the medical officer or selected by myself that are suitable and do better under women. If they are not doing well under women, one would put them under men, and *vice versa*. Certainly healthy, well-behaved chronic lunatics, when they become sick, have a right to have the sympathy of a woman, as in a general hospital or at home.

17,088. Earl Russell: A superintendent told me the other day that men did not like being nursed by women, and he had much better, sympathetic men attendants, who were much more effective?—I say that there is so much nonsense talked about it. (Dr. Goodall): You know the Scotch experience, and that is good enough for me.

17,089. Chairman: I am not going to raise inter-necine questions among you. It is enough to know that there are many male cases which can with advantage be treated by female nurses? (Dr. Lord): That is it.

17,090. The method we have pursued to-day has been to select points from your memorandum which interested us particularly, and which we have discussed with previous witnesses. I think as far as I am concerned, at any rate, I have exhausted those topics. That is not to say that the other matters you deal with will be lost sight of. We wanted particularly to take advantage of our meeting with you to put to you some of those points which struck us in perusing your memorandum. As far as I am concerned I think I have put all the points which I wanted to bring out, and the difficulties which were present to our minds. If any of my colleagues have questions to put to you, on points that have interested them, they will take the opportunity now.

17,091. Mr. Micklem: There is one small point I think we have not mentioned yet. I see your suggestion, Dr. Cole, is that where continuation orders are made they should have judicial sanction, or the sanction of two members of the visiting committee. Is that really a necessary safeguard for the patient?—(Dr. Cole): Of course, the recent action at law has rather prompted us to make that recommendation, but still we feel that we do not want to be responsible for the detention of the patient purely and simply. You know it has been somewhat ambiguous in the Courts of Law as to how long these reception orders last, and we felt it should not be put upon the medical officer of an institution to be responsible for the retention of a patient when the original reception order comes to an end. It is the continuation of the original order, and we think it ought to be continued by a justice or two members of the public visiting committee of an asylum, so that the medical officer should not feel that he is really detaining the patient.

4 May, 1925.] Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. [Continued.
E. GOODALL, C.B.E., M.D., F.R.C.P., Dr. J. R. LORD, C.B.E., M.B., Dr. W. F. MENZIES, B.Sc.,
M.D., F.R.C.P., Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S.,
and Dr. R. WORTH, O.B.E., M.B.

17,092. *Earl Russell*: He is not to feel that he is the man by whose order the patient is detained?—Yes. We feel the same principle applies in the workhouse case, where the medical man, by signing a certificate, detains the patient.

17,093. *Mr. Micklem*: What do you think of the power of the medical superintendent to discharge a patient? Do not you think he should have such a power?—In a county asylum?

17,094. Yes?—I do not think he wants to have that power. Some do and some do not. (*Dr. Collins*): It is rather a difficult point, in that you may have a man with 2,700 patients. If you give him the power to discharge, that is very nice, and one would be willing to accept it, but if he has the power to discharge he also has the responsibility of detention, and that I do not believe any man can take over a large number of people; you cannot do it for 1,000 people.

17,095. *Earl Russell*: I do not quite follow that last answer. You say he has a power of detention; but equally he would be responsible for bringing them up to the committee for discharge?—That is another matter. The committee have a duty to visit and discharge patients, and there are various ways in which patients can be brought to the committee, but if you have a power to discharge a patient no one can

exonerate you for failure to discharge the patient. I do not believe it is possible; that is the only reason I object to it. (*Dr. Lord*): What we feel is that all these matters should be apart from the medical duties. (*Dr. Cole*): You have not heard Sir Frederick Mott's views about research and medical education.

Sir David Drummond: I should very much like to hear Sir Frederick Mott upon those points.

17,096. *Chairman*: I wonder if Sir Frederick would come to-morrow morning?—(*Sir Frederick Mott*): I think it is most important. I found it so during the war. (*Dr. Collins*): I think we want that particular view to be given.

17,097. *Chairman*: Then be assured that every possible opportunity will be accorded to you. In that case I think we had better adjourn just now to half-past ten to-morrow morning, and we understand that to-morrow morning Sir Frederick Mott will give us his views on these matters of research and medical education?—(*Dr. Cole*): Will you want all the witnesses to come to-morrow, Sir?

Chairman: It is just as you please. In case any of you do not come, I should like to express our thanks to you for the valuable assistance you have given us.

(Adjourned to to-morrow morning at 10.30 o'clock.)

5, OLD PALACE YARD,
WESTMINSTER, S.W.1.

THIRTY-FIRST DAY.

Tuesday, 5th May, 1925.

MEMBERS PRESENT :

THE RIGHT HON. H. P. MACMILLAN, K.C. (*Chairman*).

THE EARL RUSSELL.

SIR HUMPHRY ROLLESTON, BART., K.C.B., M.D.

SIR DAVID DRUMMOND, C.B.E., M.D.

MR. NATHANIEL MICKLEM, K.C.

MR. H. SNELL, M.P.

MRS. C. J. MATHEW.

MISS MADELEINE SYMONS.

MR. P. BARTER (*Secretary*).

MR. W. FAIRLEY (*Assistant Secretary*).

Further evidence on behalf of the Medico-Psychological Association of Great Britain and Ireland, by:
Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. E. GOODALL, C.B.E., M.D.,
F.R.C.P., Dr. J. R. LORD, C.B.E., M.B., Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P.,
F.R.S., and Dr. R. WORTH, O.B.E., M.B., recalled and further examined.

17,098. *Chairman*: Sir Frederick, I observe that in the Appendix to the Memorandum of the Association you deal on pages 22, 23 and 24 with the topics of psychiatric education and psychiatric research?—Yes.

17,099. We recognise, of course, that you are a very high authority upon these matters, and we should

welcome from you a statement of your views?—(*Sir Frederick Mott*): My views are set out in these pages, but I should like to amplify them in one or two respects. First of all, I should like to say that I consider the institution of the diploma in psychological medicine has done a

5 May, 1925.] Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. E. GOODALL, C.B.E., M.D., F.R.C.P., Dr. J. R. LORD, C.B.E., M.B., Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S., and Dr. R. WORTH, O.B.E., M.B. [Continued.]

great work in educating the medical officers of the asylums, and has totally changed the atmosphere in the asylums of the London County Council of which I have knowledge. When I was appointed in 1895 by the London County Council to investigate the causes of insanity I noticed a totally different atmosphere from what I observe now. The medical officers were mainly concerned with administration, and not with the medical aspects of the question; and I felt as a physician to the Charing Cross Hospital that this was strange to me. I noticed in the reports that no mention was made of syphilis as a cause of mental disease. That was so contrary to my experience with regard to organic disease of the nervous system in my hospital practice that I set to work to find out whether there was any relationship. I noticed that alcohol was put down as the principal cause, so I investigated alcohol in relation to insanity, and syphilis in relation to insanity; and I observed that there were a considerable number of cases in the London asylums suffering from what I would term juvenile general paralysis, so that the causes that were assigned as being the factors in the production of general paralysis of the adult could not exist in the children. I gathered 20 cases; one or two of them had actually been under my care at Charing Cross Hospital, and I was assured from that that the main cause of general paralysis was syphilis. I worked for 20 years trying to convince the authorities that if they would only prevent syphilis they could prevent general paralysis. Eventually it came about that we had a Royal Commission, and then this view was firmly established. I believe Sir David Drummond considered all along that syphilis was the cause of general paralysis. Is it not so, Sir David?

Sir David Drummond: I believe I had the honour to be one of the early exponents of that view.

17,100. *Chairman:* May I just ask this question on the topic of education: You are in favour of a special course of medical education in psychiatric medicine, which I suppose would be a post-graduate course. The medical student would, in the first place, pass through the ordinary curriculum; and then would he take a special course in this subject?—I have mentioned these facts to show that the medical officers should have been trained in neurology.

17,101. As we know, at the present moment the ordinary curriculum of the medical student is a very full one?—I was going to say we cannot burden the medical student with more lectures than he has at present; in the five years he has too many, I think, and the text books are so exceedingly good now that really what he wants are clinical demonstrations rather than lectures. I do not think I ever attended a lecture on mental disease when I was a student. I used to go round Bethlem with Sir George Savage after I was qualified; I learnt a great deal from him. It is extremely important, as Sir George Newman said, for a medical man just qualified to have some knowledge of insanity, because the very first case he gets may be a case of insanity, and he does not know what to do with it. Sir George Newman in his admirable report referred to that fact, and he said: "It is deplorable that the English student of medicine should have no opportunity of learning modern methods of psychiatry, or of diagnosing incipient and undeveloped cases of mental disease." When I was Examiner for the Conjoint Board for the qualification of Licentiate of the Royal College of Physicians I said: "The first thing is to set a question"—and I set a question on adolescent insanity in the paper, and I took down two cases of dementia præcox—they were quite able to go—absolutely typical cases. It had the most beneficial effect, because everybody afterwards attended the lectures and attended the demonstrations, and that is the only way to get students to learn; if they think they are going to have a question then they will attend the lectures and the demonstrations. If they do not have a ques-

tion for two or three times then they say, "It is no use reading up all that, because they will not ask it."

17,102. At the present moment insanity is not one of the definite separate subjects professed by a student, but I understood that he always runs the risk of having a question put upon insanity in his general medicine paper?—Yes. He should not run any risk. He does not know what to say, of course, if they ask what he would do in the way of certification, and so on. I think there are plenty of cases that could be taken down to the examination room and shown to the students, and you might say: "What do you think this case is, and what would you do with it?"

17,103. Is it not the case that even in the existing curriculum at most of the Universities there is a short course in insanity, both theoretical and clinical?—Yes.

Sir David Drummond: And in the examination paper, too?

Chairman: Not a separate paper?

Sir David Drummond: Not always, but there are always questions set in most of the papers.

17,104. *Chairman:* The practice will vary at different Universities, but I understand you are chiefly concerned, Sir Frederick, with advocating a special diploma for psychiatric medicine, which would be on the lines of the diploma in public health?—Yes.

17,105. One knows that the medical officer of health in the ordinary case passes through the usual curriculum with all its various subjects, and after that specialises in public health, and obtains the diploma in public health?—Yes.

17,106. Your conception is that psychiatric medicine should be dealt with in the same way, that the doctor who is going into that department should pass through the ordinary curriculum, which should contain some instruction in insanity, and after he has graduated should take post-graduate classes and clinical instruction in this subject, and obtain a diploma in psychiatric medicine?—Yes. In 1907 I advocated that unsuccessfully, but it came about first at Cambridge, and then during the war it was seen how necessary it was that men should be trained. So I started courses during the war for gentlemen to attend, and after that I started a course at the Maudsley Hospital, and this is the eighth course (*handing in the same*), which was very well attended indeed. The London County Council recognise the importance of it, and now they will not appoint anybody to a senior post who has not the diploma of psychiatric medicine.

17,107. *Sir David Drummond:* Have you any idea what proportion of medical officers of asylums at present hold the diploma?—At Birmingham every medical officer at the two asylums, Hollymoor and Rubery Hill, has the diploma.

17,108. But you do not know throughout the country what the proportion is?—I do not know what the proportion is, but it is becoming more and more recognised that it is essential for any medical officer who aspires to become a senior to have this diploma.

17,109. *Chairman:* I suppose we have not reached the stage at which it could be made obligatory that medical superintendents of asylums should have this diploma?—It is obligatory at the London County Council asylums. I know recently there was a post vacant, and they asked the two seniors whether they had got the diploma, and they said: "No," and they said: "We cannot appoint you."

17,110. *Mr. Mickleth:* Is that the diploma of the Conjoint Board?—There are many diplomas; there is the diploma of the Conjoint Board; there is the diploma of the London University; there is the diploma of Cambridge University, and I believe of Durham. Most of the Universities give a diploma, but unless there are a number of candidates they have no special course for it; and I know recently a course at Manchester could not be given because there were not enough men applying to attend. In

5 May, 1925.] Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. E. GOODALL, C.B.E., M.D., F.R.C.P., Dr. J. R. LORD, C.B.E., M.B., Sir FREDERICK W. MOTT, K.B.E., LL.D. M.D., F.R.C.P., F.R.S., and Dr. R. WORTH, O.B.E., M.B. [Continued.]

London, of course, we have that great advantage; there are so many medical officers who attend, and the London County Council are very wise in giving study leave; they say: "Well, if we insist upon this we must give the men facilities for acquiring the knowledge," therefore they give them six months leave to study, at the Maudsley Hospital, laboratory methods; and they go back to their asylums, if not equipped (because it takes a long time to be thoroughly equipped in a science like pathology), at any rate, with an idea of the value of scientific work in the elucidation of disease, and they know all the routine methods, and know how to apply them when they get to be medical superintendents.

17,111. There is one other point that occurred to me; is it part of your contemplation that these post-graduate courses in psychiatric medicine should be associated with every medical school, or rather that certain of the medical schools should offer these facilities? I know it is part of the general University policy in this country just now not to duplicate or triplicate special courses in all the Universities, but rather to let one University, or a group of Universities become recognised as the proper place to go to for a particular subject?—I think you are quite wise there, because even at Manchester, which is a very first-rate medical school, they could not get enough men to attend the class to make it worth while to have a special class.

17,112. Then a student or a graduate who is going in for this special course is not tied locally in quite the same way, he may go to London or Cambridge, or wherever it may be, for this post-graduate course, and probably the matter might be more economically dealt with if certain of the medical schools specialised in this department, and got together in that way classes which would justify the courses?—There is one point I should like to emphasise, and that is the desirability of medical students having a course of lectures on general psychology at the end of their physiological course, because I think it is most valuable. At Manchester they have adopted that principle.

17,113. It would be in the ordinary curriculum?—Yes, because during the war it was really lamentable, the ignorance that was shown by medical men of functional neurosis and psychosis, and it meant an enormous outlay to the Empire in consequence, because people were kept in hospitals who need not have been kept there.

17,114. Sir Humphry Rolleston: Might I, before you pass away from the subject of diplomas, ask Sir Frederick Mott, because I think his opinion would be of very great value, a question as to whether it is desirable to have so many different examinations? I mean there is the Conjoint Board which, of course, probably has the largest number, and there is the Cambridge University, which I think has the advantage of age?—Yes, it was the first, you see.

17,115. Is it desirable to have so many different examining bodies? Is it not rather difficult to standardise them all?—I think it is: I quite agree with you, Sir Humphry. I think at Leeds the diploma is given to men who work in the Wakefield asylum only, and to nobody else; but I think myself that it would be desirable to have only a few recognised Universities, and I think you will have to keep the Conjoint Board. A man, I suppose, would be able to take a diploma at Cambridge without a degree?

17,116. Yes.—Cambridge has a great difficulty in not being able to give the clinical teaching. They could do the preliminary part extremely well, but they cannot do the clinical teaching there.

17,117. Sir David Drummond: I was very much surprised, Sir Frederick, looking through the syllabus, to see how much time is devoted to the theoretical work, and how little to practical work. There are only six demonstrations, and then twelve clinical demonstrations in neurology. I should have thought

it would have been advisable to introduce a good deal more than that?—But you see, Sir David, the diploma is only given to men who have been a year or two years in an asylum. What they lack is a scientific knowledge to apply their practical knowledge.

17,118. Would it not be desirable to offer the diploma to men who are going to asylums, but who are able to pass the examination?—It would be, but you see there are many difficulties in connection with that. What we do at the Maudsley Hospital now is, we have a class of case there consisting mainly of borderland cases, so that we could not get really all the types that are required; but arrangements have been made by which cases are brought up from all the London asylums to illustrate the different mental diseases, and once a month every mental hospital in the service is requested to send up interesting cases for discussion, so that the students get plenty of opportunities for clinical investigation.

17,119. Chairman: With regard to Sir Humphry's point, I can quite appreciate the desirability of having a recognised standard for the diploma, because if different centres give a diploma it will be very difficult to value it unless the standard of teaching and examination is more or less the same?—I quite agree with you.

17,120. Now you mentioned Cambridge University. I think Cambridge was the first to institute such a diploma?—The first, as far as I know.

17,121. Since then have a number of Universities, and also the Royal Colleges, given diplomas in psychological medicine?—Yes.

17,122. So that the movement that you have done so much to initiate, Sir Frederick, is already well under way?—Well under way, yes.

17,123. And what you advocate, I take it, is a further development of that method of instruction?—Yes.

17,124. And the desirability of the diploma in psychological medicine being recognised as the proper qualification for those who are put in charge of our great mental hospitals?—Yes.

17,125. I think that this training is desirable, not merely however in the case of the medical superintendents, but in the case of all who have to do with mental ailments?—I quite agree.

17,126. And I notice you conclude your observations on this topic by pointing out that all those who are engaged in the care and treatment of the insane, and in their after-care also, would benefit by such instruction?—Quite.

17,127. This is the programme of the current course that you have handed me, is it not?—Yes.

17,128. It is not dated, but I take it it is 1924-25?—Yes; that is the eighth course that is being carried on.

17,129. Does a post-graduate student who has attended this course, which I see is in two parts, present himself for the diploma?—Yes.

17,130. Is there a single examination?—No, there are two examinations.

17,131. Then if he obtains the necessary marks he obtains the diploma?—Yes.

17,132. But this is the programme of the entire instruction?—Yes. There is one other point I should like to mention. London University gives the M.D. in psychological medicine—that is to say, that the candidate can take psychological medicine as a special subject, and a gold medal is given. Now it was decided at the University since they have altered the curriculum for it, and made it practical as well as theoretical, that that should stand highest of all—should stand before the diploma even.

17,133. There are no specific indications in this degree, are there? Take a doctor who has obtained the degree of Doctor of Medicine with a special distinction in psychiatric medicine—probably has written a thesis, or something of that sort, and

5 May, 1925.] Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. E. GOODALL, C.B.E., M.D., F.R.C.P., Dr. J. R. LORD, C.B.E., M.B., Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S., and Dr. R. WORTH, O.B.E., M.B. [Continued.]

obtained the degree, there will be nothing to indicate that he has specialised in that department, because he might have got his M.D. for specialising in some other honours course?—No, only in this way, that if he applied for an appointment, and the question was asked: "Does this carry greater weight than the diploma of the University?" the University will say, "Yes."

17,134. *Sir Humphry Rolleston*: Do they not sometimes put after their name, "M.D. Psychological"?—That is so.

17,135. *Chairman*: There may be an outward and visible indication?—I think really it does carry more weight, and it should do.

17,136. You put it at the top of the hierarchy in the matter?—Yes. (*Dr. Cole*): There are, I believe, only a few who have the degree in psychological medicine, and one member of the College of Physicians who has passed for this work in psychological medicine.

17,137. There are a few who hold the doctorate of the University of London in psychological medicine?—Yes.

17,138. Now I think we might pass, Sir Frederick, to your observations on psychiatric research; and first of all, I suppose you will have noted with satisfaction that in Lord Onslow's Bill provision is for the first time made for visiting committees to have power, among other things, to undertake research in relation to mental disorder and the treatment thereof, and to make contributions towards the expenses of any body engaged in such research. I take it that one of the obstacles in the way of such research hitherto has been that local authorities were doubtful as to whether they had any legal power to expend their money upon this matter?—Yes, that is so.

17,139. And if this Bill, or a Bill on similar lines, were to pass, the legal difficulty would be obviated?—Yes.

17,140. But that of course would be permissive only?—Only permissive.

17,141. And I understand that in your view research is so important in connection with mental science that you would like to see every possible means taken to encourage the local authorities to embark upon it?—I should; I think it would be a good investment for them.

17,142. Then here again one must consider the organisation of it; one does not want every small centre to engage in research, because it would merely be duplicating work done elsewhere?—And it would be of no use.

17,143. And probably less efficient?—Yes.

17,144. Here again we must contemplate some concentration of effort?—Yes.

17,145. Have you in your mind any concrete scheme of research?—Yes, I have.

17,146. Perhaps you will be good enough to outline it to us?—When I reached the age limit, the London County Council asked me to go on for a year or two, which I did. Birmingham was very anxious to obtain my services, and I said, "Yes, I will go to Birmingham, and become Honorary Director of Research of the laboratory if it is associated with the University." On no other condition would I go. A Research Board was formed consisting of members of the City Corporation and the University, and Sir Gilbert Barling, who has taken a great interest in the matter and who is Vice-Chancellor of the University, is the Chairman. A Research Board has thus been set up for Birmingham; a well-equipped laboratory has been established, and it is hoped that Birmingham may become the centre of the Midland mental hospitals for research and for carrying on the teaching of psychological medicine. The asylums cannot at present subscribe to this, because they have no powers to do so, but the Guardians of Birmingham have already taken the matter up and have subscribed a substantial sum of money to the

research laboratory, in consideration of which we carry out any investigations that may be required at the colony for mental defectives at Monyhull. Recently there has been an outbreak of dysentery there, and we have examined all the cases from there; over 100 examinations have been made; so therefore they have really got all their money's worth back again, because it would have cost them more to have sent them elsewhere. We have a scheme there which I hope will be of very great service. The laboratory was opened two years ago by Mr. Neville Chamberlain, who is in great sympathy with the whole matter. The laboratory, which is very well fitted up, is at the Hollymoor asylum. Now I do not want to see the laboratory dissociated from the clinical work, but at the same time I want it to be made so that all these outlying asylums can utilise the laboratory both for teaching and research; and the University, we hope, in a year's time will have accommodation in the centre of Birmingham for laboratories for research, and for routine work in connection with this undertaking; and if the asylums, like Barnsley Hall, Powick, Hatton and Burntwood, and other asylums in the neighbourhood come in, then really a very efficient scheme can be produced there. Birmingham could give a diploma for the Midlands, at any rate do all the scientific research work under proper direction, and also the routine work which cannot be carried on in the asylums, owing to the fact that it would cost a great deal of money to set up a laboratory properly and efficiently equipped, and what is still more important, to provide the brains in the laboratory. It is not bricks we want, it is brains; and that is what people do not seem to understand. I am very sorry to say that in this country we spend no end of money on cancer research, on tuberculosis research, and there are many many generous laymen who come forward and give large sums of money for those purposes, but with the exception of Dr. Maudsley, who gave a half of his fortune which was earned in his practice, I know of nobody who has come forward to help the investigation of insanity. The difficulties are great. But I should like to mention one fact, that Sir Charles Hyde has founded in Birmingham a Lectureship on Morbid Psychology, of which I am at present the Lecturer, and he has given a sum of money, £250 a year, for a scholarship in this research laboratory. Outside that I do not know of anybody who has given anything towards research in mental diseases.

17,147. That is very remarkable, but as one knows recently there has been a great deal of generosity shown towards the Universities in various departments, but apparently mental disease has not received the same recognition?—I think it is the old metaphysical idea of mind; we have not quite got away from demonology yet.

17,148. You must make your subject more attractive?—I am going to get Miss Nethersole and the People's League of Health to preach a crusade.

Sir David Drummond: It has not advanced its claims up to now.

17,149. *Chairman*: I should imagine if its claims were made known generosity might be stimulated?—I should hope that the Rockefeller Institute, which has given enormous sums of money to various things might do something; and they certainly do in America help research in mental diseases. In 1912 I went out to America—I was invited to go to the opening of the Phipps Institute at Baltimore—that has not been mentioned hitherto, and I should like to mention it now. I went out with Sir William Osler and Professor McDougall and we were present at the opening. That was given by Mr. Phipps. It is a very fine institute in connection with the John Hopkins University, and is doing most excellent work there.

17,150. I am afraid your subject has been the Cinderella of medical science hitherto?—That is so.

5 May, 1925.] Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. E. GOODALL, C.B.E., M.D., F.R.C.P., Dr. J. R. LORD, C.B.E., M.B., Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S., and Dr. R. WORTH, O.B.E., M.B. [Continued.]

17,151. We can only hope the prince will come along?—I am very glad to hear what you say.

17,152. May I take it the essence of your recommendation is to be found on page 24, where you say: "In my judgment research would be most satisfactorily carried out by the provision of a central laboratory in association with a University for a group of asylums"?—That is the whole point. I want to say we began it at Birmingham and so far it is a great success.

17,153. Let me just take one point along with that. You speak of a group of asylums, and I quite see the desirability of having the research work for these asylums concentrated in one centre. I suppose however you do not contemplate that the asylums which at present do a certain amount of pathological and physiological investigation in their laboratories should cease doing that work?—Oh dear no. If they are going to call themselves mental hospitals they must be hospitals in fact, and in the possession of a laboratory where all the routine work can be done for clinical investigation.

17,154. I want to get the differentiation of function between the laboratory and the research department?—Supposing an epidemic occurred, as it very often does, of dysentery or typhoid fever, at present we have typhoid breaking out in one of the London asylums, there has been a carrier for some years; it requires a very long and patient investigation to find out that carrier. Every case in the several wards where that carrier has been has to be examined to see whether they are still suffering from the disease, or are likely to suffer from the disease, and that can only be done in a thoroughly well equipped bacteriological laboratory.

17,155. Then perhaps we may take from you this: that a central laboratory on the lines you have suggested is in operation, is it not, for the London County Council Mental Hospitals at Maudsley?—Yes, it is.

17,156. And is a similar laboratory in operation at Cardiff also?—Yes. Perhaps Dr. Goodall will tell us whether it is in operation for all the asylums.

17,157. Then you have described to us the Joint Board of Research at Birmingham with which you are more specially concerned. Does that represent the extent to which central research equipment has been provided in this country?—I think it does.

17,158. London, Cardiff and Birmingham?—I am not sure whether they have recently done it in Manchester in connection with Prestwich. (Dr. Collins): They are just starting at Bristol. It really has been partly covered by what Sir Frederick Mott has said. It is the difficulty in an outlying district of getting medical officers opportunities to be trained.

17,159. You need to give them study leave, I suppose?—Yes; but at the present time that is a rather difficult thing to get committees to do; it is not very easy always for the medical officers to be able to attend unless the committee can assist them in some way or other. Of course, in all these districts in the south there is no university other than London; London is practically the only place where you can go, and for anyone in a country district 70 miles from London daily attendances are impossible, practically, particularly with the small staff we now get.

17,160. You cannot afford to let one of your medical officers away?—I have only three to look after 1,140 people now. If one man is going to attend a course, it is really impossible to carry on.

17,161. Have you found your local authority reluctant to give you further assistance?—They did on one occasion give study leave with pay, and that medical officer happened to get another appointment and never came back. That was not a very fortunate example. I do not think he could really be blamed, because he had a long service, and he had to consider his future; he had been set back by the war, and

at that age he must go on; but still it has not encouraged the view that it ought to be done again. They will give leave, but they will not help them with pay. But even then it is difficult, when you have a small number like that, to spare one man for a long period. I mean temporary medical assistance is not as good as a permanent medical officer.

17,162. That is a very practical difficulty, and again it is a financial one largely, is it not?—It is financial, of course, but in all the south there is no university. There is Bristol, and there is London, but I mean there are a lot of places in between that have no possible facilities unless they let the men go right away.

Sir David Drummond: Might we have Dr. Goodall's views?

17,163. Chairman: Yes, we should like to hear Dr. Goodall on his Cardiff experience in this matter?—(Dr. Goodall): I think some gentleman said that local authorities were not sure whether they could spend their money on research. That is news to me, because they can pay what salaries and wages they like out of the maintenance account. They appoint all officers, and they pay all the salaries and wages; and with us at the Cardiff Mental Hospital there is a matter of between £1,700 and £1,800 a year being paid by the Committee of Visitors of the Corporation upon pure research, chemists, pathologists, their assistants, radiologists, and others; and, apart from that, there is a grant from the Medical Research Council in addition which comes in, but all that comes out of the maintenance rate, which partly accounts for the high rate which we have.

17,164. I think I should take a point there. I do not think legally there would be any obstacle to a local authority expending money upon research laboratories, and so on, in connection with their own asylum; but there would be difficulty in their providing funds for the establishment of a research institute outside their own district to which all doctors might be able to resort. That would be the difficulty. Now, of course, Sir Frederick's conception of a central institution could not be carried out through the local rates of another district unless it was specially empowered?—Yes. Then, again, it may be said I have an obsession on this subject of psychiatric clinics in connection with University centres; but there again I would like to see the central laboratory to which Sir Frederick Mott refers in association with the University clinic. It would be just as useful to the asylum, and it would be more consistent and logical to have it at a psychiatric clinic at the University. On that subject I feel sure that had the Early Mental Treatment Bill passed before 1914, when there was plenty of money in my district, I could have raised between £40,000 and £50,000 by propaganda certainly for the purpose; and I hope there will be a revival in business in my district, to enable it to be done with this Early Mental Treatment Bill. Lastly, if I may cite this short paragraph on page 28 of my evidence, it bears upon Sir Frederick's remarks: "The practical teaching of psychiatry to students in England and Wales as at present conducted—and I write as one engaged in such teaching—is absurdly inadequate—nearly as much so as it was over thirty years ago, when I was a student"—that was at Bethlem. "They can (with the exception of Bethlem Royal Hospital, and now the Maudsley Hospital) only go to the 'asylum' where cases such as they will be required to deal with in practice are very rarely to be seen. Compare with this the teaching of students at the University of Utrecht, for example (probably the best neuro-psychiatric clinic in existence is at Utrecht). The same lack of teaching facilities results in the appointment of junior medical officers to 'asylums' who know very little of mental disorders. This absence of tuition is, of course, very detrimental to our people. As regards nurses, it will be seen that the above plan allows for a free interchange between the various hospital

5 May, 1925.] Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. E. GOODALL, C.B.E., M.D., F.R.C.P., Dr. J. R. LORD, C.B.E., M.B., Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S., and Dr. R. WORTH, O.B.E., M.B. [Continued.]

clinics, so that the nurse can receive general and psychiatric training—a great gain to the public.” As Sir Frederick says, at Cambridge, the University of Cambridge with all its traditions, they cannot teach clinical psychiatry. That is a fearful stigma, and, of course, that is perfectly true. They have to do their clinical work somewhere else. No more powerful argument could be adduced for psychiatric work in connection with the University than that, I think. The same thing obtains at Oxford, not quite so marked, but it obtains nevertheless.

17,165. *Sir Humphry Rolleston*: With regard to Oxford, is there not very much more than there is at Cambridge?—Yes, there is the mental hospital accessible—not the same thing; in my opinion a better quality of mental hospital is to be found at the one place than the other; but to take students there, in my belief, is quite a mistake. I say to my students at Cardiff, “You cannot learn your psychiatry here.” As Sir George Newman truly said when he came round my place, “You cannot learn your psychiatry as you will want it here.” If they come round to the out-patients at the infirmary, they will see there what they want; they will not see here the cases they want, except occasionally.

17,166. *Mr. Micklem*: Has not Dr. Good opened a clinic in connection with the infirmary at Oxford?—Yes, the same as we have at Cardiff, but you want an indoor clinic, as I said yesterday, as well.

Chairman: I am very sorry to say I am called elsewhere by another engagement. I am going to ask the Deputy Chairman to take my place.

(*Mr. Micklem took the Chair.*)

17,167. *Deputy-Chairman*: I do not know whether Dr. Goodall would like to add anything as to education. I think your *précis* covers very much the same ground as Sir Frederick Mott’s does?—Yes. I entirely endorse what Sir Frederick Mott has said and he has more experience in that matter than I have. I want to see this education carried on in clinics, of course.

17,168. *Sir Frederick*, there is one question I wanted to put to you about the education, not merely of doctors, but of nurses. Your Association has done a very great work in connection with that, and you grant certificates from time to time?—(*Sir Frederick Mott*): Yes.

17,169. And we have had before us the syllabus of examination papers which are set. It occurred to some members of the Commission that those papers were, on the face of them, extraordinarily difficult?—I quite agree with you.

17,170. And the question arose whether possibly some nurses who might derive considerable advantage from training would be put off by the excessive difficulty of the examination. Is there anything in that?—I quite agree with you, Sir. I think that the book that the Medico-Psychological Association put forward is far above the heads of the nurses to whom it is supplied. I would make it much simpler. I think they give a suspicion of knowledge rather than actual knowledge. Really that book as regards the nervous system is one that I could very well put into the hands of gentlemen who are going in for the diploma in psychological medicine.

17,171. They look to me rather like papers that are set at the University of London examination?—I have never set a paper, and I have always protested against it. I think it is absurd to expect these nurses, seeing that they are not drawn from the class that one would expect to be able to answer questions like that, to know this book and profit by it. I think the great thing is to teach them to be able to observe. I have seldom, I do not think I have ever, met a nurse who could describe to me accurately what happened when an epileptic fit occurred.

17,172. There is one other matter that I do not myself quite appreciate with regard to your sug-

gestions on research. You suggest that there should be a central laboratory at some centre like Birmingham, and that with that should be associated the asylums in the neighbourhood?—Yes.

17,173. From the point of view of the medical officers in the asylum, are they to take part in the research in the laboratory?—If they wish. They should be able to come up there the same as they do at the Maudsley Hospital. At the Maudsley Hospital a medical officer has an interesting case, or he is interested in some department of research; he comes up there and carries it out under proper directions, and with the facilities that he cannot obtain in a small laboratory such as would be provided at the asylum. He is directed in his research, and no research would be published that was not approved of by the director of the laboratory. I think that is most important, because, otherwise, research work may be published which is not really of any value.

17,174. But the main research would be done by the staff at the laboratory?—The main research would be done by the staff, but still we have had two workers from institutions at the laboratory for some time, and they have done very good work. I had men sent from all parts of the world to carry on research in the laboratory both at Claybury and at the Maudsley Hospital, from Japan and from America, from the Colonies, from Egypt—and the researches have been published in the archives of the laboratory. I have brought the last volume to show you, it will give you an idea of what has been done. (*Handing in the same.*)

17,175. Is it your suggestion that the local authorities in the different parts should be asked to pay money towards the upkeep of central laboratories?—Certainly. For that they would have this in return, that investigations would be carried on for them in regard to any question of epidemics arising in those asylums, or any research work that they required done, and their students would have the facilities of the central laboratory for research and for education.

17,176. Taking your particular laboratory at Birmingham, is that maintained entirely by the University there?—No, by the Corporation. The University does not contribute to the fund, but the Corporation supplies the money, and the University co-operates.

17,177. And contributions you say are made also by the guardians?—Yes, the guardians have made a contribution of £200 a year in respect to the Monyhull colony.

17,178. *Earl Russell*: I had not the good fortune to hear your earlier evidence, I had another public engagement; but there is provision in the Early Mental Treatment Bill enabling money to be expended on research?—Yes.

17,179. We had some very strong evidence here from a representative of Cheshire who objected very much to what he called “directed research,” and he suggested that if those provisions were carried out people would be ordered to research into certain things, and the result would not be so good as if they went on in their own way. What do you say with regard to that?—What I would say about that is this, that the director of the laboratory would never interfere with any research which he thought was likely to be of use, or promising in any way; but he would like to have some control with regard to what should be published as valuable work if it was done in his laboratory. I would be very sorry to see what happens in Germany: if the research does not agree with the professor, it is not welcome very often.

17,180. But I think he went rather further than that; he deprecated altogether what he called team work, and he seemed to think that research must be like an inspiration in the mind of an inventor?—Team work one might say is quite right, because the

5 May, 1925.] Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. [Continued.
E. GOODALL, C.B.E., M.D., F.R.C.P., Dr. J. R. LORD, C.B.E., M.B.,
Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S., and Dr. R. WORTH, O.B.E., M.B.

most valuable work that has been done in America on heredity by Professor Morgan has been done by team work. He could not have done it in any other way.

17,181. *Sir Humphry Rolleston*: Was not the evidence given by a layman whose chief objection was to control from a Metropolitan centre rather than control of the laboratory?

17,182. *Earl Russell*: I think his idea was that every county should be on its own. I wanted to have Sir Frederick's comment on that?—I do not think I should agree with the idea of the Board of Control exercising control over research at all, because I do not think that is their province.

Sir Humphry Rolleston: I think his point was not the control in the laboratory so much as the central control.

17,183. *Earl Russell*: He did not like the idea of two or three counties being linked together and having one good joint laboratory instead of three bad ones?—I am sure the former is the right principle. I can assure you that the value of being connected with the University is immense. I will give you an example. I was very interested in basal metabolism, and the Medical Research Council gave me a sum of money, and I have constructed a basal metabolism chamber. Professor Haldane is the great authority on basal metabolism at the Birmingham University. I said "We will go and see him, and see how he has constructed his chamber." He has afforded us every facility and it has saved us no end of time. It is an enormous advantage to be associated with the University. I consider that a laboratory cannot be successfully carried on unless it is associated with a university, and has all the advantages which a university affords. Therefore these small places should be linked up with a central laboratory connected with a university.

17,184. *Mrs. Mathew*: I am very much interested about what you said as to the examination for nurses being too stiff. Could you give us some idea of what you would consider the right sort of examination?—I think perhaps Dr. Collins would know more about that. I have not examined the nurses. I have always maintained, however, that the Medico-Psychological Association have aimed too high as regards the teaching of these nurses in psychological medicine. (*Dr. Collins*): Perhaps I may say this: there are questions which arise to which we take exception when they appear in the paper, as being too difficult; but, on the whole, over a good many years examining now I find that the people that can do reasonably well in the viva voce are the people that get through the paper; it is very rare to find that a person who possesses practical knowledge and the ordinary simple knowledge that we ask in viva voce examinations, fails in the paper because of difficult questions, and so on; in fact, it is, I think, rather the easy papers that plough most people.

17,185. *Earl Russell*: Could you give us an idea of the percentage of full marks that you pass them on?—I have never examined a written examination. The percentage of marks in the written examination is 50 per cent., and if they get 70 per cent. in the viva voce, then between 47 and 50 per cent. on the paper will pass. Of course, a good deal depends upon the way the examiners mark, and that is a very difficult thing to control—I mean the Education Committee that is responsible for the examination of course cannot control the way an examiner marks. You can say on how many marks he is to pass, and you can say how the thing is to be conducted, but you cannot possibly control him in the way he marks the papers.

17,186. *Deputy-Chairman*: Does the Committee consider the papers that have been set by the examiners before they come to the candidate?—No

We have always taken the view that we appoint the examiners, and we do not control them in any way.

Sir David Drummond: It is at the beginning that this kind of thing may act adversely, that is to say, you may pass them on a 30 or 25 per cent. marking if you like, but when a young woman first looks into the matter she says, "I should like to go on with the nursing, but I really could not undertake to do this."

Deputy-Chairman: The original syllabus is so difficult.

17,187. *Sir David Drummond*: It is at that end that I think it operates as a deterrent?—I remember speaking about one question which, had it been set to a medical student, would have been a very difficult one, but the standard and the answer required by the examiner from a nurse was practically nothing. I remember actually entering into a private conversation with one of the examiners about this particular question, and he said: "You have taken that as though I had set the question to you, which I did not; I have set it to people whose standard of education I know very well, and I want the simplest facts from them." I quite agree they are difficult sometimes.

17,188. *Sir Humphry Rolleston*: The schedule is higher than the standard?—The schedule has to include everything. (*Dr. Cole*): The nurses are very interested in the lectures. The medical officers in asylums spend a very long time in giving lectures to these nurses, and in their spare time. It is very good food for the mind for these people, both male and female nurses; and, after all, it does not matter so much what the question set is as long as you find a fit person to be passed as a mental nurse.

17,189. *Deputy Chairman*: I think you would be rather anxious that the syllabus for the nurses' consideration should not be such as to deter any of them from entering?—We still have in the service some nurses who are defective in their education, and cannot express themselves properly in writing. Over and over again we have most excellent mental nurses who do their work extremely well, but cannot write papers. What are we to do with them? Are we to pass them?

17,190. *Mr. Snell*: You would judge on the general capacity of the person rather than on efficiency on a technical point?—That is so. (*Dr. Collins*): The General Nursing Council have adopted the same syllabus exactly; I think it is word for word the same. I mean that it was adopted by people who could not be said to be biased in our favour.

Sir David Drummond: I have been informed by matrons of some of our largest and best hospitals that they have been obliged to refuse some of the most likely young women (I am not speaking now of mental nurses), because when the matter was put to them: "Remember, you will have to pass this examination," they have said: "Well, I am afraid I could not undertake that," and they have not proceeded further in the matter.

Earl Russell: There is something in Sir David's point that, if you present to persons a thing which absolutely terrifies them, it puts them off at the very beginning.

17,191. *Sir David Drummond*: Matrons tell me that that is so. I am speaking of general nurses?—(*Dr. Collins*): Do we offend any worse than the examination of general nurses on that point?

Sir David Drummond: But the matrons tell me they object to the kind of examination that is set.

17,192. *Deputy Chairman*: In your mental hospitals so many nurses now have a certificate that it is rather a serious disqualification for a nurse who cannot get a certificate, although she may be of extreme value in the asylum?—Yes; it is a very great difficulty which is rather hard to overcome.

17,193. *Sir Humphry Rolleston*: I would like for a moment to return to the question of control, or rather, the correlation of research, Sir Frederick. I am sure everybody, including the Board of Control,

5 May, 1925.] Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. E. GOODALL, C.B.E., M.D., F.R.C.P., Dr. J. R. LORD, C.B.E., M.B., Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S., and Dr. R. WORTH, O.B.E., M.B. [Continued.]

would feel that they would not want to have research controlled, we will say, by a lawyer?—(Sir Frederick Mott): Certainly not.

17,194. At the same time there might be some advantage in having a modified correlation of research such as you pictured with regard to a centre like Birmingham, that would give a kind of hint to a man who was keen, young, and perhaps was going to investigate a problem which was really a barren one and had been worked out already; there would be an advantage in a certain amount of control, or correlation, of research?—It was exactly that I was referring to, namely, that a director of a laboratory would probably know if the research had been carried out before and would tell the candidate: "This has all been carried out, and it is no use going on with that," and suggest that he might think of something else to which he could apply his energies.

17,195. And in that way he would save expense?—Yes, save expense; but I think you will agree with me that research can only be carried on in a properly equipped laboratory, equipped as regards apparatus and also equipped as regards the staff, because you want an expert staff in a laboratory to carry out these researches. It is not only medical men that you want; you want really men you can train to carry out the technique. I have one assistant at the Maudsley who has been with me 35 years; he can do things far better than I can, but I look at them afterwards, and the same with the chemist. You must have somebody whom you can direct and control in that way, but who would carry out the researches for you.

17,196. There is one other question I would like to ask Dr. Collins. You raised the very urgent question of the shortage of medical officers in the mental hospitals. You have, I think you said, about 1,000 patients and four medical officers?—(Dr. Collins): We have myself and three others, and the Committee have now agreed to appoint another, and that is to go up to the number of 1,300 patients that we are increasing to.

17,197. In a general way in an average mental hospital, what would you consider to be the proper proportion of medical officers to patients, taking into consideration all the chronic cases?—Of course we have not got what I should like to get, that is a small clinical laboratory; we have to send everything to the Medical Officer of Health. I should like that remedied. If I had that then I think I could on the present numbers usefully employ five. If I had not got that work to do, then I do not think it would be any use, if it was not possible for them to do their clinical laboratory work, and so on.

17,198. The average proportion would be somewhere about one medical officer to 250 patients?—Yes.

17,199. That you think is really quite practicable?—Of course it would not work out that way. I mean to say the medical officers who have charge of the recent and acute cases would not have the charge of so many.

17,200. I mean the average?—The average.

17,201. Sir David Drummond: I should like to ask you gentlemen your opinion upon the desirability of so arranging matters that the superintendent is able to devote more attention to his patients than apparently he is able to do at present throughout the asylum. Perhaps Dr. Goodall would tell us what he thinks of the functions of a superintendent?—(Dr. Goodall): After 30 years as a Medical Superintendent in two mental hospitals I hold the same view as I did about 30 years ago; that is to say, there is no reason why the administration should not be divorced from the professional work. I consider that a clerk and steward should look after the stores and equipment and the farm and garden, and the workshops, and, in fact, the general administration, all to do with economy; and I see no difficulty in it. Difficulties have been mentioned in the way of friction between a steward and a medical superintendent. I deny that

there need be any friction if these men are gentlemen of the same social position, none whatever; and the benefit of that would be that the divorce of administration from medicine would procure and keep a higher type of medical man. As has recently been grasped in the Army, the promotion of medical men on professional grounds will prevent able men from abandoning the professional and taking up the administrative side, which, of course, is easy in comparison with the following up of difficult medical problems. As it is now, committees are rather apt to look for administrative ability in the officers they appoint, that comes rather first. That is an entire mistake, and there again I would point to the higher example of the psychiatric clinic, because there it is inconceivable that the director should be mixed up with economic questions. He is never in that difficulty abroad, never, and that would be an example. I believe this question will largely solve itself in the future, when medical education in respect of mental disorders is on a higher level, because men will not seek administrative posts, they will go off on medicine and will require to be appointed on medical grounds; so gradually the administration will come, I think, into the control of stewards of a proper class to carry it on.

17,202. In Germany what is the arrangement?—I know at the clinics they have what they call an "ekonom," he does the whole thing; that is a steward, of course. I shall be very much surprised if you hear from Dr. Mapother that he is much bothered with administration.

17,203. Deputy-Chairman: Would you divorce the administration altogether?—Not the control of all medical matters and nursing matters, but in regard to these purely economic matters, which I mentioned, farm and gardens, supply of produce and stores. I should make the stewards responsible for them.

17,204. One can hardly compare a clinic with a large asylum, can one?—No, it is not a medical function in any sense, and it can be very well done by plenty of men who are available with business training who are also gentlemen. I am old enough to know that this question has been obscured and made unpleasant on personal grounds as between a steward and a superintendent who have not been of the same social class; that has been the trouble, one has interfered with the other. Where they are both gentlemen I fail to see any need for difficulty.

17,205. But do not you think the ordinary medical superintendent could delegate so much of the administrative functions?—At present he is not allowed to; the committee holds him responsible.

17,206. He is held responsible, but under him there are many persons acting?—I would have the steward brought before the committee for all the economy of the place, not the medical superintendent.

17,207. Earl Russell: You would relieve the medical superintendent of the responsibility of seeing that accounts were right, and that sort of thing?—Yes. That view may be entirely eccentric, but I hold it strongly, and, as I say, I have been 30 years at it.

17,208. Deputy-Chairman: It is held by a good many more people than yourself, but, on the other hand, we have had a very strong body of evidence before us on the other side?—I believe the other view is much stronger.

17,209. Earl Russell: Of course you give the medical superintendent complete control; he would be able to give orders as to how warm the wards should be, although the steward would have to carry out the heating?—Yes, they are bound to come into contact on such questions as you raise. I say again, is not that a matter which gentlemen could arrange between themselves? (Dr. Collins): In my experience it is perfectly easy to delegate all these things. I do delegate all these things. I do not interfere in the question of cost, and I do not interfere on the farm.

5 May, 1925.] Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. E. GOODALL, C.B.E., M.D., F.R.C.P., Dr. J. R. LORD, C.B.E., M.B., Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S., and Dr. R. WORTH, O.B.E., M.B. [Continued.]

The committee take separate reports from the steward (and see him) and from the engineer, and from the farm bailiff. They make no difficulty about it, and they recognise that those people are responsible. All they do hold me responsible for is this, if I think the heat ought to be on I say it should be on, and it is the engineer's business to see that it is on—that is all. With regard to the employment of patients on a farm, and so on, a proper supervision is kept over them, but I do not go round, or have anything to do with what the farm bailiff does as regards the farm. I have never found any difficulty in the matter. You can delegate all these things; at the same time I should be very loth to think that I was not able to give any order I thought fit to give to anybody.

17,210. *Mr. Snell*: Are you technically responsible, doctor, for all these things?—I suppose I am.

17,211. That is to say, if there is a last word, it is yours?—The last word is mine.

17,212. But yet, in spite of that, you find it possible to delegate responsibility without difficulty?—Yes, without difficulty.

17,213. *Sir David Drummond*: Are you able to devote sufficient time to your patients as a physician—are you able to give that amount of time to the study and work and interests of your patients?—The thing that really interferes most with my medical work is the legal work with regard to the detention and certifying of patients. That is to say, I have 1,140 people, and a very considerable amount of mental energy is required to keep those people in mind at all, apart from doing anything else for them.

17,214. You have not quite answered my question, you know?—I mean to say I am not hampered, except occasionally when something special arises, from devoting time to the wards as much as I wish.

17,215. You think you are able to give, as things are at present, sufficient time to your patients—as much time as may be expected from the medical superintendent?—Yes, I think so.

17,216. How often do you see your patients?—Some of them I try to see every day, the recent cases, as near as I can.

17,217. *Deputy-Chairman*: With regard to the questions of consideration of the detention and certification, and so on,—those all require your medical knowledge?—Yes, they do, but they interfere with what Sir David Drummond was saying about treatment. I cannot undertake to have a particular ward under my care and directly treat people in it. Of course the larger the institution gets, the less often you can see any particular cases.

17,218. *Sir David Drummond*: I am thinking of some large institutions of which the medical superintendent has admitted to me personally that he has not been able to give that attention to his patients that they require?—I think the solution to that is that the senior medical officers in large institutions should be adequately paid and qualified to carry out this work, and simply require the medical superintendent to assist them as necessary. I do not think that you can ask any man to look after 2,000 people.

17,219. No, I do not mean in that way exactly?—Of course, the law at present does not recognise anybody except the medical superintendent as responsible. Anybody who signs any document has to sign it as "Acting." (*Dr. Goodall*): Not only is there the care of the patients, but there is the direction of any laboratory and research work. I can say honestly I could do very much better if I were divested of these functions, I could put in very much more time in purely medical work.

17,220. *Mr. Snell*: Is it not a question really as to whether the medical superintendent has the power within himself of delegation—has the faculty?—(*Dr. Collins*): Yes, a lot of these are personal matters. You will never get two people to agree, that is my experience.

17,221. Supposing you have a medical superintendent who has not this power of delegation, then you have a problem arising, and when that problem arises what do you think ought to happen?—You must try and select the right people; that is the only way it can be done.

17,222. When you have selected him you have got him. He may be the best man in the world, but he tries to take too much work upon himself?—That is so. There is a difference, for instance, between Dr. Goodall and myself. He has a laboratory in which he could profitably spend his time; I have not. (*Dr. Goodall*): You ought to have.

17,223. Supposing you have a medical superintendent of this kind, an entirely all-round competent man, but who has not the power of delegation, what is the wisest thing to do—definitely to separate the functions, or take the other risks?—(*Dr. Collins*): No, I think he can very usefully do that work, but you must provide certain people to do other work.

17,224. That is to say the right thing would be for the committee to take from him the duties of administration?—No. I do say you must provide medical men sufficient and properly qualified to carry out the medical work, if you are going to occupy your medical superintendent entirely with administrative duties.

17,225. Is it not a very great waste of training and learning to select a medical superintendent because of his technical qualifications, and then to use those qualifications for the growing of cabbages?—Yes. At the same time you must have a medical man in power to say yea or nay to everything. Beyond that I am willing to delegate everything.

17,226. *Earl Russell*: May I take you back to the earlier question of Mr. Snell's as to incidence of responsibility? Do you not think that if you are technically responsible for the accuracy of accounts and things of that sort, it makes it more difficult for a conscientious man to delegate them all to somebody else, and not to concern himself with them?—I do not think I am technically responsible for the accuracy of accounts.

17,227. Supposing a contractor is swindling an asylum of its supplies, you are not responsible for that?—No, I do not have any hand in that at all. The steward would tell me that was so.

17,228. I am not sure that a superintendent is not responsible in a public asylum. It is very desirable he should not be, you will agree?—Yes.

17,229. *Mr. Snell*: Supposing anything were discovered wrong in the accounts, would you be held responsible?—I do not think so.

17,230. *Sir David Drummond*: Do you think, as things are at present, that the medical officers of asylums have sufficient experience in general medicine? I am not speaking now of psychiatry, but general medicine?—That varies of course a good deal. In some of the places there is a good deal of general medical work. I think the standard of the new men, the men recently joining, has been very good. (*Sir Frederick Mott*): Do you think, Sir David, it would be a good thing that before a man could be appointed to an asylum he should have held a resident post at a general hospital as a physician?

17,231. *Sir David Drummond*: That is to say, you think it is desirable that the medical officer in an asylum should also be skilled in general medicine?—(*Dr. Collins*): He must be.

17,232. But it is not so, as you know?—It has not been, but it is now, I think, very much better. Until just recently it has been practically impossible to get men.

17,233. I quite agree with Sir Frederick that it is most desirable it should be so.—(*Sir Frederick Mott*): I think it would be very useful. (*Dr. Collins*): Of course we now appoint a visiting surgeon, and that has done a good deal to increase the standard. (*Dr. Cole*): Might I make this remark: do not

5 May, 1925.] Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. E. GOODALL, C.B.E., M.D., F.R.C.P., Dr. J. R. LORD, C.B.E., M.B., Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S., and Dr. R. WORTH, O.B.E., M.B. [Continued.]

we think that really and truly it depends upon the mentality of the superintendent? Some men are interested in administration. They would have done well in other walks of life, but they happened to be medical officers. Another thing that appeals to me particularly is that committees of asylums are unduly prone to think about the maintenance rate, and they think a good deal of a superintendent who keeps down this maintenance rate. This maintenance rate can be kept down by very carefully looking to the farm, and other matters on the estate, and therefore he gets kudos for that. But all this, I submit, should not be. Really it comes to a question of economy. We ought to have scientific men at the head of our institutions. I speak now because I am not a public asylum man, but I am connected with Hanwell as a teacher, and with Bethlem, and ideally we want scientific heads of establishments. That is generally agreed to, but I think that they ought to co-ordinate the work, and that a great deal of the administrative work should be done by stewards. I understand it is possible. One member of the Commission thinks that a person may be deficient in being able to delegate these duties. Then it is unfortunate that that man was selected to be a superintendent.

17,234. Do you think that in the appointment of a physician to a general hospital a committee would ever take into consideration his administrative capacities?—None whatever.

17,235. His professional skill and experience would cover the whole thing?—Certainly.

17,236. Why not in mental medicine?—I just know enough to remember some of the experiences of the past when Hanwell at one time was under the lay administration of the steward, and all I can say is that Hanwell did not work so smoothly then, and there was much more friction than now with the medical superintendent as the head of the administrative departments.

17,237. *Earl Russell*: The point I rather wish to put to you is this, that these matters of economy under the maintenance rate are precisely matters for which the superintendent should get neither praise nor blame; they should not enter into or interfere with his professional work at all. Do you agree with that?—Yes; he ought to delegate it to others.

17,238. But he ought to receive neither kudos nor blame for it. He should not be considered as the person responsible for that side of the business?—Personally I agree. (*Dr. Collins*): I do not think all committees take administrative ability into consideration in appointing a superintendent. I think committees vary a good deal on that point.

17,239. *Sir Humphry Rolleston*: The medical superintendent ought to have a final veto on all matters?—He must have, I am sure, because of the peculiar circumstances.

17,240. *Earl Russell*: And of course committees vary in the way they deal with their superintendents. They may say: "We want you to be a doctor; we will not hold you responsible for what goes wrong in the administration." Other committees, as you say, attach importance to the maintenance rate. Obviously they vary?—They do. Everybody tends to get a little sore about the maintenance rate sometimes.

17,241. The superintendent ought to be entirely free from that?—Yes.

17,242. *Deputy-Chairman*: There is only one other subject which remains, I think, the question of after care, about which Dr. Worth is going to give us evidence. At the present time there is no provision whatever, as I understand, under the Lunacy law for after care of any sort after discharge?—(*Dr. Worth*): Except in the London district. There is the Queen Adelaide Fund which allows certain grants.

17,243. That is not in the Act?—Not in the Act; but it is available in the London district, London and Middlesex and the Home Counties.

17,244. Now would you tell us what provisions you think should be made?—I think you have had evidence from Miss Vickers, who is the Secretary of the After Care Association.

17,245. Yes, we have.—So you are quite acquainted with this work, but there are certain things which have proved to us invaluable, and especially a recent action on their part in visiting the homes of patients previous to discharge.

17,246. That is the After Care Association?—Yes. We give the Secretary of the After Care Association notice that such and such a case is likely to be discharged, and would they find out for us the home conditions? They do this, and do it very successfully, and we are made then aware practically of the type of the home that the man or woman will go to, what the means are, and so forth, the number of children, and so on.

17,247. You are considering the discharge of a particular patient; you are considering whether he is sufficiently recovered from the mental ailment to be discharged. Would your knowledge of what is going to happen to him afterwards have any effect upon the judgment you formed as to whether he should be discharged or not?—Yes, certainly, because if he goes back to the old home and surroundings which have been the cause of his primary trouble, it would be useless to send him back to those surroundings.

17,248. Are you not in some difficulty there? The patient should be discharged if he is not a fit patient for detention?—We assume the man is well, and that he is fit for discharge, but before his discharge we like to find out what the conditions are to which we are sending him back. We have no knowledge of them.

17,249. What I am putting to you is whether you have regard to that in considering if he is fit for discharge or not?—Yes, and no; very often the Mental After Care Association will help us out of this, because they will take a case out on trial; they will take that case for a month and report to us the improvement or otherwise during that month on trial. But there are other cases which, of course, I would like the Commission to know; it has been said that we detain cases unnecessarily, but, on the other hand, there are many difficulties in discharging some cases that are well, or to find a place for them to go to; the wife will not have the husband, or the husband will not have the wife, and it is extremely difficult to know what to do with them. The After Care Association again step in and help us, and they will take that case to one of their homes, and will find work for them. One of the good works that they go in for, which has not, I think, been mentioned before, and which I have had personal experience of, is a clinical out-patients' department; and it has been most essential in many cases to remove a patient from his or her present environment—that is, there is no chance for them, there is no rest or anything, no prospect of that incipient trouble stopping at that stage. The After Care Association then again step in by allowing us to send those cases to their homes. Unfortunately they cannot do this for nothing, but money has to be found to pay their expenses.

17,250. Those cases you are speaking of are "pre-care" cases?—This is the "pre-care" which it is the ambition of the After Care Association to legalise. This is done more or less as a favour at the time, but they hope in the future to legalise this. Another point I may mention is that there are some rather striking figures, and that during 1923 and 1924 the Mental After Care Association dealt with 1,986 cases. Then out of these we consider that we helped by advice, or kept from relapsing, 87 cases who applied there when feeling ill or worried, and were either seen by a doctor or given the necessary advice. That is a very great help, both to the county and to the rates.

5 May, 1925.] Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. E. GOODALL, C.B.E., M.D., F.R.C.P., Dr. J. R. LORD, C.B.E., M.B., Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S., and Dr. R. WORTH, O.B.E., M.B. [Continued.]

17,251. Now, of course, all that is excellent voluntary work?—Yes.

17,252. Is it your suggestion that that kind of work should be made statutory—that there should be an obligation put upon the local authorities to undertake that?—That, again, is a very difficult question, whether it would be possible for the Government to make them a grant and keep the Association a voluntary one, or whether the rates should pay for the whole thing. It is a question which I do not need to give an opinion upon, because the Association itself, I gather, wants to remain on the voluntary basis, if possible.

17,253. *Earl Russell*: There is an intermediate course in which the county councils can be empowered to subscribe?—That they can do at the present moment. (*Dr. Cole*): It is not legal.

17,254. *Deputy Chairman*: There was provision made in the Early Mental Treatment Bill?—(*Dr. Worth*): We have applied to the Minister of Health, and he has sanctioned the granting by my committee, (and other committees, I suppose, do the same), of a certain sum to the After Care Association, but you cannot pay their actual expenses. But the Minister of Health has sanctioned this grant.

17,255. I have rather quoted the evidence that was given us on behalf of that Association. Do they act all over the country, or is their work rather confined to the London district?—It is a spreading organisation; they are gradually going farther afield. There are centres in some of the big towns, and it is a progressive thing. Then, of course, one of their works which helps us enormously is visiting patients while on trial. We frequently now, almost in the majority of cases, send patients out for three weeks' to six weeks' trial. We have not facilities to go and visit them while they are on trial, but the visitors of the After Care Association do visit them.

17,256. You give notice to the visitors of the After Care Association?—Yes, and they report to us the conditions.

17,257. There can be no doubt about the value of the work, but the difficult problem is how far that kind of work should be made obligatory upon the local authorities, whether it should be made a statutory provision?—Of course, there are a good many guardians and people who do subscribe towards their funds now, and I think it has the sympathy of nearly everybody. It would appear to me that if the Commission could recommend it, a Government grant could be made them according to the number of cases they dealt with, or something of that sort; it would be a very great thing, because they would be able to extend their energies all over the country.

17,258. *Mr. Snell*: Do you mean to be administered or granted by the local committees?—It is, to a certain extent, now; they do get their subscriptions from boards of guardians, and from county councils; but I was thinking whether there could be a central fund straight from the Ministry of Health.

17,259. To grant to the central After Care Association?—Yes.

17,260. *Sir Humphry Rolleston*: Would it not be reasonable to consider that the after treatment of patients who have been in mental hospitals, and the early treatment of patients who are attending the clinics, is really an essential part of the treatment at the clinic, or at the mental hospital, and that they ought to be under the same organisation? I mean the After Care Association has done an enormous amount of good; but, after all, it is more or less a personal administration; it is not so linked up as to be an essential part of the treatment in the mental hospital. Ought not the two things to be continuous?—We take things as we find them. The After Care Association is in being, the clinics are not. If these clinics are going to be established and supported, then a great deal of the work of the Mental After Care Association will not be required.

17,261. *Miss Symons*: I was wondering whether you feel that this work, particularly the visiting and finding out about the home circumstances, can best be done through a central association like the After Care Association, or rather in the way that it is done in the general hospitals through almoners definitely attached to the hospitals?—Yes, that is a point which has arisen, but the After Care Association, as I say, are doing the work; and we have relied upon them because they have already established their principles of visiting. I daresay each county, or each mental hospital, could establish and have its own almoner, and find out all the requirements; but it has not been done, and we have relied on the After Care Association up to date.

17,262. *Mr. Snell*: Is it your experience, Dr. Worth, that the ladies and gentlemen who do this work voluntarily are of the right type for the work they choose to do?—I think so, yes.

17,263. *Sir David Drummond*: Do you find their attentions are resented by friends and ex-patients?—Very, very rarely. I think there has only been one case in the last four or five years that I know of where it was resented.

17,264. *Earl Russell*: I think the Secretary of the Association gave us the impression that there were not infrequent cases in which they were asked not to call?—That is not my own personal experience. (*Dr. Goodall*): I could give you the local experience, if you like, at Cardiff.

17,265. *Deputy-Chairman*: If you please?—The After Care Association has been in existence for about 3½ years, and it is composed of the Cardiff League of Social Service, the Cardiff Guardians and the Cardiff Mental Hospital Committee, and there is a Committee set up representing these three. That Committee reports to the Mental Hospital Committee, who are affiliated with the central body in London by paying them merely a nominal fee. Miss Vickers came down and started this business with us. I recommended the Committee to be affiliated, I thought it was the proper thing; the actual work, however, is done by their own local organisation. Now, this body visits patients who are about to be discharged from the mental hospital, to find out about them, what they have got to say and what they want. The patients who might be found occupation, otherwise have to be detained, because they are not strong enough to face the worries of life. The most important function is what Dr. Worth has described, that is to say, visiting the homes of people who are about to be discharged, and also keeping an eye on them after they are discharged on trial, and working in co-operation with the out-patient clinic at the Cardiff Royal Infirmary, bringing these cases there and reporting upon them as to whether medicines are being taken and the steps are being carried out which have been recommended. The grant that the Visiting Committee is authorised under the Act to pay whilst a patient is on trial, is paid to the Secretary of this After Care Association and disbursed by her, not paid direct to the patient. Then our great difficulty is the hampering feature that there are no cottage homes to which these patients can be sent. We have arranged to send them to Miss Vickers' homes about London, but after the expense of having to fetch a patient back because he was still on our books, we do not want any more of it. We want our own cottage homes and our own organisations, and that is what the Early Mental Treatment Bill allowed local authorities to do, to set up cottage homes or incur any other expenditure in connection with the after care. That is Lord Onslow's Bill. Without cottage homes and convalescent homes the thing is enormously hampered.

17,266. *Earl Russell*: The advantage of a cottage home is that it enables you to discharge a patient where otherwise, the domestic surroundings being

5 May, 1925.] Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. E. GOODALL, C.B.E., M.D., F.R.C.P., Dr. J. R. LORD, C.B.E., M.B., Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S., and Dr. R. WORTH, O.B.E., M.B. [Continued.]

unsuitable, you would not be able to do so?—That is so. There is no place for convalescents, they simply go into *medias res* at once. (Dr. Lord): Some two and a half or three years ago we commenced, in the first instance at Horton, to try and throw open the hospital in a sense to the general public by the appointment of lady visitors, who should be ladies interested in mental work who would perform certain functions. One was to visit the homes of all patients admitted and tell to the medical officer (on a form which I drew up) the environment the patient had come from, hereditary points, and so on, and something about causation; and throughout that patient's time in hospital she was to be the link between the patient and the home. When the question arose of the patient's discharge we did not feel we were justified in interfering with the work so splendidly done by Miss Vickers, so our visitor's duties cease at the moment the patients leave hospital, and they are handed over to Miss Vickers. Lately we have completed that end of the scheme; and the programme is as follows, that when a medical officer views a patient as a possible discharge he sends off to Miss Vickers a form on which she has to make her comments on the environment and so on that the patient is going to. It is filled up by Miss Vickers' helpers in various districts. That comes back and is studied by the Medical Superintendent.

17,267. You know this already from your own almoner's reports?—The environment may be quite different; two or more years might have elapsed.

17,268. I thought you said they kept in touch during all the time in the hospital?—They do keep in touch with the home, so long as it exists.

17,269. Is not this duplicating work?—No, I will explain that. The particulars now sought are very different. For instance, they want to know now particulars of the income, the money coming into the home, the number of dependents; who exactly is going to be in the home to look after the patient; any views as to the possibility of employment. The environment report on discharge covers ground which is essentially different from that on admission, therefore two environment reports in any case would have to be made, whether they are done by the same person or not. Now this report comes in in due course, and is presented to me with the patient, and afterwards, if I think the patient is suitable for discharge on trial, it goes to the committee, so that the committee have a very full account of the patient. They have, in the first place, all the documents regarding the patient; they have a full and complete account of the environment the patient came from; from the notes they can judge as to the progress the patient has made, and then they have this other document showing the environment which it is proposed to send the patient to, with a lot of particulars which will help them in their disposal of their patients.

17,270. Do the people in the homes not mind having two visitors?—The experience of my hospital visitor and her helpers, is that they have never had a rebuff. Miss Vickers writes to me to the same effect. I did suggest that the friends might object to somebody from the After Care Association going to their homes, particularly if it got known in the neighbourhood; it might inform the public that a person was there who had been discharged from an asylum.

17,271. Deputy-Chairman: Would not the patients themselves sometimes take objection to that?—We have found no objection taken in any case. Miss Vickers tells me by letter that she cannot recollect any; there is no objection by the friends, and certainly no objection by the patients. All patients, whichever way the committee dispose of them, are included in the same scheme.

17,272. Is it the view of the Association that there ought to be homes for convalescents provided, or is it advisable to leave after-care really to voluntary effort assisted by grant?—The point was this: in the establishment of the hospital visitors we had to take

into account, as Dr. Worth has mentioned, the general public, their prejudices and their views. Some of them are not very well informed, and we do know this that if I had to make Miss Dale an official and pay her through the hospital, then I should start trouble for her. In other words, she would be looked upon with the same suspicions as unfortunately many people attached officially to mental hospitals are now. She is an outside person. All we can do is to pay any legitimate expenses, railway fares, and that sort of thing, and I felt that the movement is best in the hands of people that do not occupy official positions in the hospital service. I also feel (I am speaking now for the mental hospital I am in) that as far as after care is concerned, it is best undertaken by an outside body. Contribute by all means, and that is what we do; we contribute expenses in one case, and as far as the after care is concerned at present we merely are able to contribute to the maintenance of patients, when out on trial.

17,273. Miss Symons: You think that the peculiar difficulties of the mental hospitals are really not comparable with the ordinary hospitals?—That is so.

17,274. On the face of it, apart from that, one feels that there might be something to be said for the hospital system of a trained almoner rather than a trained visitor, because with voluntary visitors you might not always be able to get the right type of person?—I envisage the time when perhaps there will need to be a paid official of that sort, but her activity would be strictly limited to inside the hospital, and she would be assisted outside by unpaid or partly supported helpers. In America all this is done by one service, which is established by the medical superintendent. He has three or four officials, who deal with the patients on admission, and the same set of officials deals with them on discharge. The patients are put on parole for 12 months, and during that period it is the business of the medical superintendent, assisted by all these helpers and agencies, to re-establish the patient in life.

17,275. Earl Russell: You appreciate Miss Symons' point about the difficulty with unpaid voluntary workers as to what you may get. You may get an angel of mercy, or you may get a very tiresome woman?—At Horton we have trained nearly all the visitors attached to London County hospitals. You have to select them, of course; but even your paid official might be very irritating and annoying.

Miss Symons: But you can carry on some system of training.

17,276. Earl Russell: And you can dismiss them more readily than you can a voluntary person who is trying to be useful and trying to do good?—Yes; but I do not think you will get that right influence in the homes in England if this work is done by paid hospital officials. You might just as well send a head nurse.

17,277. Deputy Chairman: Your recommendation, No. 50, Dr. Cole, made on behalf of the Association, is a little vague, but I suppose it is as far as the Association can go. You say: "That the after-care of rate-aided patients should receive due attention, and that the work done by the Mental After Care Association, or other bodies appointed to deal with after-care, should receive adequate pecuniary recognition by statutory committees"?—(Dr. Cole): At present we do not feel it is in the statute at all.

17,278. Earl Russell: No, it is not.—For many years nothing was done for after-care at all, and in the interests of the State it is most important that these people should be put in a condition that insanity should not recur. Their homes are very unsatisfactory places for them to go to. If we had these cottage homes about the country undoubtedly they could leave the county mental hospitals earlier. It is different with private patients, they need not remain so long, because their home conditions may be satisfactory. It is not so with the

5 May, 1925.] Dr. R. H. COLE, M.D., F.R.C.P., Dr. M. A. COLLINS, O.B.E., M.D., Dr. E. GOODALL, C.B.E., M.D., F.R.C.P., Dr. J. R. LORD, C.B.E., M.B., Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S., and Dr. R. WORTH, O.B.E., M.B. [Continued.]

poorer classes. I do not know that anything more can be said. We ask that it should be a statutory permission to pay for them. It is quite true that at Wandsworth the Committee pays, but there are very few committees of asylums who do pay.

17,279. Your idea is to let it grow naturally and see how it works?—That is so. These cottage homes are very difficult to get hold of. I remember the Council of the After Care Association in connection with St. Mary's Hospital tried to use those homes for patients there, but they are always full. There are very few people who want to take in a convalescent patient of that class. They are retired nurses and attendants of asylums. You cannot send them to anybody. (Dr. Goodall): I have a list from Miss Vickers of about 25 local authorities who are paying a subscription to her Association. There is no authority for it, but it is done, and it is being done by us. (Dr. Cole): I do not know whether the Commission want to hear any of Dr. Lord's evidence with regard to the foreign systems, which your Secretary said the Commission would be glad to have some record of. It has been prepared by Dr. Edwards and Dr. Lord—Dr. Lord more especially; it is all here in print.

17,280. Deputy-Chairman: I do not think it is necessary to discuss with Dr. Lord the particular provisions in the different countries. We have this evidence that he has very carefully prepared, and this Appendix might perhaps go in as part of our evidence. I understood from Dr. Lord that he may have a further document from New York?—(Dr. Lord): Yes, I have got now a copy (which is just available for us) of the Law on Insanity for the State of New York. The State of New York is particularly interested in this matter and is the one, I think, having regard to the temperamental conditions of the people, their nationality, and so on, with which we are most readily comparable. It is very interesting, and I promised yesterday to send in a digest of this. It amplifies what I said about America.

17,281. If you kindly would, and if we add that to this Appendix, we shall really have the facts before us. Would you excuse me, Dr. Cole, going back to one point mentioned yesterday which I am not quite clear about. You make a good deal in your *précis* of the necessity of making further provision for paying patients. Is it the view of the Association that Section 207 of the Act, which restricts the number of licensed houses, should be repealed or modified?—(Dr. Cole): As I said yesterday we felt it was a retrograde step to have enacted it in 1890. It was done with a view of stimulating the growth of registered hospitals. It has done nothing of the sort. Registered hospitals, which at that date were 15, are now 13. I regret to say that there has been no public-spirited man come forward to do anything for the needy class of paying patients requiring care. It is left entirely to the local authorities to provide accommodation for them. The Chairman made reference to the Royal Asylums of Scotland which have been established at a very early date, and there was only one private asylum in Scotland. Here in England, as you are aware, the private asylums are the originators, excepting a few old places like Bethlem; but the growth of registered hospitals has not been stimulated by that section; and we think probably it would be better that there should not be a monopoly, that the Board of Control should be authorised to extend them, if necessary. As regards this Royal Commission, what we feel is

that it has undoubtedly done harm to some patients by upsetting them, and unsettling them by reading the records, and so on; but, on the other hand, we hope that it has stimulated public interest, and that some philanthropic millionaire, will come forward perhaps to supply some of these clinics, the same as Dr. Maudsley has done.

17,282. Do you think it might be advisable in this country to make the same sort of provision for paying patients as is made in Scotland in some of the asylums, because, I understand, there you can have all kinds of different treatment in several of the asylums?—Yes. I will say this, that when the veto on the fresh licensed houses was established, a section of the Act allowed more than one patient to be in single care—Section 46. The Board of Control have rather read into that section the idea that there should not be more than two patients, and they have hesitated; and only on two or three occasions, I believe, have allowed three patients to be in a house. To my mind it is a mistake. Where a medical man is competent to treat patients, a retired medical superintendent, for instance, it would be a good thing that he should be able to take patients. It comes to this: it is making a licence during the life of the individual, as it were, which expires when he dies. It should not be so much of a business. I think the licensed houses should be allowed to go on as they are, and, if necessary, be extended.

17,283. You think there should be some modification of that section?—I think the wording of Section 46 is all right, if only the Board of Control would read it in a more liberal spirit.

17,284. Earl Russell: The Board of Control have rather strained the statute as it is?—More than one patient means 100 if you like.

17,285. Deputy-Chairman: You are on Section 46?—Yes.

17,286. I was rather on Section 207, which you see restricts new licences?—Quite so. We think that that was a mistake.

17,287. Was it not partly introduced because there was a strong public feeling against the licensed houses?—Yes, that was so, and we do not think the public feeling in any way represents the feeling that existed at that day. The Lunacy Act of the present day has done very much good. There is a good deal to be said for the Lunacy Act as it is, especially with regard to safeguards. I wanted to tell the Commission in thanking you for hearing us so patiently that our President this year happens to be the Superintendent of an Irish asylum, otherwise he would have been on our Committee, but it was impossible for him to attend. What we do press for is that you will do all that you can to ask Parliament to allow local authorities to promote research; and, if possible, to induce some philanthropist to help build the clinics if local authorities do not do so. People will spend money on cancer, on tuberculosis research, and also with regard to sanatoria, but they will not provide any accommodation for mentally disordered patients. It is a most extraordinary thing. So great is the stigma. Since Mr. Holloway built the Holloway asylum in the eighties, not a soul except Dr. Maudsley has done anything for mental disorders, in this respect.

Deputy-Chairman: I think we fully appreciate the views you have put before us, and have so clearly expressed. We are much obliged to you for giving us your evidence.

(The Witnesses withdrew.)

(Adjourned.)

5, OLD PALACE YARD,
WESTMINSTER, S.W.1.

THIRTY-SECOND DAY.

Friday, 22nd May, 1925.

MEMBERS PRESENT :

THE RIGHT HON. H. P. MACMILLAN, K.C. (*Chairman*).
THE EARL RUSSELL.
SIR HUMPHRY ROLLESTON, BART., K.C.B., M.D.
SIR ERNEST HILEY, K.B.E.
SIR DAVID DRUMMOND, C.B.E., M.D.
MR. N. MICKLEM, K.C.
MR. H. SNELL, M.P.
MRS. C. J. MATHEW.
MISS MADELEINE SYMONS.

MR. P. BARTER (*Secretary*).
MR. W. FAIRLEY (*Assistant Secretary*).

Evidence of (1) REPRESENTATIVES OF THE NATIONAL COUNCIL FOR MENTAL HYGIENE. (2) The BISHOP OF CHELMSFORD. (3) The Rev. W. E. C. BARNES, M.A. (Chaplain of Hanwell and Cane Hill Mental Hospitals). (4) Sir ARCHIBALD BODKIN, K.C.B. (Director of Public Prosecutions).

Dr. E. FARQUHAR BUZZARD, M.D., F.R.C.P., Dr. H. CRICHTON MILLER, M.D., and Dr. R. WORTH, O.B.E., M.B.; called and examined.

17,288. *Chairman*: This morning we have representatives of the National Council for Mental Hygiene who have been good enough to offer us their evidence. Perhaps I should say at once, gentlemen, that members of the Commission have read the *précis* with which you have furnished us, and in which your views are summarised. If you approve, we propose to take the same course with regard to your *précis* as we have taken regarding the statements of the British Medical Association, and the Medico-Psychological Society; that is to say, where a responsible body such as the body you represent has been good enough to formulate their views in their own precise language, we think it is valuable to put that on record as it stands, so that we may see the considered opinion of your body in the form in which you wish to present it. Therefore, if you agree, I think we should incorporate in our record of the evidence your *précis** as it stands. We have treated, as I say, certain of the important and authoritative bodies in that way, differing from our course with ordinary witnesses from whom we have elicited information, merely using their *précis* as the basis of our discussion. May I say before we go into any details that most of the topics with which you deal are topics which we have explored very fully with preceding witnesses, and we do not desire to cover the same ground over again? You really come in with your opinion reinforcing views which have already been urged upon us very much on the same lines; and I think if we incorporate your *précis* in our evidence, we might usefully occupy ourselves this morning in eliciting from you any supplementary matters which you desire to bring before us. If you wish to enlarge upon any of the topics we should welcome that. I propose, first of all, to ask you to tell us a little about the nature of your Council and the scope of its work. You have furnished us with a little print which gives us, I take it, the outlook of your Council,

and we recognise, of course, the very important membership of the body. Indeed, I see that one at least of my fellow Commissioners is a member of your Council. The Council is of recent institution, I see?—(*Dr. Farquhar Buzzard*): Yes, only in the last two or three years.

17,289. It was founded in 1922?—Yes.

17,290. And what is really its distinctive purpose as contrasted with the other bodies already engaged in this class of work?—I think the idea of the Council really originated from the formation of similar bodies in other countries, and the idea of those Councils has always been rather a co-ordination of various Associations and Societies interested in the question of mental hygiene with the object of promoting their efficiency and bringing them together, with special reference to the education of the public in regard to mental matters. It was, of course, a kind of international scheme by which there were conferences between the various Associations in different countries for their mutual benefit and learning what each other are doing.

17,291. There is one aspect of your work which strikes us as important, and that is the development of the academic side of the subject. So far as you can gather, the University education in psychiatry needs a good deal of development, does it not?—I think we hold the opinion pretty generally that the education of the medical profession as a whole is rather deficient in regard to psychiatry.

17,292. Of course, the difficulty with which one is confronted is that the medical curriculum is now so crowded that, as specialisation goes on, the unhappy student may find it very difficult to compress within his curriculum all the specialised subjects which he has to take. I suppose it must be recognised that this work to some extent must be specialised?—Personally, I think that in the long run it would be very much better if the student had not to make too much of a specialty of the study of the early mental disorders. I quite agree that a student has far too

* See Appendix XXV.

22 May, 1925.]

Dr. E. FARQUHAR BUZZARD, M.D., F.R.C.P.,
Dr. H. CRICHTON MILLER, M.D., and Dr. R. WORTH, O.B.E., M.B.

[Continued.]

many specialties to take up separately, but I think what really happens is that in the general course of his work in the hospital he sees and hears extremely little about early mental conditions.

17,293. I notice you develop that point in your *précis*, that if the incipient stages of mental disease were treated in clinics in association with hospitals, the student would come to regard mental disease as just one of the ordinary diseases to which human flesh is heir, and would have opportunities of seeing mental disease at least in its incipient stages in a way which he does not at present?—Yes, and more than that of course, he does not realise as a student that a very large proportion of the work he is going to do afterwards is going to deal with the early stages of mental disease.

17,294. Then looking at it in the broadest form you deprecate the dividing line that has been drawn in the past between mental disease and all other diseases?—That is a very strong point with us.

17,295. You desire to obliterate that line as far as can possibly be done?—Yes.

17,296. Of course we have had borne in upon us throughout our deliberations the difficulty that there is a feature of mental disease which differentiates it from every other form of disease—I mean the aberrations of conduct to which it leads, the necessity for restraining liberty. That is a feature special to mental disease which really seems to be the origin of all the difficulties that have arisen in the past with regard to its treatment. Now you do not contemplate, do you, that in those clinics in association with general hospitals you would have cases treated which would require restraint?—Not for any period of time; they could not be kept in clinics of that kind, certainly; but, of course, in all general hospitals there are patients at any time who are affected mentally and have to be restrained to a certain extent.

17,297. Just as a concomitant of their physical ailments?—Yes.

17,298. The moment we get into the region of detention and restraint and compulsion then, of course, we come in contact with the difficulty of reconciling the medical and legal aspects of the case?—Yes.

17,299. One of your suggestions which is novel to us is the suggestion that all nursing homes should be under supervision?—Yes.

17,300. By that do you contemplate that every form of nursing home, all the nursing homes that are conducted in large towns at the present moment, should all be under some form of supervision?—Yes.

17,301. Do you think that view would be welcomed?—I will not say it would generally be welcomed.

17,302. *Earl Russell*: Not by the nursing homes?—Not altogether by the nursing homes.

17,303. *Sir David Drummond*: Do you think it is practicable?—I think so. We have mentioned the kind of supervision.

17,304. *Chairman*: It would involve notification, would it not, and it would involve inspection?—Yes; we refer to that in our memorandum. As regards the question of inspection, it does not necessarily mean a close inspection of patients so much as a medical inspection of the institution.

17,305. What is the idea at the back of your minds in that recommendation—is it this, that you want to obliterate the distinction between places where people are resident for mental treatment and places where people are being treated for ordinary diseases? Is that the idea at the back of your minds, to obliterate the distinction, or is it rather this, that you want to enable a larger number of places to be available for the treatment of mental disease, nursing homes of the ordinary type?—It really falls into line with what we say about the general hospitals, that is to say, where one kind of disease can be treated another can be treated under much the same conditions.

17,306. It is very undesirable you know to create unnecessary machinery. The present civilisation is almost encumbered with machinery of one kind or another, and one is not predisposed favourably to the creation of more machinery and additional forms; because we have heard a good deal about the number of forms which at present attend the treatment of mental disease. You surely would not suggest that the ordinary nursing home in which most of us have spent periods of retirement for one form of operation or another should be subject to inspection and report, do you?—I think we do. I mean that they should be registered, and that they should be open to inspection by some form of central authority.

17,307. *Earl Russell*: Have you thought of the difficulty of defining a nursing home in legal terms that would enable you to prosecute one that had not registered?—No, I have not.

Chairman: One has to think of these things when you come to make practical recommendations. One would require to set up a code under which, as *Earl Russell* points out, a nursing home would be a defined institution; then one would require to provide for the inspection of it, notification, and so on, and one would require to put penalties upon those who did not comply with the law. That is introducing a very large new feature into medical treatment which I should doubt very much that your profession would welcome as a whole.

Earl Russell: I rather want to put it to you, if you think it out as a matter of definition, may not a place get almost imperceptibly changed from a nursing home to a hydropathic establishment—how are you going to draw the line?

17,308. *Chairman*: Legal definitions are always very troublesome things?—I admit that aspect of the thing has not been considered in detail by those who have drawn up the memorandum.

17,309. What one is thinking of is whether any really useful purpose would be served by it; you do not want to embarrass life with formalities unless they serve some useful purpose. I am trying to get at the justification for new machinery. As far as I can see, the justification that is implied is that there should be no distinction between the nursing home where the mental case is treated and the nursing home for ordinary physical disease. Therefore you would assimilate the ordinary nursing homes to that in order to eliminate the distinction?—Partly that. I think most of us would agree that some kind of registration and supervision of nursing homes is rather desirable, I mean the standard of nursing homes; there are good ones, and there are lots of bad ones.

17,310. *Earl Russell*: Would it not be better achieved by some form of official recognition of them by some medical body than by legislation?—It is rather invidious for a medical body to do that, is it not?

17,311. *Chairman*: It rather looks as if you were going to encumber the ordinary nursing home with formalities, not because it requires the supervision, but merely because you want to put it upon the same platform as the mental nursing home. Intrinsically the ordinary nursing home will not require this supervision; in fact, it is outside the scope of our inquiry altogether, and we are a little at a loss to see why in your view the ordinary nursing home should be assimilated to the mental nursing home, when the conditions are really different. It would seem to be inventing new machinery in order to obviate any stigma that attaches to the mental home, because of its supervision, in contradistinction to the ordinary nursing home. I do not know whether I have really got the idea at the back of your mind. It struck me at once as a novel suggestion?—On the other hand, it would be difficult to enlarge the liberty with which mental cases are treated in nursing homes. We submit it might be difficult to do it unless all nursing homes came in the same category.

22 May, 1925.]

Dr. E. FARQUHAR BUZZARD, M.D., F.R.C.P.,
Dr. H. CRICHTON MILLER, M.D., and Dr. R. WORTH, O.B.E., M.B.

[Continued.]

17,312. Yes, unless we have an extension of the licensed house system. At the present moment there are places where under licence treatment can be given. We have heard some evidence to the effect that there is not sufficient accommodation in these places, and they are not properly distributed throughout the country. If machinery were devised for the provision of nursing homes, certified nursing homes throughout the country, would not that meet your view?—Our difficulty would be the same as regards the patient, that those homes would be marked down as mental homes, whereas there are a number of patients we would like to see treated in their early stages in homes which are not marked in that way.

17,313. Then, of course, you get into that difficulty of the border line, that the unhappy practitioner does not know whether he is breaking the law or not, and you want some machinery devised to enable cases to be treated by the doctor without the fear of an infringement of the law.

17,314. *Earl Russell*: You could do that by individual sanctions from the Board of Control for a particular patient, that he should be treated in a particular place?—Yes, that does mean notification of the particular patient.

17,315. It does, of course, but the patient need not know of it, need he?—It is difficult to get out of it.

17,316. *Chairman*: I think one of the drawbacks of your suggestion would be that it would tend to institutionalise (if I may use the word) the nursing home. The attraction to many people at the present moment of the nursing home is this, that it is a place where you are not in an institution at all; you have merely gone there for treatment because it is more convenient than to be treated at your own house, and you are not "Case number so-and-so" reported on such-and-such a form. You are merely having treatment from your own doctor in his own home. Would it be desirable to convert a nursing home into an institution with all that that means, which is repugnant to many people, you know?—We rather want to get facilities for a patient suffering from a mental disorder to have what the other patients have, that is to say, the feeling that he is going to a nursing home and not necessarily to a mental institution.

17,317. *Earl Russell*: May I put it the other way round: What is it that you find would be lacking if you did not register nursing homes—what would your difficulty be if they were not registered?—We rather took it that there would be certain difficulty from authorities in the way of our treating such cases in nursing homes unless they were registered.

17,318. *Chairman*: Because they might be cases which were certifiable?—Quite.

17,319. And therefore there might be an infringement of the law in treating the cases in such homes?—Yes.

17,320. That is a problem which confronts the medical profession at the moment, that you are never quite sure whether you are or are not within the law?—That is so.

17,321. But I am not sure that the solution is to be found in extending supervision or registration to all nursing homes, or whether the remedy might not be sought in some other direction.

17,322. *Earl Russell*: Would it be a solution to give wider discretionary powers to the Board of Control so that they did not feel bound to take action in certain cases?—I would like Dr. Worth to answer that question because he is more conversant with the powers of the Board of Control than I am.

17,323. *Chairman*: What is your view, Dr. Worth? You see the nature of the problem we are discussing at the moment; have you any view upon it?—(*Dr. Worth*): Yes; it depends. If a person loses volition I am of opinion that he should certainly

be notified. The Board of Control should be made aware of where that person is, whether he be in a nursing home or elsewhere; but as to the voluntary case who goes in voluntarily for treatment, whether he goes into a public institution or a nursing home, I think there is no necessity really for that case to be notified; but if any case requires at any time to be kept under lock and key day or night, that case should, in my opinion, be notified.

17,324. I appreciate that. You say the voluntary patient ought to be able to get treatment just for his mental disease, as any other patient is entitled to get treatment. But then you come across a difficulty there at once which is very present to our minds, and that is this: Who is going to define a voluntary patient? I have always felt the pressure of that problem very acutely. A person may be represented as voluntary, but the very nature of his ailment is such as to affect his volition, or it may affect his volition to some extent. It is doubtful whether in law the volition of a person who is suffering from mental disease can be treated as the full volition of an ordinary citizen, capable of estimating what he is doing and appreciating the situation. Who is to be the judge of whether the person is voluntary or involuntary?—I should say the doctor in charge of the case, whether it is a practitioner taking a case in a home, or a specialist called in to see that case. It appears to me that if any restraint against a man's liberty has to be thought of, that is if he is not an absolute free lance to come and go as he likes, or, if he is in a nursing home and takes objection to anything and says, "I am going to leave this"—if there is any restraint put upon him then I think notification is necessary, if it is for his good and the general public's good that he should be restrained.

17,325. But people do not unfortunately classify themselves with that precision which would be convenient, and you may have a person as to whom it may be doubtful whether he is a voluntary patient or not; he may have a certain glimmer of volition still, but his estimation and appreciation of the surroundings is a very difficult thing. He might have only a trace of volition and be very easily overborne by persuasion or pressure which would be resisted by persons in full possession of their volitional powers?—I think if a patient is fit to follow out instructions, that is, if a patient is asked to stay in bed and stays in bed, if he submits to treatment and does not resist it, whether his volition in other ways may be defective, he can be treated, we will say, in a nursing home.

17,326. We have had some instances of cases where a voluntary patient so called has found himself or herself really overborne by the pressure of the institution and really becoming an involuntary inmate, although professing to be a voluntary one. I can conceive that case, Dr. Worth?—Yes. I think when that stage has come that case should be notified as a case for certification.

17,327. *Earl Russell*: That is why I suggested you should give a very wide discretion to the Board of Control, because, after all, the thing depends upon the honesty and conscience and capacity of a doctor in the last resort. You have to provide for the exceptional cases where that may not be so?—Yes. Somebody would have to be in authority and to give an opinion.

17,328. *Chairman*: Of course the whole difficulty of the treatment of mental diseases would disappear if the British public absolutely trusted your profession. That, of course, is a thing which neither we lawyers, nor the doctors, nor any other profession is entitled to have—an absolute discretion. The law will not allow any of us to have that, therefore safeguards are required; but it is true that if you had an absolutely perfect medical profession, animated by the most perfect motives and consideration, there would be no need for Lunacy law at all. We have to assume the worst while hoping for the best?—If

22 May, 1925.]

Dr. E. FARQUHAR BUZZARD, M.D., F.R.C.P.,
Dr. H. CRICHTON MILLER, M.D., and Dr. R. WORTH, O.B.E., M.B.

[Continued.]

you were to take our police duties away, that is the power of detention, it would be a very great advantage, in my opinion, in the treatment of cases of insanity, if they would accept our therapeutic measures.

17,329. But again can you depend entirely upon your profession. Police duties can only be taken away if you have someone else in the position to judge whether the patient requires detention or not. Now we have to rely upon your profession to judge whether the case is one requiring, in its own interests, the protection of what you call police duties. So that again we come back to the medical man at the end of the day who is the key of the situation.

17,330. *Earl Russell*: You have to tell us whether the patient requires to be restrained or not?—Yes, we would have to tell you certainly, but generally the cases are so evident that I am certain that the mentality of lawyers would be quite sufficient to decide.

17,331. *Chairman*: Of course, out of the 130,000 certified cases in this country I have no doubt the great bulk are perfectly easily diagnosed—even a layman could diagnose them; but the public anxiety centres much more round the very small number of cases, borderland cases and so on; and all the instances of abuse that have arisen have always arisen round that type of case. The system works well enough on the whole, but every here and there you may have a case arising where something goes wrong. The whole purpose of the law is to prevent these things arising, or to provide the most adequate safeguards against their arising. That is really our task—to consider whether the safeguards are adequate or not?—Take persons in all spheres of life, we cannot all be perfect.

17,332. No, but we can see that you are as perfect as you can be made by the law.—If there are abuses, I think they are bound to occur whatever happens, but in cases of abuse there is sufficient punishment weighed out to be a deterrent to similar abuse.

17,333. But it is not really a question of punishment, it is a question of the perfect system. I have used the analogy more than once of the railway system. A railway system occasionally breaks down; you have an accident, but no one is going to say that the railway system is bad in itself. But when you have an accident you learn from that what new precautions to take, and safeguards are introduced by the Government, all kinds of safeguards with regard to travelling, which are the product of experience. What I think is one of our chief concerns is to see whether, learning from experience in the past, with the assistance of gentlemen like yourselves, we can devise further safeguards to satisfy the public mind that the administration is safeguarded in the public interests as far as possible. That is really our prime concern as you will appreciate. Perhaps we need not explore the nursing home topic further, we have your mind upon that. There is one other subject you touch on in your *précis* upon which I think you might give us your views, and that is the question of the medical superintendent and his duties at the present day. I know I am touching upon something that is rather controversial, and we have had different views upon it. Has your Council any view as to the delimitation of the duties of medical superintendents?—I do not think the matter has been discussed, but I am a medical superintendent myself, and, of course, one has thought a great deal about the question of the duties of a medical superintendent. I have had personal experience of a medical superintendent, who has had as a colleague a director who managed the institution. Well, they never spoke, they were not on speaking terms. The duties to my mind are so difficult to arrange that there must be one head, and I think that head must be a medical man. If you like to call that man a medical director and make it a special appointment well and good, but I do think that you must have a medical man at the

head of an institution like a mental hospital. There are so many details, so many small things about which two heads would come into controversy. In these days I think that a medical superintendent has to have a knowledge of the ordinary administration. He has to have a knowledge of, we will say, some farm work, and so on, but that is his recreation more or less.

17,334. It may be his distraction as well as his recreation—that is the trouble. It depends upon the man, does it not?—Yes, it depends upon the man. There are men who make very good medical superintendents and men who do not make good superintendents, but I think there must be one at the head of these institutions.

17,335. Is that because in the treatment of mental disease the whole regime of the life of the patient is really part of the treatment?—It is so.

17,336. That is a differentia from ordinary medical treatment, is it not?—Yes; occupation enters so largely into the treatment in a large mental hospital, and, of course, occupation is medical treatment.

17,337. Not only that, but I mean the whole outlook of the establishment and the method in which it is run may itself be therapeutic, I suppose?—Yes.

17,338. Even such a matter as the colour of the wall paper may have a therapeutic effect?—Yes, very frequently, some people say.

17,339. That of course is a difference between the treatment of mental disease and the treatment of ordinary disease, that the treatment itself consists in the regulation of the life in an institution which is all directed to conduct?—Yes. Of course in the life in the mental hospital and in dealing with the mind personality counts a tremendous amount. Patients will take to some men where they will not take to others; they will do things for one that they will not do for others, and they are dependent on some people.

17,340. I am afraid it comes to this ultimately that some people can delegate and some people cannot?—I think that is so.

17,341. And one man may be diverted from his proper function as a medical superintendent with the emphasis on the medical, and vice versa?—That is right.

17,342. You suggest what may be a mitigation of that difficulty in two ways—you are anxious to preserve the contact between the patient and the general practitioner?—Yes.

17,343. You do not wish the family doctor to part company with his patient merely because his patient goes into a mental hospital?—No—that is what we advocate.

17,344. And secondly you wish closer association between mental hospitals and teaching institutions and universities and the resort to consultants?—Yes. Of course the work in mental hospitals has advanced enormously within recent years. There are very few hospitals where consultants are not called in. In my own hospital of course we are very fortunate in being so near London, but we have a specialist for everything.

17,345. One is familiar with the arrangements in an ordinary hospital in a town—you have a resident staff, that is to say, of young men who have recently graduated and are resident on the premises, and you have the various wards which are in charge of senior medical men, surgical and medical sides, and you have in addition generally very eminent consultants who are called in in difficult cases—that seems to be the sort of general equipment?—Yes.

17,346. Now you would desire in the case of mental hospitals to have something analogous to that; you would have a resident assistant doctor who is in immediate contact with the cases; then you would have the medical superintendent at the top of that branch of it?—Yes.

17,347. Then you would have the consultant called in, probably a professor of the University, or an eminent alienist called in to assist in the diagnosis of difficult cases?—Yes.

22 May, 1925.]

Dr. E. FARQUHAR BUZZARD, M.D., F.R.C.P.,
Dr. H. CRICHTON MILLER, M.D., and Dr. R. WORTH, O.B.E., M.B.

[Continued.]

17,348. *Sir David Drummond*: Are you aware that throughout the country the consultant is almost never called in; the consulting surgeon and consulting physician is there simply in name? There is not one case in a dozen in a hospital where a consultant ever sees the patient?—I am quite aware of that. Of course, in my own hospital, we pay consultants a retaining fee. If that is done it is the duty of the consultant to pay his periodical visits. Now, for instance, the surgeon attached to my own hospital attends once or twice a week in the mornings to see any new cases or any case that is required, irrespective of whether he has been sent for. The dentist and the optician attend on certain days of the week.

17,349. Then you propose that the consultant should be a paid officer?—I am afraid he must be, because these are rate-aided institutions, and we cannot expect a man to do the work voluntarily.

17,350. *Chairman*: I think what Sir David has in mind are the ornamental names that one sees not infrequently in association with hospitals, which are really there because of the consultants' prestige or because they have been actually in charge of the wards in the past, and they keep that up, and it is thought pleasant to continue their association with the institution. That is not the kind of person you have in mind?—No.

17,351. *Sir David Drummond*: You would have to put them on a different footing altogether?—Yes.

17,352. *Mr. Micklem*: Would it be possible to arrange this in an ordinary asylum in the country which is frequently a very considerable distance from any hospital or any university?—My own personal experience is that the young surgeon not attached to a hospital is only too pleased to come out and see patients wherever they be, the young keen man. We cannot expect the fully-fledged senior surgeon to a hospital to come on to our staff, but it is the junior men we want who really come and see things which they have not seen before, many of them.

17,353. You spoke of collaboration between the patient's own medical attendant and the hospital, but would that be possible in the large majority of cases, the pauper cases?—No, I do not think so, because first of all the mental hospitals are generally removed some considerable distance away from where that practitioner lives, and, secondly, of course he is a busy man; and, thirdly, I suppose really in many instances he does not take much further interest in the case. He has certified a certain case, but except if he in a village he may know nothing of a case before that; probably he has never met the man before.

17,354. *Earl Russell*: He is not really what we mean by "the usual medical attendant"?—No, he is not, and of course in rate-aided institutions there are very few of that type.

17,355. *Chairman*: Of course, Mr. Micklem's point applies generally to the suggestion that you are bringing out. You suggest it is desirable to maintain and continue the contact between the patient's own doctor after the patient has been received into an institution, but if you are removing the patient to an institution fifty or sixty miles away from his home you can hardly expect a busy general practitioner to follow it up—it is not possible?—No.

17,356. *Mr. Micklem*: And the ordinary rate-aided case has no regular medical attendant?—I think that is so—the majority of them.

17,357. *Sir David Drummond*: What is the object of continuing the association of the doctor with the patient? He would not be allowed to have any say in the treatment of the patient?—No. I think it was more or less a safeguard. The original intention was that the private practitioner should see that that man was not detained unnecessarily.

17,358. That would depend entirely upon the superintendent?—I think it was an extra safeguard.

17,359. *Chairman*: Another critic?—Another critic, yes,

17,360. *Earl Russell*: In a case where the private practitioner was the person employed by the petitioner who wanted to keep the patient in, it would hardly be an added safeguard, would it?—No, it would not, but we send a notification; if a patient has a practitioner we send a notification to say that he is there and he can come and see him when he likes; but I must say it has been taken very little advantage of.

Earl Russell: I think it is desirable that if he wishes to see his patient he should be allowed to see him freely; that is a different thing.

17,361. *Chairman*: Indeed there is machinery existing for a visit by an outside doctor to patients in an institution, and that is eminently desirable, obviously?—Yes.

17,362. But I think it would be very difficult to get the ordinary panel doctor to make a round of institutions, possibly 50 or 100 miles away in order to see his patients. As Sir David brings out, what would he do when he got there? He might look at the patient and say "I think perhaps he might not be a fit subject for detention," and then he sees the medical superintendent who persuades him that he is, and then he goes away home again.

Earl Russell: And there are cases where he would not know the private family history as a private practitioner would.

17,363. *Chairman*: I appreciate that. You wish to preserve as many points of contact between the patient in the institution and the outside world, as possible. That of course is a very desirable thing, to make him feel that he is not segregated from the rest of the world—that is the root idea?—Yes.

17,364. Now I am much impressed, and I am sure the rest of the Commission are also, with some very interesting statistics you give showing the extent to which incipient mental disease exists in this country as exemplified in criminal statistics, statistics of suicide, and so on. These are very instructive figures for which we are much indebted to you. These are adduced, I take it, for the purpose of showing the desirability of getting at these cases at an early stage?—Yes.

17,365. The trouble seems to be now that a person must, first of all, have the disease in a pronounced and established condition before he can get the benefit of treatment?—Yes.

17,366. Now you want in common with the general development of medical science to go in for prevention rather than cure?—Yes.

17,367. You wish to get at the case at its earliest stage?—Yes.

17,368. And the fact that these cases, through the aberrations of their conduct, come in contact with the criminal law in various ways is used by you to illustrate the fact that these people are abnormal persons, who ought to have been in medical hands before they reached the hands of the law?—Yes, that is our point.

17,369. Now developing that, the practical suggestion you have to make, which is in line with the other suggestions we have received, is that facilities should be provided for the early treatment of mental disease?—Yes.

17,370. People should be encouraged when they feel mentally unstable to go to a clinic or an out-patient department, just as they do when they have any other form of ailment?—Yes.

17,371. And receive advice and medicine possibly, and in that way escape the consequences which are illustrated by your statistics?—Yes.

17,372. Now in that matter I gather that your Council is in favour of the dissociation of the institutions for early treatment from the mental hospital, on the one hand, and the general hospital on the other. I am not speaking merely of the out-patient clinics in association with general hospitals, but the provision of places where mental disease could be treated short of certification?—Yes,

22 May, 1925.]

Dr. E. FARQUHAR BUZZARD, M.D., F.R.C.P.,
Dr. H. CRICHTON MILLER, M.D., and Dr. R. WORTH, O.B.E., M.B.

[Continued.]

17,373. Then you contemplate really the establishment of intermediate institutions?—That is rather a difficulty, because in my own county, which is Middlesex, both the mental hospitals are out of the county, and it is proposed to build a third, also out of the county. You want, it seems to me, to attack these cases at their own homes, and to give them facilities for attending a hospital somewhere in their own neighbourhood; and the Committee of the County Council with whom I have dealings are very concerned as to what is best to be done. At Wandsworth we are thinking of building an acute hospital for voluntary boarders, separate entirely from the institution, a very up-to-date place where students and so on can be taught; but we cannot expect the ordinary out-patient to come right from, we will say, Staines to Wandsworth for consultation, and it would seem that to attract that person you would want some local clinic with a few beds to deal with such cases.

17,374. Now may we envisage the situation practically and at large. You have the case of incipient mental disease, let us say, a person at home developing abnormal symptoms. Some mischief is at work; the doctor appreciates there is something wrong; it is not a certifiable case at all. That case, I take it, would be advised by you to go to the general hospital, and would receive there advice and treatment in an out-patient clinic, in the first instance?—Yes.

17,375. The doctor in attendance there would ordinarily be the resident doctor, with a visiting doctor present also, no doubt, and might diagnose that the case was on the road to become a serious one?—Yes.

17,376. And that it was desirable that the case should leave the home surroundings at once?—Yes.

17,377. That might be the result of the diagnosis?—Yes.

17,378. Then would you contemplate that case becoming an in-patient in the general hospital, or being relegated to some institution on the lines, for example, of the special tuberculosis departments which we have in most of our cities? You see, you do not want him to go to the mental hospital right away; he is not fit for that stage, and may never reach that stage if you are able to arrest the progress of the disease. Where would you send that case to?—I have had practical experience in this matter.

17,379. That is the very thing we want to get your help upon?—At Ealing attached to the hospital I have an out-patient department; it is rather more than a cottage hospital. Patients come there for consultation. If I had 20 beds attached there I could do quite a lot of good work, but it would have to be a separate building, in my opinion.

17,380. Why is that—is that because the conduct of the patients may be disturbing to the others?—Yes, and I think that the idea of mental patients being admitted into that hospital would rather tend to upset the other patients.

17,381. Do you contemplate that the mental hospital, which is at the end of the system, so to speak, is really to contain only those cases which are established cases of lunacy, cases as to which there is comparatively little hope from the treatment?—No, just the contrary; I cannot help but say that the mental hospital is for a mental case, and where there is any prolonged treatment, then I think that case should go to the mental hospital.

17,382. Right away?—Straight away.

17,383. Some view has been put before us to this effect that the mental hospital is really the last resort—I am not sure that that is a sound view?—That would be an absolutely fatal thing to do, because people would be under the impression that that was the last resort, and that they were finished.

17,384. It would be as depressing as the title given to some places—"Hospital for Incurables," for

instance, which has always struck me as a most depressing name to put above the door of any institution?—Of course one must recognise that hospitals themselves have a high percentage of cures, and that cases are bad before they come to them.

17,385. Consider the classification of the cases for the different forms of treatment. I can envisage the out-patient department where the patient visits and gets advice; and I can envisage a place where patients are temporarily resident, they become in-patients for observation and treatment. Then I can envisage a mental hospital which is the normal place for the treatment of mental disease in all its stages, and curable cases as well as incurable cases. But the difficulty is to get your cases sorted out so that each would be relegated to its appropriate department. At each stage you will have to have a judgment passed upon the case?—Yes; I do not anticipate a great deal of difficulty in that. If you have a small ward attached to a hospital, if the case is going to be there for some time—that is a week or two, it must be moved on to a mental hospital. If it is, as so frequently happens, a mother at the change of life who is worried at home with lots of little children and lots of troubles at home, a little rest of a week or two is all that that woman requires, a little explanation of her symptoms puts her right.

17,386. *Earl Russell*: Rest her body and ease her mind?—Yes, but you just want to take that case out of its environment—

17,387. *Chairman*: And restore its balance?—Restore its balance.

17,388. But some of the cases, of course, are from their inception violent cases; I mean you may have an acute case of mania supervening with more or less suddenness. That case would not be appropriate for the out-patient department, but would go straight to the mental hospital?—Yes, under the provisional order.

17,389. *Sir David Drummond*: A case might recover in a fortnight—do you mean that should go to a mental hospital?—I think the mental hospital is the place for it.

Sir David Drummond: We have heard different views on that point.

17,390. *Chairman*: It has been suggested that in an acute case requiring detention at once, but nevertheless a highly recoverable case, as many of the acute cases are, it is unfortunate that the patient should have to enter the portals of a mental hospital as a certified case and for ever afterwards be known as having been certified?—We do not contemplate certification; we contemplate provisional detention for three or four days in a mental hospital.

17,391. They would not be voluntary cases, and therefore they are cases with regard to which the law would require some form of safeguard, because detention is going to be applied to them?—We suggest that that period of three days should be extended to 28 days by a justice, and if the case recovered in that time so much the better, or if the case at the end of 28 days had enough volition to decide for himself whether he would stay or not—

17,392. But you do not contemplate that class of case going to an intermediate institution short of a mental hospital?—You want a complete little mental hospital to deal with it; you want the equipment and the staff and everything.

17,393. Take the acute case, possibly recoverable, possibly not—your view is that that case should at once go to the mental hospital but under some form of provisional restraint, which would enable the case to recover short of full certification?—Yes.

17,394. Take the other case, the true incipient case, or the mild case; that class of case you contemplate should go to your outdoor clinics in association with the general hospital, that there should be a department of the general hospital dealing with these cases, giving advice and assistance, and so on, and provisionally diagnosing them. If the case were found to

22 May, 1925.]

Dr. E. FARQUHAR BUZZARD, M.D., F.R.C.P.,
Dr. H. CRICHTON MILLER, M.D., and Dr. R. WORTH, O.B.E., M.B.

[Continued.]

be one where it was necessary to remove the patient from the home environment you would wish in the general hospital, or in association with a general hospital, to have means of treating that case?—Yes.

17,395. This is not an emergency case, not a violent case, and possibly not a certifiable case?—Yes.

17,396. Which can be treated really more on medical lines without any legal flavour about it at all?—Yes.

17,397. Now would that place for in-patient treatment be a ward of the general hospital, or would it have to be a separate institution?—I should say it would have to be separate from the hospital proper.

17,398. Why is that—because there again you get the differentiation which one is rather anxious to obliterate?—First of all, I think, you would have to have some special nursing to look after that kind of case.

17,399. But you have in each ward of a hospital special nurses; you have the surgical nurses on one side and medical nurses on the other; they move about no doubt between the departments, but you have special surgical nurses?—Yes. Of course this is a very big question. I do not think you can in the ordinary way treat a mental case in a general hospital ward. There are very few that you can treat in a general hospital ward, the rather depressing surroundings of many hospitals are not conducive to the happiness of a mental case. In my opinion you would have to build a bright little sort of annexe to your hospital where these cases could be treated.

17,400. *Sir David Drummond*: Much brighter than the average mental hospital?—(*Dr. Farquhar Buzzard*): I am afraid I should not associate myself with that view. I think these cases could be treated in a ward of a general hospital.

17,401. *Mr. Micklem*: Has not the experiment been tried in Scotland with great success?—In special wards. I think if we start the special building we shall be doing exactly what we do not want to do, that is, emphasise the difference.

Earl Russell: It seems contrary to the basic principle of your Society.

17,402. *Chairman*: The obliteration of the distinction?—Yes. Dr. Miller has himself personal experience of treating the kind of case we are talking about in his own institution.

17,403. *Chairman*: Perhaps Dr. Miller might take up the story and let us have his views?—(*Dr. Miller*): I think it would clarify our ideas a little bit if we focussed them on one single case. When we talk of early mental derangement we are apt to be talking of cases, a group of cases that may require completely and utterly different treatment, and we really get no where. I think that if we focus our attention for a moment on the potential suicide which we have referred to, and you have seen the figures about it in our evidence, you will be able to realise the situation that exists at present. As far as the potential suicide goes he may need just the same sort of treatment Dr. Farquhar Buzzard has described attached to an ordinary hospital. He may need psycho-therapeutic treatment which may in some cases save him; but the fact that really matters is that in many if not most cases he needs a change of environment. I use that word on purpose to avoid saying either hospital, or mental hospital, or anything else—change of environment. The moment the change of environment is undertaken, instantly the doctor who has been treating him assumes very grave legal responsibility, and it is on that that the whole situation really turns, at least in regard to the potential suicide. It is that, I think, which reveals the anomalous position of the Board of Control, the statutory position of the Board of Control at the present time. You see Dr. Farquhar Buzzard may save a man from committing suicide by giving him suitable medical remedies at St. Thomas's out-patient department, very likely.

There may be others that having obviously announced their intention of committing suicide must necessarily be protected from themselves by being handed over to Dr. Worth. On the other hand there are a large number who do not give us any obvious indications of their intentions of that kind, and the physician who sees them may have the profoundest doubts as to their intentions, but he knows if he takes them into a nursing home, whether that nursing home be registered or unregistered matters not at all, he is instantly assuming a tremendous responsibility. He is playing a game in which his success counts for nothing—his failure counts for everything. If he cures his patient, nobody hears about it and he gets no kudos or anything like that. If the patient happens to commit suicide while he is under his care he is proved to be wrong, and the Board of Control then proceeds to apply legal criteria to a matter of opinion. It is all very well to say that if the doctor has acted in good faith he is immune. That is not so manifestly. The doctor if he commits a sufficient series of blunders pays for it obviously, he is prosecuted. In other words, as far as I know, not being a lawyer, it is always the endeavour of the Legislature to avoid applying legal and objective criteria to matters of opinion, and the position of the unfortunate doctor with regard to the Board of Control is that his opinion may ultimately, in this particular case I am discussing, be subjected to legal criteria *post facto*. Now I maintain that as long as that situation exists there is no good in our thinking of really encouraging any sort of institution such as Dr. Worth has been referring to, the nice little special ward attached to the hospital, and so on, because the doctor is always going to bear a perfectly unfair burden of responsibility in connection with any case that he may feel is suicidal. Now it is a very very serious thing, and I am sure that there can be no real progress in that department until what Lord Russell referred to, wider discretionary powers, have been granted to the Board of Control; until the Board of Control has emerged from the present state in which, to the horror of the medical profession, it was found that non-technical opinion could condemn a member of the Board for holding a certain opinion. We have got to get a little beyond that, to a point at which the Board of Control has statutory consultative powers, and then I think something will move. But otherwise I do not see that with regard to any early case of mental disorder requiring environmental, institutional nursing-home treatment, short of actual certification, there is going to be real progress in the treatment of that case. If I do see a case such as that, about which I have some slight doubts in my consulting room, I am frequently faced with the alternatives. I certainly do not want to take that man into my nursing home; I would like him to go into somebody else's nursing home.

17,404. *Earl Russell*: You mean the doctor now has to stake his career practically upon his treatment being right?—Certainly.

17,405. Of course, even a coroner is not quite non-technical; it is better than a mere Law Court in a sense?—Yes.

17,406. *Chairman*: Of course, has not every professional man to run risks of that sort? Take even an engineer. He perils his reputation on the stability of the bridge which he designs. If the Forth Bridge collapses, he may not be prosecuted, but at the same time his career is ruined, because he has pledged himself to an opinion and he thereby proffers his opinion as something upon which the public may rely. Every professional man has in a sense to warrant his opinion. That is the privilege of a profession, if I may say so, as distinguished from a trade; that we do take responsibilities in our profession. One may, as a lawyer, give advice which may mean the loss possibly of millions to one's clients

22 May, 1925.]

Dr. E. FARQUHAR BUZZARD, M.D., F.R.C.P.,
Dr. H. CRICHTON MILLER, M.D., and Dr. R. WORTH, O.B.E., M.B.

[Continued.]

or the gain of millions to one's clients. Similarly, the doctor in matters of health, which are perhaps even more cogent than legal matters but still are comparable in that respect, pledges his opinion for what it is worth. Is not that an incident of all professional men?—No. A surgeon advises an operation wrongly, the *post facto* proves his opinion was incorrect, and he loses a certain amount of prestige and a certain amount of prosperity, but he is not put in the dock.

17,406A. Then it is the criminal factor in the situation that you are apprehensive of?—Yes. A man who makes a mistake of opinion in connection with this particular type of case; and I repeat again when there are 5,500 suicides (successful or unsuccessful) per annum, it is a case worth discussing.

17,407. Certainly?—The man who handles that case and is proved *post facto* to have made an error of judgment is prosecuted, roughly speaking, approximately—not every time.

17,408. *Sir David Drummond*: As a matter of fact, does that occur—I am not familiar with these prosecutions you are referring to?—Yes, there are prosecutions on record.

17,409. *Earl Russell*: Surely much fewer than the mistakes which have been made?—Yes, fortunately.

17,410. *Chairman*: What kind of prosecutions are you contemplating? I can conceive a prosecution for giving an opinion which had been given recklessly. The Lunacy Act is full of penal provisions, but I am not sure that I have in mind the particular one you are contemplating. Supposing a doctor has a patient: somebody comes to your consulting room, and you have doubts as to whether it is a suicidal case or not. You say: "I think this is a case where I may risk it," and the patient leaves your consulting room and goes and throws himself in front of the first express train. You would not be subject to prosecution?—No.

17,411. You may not even have made an error of judgment. The jury might find that you had come to a perfectly sound opinion, but in point of fact the event disproves it. But what are you contemplating as the risk now?—Because if I make up my mind that that is a man who must at once be given rest and put in a nursing home—

17,412. An uncertified patient is what we are thinking of?—Exactly, the uncertified patient is harboured. Even supposing I send him to an ordinary nursing home where I know the matron, she after all depends upon my judgment, and if a man commits suicide in her nursing home, she is prosecuted, and of course I am brought into it.

17,413. *Earl Russell*: So that to play for safety you would certify them fully?—Yes, that is exactly my point.

17,414. *Chairman*: May not we link up what you are telling us with what Dr. Worth and what Dr. Buzzard have been saying? Would it not be to you considerable consolation if you were able to say "I am not quite sure about this case; I should like to have it under protective observation for a period, so that I may visit the case and make up my mind on better data"? Or if there were a place to which you could recommend that patient to go, and where under proper safeguards reasonable precaution could be taken, would not that largely meet your case? Then there comes in Dr. Worth's suggestion, that there might be, in association with hospitals, wards to which you could send such a patient where without certification—(the case might not be ready for certification)—observation might be secured, and the case might possibly recover. Or it might become a pronounced case, in which event you would certify and the patient would go to the mental hospital for the better and more prolonged treatment required?—Entirely, provided somebody else takes the responsibility. We rather contemplate that this ward of a general hospital would be a place which would be

protected legally; it would be an institution which would be under some statutory warrant so that there could be no prosecution if there were a general observance of the law. The medical superintendent at the present moment, as you know, is not prosecuted, although he has cases as to which there is a doubt whether they are legally detained or not.

17,415. *Earl Russell*: And he has cases of people he lets out on trial—he has to take that risk?—Yes.

17,416. *Chairman*: But you must have a large experience of the class of case that would not go to a general hospital at all. Let us take the ordinary professional classes, and people who have reasonable means to have themselves treated; at the moment, that class of case in your hands, as to which you are apprehensive, must either be sent home with the risks attendant upon that, or sent to the nursing home with the possible risk that you may be detaining a person without legal warrant. I think there we may be able to meet your view by some provision for that class of case. It is an obvious case that must be met in some way or other, and if certain legal protection were given by way of provisional protection for nursing homes where such incipient cases were treated, (private cases yours would be, and Dr. Worth's would be the rate-aided cases probably) that would meet your difficulty, would it not?—Entirely.

17,417. It is along those lines I think that progress must be made. It is perfectly obvious that in a great many cases the best thing to do is to get the case out of its environment. As you say in your *précis*, the presence of a case in a home may permeate the whole atmosphere of the home and produce other cases. You want, therefore, in the interests of the patient and the patient's family, to get the patient away into a new environment, and get him to take a new outlook on life again, and to have the necessary treatment and rest. If you could have any institution which was, so to speak, a half-way place, a place for observation and treatment under precautions but short of certification, that would meet your view, would it not?—Yes, provided that the combination of restraint and ostensible freedom could be achieved, which is always the difficulty. That is to say, that if the patient knows beforehand that there is the possibility of restraint within that place, he is probably not going to go to it. At the same time you want the possibility of restraint in case of need, and you also want to feel that you are not landing yourself with grave responsibilities.—(*Dr. Buzzard*): I think behind that, what we all want to aim at is not to stamp the patient. Would not Dr. Miller for example, finding such a case in his consulting room, give a certificate regarding that case which would not be an ordinary medical certificate of insanity at all, but would be a certificate to this effect: "You have examined A. B., and you are of opinion that the case is one which should be under observation for a period in a nursing home"—or it might be a certified nursing home, a licensed nursing home, for a period which might be a fixed period of a fortnight or a month, and which would give the warrant to that institution to handle the case and if necessary to detain it. It seems to me that you must have a certain sanction behind you, because otherwise you are very helpless in dealing with the case.—(*Dr. Miller*): The Maudsley Hospital is really the only example we have. The Maudsley Hospital is more or less, I take it, run *ultra vires*, I mean very excellently, and very admirably and very desirably, but it is I suppose a legal anomaly to a certain extent at the present moment.

17,418. *Earl Russell*: If you saw our evidence from Scotland, it shows a good deal of restraint is exercised which you could not have justified in a court of law?—I know something about that.

Chairman: It was once said by an eminent judge that the best trustee was the trustee who knew when to make a judicious breach of trust, but you do

22 May, 1925.]

Dr. E. FARQUHAR BUZZARD, M.D., F.R.C.P.,
Dr. H. CRICHTON MILLER, M.D., and Dr. R. WORTH, O.B.E., M.B.

[Continued.]

not want an important profession like yours to be in the unhappy position of feeling that the law is not in sympathy with their aims.

17,419. *Earl Russell*: The doctor should not have to think of the law at all?—Surely that can only be done by our knowing that we have at our back a consultative statutory body.

17,420. *Chairman*: Yes. Then your solution is to be found along the lines of giving the Board of Control more executive power. You contemplate the reference of such a case as you have in mind to the Board of Control for power to deal with it, so to speak?—Yes, and I should like to say that already, without any change in the law, there is a very great change in the Board of Control—I expect Dr. Worth will support me there—in the last eight years. I have been at this work long enough to remember the day when I asked them a particular point, who was to certify a patient, and I was told laconically that “The Board of Control exists to see that the law is not broken,” and that was all. Those days are past, and I am sure we are all very grateful they are. At the same time, one recognises that their power of advising is necessarily very limited. They are very careful and kind nowadays but they cannot go beyond that.

Chairman: Of course you must remember that every Government Department is in that difficulty. We are all familiar with the fact that a Department, on being applied to, says “We cannot give an authoritative exposition of the law, but we think so and so.” No minister can declare the law; nobody but a Court of Law can declare the law.

17,421. *Sir David Drummond*: How is enlarging the powers of the Board of Control going to assist the profession of medicine?—By enabling a doctor to treat a case with a feeling that he has no legal responsibility.

17,422. How can you imagine the Board of Control having the power to do that? I do not quite follow you.—Well, they do it in point of fact now largely in certain cases. One of your witnesses some time ago said he thought the solution of the problem lay in certifying the doctor and not the patient, which I thought a happy expression, and I think that that in practice is what the Board of Control does to a certain extent. There are certain doctors who they think are more or less reliable, like for instance, Dr. Mapother at Maudsley, and Dr. Ross, and so on, and they are going to let them have rope; but in other cases, if disasters happen, especially with people new to the work, they have simply to come down on them and do prosecute from time to time.

Sir David Drummond: I cannot yet see how your proposed enlargement of the powers of the Board of Control is going to help.

Earl Russell: Because as it stands now, the Board of Control have no discretion as to whether they should take up or should not take up a breach of the law under Section 315.

Sir David Drummond: They exercise a discretion.

Earl Russell: But they exercise it without any right to do so. If you gave them the power only to prosecute in suitable cases—

Chairman: They need not and do not prosecute in every case; it is not an automatic prosecution.

Earl Russell: I can quite understand if you were a member of the Board of Control you would feel, after all, “The statute says we are to do so and so, and it is not for us to say we will not.”

Chairman: But as every prosecution must proceed, as we shall hear this afternoon from Sir Archibald Bodkin, upon an order by the Commissioners, the Commissioners need not make that order in a particular case. They have a discretion to direct or not to direct a prosecution, because every case of a breach of the law is not prosecuted.

17,423. *Sir David Drummond*: Is it only to that extent?—No. I mean actual consultative power. If

you have a doubtful case, state the case, or possibly even ask a Commissioner to see him.

Earl Russell: Get leave to treat in a particular way?—Yes, and say: “Now my evidence is very slender; I am anxious about this case. I feel if he were certified and put under control, it would be very undesirable from a purely therapeutic point of view,” which it often is. “What do you think?”

17,424. *Sir David Drummond*: You do not mean to say that the Board of Control are going to assist doctors in outlying districts in that way?—I should have thought it was possible. I mean it is done already in an informal way. I have had cases in which they have been very helpful, but it is informal.

17,425. *Chairman*: I think your particular difficulty, Dr. Crichton Miller, is just this, that in your ordinary practice you come across cases as to which you have doubt and anxiety, and if you take that case into a nursing home, and the symptoms develop, you are in a dilemma under the existing state of the law. You say this case medically requires detention and restraint in its own interests. On the other hand, it would be unfortunate if the case had to be certified; it is a recoverable case, and possibly a fortnight's treatment here with a reasonable measure of care and restraint may result in a complete cure. Why should that person be removed to a mental hospital and certified, because after all it may be really an episode in the patient's life? That is your problem?—Yes.

17,426. And you want to have the scope for the medical treatment which you feel is in the interest of your patient, unhampered by the fear of legal risks?—It is enough for me to feel that my misjudgment may result in losing a patient, but to feel that I may also be put in the dock is a risk that I do not feel prepared to undertake.

17,427. *Mr. Micklem*: Do you want in a case like that every time to consult with the Board of Control, let them see the patient, and so on, because it would mean putting an enormous amount of work, would it not, on them?—The Chairman has referred to these special wards such as Dr. Worth mentioned as being protected and safeguarded, and, whatever that means, would satisfy me.

17,428. You would let them get into a clinic or a certified nursing home?—A certified nursing home, yes, I have no doubt that would answer the purpose.

17,429. *Chairman*: You are getting near the licenced house, are you not, but you want something that is short of that?—(*Dr. Farquhar Buzzard*): Any nursing home.

17,430. Then, again, that brings us back to your original suggestion, that all nursing homes should be registered, and that you would find in nursing homes a population of persons, some mentally affected and some physically affected?—Yes, otherwise the certified nursing home is going to stamp the patient exactly the same as certification. It does not make any difference.

17,431. Well, gentlemen, I have put to you the points which have struck me as of special interest in your *précis*; if we have not covered any point, please do not part from us without letting us have your view on it?—I should like to thank you for the way in which you have listened to us. I think we have put down everything we want to lay before you. We have not laid much emphasis on the question of the financial side of providing early treatment—I do not know whether that comes within your purview.

17,432. We will have to consider that, but I think that is more an administrative question about which we will hear from other quarters?—I meant the financial side of providing early treatment for poor patients at the general hospitals, and so on; it is a big question.

22 May, 1925.]

Dr. E. FARQUHAR BUZZARD, M.D., F.R.C.P.,
Dr. H. CRICHTON MILLER, M.D., and Dr. R. WORTH, O.B.E., M.B.

[Continued.]

17,433. What we wish or you may wish is one thing; what we can pay for is another thing?—Quite. We do feel so strongly about the treatment of early cases.

(The Witnesses withdrew.)

The Right Reverend the LORD BISHOP OF CHELMSFORD (accompanied by the Rev. W. E. C. BARNES, M.A.); called, and examined.

17,434. *Chairman*: We are now to have evidence relating to a topic which we have not hitherto discussed—the functions of the chaplains in our mental hospitals and institutions for the treatment of the insane. My Lord Bishop, I understand that you are good enough to come this morning on behalf of the Bishops generally?—Yes.

17,435. And to represent their views to us upon the relation of the chaplain to the Lunacy law?—Yes.

17,436. You draw attention at the outset of your *précis* to the fact that the very first of the officials of a mental hospital who is mentioned in Section 276 of the Act is the chaplain?—Yes.

17,437. He is to be appointed even in advance, I notice, of the medical officer and superintendent, and therefore he has been put in the position, by the Statute at least, of prime importance?—Yes.

17,438. I think you have some views to offer us on behalf of the Bishops as to the place of the chaplain in the mental hospital, and we should be very glad if you would favour us with any suggestions which you may wish to make?—Thank you very much. As you have just reminded us, the chaplain is appointed first in the Statute of 1890. He is appointed, of course, by the visiting committee, which has power to dismiss him. He must be licensed by a Bishop, and the Bishop has power to revoke that licence. In actual working, although appointed by the committee, his position of influence appears to be very largely dependent at present on the good will or otherwise of the medical superintendent. There have been difficulties, of course all corporate work involves difficulties; but the little Committee of Bishops, in whose name and on behalf of whom I am here to-day through your kindness, would like to call your attention to the position and status of the chaplain, and to express a hope that in days to come the status of the chaplain should be recognised a little more clearly. Sometimes, to put it roughly, he does not quite know where he is, and sometimes at least his work appears to be made rather difficult owing to the fact that his status is not very clearly defined in relation to other people. Then we have been in consultation with a good many of the chaplains, and I think we all of us feel both for the chaplain's sake and for the institution's sake generally that the chaplain should be held responsible for the spiritual welfare of the staff, as well as for the spiritual welfare of the patients. It gives him variety of work, and therefore improves his work; it brings him into touch with the staff in a friendly and pastoral way, and therefore helps him with the patients.

17,439. I notice, my Lord Bishop, at the very outset the contemplation is that the chaplain must manifestly be a chaplain of the Church of England, because he is defined as a person who is in priest's orders, and shall be licensed by the Bishop of the Diocese. He is the official chaplain of the institution to be appointed by the visiting committee, but I suppose we must take it that the population of mental hospitals is not entirely composed of members of the Church of England?—Quite.

17,440. That other members of other denominations will find their way there also?—Yes, and in fact I think the visiting committee not only may, but actually does, appoint other ministers.

Chairman: You may rest assured that we have had that fully expounded before us, and that it has had our most sympathetic consideration. I can only thank you gentlemen for your evidence this morning, which has been most helpful and interesting.

17,441. One is struck with this, that the statutory provision is that the chaplain shall be a Church of England chaplain?—Yes.

17,442. It is quite true that provision is made for a minister of any other religious persuasion (subsection 2), but the official chaplain of the institution is a chaplain of the Church of England—that is the contemplation, I think?—Yes.

17,443. But ministers of other denominations may also attend and, as you say, such arrangements are made. Have you any idea as to the extent to which the asylum population belongs to the Church of England?—I have not, generally speaking, but I have in front of me the figures in connection with Claybury Asylum, which is one of the London County Council asylums, and happens to be in my own diocese. I think at the last census there were 2,700 inhabitants at the asylum, which I presume included officers, and the figures I have are that 80 per cent. of those are registered as Church of England patients; that 9 per cent. of them are registered as Nonconformist patients, and 11 per cent. of them are registered as Roman Catholic patients.

17,444. I wonder whether in compiling these figures the 80 per cent. said to be Church of England have been taken as they are sometimes in the Army, that is, that every person who does not belong to any special denomination is said to be Church of England?—I am afraid that is so.

17,445. We are all supposed by law to be members of the Church of England?—The Church of England is the last refuge of the destitute, and it is very proud to be so.

17,446. But the 80 per cent. are not necessarily members of the Church?—No, it is a very loose adherence, but being nothing else, they call themselves members of the Church of England, and we look after them; we bury them, amongst other things.

17,447. But you also desire to minister to them?—Quite; we much prefer to minister to them, but looking at the work, it does mean that a very large proportion of the work is naturally ours.

17,448. Also may one not say this, that it is not distinctively denominational work that you are concerned with in the asylums; it is really bringing relief to the suffering?—Quite.

17,449. I should imagine that the work of a chaplain is not distinctively denominational work; it is rather the work of helping and relieving those under his charge, irrespective of their sect or creed?—I think that is absolutely true. I have never been an asylum chaplain, but I have been a Poor Law chaplain for a considerable time, and that certainly was my purpose. I did not look at the character of the ticket always before I attempted to minister.

17,450. No, but it is of course desirable that the chaplain who has important duties to perform should have a position which will attract the best class of man. The labourer is worthy of his hire, and I notice that you draw attention to the fact that the present tenure of office and the emoluments of the office are not satisfactory to you?—In some cases certainly that is so, and the whole tendency seems to be in these days when we are all aiming at economy, instead of appointing a whole-time resident chaplain, to appoint a part-time and frequently non-resident chaplain; appointed only for a limited period of time, and so non-pensionable. There are I believe some cases

22 May, 1925.]

The Right Reverend the LORD BISHOP OF CHELMSFORD.

[Continued.]

where a house has actually been built for a chaplain when the institution was brought into existence, but the chaplain has been deprived of it, and it has been used for others.

17,451. Would you regard one of the large London County Council institutions as constituting in itself a sufficient parish for a chaplain?—I should certainly say that the Claybury Asylum with 2,700 people, most of them sick in some shape or form mentally or physically, is a very large cure indeed for one man; and if it be true that 80 per cent. of those 2,700 are patients for whom he is especially responsible, it seems essential that he should be a full-time officer. Indeed the evidence of my own little Committee had seemed to suggest that in all cases where the patients number 1,000, the chaplain should be a whole-time officer.

17,452. Of course his sphere of work differs from that of the ordinary parochial clergyman; his cure is concentrated in one place, and many of the activities of an ordinary parish would naturally be absent in this particular type of cure?—I think that is absolutely true. He saves a good deal in shoe leather compared with the parish priest, but as far as my experience of dealing with sick folk, whether mental or otherwise, goes, they take a lot of time. You must be very patient with them, and the small experience that I personally have of ministering to those who are mentally diseased suggests an enormous amount of patience, and consequently an enormous amount of time.

17,453. And a large outflow of sympathy?—A very large amount of sympathy, and you cannot show sympathy in a hurry, not as a rule. If a patient feels that he is simply a patient, that you deal with him and pass on to the next as quickly as you can, your chance of helping him becomes increasingly smaller.

17,454. You have been good enough to tell us that you have yourself done some work among the mentally afflicted. Have you found your ministrations appreciated by them?—Very much indeed.

17,455. Do you find that they will confide their troubles to you?—Yes. Of course one always has the kind of person who explains to you that he is perfectly sane and ought not to be there. But quite apart from that kind of explanation of trouble, I have had a certain amount to do with curable cases that have been cured, and have passed out, and I have kept in touch with them afterwards; and I dare to say that I think the kind of ministrations that one tries to give are ministrations that not only comfort the person, but do really help the recovery.

17,456. I can well imagine that a person who has possibly still a large measure of intelligence, although suffering for the time being from mental upset, might find much help in talking about himself and his affairs with someone who is not a medical man, someone whose relation to him is different?—I remember in Chester Asylum, when I was in Cheshire, there was a man who showed me a Greek book, he was a very bad tempered person, with whom the staff had a good deal of trouble; I taught him the Greek alphabet and to read the Greek Testament, and the medical officers told me it had made all the difference in the world to the management of him.

17,457. That is a very interesting case.—That of course took some time. It is indicative of the kind of thing I meant in saying that a man who is really to be of any use must have a certain amount of time at his disposal.

17,458. His relation to the establishment is entirely different from that of anybody else. His function, although it is not precisely defined, is quite different from that of anybody else in the institution?—Quite.

17,459. But you regard that as a function of great value?—Certainly I do.

17,460. Of course he will have, in addition to seeing the patients who wish to see him, and moving about what one may call his parish, the conduct of the regular services, I suppose. Most of the institutions as we know, have a chapel?—Yes. With regard to those regular services, there is one thing I should

like to say. According to the Act, he must perform Divine Service according to the rites of the Church of England every Sunday, Christmas Day, and Good Friday (Section 277). Of course that is statutory. We think that greater elasticity should be allowed to the chaplain as to the type of service that he may take in the asylum, under proper authority. I am afraid most clergy, I hope under proper authority, do vary their services a little nowadays, but the Statute in the case of asylums insists upon the service from the Prayer Book, the whole service and nothing but it. We, as Bishops, would be quite prepared to grant, in fact we do, very much larger elasticity, but that elasticity is contrary to the Act as it stands.

17,461. *Mr. Micklem*: I suppose there are no prosecutions under that?—I think I should prosecute a person who adhered to the Statute if I could.

17,462. *Chairman*: Is that because of the words "According to the rites of the Church of England"?—Yes. I have the Chaplain of Hanwell with me, and he tells me he never takes the whole service; so if anybody needs to be prosecuted, here he is!

17,463. Of course it is not desirable that the functions of the chaplain should be defined by Statute?—No, I think not.

17,464. You want naturally that the chaplain should exercise his own office according to his own discretion?—Quite.

17,465. He knows his office better than anyone else can do. The relationship between parishioner and clergyman is not one susceptible of statutory definition?—Quite.

17,466. But on the other hand, the position of the chaplain is a secular matter as to which it may well be desirable to improve the conditions?—Yes.

17,467. Is the chaplain to an institution in your Diocese one of the regular clergy of your Diocese?—Yes, he holds my licence, and that puts him on the list of my regular clergy.

17,468. And to what extent does the Bishop of the Diocese come into contact with the chaplains of such institutions? Does he have opportunities of conferring with them from time to time?—Yes, I see them from time to time, just in the same way as any other clergyman. One of the chaplains came to see me only a fortnight ago, quite apart from my present position here, simply to talk over his work and things generally.

17,469. Then I understand that the Bishops do not desire that the Statute should in any way prescribe with more detail the duties of the chaplains. You are quite content that that should be left as it is?—Quite, I think.

17,470. Left to his own discretion, subject to the directions of his Bishop?—Yes.

17,471. But in the secular aspect of it your anxiety is that the present conditions, particularly in view of recent economies, are not likely to encourage the best type of man to take office?—That is so. The appointment of a part-time chaplain for three years is not the kind of appointment that you can expect a man who really means business quite willingly to accept, because a task of this kind takes some time to learn.

17,472. Do you find that this class of work attracts your clergy?—No, only very few.

17,473. It is obviously a very exacting form of work, and takes a man, I should think, out of the ordinary lines of promotion?—Yes; I think that has been true in the past. My own little Episcopal Committee, which was appointed before any thought came into our minds of giving evidence before this Commission, was formed with an idea of keeping an eye upon those who are doing useful service in a way that in the past perhaps has not been done, with a view to sympathy and presently possible preferment elsewhere.

17,474. Of course, in one sense the topic is not very closely related to our reference; it only comes in in this sense, that we have to consider the care of the mentally afflicted, and in that aspect any person

22 May, 1925.]

The Right Reverend the LORD BISHOP OF CHELMSFORD.

[Continued.]

who is concerned with the daily life of the patients is of importance to us; but the only practical matter with which we might be concerned would be to see that the best class of man was obtained. That is probably the only way in which it comes into our purview?—Yes, I quite see that, and it is on that point I desired to say things that I have said; that the chaplain's duties, not being very easily put into categories, may be to a certain extent disregarded, and paid very little for, with the result that at the same time they cannot be very adequately done by a part-time man, who has perhaps the whole of a parish. I have a case of that kind; it is a new appointment, so I do not know how he is faring, but he is chaplain to 600 or 700 patients, as well as vicar of a parish, and has a small remuneration. I am not putting this forward as a case where it does not work, because I do not know the details; it has not had a long time to run, but I should regard that as quite impossible in a place like Claybury, for instance. As Claybury has been mentioned—that is a London County Council case—the chaplain of Claybury is not paid a very large sum; I think it is about £200.

17,475. *Mr. Micklem*: How many chaplains are appointed; is there a Nonconformist and a Roman Catholic chaplain there?—At Claybury apparently half the money is given to the Church of England chaplain and the remaining half is given to the Nonconformist and Roman Catholic chaplains between them.

17,476. *Chairman*: Is there any objection to our having the actual figures?—No objection. I am not quite certain that they are absolutely accurate, but the actual salary at which the present chaplain of Claybury was appointed was £170, which, with war bonus, now amounts to £240.

17,477. *Sir Ernest Hiley*: Is that a whole-time appointment?—Yes.

17,478. *Chairman*: With residence?—He resides on the spot, but whether he has to pay for his residence I cannot be sure.

17,479. And what allowances are given to the other ministers?—The Nonconformist chaplain gets the same salary as the Church of England.

17,480. He is not resident, I take it, is he?—I think not.

17,481. And what is paid to the Roman Catholic priest?—The chaplain says he is paid *per capita*. I do not know what it means—at least, I know what it means—but I do not know what it works out at.

17,482. *Mr. Snell*: Are we quite clear, my Lord Bishop, that the Nonconformist chaplain gets precisely the same amount of pay for the smaller number of people that he attends?—I am not quite clear as to whether the whole of the half is given to the Nonconformist chaplain or whether it is given to the Nonconformist and the Roman Catholic together.

17,483. *Chairman*: In any event, it appears that of the total remuneration 50 per cent. is given for 80 per cent. of the patients, and 50 per cent. is given for the 20 per cent. of the patients?—Yes. The Chaplain of Hanwell tells me that it is exactly so in his case. You will quite understand, Sir, that my presence here is in no degree antipathetic to my Nonconformist brethren, with whom I am on the best of terms, and one wholly sympathises with the quite proper provision that Nonconformist patients should be looked after by their own minister.

17,484. One knows that in institutions denominationalism is fortunately largely lost sight of, because the people are there to get better, and therefore these elements are not unduly pronounced?—Yes.

17,485. Then may we take it, my Lord Bishop, that the point that you desire us to consider specially is whether in the first place the status of the chaplain could be recognised more clearly—that is, his civil status?—Yes.

17,486. *Mr. Micklem*: You are not suggesting, my Lord Bishop, that the chaplain who is named first

in Section 276 should be the leading authority in the asylum, are you?—No. I only mentioned the fact that he is named first, as indicative of the view that the Legislature of that day took, that he was a very important functionary.

17,487. And is there really anything in the order at all?—I take it that the superintendent of the asylum is the principal.

17,488. *Chairman*: I think the Lord Bishop's idea is quite clear; it simply happens to be the first name that occurred?—If you have an asylum, you must have a chaplain; your also want a superintendent.

17,489. I do not think you consider that this is a carefully adjusted hierarchy in the Statute?—No.

17,490. Now you think that the status of the chaplain might be made clearer. That is really from the point of view, I take it, of tenure and emoluments?—Yes.

17,491. On this point about the staff, at present he is appointed, I take it, as chaplain to the asylum; and does he not at the moment concern himself with the staff as well as with the patients?—He very frequently does.

17,492. The staff will attend the services, for example?—Yes.

17,493. But it does not appear to be his business?—It is not clear as it stands. It merely appoints him as a chaplain, and I take it that is as chaplain to the asylum.

17,494. *Mr. Micklem*: One would be rather inclined to doubt whether that is not in the hands of the staff rather?—As long as it is quite clear that the chaplain is quite free to minister to the staff, I think our point will be met.

17,495. *Sir David Drummond*: Is the chaplain under the control in any sense of the medical superintendent, or is he entirely independent? His ministrations are as he wishes apart entirely from the medical superintendent's views?—I do not think anything is laid down definitely which answers that question.

17,496. *Chairman*: Let me put a practical question to you, my Lord Bishop. Suppose the medical superintendent said "I think it is inadvisable that the chaplain should see this particular patient." Suppose the patient's mental aberrations are concerned with religion, and it is found to be disturbing to the patient to meet the clergyman; in such a case I take it the medical superintendent would be entitled to say to the chaplain "You must not see that patient at present," and, I suppose the chaplain would to that extent be under the directions of the superintendent?—I should certainly take that view.

17,497. I am a little in doubt as to the position of the staff. If you look at the institution as a whole as the cure or parish of the clergyman, one would assume that he would attend to and meet with the staff itself as he would with the patients, and of course some of the staff would attend the services and so on. The sphere of his cure is the institution and all whom he finds therein, I should have thought. Of course he cannot compel any member of the staff to attend his ministrations?—No, I doubt if it would be desirable to make that more precise.

17,498. *Mr. Snell*: There would be no danger, my Lord Bishop, would there, in that being the beginning of some creedal test for the staff, as to whether they would or would not attend the service?—Nothing is further from my mind than that. I think it should be absolutely voluntary as far as the staff are concerned. As Vicar of Bradford I was chaplain of the various Poor Law hospitals and every year I prepared a certain number of nurses for confirmation, but it was absolutely at their good will.

17,499. *Chairman*: Then at the moment really the position is this, that no medical superintendent, I take it, would object to members of the staff conferring with the chaplain and attending his ministrations?—As long as he does not, we are quite content.

17,500. *Sir Humphry Rolleston*: I suppose the question is one of some practical importance, because if he attends to the staff, he ought to receive remuneration

22 May, 1925.]

The Right Reverend the LORD BISHOP OF CHELMSFORD.

[Continued.]

per capita in relation to them, ought he not?—I hope he will never receive remuneration *per capita*.

17,501. I thought you said they did?—That actually is done in the case of Roman Catholics, because there are very few.

17,502. *Chairman*: The measure of remuneration, after all, must have some relation to the size of the cure, and if you augment the persons for whom the chaplain is responsible, then he is a minister of a larger cure, and it might be said he is entitled to a larger remuneration?—That is not how we are paid in the Church of England. I have one of the largest Bishoprics and I am paid, I think, as little as any of the other Bishops; but our point would be that a whole-time man should be paid an adequate salary for his whole-time work, whether they be a little fewer or a little more.

17,503. Then you think that the scale should be this: that if you have an asylum with 1,000 beds or more, there ought to be for such a community a full-time chaplain resident?—Yes; that is our view.

17,504. That there is sufficient work for him to do there, really parochial work in the institution?—Yes. Taking that work in its broadest sense.

17,505. Then you raise a point with regard to the Bishop's power of licensing. Now the Statute provides that the chaplain shall be licensed by the Bishop of the Diocese. Do I gather what you have in mind is this, that you might make it a condition of granting the licence that satisfactory terms were given?—Yes, that the terms and conditions of his appointment should be satisfactory.

17,506. I suppose the licence at present is given by you in view of his qualifications for the work rather than in view of the nature of the appointment, the terms of the appointment?—Not wholly so. In other cases I reserve to myself the right, when I license a curate to a parish, to insist that he shall be properly paid, so that other considerations do enter into it. Only a few weeks ago I refused to license in a case of that kind.

17,507. Then you suggest this, that you should be entitled to withhold your licence from a chaplain who has been appointed by the visiting committee, on the ground that you are dissatisfied with the adequacy of the terms offered to him?—Yes. I think there would have to be consultation first, and one would only do that as a last resort.

17,508. *Mr. Micklem*: This asylum will be in a parish—suppose there is a vicar in a parish, does he require a special licence from you to undertake chaplaincy work at the asylum?—Yes, he would, under the Act.

17,509. Under this Act do you think? Does that mean shall be licensed *ad hoc*?—I imagine so.

17,510. I should doubt that, with great deference.—If he were being paid a salary.

17,511. Suppose you took the Rector of Claybury, and the London County Council asked the Rector to undertake the chaplaincy, would he have to get your sanction for it?—I do not think he would if the London County Council did not pay him, but if they paid him, I think he would have to be licensed by the Bishop for that particular post.

17,512. Do you mean he could not make money without the licence of the Bishop?—Not in that way.

17,513. But he could do it voluntarily?—When I was Vicar of Bradford I was licensed to the Poor Law Union by a separate licence.

17,514. You mean it is work that could not be undertaken voluntarily?—It could be undertaken voluntarily, but that would not be a person paid under the Act. I confess I do not quite know what would happen if the Bishop revoked the licence and the visiting committee continued the man in his employment.

17,515. *Chairman*: It is a little difficult to construe, as Mr. Micklem points out. Take the case of a vicar in your diocese; he is a person who is in priest's orders, and he is a person who has been licensed by the Bishop of the Diocese; therefore he seems to meet most of the statutory requirements, but you say there is a further requirement that he

shall not only have been licensed by you, but shall be licensed *ad hoc*, that is to say, licensed for the particular office of chaplain to the asylum?—That is my experience.

17,516. That may be the reading of it, but I am not sure that it is.

17,517. *Mr. Micklem*: You see as the Act stands with regard to his stipend and so on, that has to be fixed by the committee?—Yes.

17,518. And you would wish to see that altered in some way to say that it must be fixed by the Bishop?—No, I would not go so far as that.

17,519. *Chairman*: Indirectly, you would?—I should ask to be allowed to refuse my licence in a case where an unconscionable bargain was being made between the committee and the man.

17,520. That, of course, is an indirect compulsitor?—It is.

17,521. They could not get a chaplain at all if you withheld your licence?—I do not know what would happen to me if I refused again and again men who were nominated to me. The Act says that the committee 'shall,' and says that I 'shall.'

Chairman: One does not contemplate the contingency, but still one has to envisage these things sometimes. It might be resented, you know, if you were put in this position of having really a veto upon the appointment, in the event of your dissatisfaction with the terms. We are dealing with the local authorities; they are made the judges of what is adequate remuneration, and it may be said that if they have fixed the remuneration the question for yourself, in licensing, is rather whether the person has the proper spiritual qualifications for his office.

17,522. *Mr. Snell*: Might I ask, my Lord Bishop, have you the power to revoke a licence already given for teaching or ministration of which you do not approve?—Yes. The Act says the Bishop has power to revoke his licence. Of course ordinarily that would prevent him from continuing to officiate, but I do not know quite whether that case has ever arisen or what would happen in that case.

17,523. *Chairman*: Then I see that you wish the appointment to be for a stated period of at least five years renewable at the end of each period?—Yes; on the whole most of us feel that it should be a permanent appointment, so that a man who feels a vocation for that kind of work may be attracted to it; at any rate we feel that three years is too short a period.

17,524. Is three years always the period in the present practice?—The practice until recently has been a permanent appointment; but recently, and I think the London County Council are especially concerned, they have appointed for three years only. A task of this kind requires a man to learn his job; he becomes useful as he learns it, and three years is a very short time for a post of this particularly extraordinary kind.

17,525. Of course, if the chaplain in the three years has learnt his job, and has proved himself, the renewal of his appointment is granted. On the other hand, the three years may disclose the fact that he is unsuited for it, and it is desirable that he should expend his energies in some other direction?—The three years keeps him out of superannuation incidentally.

17,526. That is a very important result. Still, if a man were shown in three years to be unsuitable for his work, it would be dangerous, would it not, from the patients' point of view, that he should remain there?—Absolutely, and I think that is sufficiently safeguarded by the committee's power to dismiss the chaplain, and the Bishop's power to revoke his licence.

17,527. These are very drastic powers. One knows in public life there may be an official as to whom you could not take such steps, but, on the other hand, you would never have appointed him if you knew what you now know about him?—Quite. Speaking for myself, if it were made clear to me that a man who was a chaplain in an asylum

22 May, 1925.]

The Right Reverend the LORD BISHOP OF CHELMSFORD.

[Continued.]

was an unsuitable person for that particular job, I should be very glad to go into partnership with the visiting committee in finding him a fresh one.

17,528. *Mr. Micklem*: I see you speak in the *précis* of specialised training for this particular ministry, but has the Church of England some specialised form of training for it?—I do not think we have for the moment, but that is one of the things which I think we are very anxious to try and find.

17,529. Has not the minister really to get his training from his experience in the place?—That is where most of us have learnt ours, such as it is, and I think that is the best training school, but in these days we are trying to begin to give some simple and non-controversial psychological instruction to our ordination candidates, and I hope that that may develop further than it has at present gone. We do not in the least want to instruct our chaplains so that they will interfere with the staff; that is quite alien to our minds, but simply to instruct them so that they shall be more capable of dealing with odd persons.

17,530. *Chairman*: On this matter of superannuation, at the present time if the chaplain remains in the service for 25 years does he mature a claim for pension?—I think so. (*The Rev. W. Barns*): That is so. It is the new idea under the London County Council that the man's appointment is for three years only, and he does not come under superannuation; he is not a permanent officer.

17,531. *Mr. Snell*: Is the suggestion, my Lord Bishop, that the County Council restricts the appointment to three years for the purpose of disqualifying him from pension?—(*The Bishop of Chelmsford*): I do not like to impute motives, but being appointed for only three years, he is a temporary officer, and therefore is outside the scope of superannuation.

Chairman: It seems rather unattractive to the young energetic man, if he does service on the basis of a three years' appointment and then at the end of 25 years' work, after enjoying the very exiguous emoluments you have referred to, finds himself with no pension rights at all.

17,532. *Sir David Drummond*: Apart from his religious ministrations, does he visit the wards?—He is supposed to visit the wards.

17,533. But at certain hours I mean.—I do not think he is tied to hours, but it must be at the convenience of the establishment.

17,534. *Sir Humphry Rolleston*: It is a very interesting question which Sir David Drummond raised as to the relation of the clergyman and the medical man; because there is a certain amount of overlapping, the spiritual comfort which the chaplain might give is related to some of the processes which are employed by medical men, such as psycho-analysts,—I mean, the treatment by some psycho-analysts is very much like the comfort which may be brought to a patient by talking over his troubles?—Quite.

17,535. I was wondering whether you have got any ideas with regard to combined action on those lines?—I think we should hope that there would be a happy partnership between the medical officers and the chaplain, as exists in so many cases between the parson and the doctor in ordinary homes. In my own experience, again and again the doctor and I have talked over particular cases with a view to my doing something as well as with a view to his doing something; and it was partly with that end in view that we hoped that the right kind of man would be attracted to this particular task, and that we might be able to help him, in the way of training, to become more adequate for it; but if he is only appointed for three years it is difficult for him to feel that it is a vocation.

17,536. *Chairman*: Do you think there is really a career in it, if I may so put it? Take a clergyman, for example, who takes up teaching, and many of the teachers in public schools are in Orders. He may look forward to very high promotion indeed; he may occupy an episcopal chair ultimately, as many most distinguished teachers have done;

but it rather looks as if there was very little outcome in this profession for the asylum chaplain. At the best, if he has to be specially trained and to be sent there, so to speak, he is left at the peril of losing his superannuation, and there does not seem to be much to stimulate him. Would it not be better that persons should do some work of that sort, and then pass back into ordinary cures?—For most men I think my answer would be very decidedly yes. I think a period of something like ten years is probably all that a man ought for his own sake and for everybody else's sake to have.

17,537. One is apt to get stale?—Quite, because it is one kind of task.

17,538. And it may become routine, too?—Yes, there is a danger of that. Of course, the superannuation difficulty arises if you leave the service, even if you are open to superannuation; if you leave the service of your own free will, you lose all your rights, do not you?—Yes. That has happened to me, so I know, in connection with the Poor Law.

17,539. *Sir Humphry Rolleston*: There are not sufficient men in the Medical Mission to utilise for this purpose, I suppose?—There is a certain number of medical men in Holy Orders, but that is quite a new thought to me.

17,540. I was rather thinking of medical missionaries—are there not a certain number of clergymen in the mission field who have some knowledge of medicine, who are invalided home from China and places of that kind, and would not they be rather good people to put in asylums?—I think some of those men might be very excellent.

17,541. *Chairman*: The only fear is they might want to arrogate some of the functions of the medical superintendent.

Sir Humphry Rolleston: They would not if they had not medical qualifications. There are a good many medical missionaries who come back and are at a loose end.

17,542. *Chairman*: What rather strikes me is that looking at the secular aspect there is not very much attraction in it for a man. I can imagine a man saying: "I should like very much to spend a few years in doing that work, and I should like to help in it, take a share in it, and then pass on to other work", but to devote himself to the career of an asylum chaplain seems to me a rather depressing outlook, and he might soon drop into routine and the founts of his sympathy might dry up?—I quite agree.

17,543. *Mr. Snell*: In fact might it not be that the only persons who would spend a life at it would be those who have not particularly suitable gifts?—If you are only going to keep a man for a few years it rather points to making an effort to get a man who really does for those few years regard the thing as a vocation, and treating him decently while you have got him.

17,544. *Chairman*: Take the ordinary hospital, such as the general hospital; there the visiting clergymen of various denominations come in with a fresh breath from the outer world, so to speak, and they are in contact with all the interests which they have outside; but the asylum chaplain, immured within this very special parish of his, would, I think, be very liable to get out of touch with things and begin to lose freshness and sympathy?—Speaking solely for myself, and against the mind of some of my brother Bishops, the difficulty of the man outside, who might make a very adequate chaplain while he was doing other work, is that so many of these mental homes are so large that the task is a whole-time task.

17,545. There are two views, either it should be a part-time job, or it should be done as an episode in the career of a clergyman. He might be willing to do that work for a time just as he might be willing to engage in East End Mission work for a time before he got a more normal country charge; or it might be

22 May, 1925.]

The Right Reverend the LORD BISHOP OF CHELMSFORD.

[Continued.]

a service of a more or less specialised type like the Army chaplain, or the Navy chaplain, who remain in the services until they retire. I gather you rather favour the plan of making it a service by itself, because you say it requires special qualifications. The danger of that, on the one hand, is that the atmosphere of the asylum is an atmosphere of depression and difficulty, where a man may lose his usefulness more rapidly than he would in the other services.—I think that is perfectly true. I do not think at all, speaking for myself, that a man should give his whole life to it. I do think he should give a period of his life to it, if he is going to do it at all.

17,546. As a Bishop of a diocese, would you favourably consider the claims of an asylum chaplain who found in himself that he was less useful than he had been originally, would you consider his claims to preferment elsewhere?—I am doing that very thing at this very moment.

17,547. *Mr. Snell*: Do you think it is advisable to give the patients the advantage of experience? I mean I would rather like to have the chaplain to come to them at the other end of his experience when he has had a good deal of contact with humanity?—I do not think that an asylum chaplain should be a newly ordained man, and that is partly the reason why I deprecate the very meagre pay that is paid to some of them, because you are only likely to get newly ordained men, or quite inefficient men, at the kind of pay that is now being offered. I shall be ordaining a dozen men in a fortnight's time, and nearly all of those will be getting over £200 a year to begin with, and apparently there are some asylum chaplains who are only getting that after years of service.

17,548. But assuming that the chaplain in his ministration has some real comforting and steadying effect, some therapeutic value, if one may put it so,

(*The Witness withdrew.*)

(*After a short adjournment.*)

The Reverend W. E. C. BARNES, M.A., called and examined.

17,554. *Chairman*: Mr. Barnes, you are Chaplain at present at Hanwell and Cane Hill Mental Hospitals?—Yes.

17,555. And I think you have held your appointment as Chaplain to Hanwell since 1920, and to Cane Hill since 1923?—Yes.

17,556. Were you formerly for six years Chaplain to the British Embassy Church in Petrograd?—Yes.

17,557. You have had a varied experience, because I see you served during the war as a Lieutenant in the Royal Naval Volunteer Reserve, as Gunnery Officer attached to H.M.S. "M.25" in the White Sea?—Yes.

17,558. You must find your present life rather a change, I should think, from your previous pursuits?—Yes.

17,559. Now are you also a member of the Guild of Health?—No. I was merely asked by the Bishop of London to come and give my evidence.

17,560. I see that appended to your *précis* there is a statement by the Bishop of Kensington, who speaks as President of the Guild of Health.—Yes, we were called together there, and he addressed that letter to the Royal Commission, I believe; and I wish to identify myself with all that he said as regards the work of the chaplains; that is why I mention it.

17,561. What happened was that the Bishop held a meeting of chaplains?—Yes. He is President of the Guild of Health, and he called together this meeting at their offices; but none of us belong to the Guild of Health, as a matter of fact.

17,562. It was a meeting called at the offices of the Guild of Health?—Yes.

17,563. And they invited a number of you to meet and express your views?—Yes.

17,564. May I take it that you and your colleagues who attended that meeting find your views adequately expressed by the Bishop in his communication to our Commission?—Absolutely, yes.

upon the patients, it is advisable that the chaplain should be almost as efficient as your medical superintendent should be in his own line?—Quite, in his particular sphere.

17,549. *Chairman*: Then, I think, my Lord Bishop, we have covered the various points which you have been good enough to bring before us in your *précis* and, unless you have anything else you would like to bring before us, it only remains for us to thank you for your kindness in coming here and assisting our deliberations?—I am most grateful to you, Sir, for allowing me to come.

17,550. *Mrs. Mathew*: I should like to ask you, my Lord Bishop, do the local authorities invariably fix the salaries?—Yes, I think so.

17,551. And what is the rate of superannuation, do you happen to know?—That depends upon the amount that they are paying, and the years of service that they have rendered. It is according to scale.

17,552. The other question I wanted to ask you was this: Would you do away with all chance of superannuation and just raise the yearly salary—would you recommend that?—Some of the chaplains would prefer that, and some of them would not. Personally, speaking only for myself, I should prefer proper remuneration, leaving the pension question to be dealt with by the Church. We are in fact dealing with it, and I hope we shall deal with it successfully. I believe that is the better way in the long run, because then it does make it easier to move a chaplain who has fulfilled his term of service as a chaplain; but if you take him away, and he thereby forfeits all his superannuation payments, it is a thing that he sometimes does not feel inclined to face.

17,553. On the other hand, he would be leaving a much better salary if you took him away?—Yes, that would be so in some cases.

17,565. We need not go into them in detail; but I think you might help us by giving us some idea of your daily work as chaplain in the institutions with which you are associated. One wants to see the sphere of your activities, and what work you can do, and what help you can give. Would you mind telling us the nature of your day-to-day work?—Of course, my evidence is that I am a friend to the patients; the patients look upon me as a friend, in a different way from the way they look upon the doctor; so that anything I may say will be from the patients' point of view. Of course, they come up to see me; I go in at odd hours of the day, I see them socially and spiritually, I am at their dances, and I look after them in church, and I see them in the wards and the airing courts, and when they are sick; and of course they would speak to me naturally on all that happens to them. The public, I suppose, is interested anyhow in their treatment—is that so?

17,566. Yes, but I would like to know a little of your daily routine. First of all, do you live in the institution?—No, I do not. I have to find a house outside.

17,567. Do you go daily to the institutions?—I go four days a week to one and four days a week to the other.

17,568. That sounds like eight days.—On the Sunday I am alternately in the evening at Hanwell and in the morning at Cane Hill.

17,569. Do you find that the work which you have to do takes all your time?—All my time now, because I run the two institutions. Before, I was only chaplain of Hanwell, and also chaplain to the Malvern College Mission down in the east end. I felt I could not keep the two going, so when Cane Hill fell vacant I happened to get the appointment.

17,570. Can you manage all the work of those institutions?—I can, because the day I am at Han-

22 May, 1925.]

Rev. W. E. C. BARNES, M.A.

[Continued.]

well I am not wanted at Cane Hill; it is only part time at each place, of course.

17,571. I forget for the moment how many patients you will have in the two institutions?—2,500 at Hanwell, and just under that, I think, at Cane Hill.

17,572. That is a very large number of people to have under your charge?—Plus the staff, of course. I am in very happy relations with the medical staff and the nursing staff on both sides, and I look after the nurses socially, because I am chairman of their social club; so that it is the staff as well as the patients.

17,573. What takes you to see any particular patient, if there are 2,500 patients? When you arrive there in the morning, what is your routine work; do you find that certain individual patients wish to see you?—I find on my office table a number of envelopes which have arrived, giving the cases of sickness. The relatives of certain patients are notified that their friend is sick or is ill or is dying, as the case may be, and a similar notice comes to me. I deal with that, and naturally take my routine of going through a certain number of the male wards one day and a certain number of the female wards; it is a regular routine. I make a point of doing all I can in the time, seeing the patients both in the wards and also in the various workshops. It is like a parish, really. You have certain cases; your communicants come first, of course. I have quite one hundred at one place, and not so many at the other. It is like parochial work, exactly.

17,574. Apart from those who are sick, and who require special ministrations, in what degree are you brought into contact with patients individually?—I was going to give you the case of a man named W—. I get interested in these cases, like you get interested in people in parochial work. I first met W— when I became chaplain of Hanwell, in No. 7 ward. He is a man without a leg; he tried to put an end to his life, and lost his leg in the attempt. He insisted upon being put into a padded room—padded all round, with only just a certain amount of light coming in; he insisted on living in that dark little place; he was there the whole of the winter; he is an intellectual man, well educated, and a journalist. I was interested in the man. I was talking to him quite naturally from a religious point of view, and also on all kinds of matters, and then he expressed a wish for his communion. I went into the details as to whether he had been confirmed, and so on, and I said, "Look here, I cannot give you communion in this dark little hole; I could not put a table in here, for one thing." There was no light, or very little light. I said, "If you want your communion, I know you can come out; there is no need for you to be in this room. You must ask for a lighter room, and get out of this." After about a fortnight he asked for a lighter room. He got into a lighter room, his condition improved, but he was still in bed. Then I said, "It is no good your remaining in bed. You come along out to church." He is coming out to church now, and he is coming to his communions and taking them himself. There are other cases like that. There was a case of a man named R—, who complained to the doctor of his heart; the doctor said there was nothing the matter with his heart, but he insisted upon remaining in bed, and he wanted his communion. I said, "You must come out and get it." He ended by coming out and getting it. Those are two cases where the patients have improved merely because of—call it auto-suggestion, or whatever you like. Anyhow, he had to come and make use of his faculties to get what he wanted. I was not going to give it to him otherwise. I am very friendly, of course, with all the doctors. If I want to know what the condition of a patient is, I ask the doctor in charge.

17,575. Do you find that you are able, through spiritual ministrations, to help many of the cases that are in a distressed condition?—A great number;

because religious mania forms a great part of their difficulties. Take the case of a man man who will say, "Shall I always be like this in the after-world?" and things like that. My answer to him, of course, is "No." I comfort him in that way. It is a tremendous comfort to the great majority of these people.

17,576. Then do you find that they use you to any extent as a link with the outer world, that is to say, as a means of communicating with relatives?—Absolutely. Another thing is this: I come across various patients whose relatives, possibly, take very little interest in them. I write to those relatives and tell them they ought to do so, and in a certain number of cases that has been instrumental in the patients getting out. Otherwise, if a patient remains in, and his relatives take no interest in him, he may remain in for the rest of his life; so that in a great number of cases I have been a help in getting the relatives to take the initiative and come and bother the medical authorities about the condition of the patients. It is a tremendous help to those men and women to know that they have got a person who is their friend. They do not look upon me as one of the staff.

17,577. Your position is distinctive in that respect?—Yes.

17,578. Then of course you will hold the regular stated services?—Yes, regular stated services; of course, it is up to the medical superintendent to say what sort of services should be held. I mean I can always go to him and say, "Is it convenient to have a service on Tuesday instead of Wednesday?" and so on, and it is up to him to say whether it is convenient or not. He is the absolute authority. In both the institutions the medical superintendents are tremendous friends of mine, and I find the relations between us are extremely friendly in every way.

17,579. Have you ever had cases where, because of the medical specialties of the patient, it has been thought undesirable that the patient should have spiritual ministrations?—Never.

17,580. What one had in mind (you heard us putting the question to the Bishop of Chelmsford this morning) was that certain cases might possibly be excited by controversy on religious matters, if they chose to become controversial?—No, I do not think so, unless there happened to be a chaplain who stirred people's emotions up so. I did hear of a case at one of the hospitals where the medical superintendent, when the chaplain was appointed, told him that he must not do that or must not do this in the pulpit, or say that or say this in the pulpit. Of course the medical superintendent has no right to say anything of the kind, or to interfere with his work like that.

17,581. How many actual communicants have you under your charge?—I have got 100 at Hanwell and about 50 to 60 at Cane Hill. That is a fair percentage, when you come to think of what it is outside; it forms about one-third of the church-going population at Hanwell; they are tremendously responsive; the patients get confirmed. I am an extreme church man, and I make use of various other sacraments. I baptise babies. It is all the usual work of a parish, as a matter of fact.

17,582. I do not quite understand. Are babies born in the institutions?—Yes, babies are born to the staff as well as to the patients sometimes, so I mean there are all sorts of things to think of.

17,583. To what extent are the patients in these institutions under your charge members of the Church of England?—They are fully 75 per cent.; I do fully 75 per cent. of the work.

17,584. Do ministers of any other denominations attend at all?—There is a Free Church minister at both institutions, and also a Roman Catholic.

17,585. Do they come at intervals?—It is half-time work with the Presbyterian minister; he is paid exactly the same salary as I am. As a matter of fact it is the old sum of £400, plus a house, which

22 May, 1925.]

Rev. W. E. C. BARNES, M.A.

[Continued.]

the old chaplain got, and which was not divided up. It does not work out at so much now. There is a saving on the religious side of the hospital. We each draw £170 a year, of course plus war bonus, which will drop in time. But he is half-time with me. However, it means that in the case of funerals and all kinds of work like that, and sickness, I get 75 per cent. of the work. He takes a funeral once or twice a quarter, and I take during the winter, anyhow, a great number.

17,586. May one ask, if it not trespassing upon your conscience, what attracted you to this work?—When I came home—my own home was broken up in Petrograd, and I lost everything; I had just been newly married in 1913, and I lost everything I possessed—I came home after demobilisation I was out there all through the Bolshevik business with Lenin and Trotsky. I came out in 1917, then I joined the Navy, and went to Archangel; I volunteered my services. When I was demobilised I had to look round for something, and I found there was an ex-service man wanted as a chaplain to a hospital, and I applied for it.

17,587. You had not had any previous experience?—No. One of the people said to me, "All your work has been among the lunatics outside."

17,588. Now you have had some years' experience of it, do you regard it as a sphere of work attractive in itself?—I certainly think so; of course I have come to like it very much, but it cuts one off entirely from the church outside, as far as the bishops are concerned and preferment is concerned. It is a special form of work. It is the same with the doctors; the medical staff will tell you you are an outsider, almost.

17,589. One wonders whether there is a sufficient career to attract clergymen to join it?—I certainly think so, because it is a thing that is going to increase; the institutions are going to be enormously on the increase. It is only a question of pounds, shillings and pence. It is not a career at present. Down in the East End I was chaplain of the Malvern College Mission, and I got paid for my half-time job very much more than I do where I am at present, although I am running both. I am prepared to work seven days a week. I make enough to live on, and my wife works as well; but so far as attracting a man is concerned, of course it would not, especially now they are making it not a permanent job. I would not have looked at it if it had not been a permanent job.

17,590. What are the terms of your appointment?—I am at the mercy of the committee. I might be turned off at a month's notice, but, of course, coming under the superannuation, they could not turn me off unless for some offence. I suppose that is so; I do not know.

17,591. Is your appointment subject to a month's notice?—A month's notice on either side, yes.

17,592. You are not even under a three years' engagement?—No, I am not under a three years' engagement. Supposing I was found incapable one Saturday night, or something of that sort, and the committee thought fit to turn me down, they might give me a month's notice. If they make other arrangements, if they wanted a chaplain under the new conditions, I do not know whether they could turn me off, but they would have anyhow to pay my superannuation, because I come under certain terms.

17,593. *Mr. Micklem*: Would they have to return your contributions, or more than that?—More than that. A case occurred in one of these other chaplaincies, where the place was pulled down. The chaplain there got a sum of £300, or something of the sort.

17,594. Have not you got a written contract with them?—No, I have no written contract. I do not know what that month's notice on either side really means, except that it is so.

17,595. *Chairman*: Do you contemplate remaining on in this irksome work?—I contemplate remaining on till I am 65.

17,596. And do you feel (again one is asking rather a confidential question) satisfaction in your work; have you the satisfaction that a man has when he feels he is doing useful work?—Most certainly. At Hanwell I have seen a tremendous difference. The patients are so very responsive. The importance of the chaplain's work lies in the fact that he is a permanent officer, and does not change; the medical officers change. In the wards for three months there will be one of the young doctors in charge; the three months come to an end, and he is changed, and another comes on, but he has not got time in those three months to know his patients. I know them, because I am there year in and year out.

17,597. You move about throughout the institution, and without any notice, of course, as to when you are coming; you are at liberty to go anywhere in your own institution at any time?—I do at all odd times.

17,598. And, therefore, you must have opportunities of seeing the institution as it is working in ordinary routine?—Yes.

17,599. I would like to know, from your observation of the way in which patients are treated, and your observation of their day-to-day life, have you seen anything in the nature of ill-usage of a patient?—No, not to my knowledge. I have heard of cases where there has been ill-treatment, but, of course, I have only heard of them because they are cases which have come before the notice of the authorities; they do occur; they are bound to occur; but, personally, I have not seen any.

17,600. You have moved about at all hours of the day?—At all odd times, in and out, in every place—every ward.

17,601. And so far as your observation is concerned, you have not seen anything which called for comment in that respect?—No. I have, of course, seen patients suddenly become violent, and it means there is a rush to get them under, otherwise they would put their heads through a window, or something of that sort, and there are all sorts of funny things, of course, with funny patients. You have to take all things as they come. There was a case of a woman who came into the field and jabbed a pin or something sharp all down here, across my coat (*describing*). I did not do anything, until she passed on. But these patients become suddenly violent, whether they are women or men, and they have to be got under. They have to be taken forcibly under the arms and put into the room where they came from, or put away somewhere.

17,602. I was thinking rather of ill-usage, either malicious ill-usage or punitive ill-usage. Have you seen anything of that sort?—Never.

17,603. Do you take an interest in the general intellectual life of the institution?—I do, yes.

17,604. Is there a library, for example?—Yes; I look after it with the medical superintendent; we agree together what is wanted, but I do all the work there, with a patient under me.

17,605. Do you find that the library is taken much advantage of?—Certainly, in some wards; in other wards they do not care a bit. You send them down something to read and they tear it up; but otherwise the books are used tremendously. They are changed every week; we have got a very large library.

17,606. Is there a demand for religious works at all?—Except for bibles—not for reading purposes.

17,607. You were present while the Bishop of Chelmsford was giving us the benefit of his evidence this morning, and he put forward various views as to the improvement of the status of the chaplains in asylums. We need not cover that ground again, because I take it that what he has said has your entire agreement?—Yes. I thought I was coming to give evidence of my work there; but I personally wanted to press that home, because I think it is very import-

22 May, 1925.]

Rev. W. E. C. BARNES, M.A.

[Continued.]

ant, and I feel that this change that is taking place, making the chaplain no longer a permanent officer, is absolutely wrong. You will not get the best type of man, and it wants the best type of man, because the patients derive a tremendous amount of good from the work of the chaplain, if he is permanent. You asked me whether there was ill-treatment; but on the other hand, I go in on a Monday, we will say, when all the friends and relations are there, and I hear nothing but praise from the friends and relations of the treatment of their friends. Only the other day a certain patient, called E. B., died in No. 3 ward at Hanwell. Her relatives wished to express their thanks to the medical staff, and also to the chaplain for the kindness she had received whilst she was in the institution; and I received the other day a crucifix to be placed in the chapel in memory of their relative. That shows anyhow that there is the other side to it. I have told you that, because one reads a lot in the papers about ill-treatment going on. I must deny that, knowing the staff as I do, both the nursing and the medical staff, intimately. Of course, cases do occur when you get a person who is cruel by nature; they are eliminated if the case comes before the authorities; but I have never seen during the whole time anything untoward happening.

17,608. How many cases have there been during the time you were there which were investigated by the authorities—if you knew about them?—I just happen to hear of them if I happen to be in the medical superintendent's house at the time, or in the doctor's house, when the case is on. I have known of two.

17,609. When was the last one?—About two months ago, and I think there is one coming on now.

17,610. These are official investigations into cases where cruelty is alleged?—They are coming before the medical superintendent, yes. But in the kind of ward, where the other case occurred, it is very difficult. I will just tell you the difficulties. We get a strong man—a tremendous chap, I am thinking of; his great idea is that the people who are keeping him there are the doctors. He says: "I am going to get so-and-so in time"—thinking of a certain doctor or a medical superintendent. The other day he did get the medical superintendent; he met him in the field, and he gave him a tremendous blow *here*—(describing); it took eight men to get that man under. Those are the difficulties we have to put up with; and sometimes a patient comes up against a young attendant, very likely. I do not know what class the male attendants are taken from, but the females are taken from the servant class. If you get a malicious attendant she is going to take it out of the patient, until she is found out. With a tremendous staff of 500, cases do occur, but when they are known they are tried, and the evidence is all for the patient and not for the nurse.

17,611. Of course, it is quite obvious that you cannot eliminate every possible chance of ill-treatment occurring, because there are so many people, but what one is desirous of achieving, if it is possible, is to have it ensured that when such cases do occur they are brought to light, and the persons who have been found in the wrong are properly dealt with?—Yes.

17,612. Such cases of course will occur, and will occur under any system; but so far as your experience goes, have the cases which have occurred been brought under the cognisance of the authorities? Take the case you spoke of as occurring two or three months ago?—Certainly; the man was dismissed, and they are very, very severe when it does come up.

17,613. As long as it is clear that the cases, when they do occur, are investigated and dealt with, that is the important thing to ensure?—Yes; but it is wonderful, really. I must tell you this. When I was first appointed at Cane Hill I was in one of the infirmary wards there, and there was an elderly man out of bed. I said, "Is that the remains of a bed-sore?"—I could see he had a sore on his back. The

attendant said to me, "Bed-sore? Bed-sore? We never have bed-sores here. He has been in bed 16 weeks now, and he has never had a bed-sore." There are a great number of hospitals—I mean private hospitals—where the patients do get bed-sores. But they are very careful with the nursing, and I must say as far as the cleanliness of the patients is concerned, and the care they get—well, I mean, you could not get better care or more comfort.

17,614. How many attendants have you at Cane Hill?—I cannot give you the exact numbers of the male staff; they are pretty large, because you have to have three shifts nowadays. It is about the same as, perhaps a few less, than at Hanwell.

17,615. Do you move about among the staff as well?—Yes, at all odd times.

17,616. And do they take advantage of your spiritual ministrations?—Certainly, yes.

17,617. They attend the services, I suppose?—Yes.

17,618. Will you tell us what impression the staff has made upon you? You have said that there are some cases, as in every large community, where the staff is not satisfactory; but what impression have you formed of the type of men and women engaged in this service of nursing?—Very excellent, considering, as I say, the type from which they are drawn. I mean, supposing a nurse is not cut out for it, she goes on probation for a short time, and is turned out. But they are an excellent set of girls and an excellent set of men. I am chairman of a social club called "The Nightingale Club" at Hanwell, and I have to arrange all their particular entertainments, both in summer and in winter, and I know them pretty well. I have an excellent choir of men and women at Hanwell. They are awfully keen.

17,619. They have a difficult class of work to do, and they must be subjected very often to very provocative treatment from patients?—Absolutely; most trying circumstances; they have to put up with a good deal. I can think now of a nurse with her finger bitten through; it was not her fault. She will always have a deformed finger until she goes down to her grave. I should be very sorry to put up with some of those patients, and it is wonderful what the nurses do with them, and how kind they are with a great number of them. Of course, numbers of the patients are very, very difficult, those cases who never come out of their rooms, for instance. Of course, a great number of them are absolutely senile.

17,620. Then I think, Mr. Barnes, that with your evidence and that of the Bishop we have had a very full account of the chaplain and his functions in the asylum, and also the points with regard to which you think the present system might be improved—unless you have anything further to add?—No, nothing.

17,621. *Sir David Drummond*: During the course of this inquiry we have heard that it is desirable, or probably will be desirable, to reduce the size of the asylums, to reduce the numbers. In your opinion, if they were reduced, say, to 1,000, would it be necessary to appoint a whole-time chaplain?—I do not know, except that I think it would be most desirable to reduce the numbers.

17,622. We have heard that the asylums at present are perhaps too large, and that it might be desirable to reduce the number in any institution?—Not necessarily a whole-time officer, I should think, except that if you are going to give care to these people you must not get a man who is just going to make it part of his work, and drop in when he likes, and that sort of thing.

17,623. There is one other point I would like to elicit from you. Does the doctor make use of the information that you acquire in your process of interviewing the patients? You probably get a lot of information from them. Does the doctor make use of that information?—Most certainly he would, if I thought fit to pass it on to him. As I say, when

22 May, 1925.]

Rev. W. E. C. BARNES, M.A.

[Continued.]

I go to see him, which is pretty often, I discuss things with him.

17,624. So that you are able to furnish him with useful evidence?—Yes. I just want to put right what the Bishop said this morning. He was wrong about Claybury. I do not think the chaplainship at Claybury is a whole-time job; I think it is only, at the very most, three-parts time—I do not think it is even that.

17,625. *Chairman*: We can ascertain that, of course?—Yes, only I heard it stated this morning, and the statement is not accurate. It is an appointment the same as mine; anyhow, he draws the same stipend.

17,626. *Sir Humphry Rolleston*: Can you give us your idea as to what percentage of the inhabitants of mental hospitals really come within your purview? I mean, the Bishop said that a parish of 1,000 required a whole-time man?—I get 500 to church; of the others, there are certain cases which never come out of their rooms, and there are a certain number who cannot leave the wards, but I deal with the whole lot of them. I deal with them in their side rooms, patients lying in a bed, and never leaving

it, and I deal with the bed cases in the ordinary dormitories.

17,627. How many of those, do you think, are capable of receiving any benefit from your ministrations?—A great part of them.

17,628. 50 per cent.?—More than 50 per cent. I should think. I mean, there it is like being in a parish. You might have a parish of 10,000 people. It is only so because it happens to be divided up into parishes and there are 10,000 people. You look upon them as belonging to you, but there are some you never see; they belong to other denominations. I say prayers in the dormitories and for the bed cases, and talk to them, and see their relatives when they are there.

17,629. You do not think it necessary to make any modification in the statutory directions for the performance of your office?—I think that is the Bishop's point of view. I do not take the full service, merely because it is too long. Where there are four Psalms I only give one; where there are two Lessons I give them one.

Chairman: Thank you very much for your attendance, Mr. Barnes.

(The Witness withdrew.)

Sir ARCHIBALD BODKIN, K.C.B. (Director of Public Prosecutions) called and examined.

17,630. *Chairman*: *Sir Archibald*, we are much indebted to you for coming to see us this afternoon, and there are some matters within your province upon which we should like to have your assistance. I quite appreciate that your relation to this branch of the law is a limited relation, but a very important one. I gather from your *précis* that there are various points, some of them of a technical character, where you think the law might well be amended?—Yes. I think Part XI of the Act of 1890 might well be re-drafted, and very much condensed. I have not pursued the history of each one of these sections, but I have some reason to think that they are survivals from the earlier statutes, and they overlap in certain cases. Their phraseology is not what is usually met with in more modern Acts of Parliament.

17,631. I think that is characteristic of the Act of 1890; there are vestiges in that of previous stages of civilisation which have been carried forward, which is so often the case in a consolidating measure; but now that we have had over 30 years' experience of the 1890 code I gather that quite a number of points have arisen in practice where it would be desirable to effect improvements?—Yes.

17,632. Now Part XI is your province?—Yes.

17,633. And I think we might just go through the sections and obtain from you your suggestions as to the points where amendment is required. If we start with Section 315 that certainly at once strikes a lawyer's eye as an odd provision?—Yes. Might I before dealing with Section 315 mention, in the order in my *précis*, a point that really is of practical importance?

17,634. If you please.—When the Legislature passed the Mental Deficiency Act, 1913, they repealed a section which provided that the Order of the Commissioners should be accepted without further proof; and the result is that as the cases in Part XI are criminal cases, where an Order of the Commissioners is necessary, you have to call somebody from the office of the Board of Control, say, to prove the Order instead; whereas previously to the Mental Deficiency Act, 1913, it proved itself.

17,635. I am quite familiar with that difficulty, and if you omit to prove the Order the proceedings will be quashed for informality?—If the gentleman on the other side, if I may use the expression, spots it.

17,636. *Earl Russell*: You do have to prove by-laws if you proceed under them?—There are various provisions which enable you to get out of that. You have a sealed copy which you keep, and there are

provisions for proving Statutory Rules and Orders which relieve you very often of the necessity.

17,637. It seems childish to have to prove this?—Yes. There is a clause in a Bill now before the House, called the Criminal Justice Bill, which is to do away with the necessity of proving signatures and Orders of public authorities. For instance, as you know, *Sir*, there are cases where the Attorney-General's fiat is necessary; some cases where there has to be a certificate or a consent of the Board of Control, the Inland Revenue, the Customs and so forth. That clause sweeps all these matters up into one and enables the document to prove itself; and this defect, which has resulted from the Mental Deficiency Act, will be cured if that passes into law.

17,638. *Chairman*: Is it Section 152, the repeal of which has caused the trouble?—Yes.

17,639. Probably the point which you have in mind was not adverted to by the draftsman when he repealed Section 152?—No; perhaps he did not visualise the really practical difficulty. I have no doubt it is a very pleasant holiday for somebody from the Board of Control to go down to a place in the country, prove a document, and go back again.

17,640. Therefore you would desire that these Orders should be dealt with by legislation and put in the position of proving themselves?—Yes.

17,641. Just as one knows the King's Printers copy of an Act is evidence, so you wish an Order to be evidence that such Order was made?—It proves itself with all its mistakes, one of which appears in this part of the Lunacy Act.

17,642. Then we might look at Section 315.—The first subsection of Section 315 deals with two groups of offences. The first is "receiving or detaining a lunatic or alleged lunatic in an institution for lunatics"—otherwise than in accordance with the Act. Now the words "alleged lunatic" of course are inserted because it was necessary to meet the case of a person who is dealt with as a lunatic but is not one, who is alleged to be one, who is treated as one in relation to his reception or detention, although he might not be a lunatic at all.

17,643. *Earl Russell*: Who do you think it is who is to make the allegation? The person detaining him?—It is a difficulty, the alleged lunatic, but I think it means, and is generally accepted to mean, a person who has been treated as a lunatic, the subject of some kind of order or procedure under which he finds himself in an institution for lunatics, but is in fact not a lunatic.

17,644. *Mr. Micklem*: Supposing the certificates are wrong he is an alleged lunatic?—Yes. That is

22 May, 1925.]

Sir ARCHIBALD BODKIN, K.C.B.

[Continued.]

one branch of the subsection. Then the second branch is "for payment taking charge of, receiving to board or lodge, or detaining a lunatic or alleged lunatic, but in an unlicensed house." The great distinction between those two is that the first requires no payment; it implies some irregularity or non-compliance with the provisions of the Lunacy Act in regard to the person's reception or detention. The second one postulates a payment, doing it for money, and in an unlicensed house; and, as I have said in my memorandum, the second group is far more serious than the first group of offences, because in the first the person goes into an institution for lunatics which one assumes (with the strict control of the Board of Control) is a proper place where a person will be properly treated and have proper accommodation; the second is a case in which for money somebody who does not keep a licensed or recognised house at all takes in a lunatic or receives to board or lodge, or detains a lunatic. Therefore the second group of offences I submit involves much more serious matters than the first. But then if you read on in this section you find that the person who offends against either branch is to be guilty of a misdemeanour, and in the latter case shall also be liable to a penalty not exceeding £50. So that in the second group, the more serious cases, those last words "and in the latter case shall also be liable to a penalty" expose him to a pecuniary penalty recoverable before the justices; and the person who offends against the first and less serious part of the clause must be dealt with as for a misdemeanour.

17,645. You do not think the first head is, so to speak, cumulative?—No, because under the criminal law, as the Commission will appreciate, a misdemeanour is an offence which is not a felony, and for a misdemeanour in English law both fine and imprisonment to an unlimited amount may be imposed; and, as I think I said in my memorandum, the only restriction on the amount of the fine or length of the imprisonment is that it should not be unreasonable.

17,646. It is very oddly expressed "in the latter case shall also be liable"?—It is.

17,647. Would not the most appropriate amendment be to split up that subsection into two heads, and then assign a proper penalty to each head?—Yes.

17,648. This attempt to do the two things, to link up two things which are really different in character, as you have pointed out, with differing penalties in one subsection, is very liable to lead to difficulties?—Yes. I was going to suggest a little later that when you come to subsection (2) of this section we get a third group.

17,649. That is so, yes.—"Except under the provisions of this Act it shall not be lawful for any person to receive or detain two or more lunatics in a house" unless it is an institution. In respect of that offence you see they have attached a separate clause to provide for the punishment, subsection (3).

17,650. *Earl Russell*: These are not alleged lunatics?—No, and no payment is necessary under that. I have got one or two criticisms about that clause in a moment, but I was going to suggest that the proper way to deal with this section, as your Chairman has suggested, is to split it up into so many sub-clauses as there are offences, and if the punishment attached to one is to differ from the punishment attached to another, make it perfectly clear. But I think in such cases, as I have said, it would be quite possible for any offences under Part XI to provide a comprehensive punishment of a fine of £50, or whatever the pecuniary penalty is, and/or imprisonment for three months on summary conviction; or if the case is a serious one, provide that it be dealt with on indictment, when the maximum pecuniary penalty shall be X pounds and/or imprisonment.

17,651. *Chairman*: With whom would lie the discretion to direct that the matter be dealt with sum-

marily or on indictment?—Usually it is the prosecution who submit to the Court that the case is a serious one, and the matter should go for trial. There is a very little, but there is a little, difference in the initial stages of laying the information, and so forth, for a summary offence, and laying the information for an indictable offence; there is a very little distinction. If a precedent is wanted there is a precise precedent that just occurs to me, the Merchandise Marks Act, 1887, Section 2, or 3 I think it is, which provides for the offences being summary offences, but allows the magistrate to commit for trial.

17,652. *Earl Russell*: The discretion would reside with the justices.—Yes.

17,653. *Chairman*: I think under the Merchandise Marks Act, if I remember rightly, the person accused is entitled to ask that his case be submitted to a jury.—Yes, he has that in addition; but if he consents to a summary jurisdiction after that option has been given to him, and the punishment is more than three months, he then has a right to claim a jury; but even if he elects to be dealt with summarily, the magistrate may say "No. I think I shall send this case for trial."

17,654. *Earl Russell*: But you leave the option with the magistrate?—Yes, I think so.

17,655. It might scarcely be safe in these cases. I have known cases, and so have you, where magistrates ought to have sent cases for trial and have dealt with them too lightly?—Yes.

17,656. *Mr. Micklem*: Under that first clause, supposing you recovered a penalty by summary proceedings, say £50, would it be possible to indict for the same offence?—No; he would plead *autrefois convict*, and the way we look at things in these non-technical days, even if the offence were not technically the same but arose out of the same set of circumstances one would regard it *autrefois convict*.

17,657. In taking summary proceedings, could you apply for the penalty plus imprisonment?—That would be in the discretion of the court; one would not make for an application for a man to be punished in any particular way, but I think it would be well to provide that the Court of Summary Jurisdiction might both impose a pecuniary penalty and in addition imprisonment in some serious case; and there are numerous precedents to that effect in statutes.

17,658. *Earl Russell*: In statutes, but it is unusual to give a sentence of both fine and imprisonment in this country?—I think not.

17,659. *Chairman*: It would not be fine and imprisonment, it would be penalty and imprisonment—it is not quite the same thing?—I think "fine" and "penalty" are interchangeable in connection with criminal matters. You get the word "fine" under a conviction, or "penalty" under a conviction. I do not think there is any technical distinction between the two.

17,660. Recurring to Section 315 one cannot but notice, and indeed your memorandum draws attention to the curious variation in terminology through it. The language used has not the precision with which one expects a criminal offence to be described. Take the words, for example, "receives or detains" in the first group. In the next case it is "takes charge of, receives to board, or lodge or detains," and in the third case it is "receives or detains."—You revert to the first clause in the terminology there.

17,661. Expressions like "takes charge of," "receives to board or lodge or detains" I should have thought were very difficult of precise ascertainment.—Yes, and it has a very practical result. I have taken the view for what it is worth that a person who receives a lunatic, or receives a lunatic to board or lodge, or takes charge of to board or lodge, if he otherwise contravenes Section 315 has committed the offence on the day that he receives him.

17,662. And the six months' limit will apply?—Therefore the six months' limitation in all summary proceedings dates from that date.

22 May, 1925.]

Sir ARCHIBALD BODKIN, K.C.B.

[Continued.]

17,663. The act of reception being the offence?—The act of reception, the act of taking charge of, is the offence.

17,664. That is in contradistinction to "detains" which contemplates a continuing act?—Continuing detention.

17,665. "Permits the continued residence of a lunatic or alleged lunatic," is your equivalent for receiving?—Yes. I should keep the language of the clause as it is, but I should add "or permits"; and then I thought this afternoon, on just looking at this before coming here, of a little addition "or permits or is a party to the continued residence of a lunatic or alleged lunatic." That would get over the obstruction of the six months' limitation in regard to the act of receiving, or the act of taking charge of, which perhaps one does not hear of for a year afterwards.

17,666. How does this relate itself to the voluntary patient who may be a new feature in lunacy administration? Of course he already exists in certain types of institutions; but it seems to me you might have a person who was a lunatic taken charge of, without committing any offence, if that was a voluntary person and (though a lunatic) desired to enter an institution and was there taken charge of and received. We would need, if we are introducing the system of voluntarism to take care that Section 315 did not forbid that; would not that have to be guarded?—Yes, I think it would. I am not familiar with the administration of this Act, but I know of one institution in London where frequently people who are a little on the border line voluntarily go for care and treatment and receive very considerable benefit there, but they perhaps do not go as lunatics or alleged lunatics. If they go as lunatics there must be reception orders I think.

17,667. Of course the safeguard is to be found in the words "except under the provisions of this Act," and therefore there are certain ways in which persons may be received or detained lawfully. This is striking at unlawful reception or detention, otherwise than under the provisions of this Act?—Yes, or if in the earlier part of this Act, or any new Act, there were provisions recognising voluntarism, then it would not be contrary to the provisions of the Act to take a person for care or treatment.

17,668. That is exactly what I have in mind. If you amended the body of the Act, then of course the amendment would form part of the Act and anything done would be done in pursuance of the provisions of the Act?—Yes, and, in compliance with them, would be legal.

17,669. *Earl Russell*: Supposing a fraudulent relation puts his brother away with a corrupt doctor, the brother being perfectly sane, you would take the view that he could not come under this section as an alleged lunatic if he held no certificate of insanity. You would go for him in the ordinary way for false imprisonment?—If it was for payment would it not be taking charge of?

17,670. But who has alleged that he is a lunatic, that is my trouble?—If he is not treated at all as a lunatic?

17,671. No?—The criminal law would probably meet that by a prosecution for imprisonment.

17,672. No doubt it would, but this particular section would not hit that?—I do not think it would.

Chairman: Section 317 would catch him;—"Any person who makes a wilful misstatement of any fact"—this would be a wilful misstatement that A.B. was of unsound mind.

17,673. *Earl Russell*: I am assuming there was not any petition—that he was put away?—A mere incarceration.

Earl Russell: Yes.

17,674. *Sir Humphry Rolleston*: But the word "alleged" there would cover the case that Lord Russell suggests?—If the wicked brother affected to deal with his brother as a lunatic, I think he might then be regarded as an alleged lunatic.

17,675. Is not that why the word "alleged" is put in?—Yes. I think it was put in because, if it were not, the subsection would only deal with lunatics as defined under the Act. The person who is being wrongfully detained might not be a lunatic as defined by the Act, but yet have been purported to have been sent there as a lunatic; therefore, they adopted the phrase "alleged lunatic" where something like the procedure of the Lunacy Act was adopted in regard to him, but wrongfully, so that while he was not a lunatic he was being incarcerated as if he were one.

17,676. *Earl Russell*: Of course, we have similar words in the earlier part of the Act where the relieving officer can take charge of people on his own motion when they are alleged to be lunatics?—Yes, until the justice supervenes.

17,677. *Chairman*: You have not any difficulty with the words "takes charge of," have you, Sir Archibald?—That again is in the present tense, and it is in conjunction with "receives." I do not know what a court would say.

17,678. "Has in charge" would rather be your idea?—Yes; that is not the expression used.

17,679. *Mr. Micklem*: There has not been a decision on the section, has there, to which you refer?—There have been decisions, but not on this language.

17,680. *Chairman*: In actual practice, have you found difficulties such as you are discussing with us?—I have found difficulties. For instance, it is contended that those words "and in the latter case shall also be liable to a penalty" put a limit upon the penalty even where the trial is on indictment.

17,681. *Earl Russell*: It does look like it when you say "not exceeding"?—Yes. First of all, you are met with a little difficulty in the English language. Under subsection (1) you have got five different things provided against: receiving and detaining a lunatic, for payment taking charge of, receiving to board or lodge or detaining a lunatic in an unlicensed house—and yet it goes on to say "and in the latter case." Personally one has a little difficulty in finding out which is the latter of five.

17,682. *Chairman*: But it is comparatively easy to proceed to tear to pieces any section of almost any Act; yet we are perhaps more concerned with whether in the actual administration of the Act these are practical difficulties which have been encountered or are merely theoretical ones which you and I can rear up out of the Act?—I have to think of them beforehand, but I do not want to conceal from the Commission that they are very often rounded off with the good sense of the tribunals of the country. There is no reason why they should not be put in such language as even an alleged lunatic can understand.

17,683. Have you ever found yourself debarred from instituting a prosecution, because of the six months' period which applies to summary prosecutions, in the case where a patient has been received unlawfully, where you would have thought it desirable to have prosecuted were it not for the phraseology of the section?—I have taken the view more than once that a case which may be a contravention of Section 315 was of such a character that it would be proper to prosecute it summarily; but with all the expense and delay and trouble involved in an indictable procedure, which was the only course possible because of the six months' limitation, did not think it was a case which would justify such expenditure.

17,684. Then you have had actual practical cases?—Yes.

17,685. *Earl Russell*: Cases not very serious, but cases in which there should have been prosecutions if you could have proceeded summarily?—Yes, you must have a sense of proportion, of course, and in a slight case you ought not to have to go for trial to the assizes and face a grand jury and a petty jury.

22 May, 1925.]

Sir ARCHIBALD BODKIN, K.C.B.

[Continued.]

Chairman: I think we have your criticisms both on the structure and the terminology of Section 315.

17,686. *Earl Russell:* Just before we leave that, does not Sir Archibald think that there is a reason for the difference between the words "receives and detains" and the other words? Do you not think "receives and detains" were meant to be applicable to the institution?—When you come to subsection (2) you get "receives and detains" in a house which is not an institution.

17,687. Yes, you do, that is quite true.—The word "detains" is the word that ought to be there, but I am bound to say I very very rarely hear of any case of actual detention.

17,688. *Chairman:* That is interesting. All cases would not necessarily reach you, would they?—The Board of Control generally, I think always, send their cases to me.

17,689. *Earl Russell:* Do you find as a rule that these cases are cases of real wrong-doing, or that they are more technical breaches with good intentions?—I think the cases in which there is any hardship or improper treatment of patients are very very rare. Of course there are houses that you would not like to see relatives housed in, they are rather bare and scanty, I hear, sometimes, but, speaking generally, the old days of any cruelty have long since passed. You get males using the same public rooms and sitting rooms as females, and things of that sort, but generally the cases that I see are cases that might be almost called borderline cases of insanity.

17,690. *Chairman:* The gravamen of the crime, of the offence, under Section 315, really is detaining as a lunatic a person who is not a lunatic, applying the coercions which are legitimate in the case of an insane person to a person who is not insane. Is that case frequently brought under your notice?—No.

17,691. Have you very few cases of it?—I have been functioning for five years, and I suppose I have not heard of more than eight or ten cases in those five years—about two or three in a year. Then a year passes.

Earl Russell: The mischief I think is the secrecy—that is the mischief the Act aims at, the fact that no authority knows where these people are, or what is happening to them.

17,692. *Chairman:* Have you no duty of investigation? These cases reach you on report, so to speak?—I have to get satisfactory evidence together.

17,693. You do not initiate investigation until the matter is brought within your official cognisance; therefore there may be cases, of course, which do not reach you. You address yourself to your task after a case has been brought to your notice by somebody else?—Yes. Now and again the Secretary of the Board comes and sees me about a case with regard to which the Board of Control would like to hear anything I should have to say about it, before they send it to me. One works in the greatest harmony with, and receives the greatest assistance from, the Board.

17,694. Then under Section 317 one finds you mentioned by name in subsection (3)—I think you have some comment to make upon that?—I do not know why I am dragged in there; that must be more or less a modern clause.

Earl Russell: Is that the only place in the Act where you are mentioned?

17,695. *Mr. Micklem:* Do not some of these ex-patients come and worry you, and try to make you take prosecutions?—They do not come and worry me; my room is upstairs; there are various Rubicons to pass.

17,696. Have you not communications with them from time to time?—Oh yes.

17,697. Is not this intended to give them the right to come to you as their adviser to direct proceedings?—Under Section 317?

17,698. Yes.—No, I think if you look, it prohibits a wilful misstatement in the petition, or in some

formal document. I never get those formal documents.

17,699. Do not some of the ex-patients communicate with you and suggest that false statements have been wilfully made under which they have been certified, and that some prosecution should be taken?—Yes, sometimes; very rarely. Then I should ask the Board of Control if they would be good enough to let me see their file relating to that person.

17,700. *Chairman:* Supposing you found that, in fact, there had been a wilful misstatement of a material fact in a petition, would it not be useful that you should be in a position to direct a prosecution to proceed?—Yes, but the section also contemplates that the Commissioners or Board of Control shall make an order for it, and they would be much more likely to hear it; of course they get the official papers and I should refer any such complaint, if I thought there was any substance in it, to them; then they would consider it and assist me by looking into the question as to whether there was in fact any false statement.

17,701. *Earl Russell:* Unless it is suggested they are not doing their duty, there is really no point in putting you or the Attorney-General in?—No, not in putting me in.

17,702. *Chairman:* Of course, again in this case, if you were instituting a prosecution for such a wilful misstatement, you would have to produce in the proceedings an order authorising the prosecution?—Yes.

17,703. *Earl Russell:* Would he, under this?—No; my powers are only limited to Section 317.

17,704. *Chairman:* That section begins, "A prosecution for a misdemeanour under this section shall not take place except by order of the Commissioners." If I were defending a person I should ask, "Would you be good enough to produce an order by the Commissioners or a direction of the Attorney-General, or a direction of the Director of Public Prosecutions?" Would I not be entitled to see that? One or other of those various acts should have preceded the prosecution?—Certainly.

17,705. Would it not be rather ridiculous for the Director of Public Prosecutions to produce the order for the prosecution which he himself was conducting?—Yes; he would be directing or misdirecting himself.

Earl Russell: I am not sure about that. There are plenty of cases where it rests with the Director whether a case should be prosecuted or not.

Chairman: The question is whether there should be a formal order.

17,706. *Mr. Micklem:* May it not be inserted there, because possibly you may be the only source through which one of these patients may get justice?—I really do not know. I have no objection, of course, to it at all; I do not mind it, but it seems unnecessary, because the Board of Control are so alert in looking after the complaints that come in.

17,707. *Chairman:* At any rate, the fact remains that you have never had to avail yourself of it?—Yes. If I am to be the protector of these possibly unfortunate people why am I not given a power under Section 315? I am just as likely to hear of some breach of that clause as any other, but it is specially assigned to me to direct prosecutions under Section 317; although when you get on to Section 325 you find that "Except as by this Act otherwise provided proceedings" may be taken by so-and-so and so-and-so, and then sub-section (2) is "Except as by this Act otherwise provided, it shall not be lawful to take such proceedings except by order of the Commissioners or of visitors having jurisdiction in the place where the offence was committed, or with the consent of the Attorney-General or Solicitor-General"—whereas when you go back to Section 317 you find that the only reference to "Except as by this Act provided" is the reference in sub-section (3) to myself.

Chairman: Then the Solicitor-General comes in in Section 325 for the first time.

22 May, 1925.]

Sir ARCHIBALD BODKIN, K.C.B.

[Continued.]

17,708. *Earl Russell*: Does "Attorney" include "Solicitor" in the fiat?—Yes, unless the language is definite.

Chairman: Is there any real justification from the practical point of view in this curious classification of the offences against the Lunacy laws? I can imagine that the penalties to be meted out for the offences would naturally be graded according to the gravity of the offences, but these peculiar conditions precedent of prosecutions, and the modes of prosecutions seem to be unnecessarily complicated, unless there is some reason at the back of them which I have failed to detect.

17,709. *Earl Russell*: I suppose you will agree that it is desirable that the public at large should not be able to prosecute all these alleged breaches?—I think so, yes. A kind of veto is preserved to official persons; the Board of Control or the Attorney-General, or myself.

17,710. *Chairman*: I was thinking rather that the application of the veto might be on a more uniform basis?—Yes.

17,711. As regards Section 315 for example, I suppose the offence thereby constituted would be a case in which proceedings could not be taken except in conformity with Section 325?—Yes.

17,712. Therefore you would have to satisfy the conditions precedent of Section 325 before you could initiate a prosecution under Section 315?—Yes. The practical way in which it works is this: the Board get some information, perhaps the Lord Chancellor sends an expert gentleman to the establishment, who reports that A, B and C are certifiable lunatics; no reception orders, nothing. The Board hear that, send the papers to me. If I find that I can get evidence of payment, if it is for payment, and taking charge of, or other evidence of the essentials of the offence, I intimate it to the Board. Next I get an order, then I lay the information.

17,713. Can you conceive of any reason why there should be attached to prosecutions under Section 317 this speciality which you find in sub-section (3)?—No, none.

17,714. It is probably just a historical survival?—It is.

17,715. Could it be brought appropriately within the general ambit of Section 325, and would that afford sufficient protection?—Yes. I seem to be getting increasingly unpopular, but I do not mind. At the end of Section 325, if it be thought right it might read: "But this provision shall not apply to proceedings instituted by the Director of Public Prosecutions," so that that would give me the right to institute proceedings without an Order of the Board, and as my office is under the Attorney-General, for I act under his directions, it will perhaps not be necessary to trouble about it.

Sir David Drummond: Is there any fear of these penal clauses cutting at what we are all concerned with, the early treatment of mental cases, and the reduction of the number of certified patients?

Chairman: I think, Sir Archibald has met our apprehensions on that by pointing to this, that all those offences are offences alleging non-compliance with the Act. If the Act is amended by making provision for early treatment by proper methods then no one would be brought under the lash of these penal provisions because they would be acting in conformity with the law as amended. I think that is the answer to that. That would, of course, require to be made clear; the draftsman who carried our recommendations into legislation would have that plainly in view.

Earl Russell: Section 315 will have to be amended in its verbiage.

Chairman: I think so.

17,716. *Mr. Micklem*: Outside the Lunacy Law altogether, as Director of Public Prosecutions do you always act under the direction of the Attorney-General, or do you act on your own authority?—No, my chief is the Attorney-General, and under the Prosecution of Offences Act I act under his directions.

17,717. Cannot you act except under his fiat?—Yes, I do. I mean it is impossible with 2,500 cases a year to be dealing with the Attorney-General in each case. He has his own official duties; but it works very well. Most things are left to the Director of Public Prosecutions, and it is in his discretion if he gets a difficult case or a case of great gravity, to consult with the Attorney-General.

17,718. *Earl Russell*: Historically you are partly the successor of the Treasury Solicitor?—Yes; the offices were combined in the days of Sir Augustus Stephenson and Lord Desart, and then they were separated in 1908.

17,719. *Mr. Micklem*: I think there is an idea in the public mind that they can come to the Public Prosecutor and enlist his sympathies on their behalf, and get him to direct a prosecution in certain cases?—Yes, but I do not direct prosecutions. I have to undertake them, I am the one who initiates and carries on, but at the same time I am not the Public Prosecutor. I wish people would not get that into their heads—I am only the Director of Public Prosecutions. If I were Public Prosecutor there would be a great many more people prosecuted by me, but I am not. I am the Director of Public Prosecutions, of such prosecutions as affect the public or of a class specified under the statutory regulations under which I act.

17,720. *Earl Russell*: Or I suppose as the Attorney-General directs you to prosecute?—Yes.

17,721. *Chairman*: You are not like the holder of the office which I formerly held, who is the Public Prosecutor. The Lord Advocate for Scotland is the Public Prosecutor.—Yes; I am not claiming to be put upon a level in that respect; there is quite enough to do without that.

17,722. Again you draw attention to the curious variations in phraseology. The last word in Section 320 is very odd, the person "sued"?—Yes. There is no such thing, of course, in criminal proceedings as suing for penalties; you prosecute him and the Court imposes a punishment.

17,723. Now in Sections 317, 318 and 319 I think your view is that it would be much better if you had a uniform system and the alternative of summary proceedings?—Summary proceedings, alternative by indictment in really grave cases, or where the limit of time does not permit of summary proceedings.

17,724. *Earl Russell*: I should like to ask you one general question on summary proceedings. There is a great tendency nowadays to make a great many cases triable summarily?—Yes.

17,725. Do you think that may operate unfairly by not giving the accused a chance of a verdict of a jury?—I do not think so. If he should be convicted he can appeal to Quarter Sessions.

17,726. But again he does not get a jury?—No, but he gets the whole concentrated wisdom of the justices of the county at Quarter Sessions.

17,727. In London a man goes to Quarter Sessions with two magistrates sitting, one, it is true, a paid and legal Chairman?—Yes. I am very strongly in favour of Courts of Summary Jurisdiction being given even a larger jurisdiction than they have; I think the work is admirably done.

17,728. It is very convenient, and I agree on the whole it is admirably done, but in some classes of cases the accused may find himself prejudiced?—Do you not think that benches of justices now are about the most democratic tribunal one can think of? The justices are appointed from all levels of society?

17,729. I am not sure that my mind was not running on some of the old stipendiaries?—Yes. I am in favour of Courts of Summary Jurisdiction. The penalties are, after all, very small, comparatively speaking, and the thing is over very quickly, and there are large powers of mitigating imprisonment or fines, and large powers of allowing fines to be paid by instalments, and so forth; so that if Courts of Summary Jurisdiction do their duty according to the powers they possess they cannot be called harsh.

22 May, 1925.]

Sir ARCHIBALD BODKIN, K.C.B.

[Continued.]

17,730. It is true the machinery is excellent, I agree?—Yes.

Chairman: And it certainly is a great advantage to have despatch.

17,731. *Earl Russell*: And to avoid, of course, waste of public money in an indictment?—Yes.

17,732. *Chairman*: I omitted to notice in passing one point you make with regard to two or more lunatics. Again I do not suppose that has arisen in practice?—I have never met with such a case, but it only occurred to me—you receive two or more. If "receive" points to the moment of reception they must simultaneously arrive; and those are not alleged lunatics in that clause.

17,733. The two lunatics must arrive together in a taxi?—Yes.

17,734. *Mr. Micklem*: I should like a case to come in the High Court of Appeal and have a decision on that?—Yes; I think it would give rise to some ingenious arguments.

17,735. *Chairman*: I think it would. Of course one does not want the law to expose itself to ridicule of that sort?—The word there ought to be "harbour"—"except that it should not be lawful for any person to harbour or detain two or more."

17,736. Then you have detected an anomaly also in Section 321?—Yes, there is an extraordinary thing. If you look at the end of Section 315 (1) "shall be guilty of a misdemeanour and in the latter case shall also be liable to a penalty,"—then you come to Section 321 "liable to a penalty," that is the summary penalty, "and shall also be guilty of a misdemeanour"; but the unfortunate thing is that every person who commits a summary offence also commits a misdemeanour. The words are meant to provide punishment on indictment if necessary.

17,737. It is a very odd thing?—Yes, and may I call the Commission's attention to the beautiful gradation of sub-clauses (1) and (2)—if you obstruct a Commissioner or a visitor then you may be fined £50, or you may also be dealt with on indictment, but if you only obstruct a person authorised by the Lord Chancellor or other person inspecting, then your obstructing him is not so serious, and you can only be fined £20, and cannot be punished on indictment? It is drawing invidious distinctions.

17,738. There is no principle in that, Sir Archibald.

Earl Russell: These certainly want looking at in the interests of Sir Archibald's Department, I think.

17,739. *Chairman*: Plainly. Then I think Section 327 is worth considering, because we have had references to it before in our proceedings. It was thought that the order of the justices there might apply to a reception order. That is one view that has been taken by an Association that appeared before us?—Yes, so that a person in an asylum under a reception order to which he takes exception may appeal to Quarter Sessions against it.

17,740. I took the liberty of explaining at the time the point came up that I did not think the order of the justices meant that kind of order at all. But the language is unfortunate. What do you suggest there?—Conviction. I think, if I may say so, it points to the convictions under the preceding clauses.

17,741. That is how I read it myself.—The word "order" in summary matters is a technical expression, and under the Summary Jurisdiction Act, 1879, a person is entitled to appeal against a conviction or an order.—Section 31. An order ordering the payment of money; an order in bastardy; an order for demolition; an order for 50 things—you may appeal to Quarter Sessions. That is not a criminal offence at all; that is an order, as you would get an order in the High Court.

17,742. *Earl Russell*: You have got this exact phrase in previous Acts, "Any person aggrieved by an order of the justices"?—Yes, but the unfortunate thing in Section 327 is that there is not in this

part of the Act a single order contemplated; they are all convictions.

17,743. What is an order of the justices that a person should be bound over? Is it a conviction, or an order, or is it neither?—I am afraid you have put a very ingenious illustration. Binding a person over is not a conviction of a criminal offence; it is a precautionary measure.

17,744. Nor is it an order from which you can appeal, I think?—No, I do not think you can.

17,745. I think it depends upon their old common law jurisdiction to take sureties of the peace, like the case of Mr. Pickwick in Ipswich?—Yes, under the commission of the peace.

17,746. *Chairman*: It does not even say an order of the justices under "this part of the Act"?—No.

17,747. It is "under this Act"?—Yes.

17,748. That is rather calculated to mislead people, because a reception order after all under this Act is an order of the justices under this Act?—Yes, but I think I may say that there never has been an appeal against one to Quarter Sessions.

17,749. *Chairman*: It manifestly applies to the case of any person who has been convicted?—There is another thing about Section 327, if I may say so, which confirms your view that "order" means conviction there: "subject to the conditions and regulations of the Summary Jurisdiction Acts." Nothing under the Lunacy Act comes under the Summary Jurisdiction Acts so far as the reception order is concerned.

17,750. Then in Section 328 you also wish to draw our attention to a point, I think?—I am afraid that was not very seriously intended as a criticism, but a Secretary of State, on the Report of the Commissioners, may direct the Attorney-General; when all that the Commissioners of the Board of Control have got to do is to make an order themselves and send it to me.

17,751. It seems surplusage?—There might be cases where they would desire the approval of a Secretary of State.

17,752. Then you indicate, of course, that the Attorney-General may decline to accept the directions of the Secretary of State?—I do not know what would happen. A Cabinet crisis!

17,753. *Earl Russell*: Clearly a change of Government?—Probably meanwhile I might hear of it and be getting on with the case.

17,754. *Chairman*: While these high matters were in debate?—Yes.

17,755. It rather looks again as if that were a survival from something which had preceded; it seems to be idle as it stands?—Yes. There is only one other point: Section 331.

17,756. That has been repealed by the Public Authorities Protection Act, 1893, and the six months limit is fixed there. In Section 322 you have noted in passing that the word "patient" there might not be held to include voluntary patient?—Have I noted that?

17,757. It is the very last sentence of your memorandum, and I can see the point, because that is the section dealing with ill-treatment, and of course it would require to be made abundantly plain, that it would cover not only certified patients, but that ill-treatment of voluntary patients should also be an offence?—Yes, certainly.

17,758. Of course it is a different kind of offence in one sense, because if it was a voluntary patient not certified then it is really a common law assault?—Yes. I was going to say the Offences Against the Person Act practically covers all cases of ill-treatment to another human being.

17,759. But it has been deemed proper apparently to regard ill-treatment of patients in an asylum by the officials of the asylum, the nurses, and so on, as an offence by itself.

Earl Russell: That is because they are unable to take proceedings for themselves.

22 May, 1925.]

Sir ARCHIBALD BODKIN, K.C.B.

[Continued.]

17,760. *Chairman*: Yes, because the person assaulted is not capable of taking the ordinary remedies?—Yes, but what is a very serious offence in ill-treating or being cruel to a patient in an asylum seems to me to be treated with remarkable leniency by the maximum penalty of £20, and the minimum of £2. The ordinary law is much more severe than that.

17,761. *Earl Russell*: I suppose if it were a serious ill-treatment you would have a charge under the Act of 1861?—Yes.

Chairman: Well, we are much obliged to you for drawing our attention to these anomalies in that part of the Act.

17,762. *Earl Russell*: There is one more question I should like to ask. Have you looked at the extra-

ordinary distribution of penalties under Section 326? Is there any reason for retaining that odd way of distributing them? It is a most unnecessary complication, is it not?—You see, Sir, my duty ends by getting the penalty inflicted; I do not care where it goes.

Chairman: The subsequent proceedings do not interest you any further, but it does seem anomalous; the disposal of the proceeds of your labours seems to be a little odd.

17,763. *Earl Russell*: It is better from the point of view of the county that they should all go to the county funds?—If the Commission would like to suggest an addition to paragraph (e), "or to the Director of Public Prosecutions," I should be quite happy.

(The Witness withdrew.)

(Adjourned to Monday next at 11 o'clock.)

5, OLD PALACE YARD,
WESTMINSTER, S.W.1.

THIRTY-THIRD DAY.

Monday, 25th May, 1925.

MEMBERS PRESENT:

MR. N. MICKLEM, K.C. (*in the Chair*).

THE EARL RUSSELL.

SIR ERNEST HILEY, K.B.E.

SIR DAVID DRUMMOND, C.B.E., M.D.

MR. H. SNELL, M.P.

MRS. C. J. MATHEW.

MISS MADELEINE SYMONS.

MR. P. BARTER (*Secretary*).

MR. W. FAIRLEY (*Assistant Secretary*).

Evidence of The LORD SANDHURST and Mr. G. M. HILDYARD, K.C. (Master in Lunacy).

The LORD SANDHURST, called and examined.

17,764. *Deputy-Chairman*: The Commission this morning is to take evidence in connection with lunatics so found by inquisition and other persons whose cases have been judicially treated under Section 116, and Lord Sandhurst who is one of the Chancery Visitors is to give us the advantage of his experience and knowledge in these matters. Lord Sandhurst, I think you have been for many years one of the Chancery Visitors?—Since November, 1910.

17,765. And you have had a very large experience?—I have had some experience by this time.

17,766. Now I think it will be of advantage if, in the first place, we were just to turn to the sections of the Act under which the Chancery Visitors are appointed, and to deal with their duties of visitation, and so on; I think the appointment is made

under Section 163?—I have not got the section before me, but I take it from you.

17,767. There are both medical and legal Visitors?—There are two medical and one legal Visitor.

17,768. There is no provision made under the Act confining it to three?—Well, there is no power to appoint more than three that I am aware of.

17,769. At all events only three have been appointed?—Only three have been appointed and, so far as I am aware, there is only power to appoint three.

17,770. It may be so under the Rules, but I do not think the Acts says anything about it. Section 163 says "There shall continue to be medical and legal Visitors of lunatics so found by inquisition, and they are in this Act referred to as the Chancery

25 May, 1925.]

The LORD SANDHURST.

[Continued.]

Visitors"?—Yes. That appears to continue what was the practice before. There were two medical Visitors and one legal Visitor before this Act was passed and the words are "shall continue to be."

17,771. I see Section 167 says: "The Chancery Visitors and the Masters or so many of them, not being less than three in number, as may from time to time be able, consistently with the discharge of their other duties to attend, shall from time to time form themselves into a board for their mutual guidance"?—Three is only a quorum.

17,772. A quorum of the board?—Yes.

17,773. It does not limit the number of Masters and Visitors to be appointed?—No.

17,774. As a matter of fact there is only one Master now, Mr. Hildyard?—Yes, and I think that was done under an Act of Parliament. There were two Masters down to the death of Sir David Brynmor Jones; and pursuant to a recommendation of the Royal Commission on the Civil Service, the staff was reduced to one Master, and certainly an Act of Parliament was required, and an assistant Master was appointed to exercise the powers practically of a Master.

17,775. Mr. Theobald I think was the first Master?—Mr. Theobald was the first single Master.

17,776. Then the provisions for visitation are contained in Sections 183 to 186?—Yes, and there is a provision under the Rules of Lunacy, rule 5 of the 1893 Rules.

17,777. I am afraid I have not got a copy of those Rules. What is the rule?—That is a rule which enables the Master to direct a visit in any case in which an application for an order appointing a receiver is pending, or in which an order has been made under Section 116.

17,778. And he appoints one of the Chancery Visitors for that purpose?—Yes, he appoints the Visitors in terms.

17,779. I observe that in the Act, Section 183, the visitation is of lunatics so found?—I think the correct interpretation is that the whole of that group of sections applies only to lunatics so found.

17,780. Subject to Section 184. It says "The Chancery Visitors shall also visit such persons alleged to be lunatics"?—I think that relates to persons with regard to whom an inquisition is pending or has been applied for; I think that is the strict interpretation of it.

17,781. It would seem that it must apply strictly to that. It cannot mean alleged to be lunatics at large, so to speak?—No. It might mean persons alleged to be lunatics with regard to whom either an application has been made or has been granted for a reception order—it might mean that.

17,782. Would not that be interfering rather with the other jurisdiction? Would not that be going outside the Lord Chancellor's special jurisdiction?—I agree with you. I do not think that the section properly interpreted does apply to lunatics other than lunatics so found, or persons with regard to whom an inquisition is pending, but it is capable of interpretation. I mean one sees so many cases, or one used to when the title was rather different from what it is now; "re so-and-so, a lunatic not so found by inquisition."

17,783. That would appear in the ordinary Chancery pleadings, of course?—Yes.

17,784. We have heard the phrase once or twice before, and we have not quite understood what it was intended to mean; but in some places in the Act it might mean persons who had been certified as lunatics who were really sane?—That may be so in some of the cases, yes. It certainly might apply to a person with regard to whom a reception order was being asked for; but I think, having regard to the whole of the group of sections, that here they are really speaking of inquisition cases.

17,785. If you please. I observe in Section 185 special reports have to be made in certain cases and

particularly where the Visitor is unable to discover the residence of the lunatic?—Yes.

17,786. Curiously enough they do not insert there the "lunatic or person alleged to be a lunatic"?—No. It has only occurred to me once to make a report to the Lord Chancellor in a case of that sort, and that was a case not of a person so found by inquisition; that was a lady who had been certified, who had been discharged, and with regard to whom the order appointing the receiver was in force. It was a peculiar case.

17,787. Would your visitation be confined to persons so found, or in respect of whom inquisition proceedings were pending, or in respect of whom some judicial proceedings had been taken under Section 116?—Well, I suppose strictly speaking that would be so, but I think it has happened that when the Lord Chancellor has received a letter from a patient which has troubled him he has asked one of his Chancery Visitors to go and visit, although there might not be any proceedings for administration of the property.

17,788. I am referred to Section 205 which perhaps would cover that, "The Lord Chancellor in the case of a lunatic so found by inquisition, and the Lord Chancellor or a Secretary of State in any other case, may at any time, by an order in writing under the hand of the Lord Chancellor, or the Secretary of State, as the case may be, directed to the Commissioners or any of them, or to any other person, require the persons or person to whom the order is directed to visit and examine a lunatic or alleged lunatic"?—He certainly has power under that section.

17,789. Those are special visits outside what one may call inquisition visits?—Yes.

17,790. Now with regard to lunatics so found you have to pay two visits in every year?—Two visits in every year in every case.

17,791. And I suppose your visit is connected not only with the person of the lunatic so found, but with his property, is it?—It is so far connected with his property—I think there is a direction in the Act that we are to be informed of the amount of income and the amount of expenditure; and of course when we visit the patient, to consider the comfort and the manner in which he is maintained, we have to do it with relation to his income; so we require to know something about his property; and we may make recommendations about his property. We may, for instance, recommend that a portion of his capital should be sold and applied for his benefit, or even that his capital might be more profitably invested, that a house might be sold and the proceeds invested in some other form.

17,792. I suppose the main part of your duty in connection with these persons is to ascertain what their bodily and mental condition is, and how far they are treated with care and in comfort?—Yes; those are our duties with regard to them.

17,793. Now you have given us in the appendix of your *précis* some useful figures which indicate the number of cases which come under, or may come under, your jurisdiction. I think you say in your *précis* the number of lunatics so found at the present moment is only about 200?—Yes, it is 219.

17,794. But in addition to that you have your cases where a receiver has been applied for; and the cases on the Master's books approximately number 6,100?—That is information we derive from the Master's office.

17,795. And in all those cases there is a possibility of your being asked to visit?—There is.

17,796. As a matter of fact the number of cases on the Visitors' books is 1,100?—Yes; that is the figure our Secretary has ascertained.

17,797. Of these, 219 are inquisition cases; 500 are cases under Section 116, subsection (d) which are not detained. In many of those cases it would be where the person is of weak mind?—In a good many cases

25 May, 1925.]

The LORD SANDHURST.

[Continued.]

they are weakminded persons. I think I should say the vast majority are really cases of infirmity arising from old age.

17,798. And they are cases where the relatives, I suppose, have taken proceedings on the footing that the person was unable himself to manage his affairs?—Yes.

17,799. Then 300 are cases in institutions for the insane?—Yes.

17,800. And the balance would be cases under Section 116 (c) or (c)?—I do not know; I have not enquired about it. I do not know whether those 300 cases include or do not include the inquisition cases who are detained in asylums.

17,801. Now I was going to ask that question, Lord Sandhurst. Where you have an inquisition case sent to an asylum, or sent to a licensed house, are those patients subject to the enquiries which are directed in ordinary cases as well as to your visitations?—The Commissioners certainly regard them as patients to see. They are supposed to see every patient in an asylum.

17,802. Yes, but you see special provision is made under the Act for their visitation by other persons as well?—Yes.

17,803. Do they get, so to speak, a double set of visitations?—Inquisition cases do, yes. There was one qualification I ought to have made; I thought perhaps you would come to it in your next question. When I said that every inquisition patient had to be visited twice, every patient so found by inquisition who is in private care is expected to be visited four times in a year for at least two years after the date of the inquisition.

17,804. Is that merely a matter of practice?—No, that is in the Act of Parliament. It is the third subsection of Section 183, "Every lunatic resident in a private house shall, during the two years next following inquisition, be visited at least four times in every year." I merely call attention to that because inquisition cases are so rare now that we have not got more than two or three of what we might call "the four visit" cases in our list now.

17,805. A lunatic resident in a private house would not have the advantage of other visitation?—He does not have the advantage of visitation by anybody else.

17,806. Then I observe in your *précis* you say that special visits by request in the year from April 1924 to 1925 numbered 234. That means 234 outside those on your list?—Yes.

17,807. Visits paid each year number about 1,850—would a very large proportion of those visits fall to you, Lord Sandhurst?—They are about evenly divided. Our practice is to divide the country into three divisions, the north, the west, and what we call the home district. The home district, I think even now has much the larger number of cases, though the distances are not so great, and it tends to increase. We have been steadily reducing the size of the home district at the expense of the others in order to try and keep the work even, but so far as the list cases go one may say one visits one-third of the cases. There are a good many special visits which are required to be paid by the medical Visitors where there is any difficult medical question. Until quite recently it used to be the practice for all recovery cases—and when I say recovery cases, I mean cases in which the question was whether the patient was fit to manage his own affairs—should be visited by a medical Visitor; but it was found in practice that the medical Visitors really had not time to take all those cases, so that for the last year or two a good many have fallen to me, and I have exercised a certain discretion. If it appeared to me upon the face of that case that it was a case in which there was some conflict of medical opinion, or something of that sort, I should suggest they should go to a medical Visitor. But still a good many of them are pretty simple; a layman can deal with them.

17,808. I see that the Rules authorise you to visit in any cases coming under the Master's jurisdiction and require you to visit where a receiver has been

appointed, but, on medical grounds, it has not been thought prudent to serve the person visited with notice of the proceedings?—That, I think, is Rule 7 of 1919.

17,809. Yes. I have not got a copy of either of those sets of Rules, but they are dealing mainly, are they not, with the property of lunatics?—They are dealing with the property, but they are also dealing with the mode in which the patient is maintained, and with the propriety of an order having been made without the patient having been served with a copy of the summons. It not infrequently happens where a patient is in an asylum that the medical officer is of opinion that he should not take the responsibility of serving a patient with a summons; he says it will disturb his mind; and sometimes the Master asks the medical Visitor to go and enquire into it, and to form his opinion about it. But the Rule requires that, where in any case an order is made without service of summons, he should be visited at an early date by a Chancery Visitor. That is to see that there has been no abuse of the process.

17,810. I suppose the Master would often ask you to visit in order to see whether they should be served with notice of proceedings or not?—It was done several times, I think, until this Rule was passed.

17,811. In face of this Rule it did not really so much matter whether the order was made or not made?—No; it is analogous to the case of a patient who has not seen a magistrate when he is certified; he is entitled to see a magistrate within a few days after a reception order.

17,812. Here you have got a definite rule that they shall be seen?—Yes. In the other case there is an Act of Parliament, of course.

17,813. Is there not rather a multiplicity of the Rules in Lunacy?—They are a little difficult to find certainly. I think it would be truer to say they require codification.

17,814. There must be at least half a dozen different sets of Rules?—I think there are certainly three or four. It was only the other day I was giving evidence in Court, and I was asked under what authority the Master directed a visit, and Counsel in the case had not been able to find this rule—Rule 5 of 1893. They are difficult to find.

17,815. Could you give the Commission shortly the general nature of the ordinary inquiries which you make when you visit these patients?—Yes. A good deal depends upon whether the patient is a new case, or an old case. If it is a new case one invariably pays a surprise visit. Then you ask for the patient. I generally ask something about the patient before I see him; I want to hear what his idiosyncrasies are, if I can. Sometimes I am shown straight into a room where the patients are, and you cannot do that; but it facilitates matters if you can learn something about the patient before you see him. Then one tries to establish friendly relations with him, find out whether he has got any tastes, or whether he can deal for instance with a little pocket money, whether he likes music, whether he likes going for drives, and so on, and then one looks at the premises, one goes and sees his room, and tries to find out whether things are clean, and so forth. In fact, one directs one's attention to everything one can think of which concerns his comfort and wellbeing. I generally find out what is spent upon him; what they do with his money, and how much is paid for his maintenance. Very often you find that relations are, well, a little bit near in dealing with the person with whom the patient is lodging, for instance.

17,816. Is there any authority of any kind which could step in? Supposing the relative of one of these patients is really not paying sufficient or providing proper accommodation, is there any method of stepping in?—Of course, in the case of an inquisition patient it is very easily done. In point of fact within the limits of the maintenance allowance the committee of the person is expected to comply with the directions of the

25 May, 1925.]

The LORD SANDHURST.

[Continued.]

Visitors; and if they do not comply with the directions of the Visitors, we go to the Master and ask him either to put pressure upon the committee, or, if necessary, to remove the committee and appoint somebody else. With regard to patients under sub-section (d), that is to say, patients who are neither certified nor so found, the Master is in direct relation with the only person who really has any control, and that is the receiver, and he gives directions to the receiver. The receiver generally carries them out, but considerable difficulties do arise with some of the sub-section (d) cases, because it is very difficult to keep them in control without some control of the person. I have known one or two cases in which I really felt that the protection of a receivership order was being used to defeat creditors. I mean, the patient was going about apparently sane, ordering goods, and that sort of thing. Then the question arises, how are they going to be paid for? The patient has not got the means, unless he is supplied with the money, and the receiver is not liable. There was one notorious case in which the patient's income was derived from a settlement under which if he purported to charge his interest he was deprived of the benefit of the settlement. He did purport to charge his interest, executed a deed; thereupon the question arose whether he had deprived himself of his interest under the settlement. Mr. Justice Byrne tried the case, and he held that the position was exactly the same as if the patient had been so found by inquisition, and that the settlement was not invalidated.

17,817. I do not quite follow that. Was that on the footing that—?—That a receiver had been appointed.

17,818. Yes, but was that on the footing that he was not mentally in a position to anticipate his income?—No, it was merely that the receiver having been appointed as I remember the case—any dealing with his property was a nullity.

17,819. And you have found, have you, that there are more of these cases?—I have found that. I think I remember one other case in which it seemed to me that unfair advantage was being taken of the position of the patient in having a receiver appointed.

17,820. You rather intimate that in consequence of recent decisions, particularly the Harnett case, medical men have been shy of signing certificates, and accordingly more cases have come under sub-section (d)?—They certainly did receive a considerable shock in the Harnett case. I have met one or two medical men who have said that they are refusing altogether to certify patients. Probably the recent decision in the House of Lords will help to settle things again.

17,821. Still you think that recently there have been more cases under sub-section (d) of Section 116 by reason of the decision?—I was told that; an opinion was given to me in the office. It had not occurred to me myself, but that was an opinion which was offered to me in the office.

17,822. Now, Lord Sandhurst, in addition to those cases which you have told us of, you also visit at the Master's request certain persons who have been discharged, but who are not sufficiently recovered to be entrusted with the management of their affairs?—Yes; there are a good many.

17,823. I suppose those are all cases where there has been an order appointing a receiver?—There has been an order appointing a receiver on the ground that they were lawfully detained; they were discharged relieved in most cases, sometimes I daresay they might have been discharged as recovered, but for some reason, generally because some mental infirmity remains, or perhaps some anxiety not to be worried by their affairs, some of them would rather have their affairs administered by the Court. A good many are really not much better than when they left the asylum.

17,824. Those patients may give useful information as to the treatment they have had in these different

institutions?—Yes, those patients to whom I have been sent to enquire whether they should be restored to the management of their affairs. I always take the opportunity if I can of asking a patient who has been in an asylum what he could tell me about it.

17,825. Now, generally speaking, what has been the information furnished to you?—Speaking generally, with persons of that class one finds them grateful for the care that has been taken of them. It is very common to hear a complaint of a certain amount of roughness and routine, coarse food, and unappetising meals, and that sort of thing.

17,826. Those are complaints made rather by the patients that you visit at the institution?—No, I have met with that with patients who have come out; they tell me, of course, that it is not like being at home.

17,827. Have you had any instances of serious complaints by persons who have come out?—No, I do not think I can recall any cases. Well, yes, I did meet with a case the other day; it had occurred a long time ago, and I have not had any real opportunity of enquiring into it; but the patient, I think, had had his wrist either dislocated or broken by a blow. It was a considerable number of years ago; I visited this patient for the first time (he was one of these people who had been discharged) and he was disposed to make very great allowances. He said that he was hanging on to a bed or something of that sort, and they could not detach his hand and they gave him a blow which, I think he said, broke his wrist—it either broke it or dislocated it; and I must say that gave me rather a shock. It was the first case of the kind I had really met with.

17,828. But had you not an opportunity of making further enquiry about it?—It is a thing that happened 19 or 20 years ago, and I know that the medical superintendent of the asylum, who was then medical superintendent, is dead.

17,829. Mr. Snell: Did the case seem to you, my Lord, to be established?—He had an injured wrist; he could not use his wrist properly, it had never been properly set. Of course that might not necessarily be so, I can only tell you what the patient told me; and that is the only case I can remember of a patient who made what I should call a serious complaint of that sort after his discharge.

17,830. Deputy-Chairman: Most of your visits, of course, are made in private houses?—Yes, the majority of the visits are in private houses.

17,831. That is because most of the patients are people of considerable means, and are sent to private houses rather than to an institution?—They are mostly people with some means, but a good many are in private houses, I think—well, I was going to say because they cannot afford the rates that would have to be paid as a private patient in an institution. I mean that it very often is the case that a patient is maintained at home or with friends for less than he could be maintained for at an institution as a private patient.

17,832. But where a patient is at home and is looked after at home do you visit him there? Have you any jurisdiction?—Certainly we have if their property is administered under sub-section (d), or they may be inquisition patients of course who live at home. The question you ask would apply rather to the Commissioners. A patient under sub-section (d) who is living at home is not under the protection of the Commissioners; the Board of Control have nothing to do with him; it is not until a patient is certified that the Board of Control come in unless they suspect that there has been a breach of the law.

17,833. Under Section 116 the Master has no jurisdiction with regard to the person, has he, except that he can direct the visits?—He has no jurisdiction over the person.

17,834. He cannot say where he is to live?—No, but he can recommend where he is to live, and of course he can put considerable pressure—

17,835. Financial pressure that is?—Financial pressure—upon the receiver. Of course if he thinks

25 May, 1925.]

The LORD SANDHURST.

[Continued.]

that it is a case which ought to be certified, if he is advised that the position is such that the law has been broken, or even that detention in an asylum would offer the best chance of cure, he can put considerable pressure upon a receiver to have the patient certified.

17,836. Do you mean, to get the receiver to present the petition in that case?—Yes.

17,837. Against the wish of the family would that be, or might it be?—The receiver generally is a member of the family, but it might be against the wish of the family. I mean one does meet with cases in which the family are rather anxious to hush things up; there is such a dread of what people call the stigma of an asylum.

17,838. But is it the case that the receiver from time to time does make application by petition?—Certainly; the Official Solicitor has done so.

17,839. Would not that be only in the case either of infants or persons who have no friends, so to speak—nobody who could represent them?—You see, I suppose in the majority of cases the receiver is a friend—I mean he is the person who naturally would present—he has applied for the receivership order, he has been appointed receiver; or some other relative has applied for a receivership order and either suggested or acquiesced in the appointment of some other near relative, so that he would naturally be the person who would file the petition. As I think I say in my *précis*, there are a certain number of cases in which orders have been made under subsection (d) in which the patient really is insane. I remember one case in which (I think he was afterwards certified) the patient hardly seemed safe.

17,840. Now with regard to the complaints which are made to you, Lord Sandhurst, on your visits, may we just take them a little in order. The first is as to the unappetising character and monotony of the food?—Yes.

17,841. That is a fairly frequent complaint which is made?—Yes.

17,842. What has been your own experience as to the facts there; have you considered that question in the institutions and in the homes?—In institutions, I have been into the kitchens and seen the meals that were about to be served, and I have seen the patients having their meals.

17,843. And what should you say on the whole of the complaints made?—I should say that the meals are as good as one can expect in an institution of that character. A very large number of patients have to be provided with meals, and there must be a certain amount of routine about it.

17,844. Of course, the Commission have seen for themselves in a good many of these places, and as far as my own small experience goes I have been rather struck with the excellence of the provision which is made. No doubt it becomes monotonous, but it seemed good in every case that I have seen?—Yes, but not always dainty I should say. I remember not so long ago considering the case of a patient who had some independent means. He was in one of the public asylums as a private patient, and when I went there he was having his tea, and the bread and butter was cut very thick. It was not the sort of thing that one would suppose he had been accustomed to when he was living at home.

17,845. Supposing you on your visitations come to the conclusion that there is reasonable fault to be found, do you make representations to the institution, or do you simply report to the Lord Chancellor?—I report to the Master. I do not think I could say that I ever have been able to report that there was any complaint to be made of an institution which could lead to the Master interfering.

17,846. No, but sometimes a suggestion will go a longish way?—One suggests rather that something more may be done for a particular patient—I mean that he may have some extra allowance.

17,847. You would make that suggestion to the medical superintendent?—No, I should make that to

the Master, and the Master would convey it to the medical superintendent. I should previously ask the medical superintendent whether it could be done within the scope of his practice and facilities that he is able to provide.

17,848. *Sir David Drummond*: Does the superintendent see Lord Sandhurst's report?—No, he would not see my report.

17,849. So that if nothing arose out of your report he would not know anything about it?—He would probably know nothing about it until he heard from the receiver. I should consult him probably before making any report. I always do ask him: "Is there anything more we can do for this patient?"—and so on. "What about his diet? Can you improve his diet at all, or anything of that sort?" and he says "Oh yes, if I could have so much a week or so much a quarter, I can give him some advantages." Then I pass that on to the Master, the Master communicates with the receiver, and it goes through.

17,850. He pretty well gathers the tenor of your report?—Yes. I do not know that I could do my work without a good deal of help from the medical superintendents.

17,851. *Deputy Chairman*: Have you found that they are usually ready to meet your suggestions?—Very.

17,852. Does that apply to the case of patients in private houses where sometimes there is no medical man?—I never met with any difficulty; I do not think I have ever met with any difficulty in getting suggestions carried out.

17,853. There is one question I meant to have put to you before, but perhaps it is rather one that ought to be put to the Master. There is frequent reference to the Judge in Lunacy?—Yes.

17,854. That covers, does it not, the Lord Chancellor and the Lords Justices?—I think the Judge in Lunacy now covers the Master. I have often heard Sir Henry Theobald say—in fact it is so stated in his book—that the Master is now the Judge in Lunacy.

17,855. One of the orders provides that, as far as management and administration is concerned?—Yes; I think the only jurisdiction of the Judge in Lunacy which the Master cannot exercise is the granting of a "supersedeas." I think that has to be directed by the Lord Justice still.

17,856. He cannot direct an inquisition, can he?—He can direct a petition for an inquisition.

17,857. I thought the application had to be made to the Lords Justices of Appeal?—That is so.

17,858. Then you get complaints associated with noisy, offensive and insane patients—that is a question of classification, of course?—That is a question of classification.

17,859. One would realise that those complaints are well founded?—They are very often well founded, and the first people to admit them are some of the medical superintendents. I mean they lament that they cannot classify their patients more, they have not got the means. I think that was one of the complaints which Mr. Harnett most commonly made, and it is a very common complaint.

17,860. What is the remedy—a larger expenditure of money?—I do not think there is any remedy except further expenditure of money. Of course in the most modern asylums—there is one near Basingstoke, and the asylum at Colchester—they have a number of different buildings, so that they have better facilities for classifying patients than they have in the old ones.

17,861. You refer to the Hampshire Asylum at Basingstoke, which is one of the modern ones?—Yes; I think that is the most modern of all. In fact, they have got a special building for general paralytics.

17,862. Is that on the villa system?—It is on the villa system—at least it is what I believe they call the villa system. They have a special villa for general paralytics which they could not fill because

25 May, 1925.]

The LORD SANDHURST.

[Continued.]

they had not got enough general paralytics, and they were using it for some other purpose.

17,863. Then you get complaints of roughness and bullying on the part of the staff. I suppose there you make enquiry when you get a complaint of that kind?—I do, yes.

17,864. Are you able to carry that enquiry through. Do you find you get assistance from the medical superintendents?—They will help you fast enough certainly. Of course there is great difficulty; I always feel there is a great difficulty in satisfying oneself as to whether there is anything in a complaint of that sort or not. Many patients no doubt do require a certain amount of physical force to control them. Again there are a good many patients who are themselves aggressive. Now I was visiting an old gentleman the other day, quite a senile case in an asylum; he was not always in bed. He was in bed when I saw him, and they told me he required a great deal of observation, because he was rather impulsive, liable to hit out, and if he was to hit out some other patient would probably hurt him. It is very difficult to satisfy oneself that there has been serious ground in a complaint of that description; at the same time one is almost disposed to wonder whether there is not possibility of ground for complaint.

17,865. I suppose human nature being what it is, it is inconceivable from time to time that a nurse may not exercise quite sufficient patience to govern his or her temper?—That is so, I think. Of course they have great opportunities, and very often great provocation.

17,866. *Sir Ernest Hiley*: Might we know what Lord Sandhurst does when he gets one of these complaints made to him?—I should ask the nurse or the superintendent.

17,867. Do you investigate it yourself?—As far as I can; I talk to the nurses, and then I talk to the medical superintendent about it, and I am generally satisfied that there really is nothing that one can lay hold of.

17,868. *Miss Symons*: Do you ask other patients about it in any case where the patients suggest that they might know?—I think I have done so.

17,869. *Deputy-Chairman*: Supposing you were not satisfied quite with the result of your own investigation, should you make a report and could the Master or somebody else direct a formal enquiry?—The only persons who could direct a formal enquiry would be the Commissioners, and if I thought that there were serious cause to suppose that there was anything like ill-treatment of patients I should report to the Master, and the Master would probably communicate my report to the Commissioners. That would be the course that I should probably suggest.

17,870. But that would apply, would it, in the case of ordinary institutions where the Board of Control has jurisdiction?—Yes.

17,871. It would not apply to your cases in private care?—No, not to uncertified cases.

17,872. Supposing any of those cases came before you?—Then one would have to enquire into it to the best of one's ability and one would suggest the removal of the patient to some other care.

17,873. *Sir Ernest Hiley*: In your 15 years' experience, how many times have you had to report a case of a complaint of ill-treatment or bullying, or anything of that sort?—Well, I do not know that I could answer that question, but it would be very seldom. I mean, when I have reported I have reported my conclusion upon it, which I think I may say has always been that on the best enquiry I could make there was no serious foundation for the complaint.

17,874. *Mr. Snell*: The only source of complaint, Lord Sandhurst, would tend to be from the patient himself, the aggrieved person?—Yes.

17,875. It is never reported to you by other patients that another patient has been assaulted or harshly treated?—I should not like to say that, but I do not think it has ever been reported to me on

evidence—I mean one has known a patient who has reported that sort of thing.

17,876. *Sir David Drummond*: Are you concerned with what I call the therapeutic treatment of the patients at all?—Very little.

17,877. Do you enquire into the treatment, whether the patient is allowed out, whether he has got occupation?—Yes I enquire into that. I do not consider that I am in a position to advise, but I enquire very much as to their occupation and their opportunities for going out, and that kind of thing. I mean, sometimes one does enquire, for instance, whether a patient has been treated with thyroid extract, or whether a general paralytic has had any special treatment, and so on, but not in the way of advice, only in the way of enquiry.

17,878. Generally speaking, what determines whether the Visitor would be a legal or a medical Visitor?—It is only accident in a way. The routine work we do in rotation. That is to say, I have got the home district this year; next year I shall have the northern district, and the medical Visitor will have the home district. If there is a medical question, and the Master particularly asks for a medical Visitor, he goes and visits. Sometimes it happens that the Master asks for a legal Visitor to visit when he wants something enquired into, but in the ordinary course we work in rotation.

17,879. *Deputy-Chairman*: I am not quite sure that I did not mislead you just now in a question as to whether the Commissioners could interfere in the case of a private patient. I think under the Act probably they could visit a private patient in an institution?—Yes, certainly anybody in an institution.

17,880. And in single care too?—I am not certain that they can. They certainly have no jurisdiction to visit a patient under subsection (d) unless they suspect a breach of the law or cruelty, or something of that sort.

17,881. But after inquisition?—After inquisition, I am not aware that they have any power to visit an inquisition patient in a private house. They may have it. As a matter of practice I do not think they ever do it.

17,882. You are suggesting they could only do it where there had been certification and not a finding on inquisition?—Yes, that is what I believe to be the case.

17,883. Then the next complaint which is constantly made to you is with regard to alleged inattention on the part of the medical superintendent?—Yes.

17,884. That again appears to be rather a common form of complaint?—Yes. I have met with that in large institutions, and in perhaps one small institution. In a large institution it usually amounts to this that they do not see the medical superintendent and they are not content really with the assistant medical officer who is in charge of the ward in which they are.

17,885. Have you yourself formed any definite view as to the duties which the medical superintendent should have to undertake in these large hospitals; whether he should be responsible for the whole administration indoors and outdoors, or whether he should confine his attention rather to the medical side?—For what it is worth my opinion favours his confining his work to the medical side. I think it is a misfortune that a skilled alienist should have to devote a great and probably the greater part of his time to administrative details.

17,886. You have considered the question pretty carefully in connection with many of these institutions?—I have considered it, and I have discussed it with medical officers. I am not sure that they all agree with me.

17,887. No, there seems to be a very great difference of opinion?—I think some of them would prefer to have the whole administration under their own

25 May, 1925.]

The LORD SANDHURST.

[Continued.]

hands. I suppose they think there would be a loss of control.

17,888. And a sort of rival jurisdiction in some cases?—Yes.

17,889. There might be considerable friction between the head of the administrative department and the head of the medical department?—As far as I know it answers very well in some of the military hospitals.

17,890. I was going to ask you whether there were cases in which administration is separated in any of these institutions?—The only institution I can call to my mind has nothing to do with lunacy. It is the facial hospital in Sidcup in Kent where the Commandant is a layman. He happens to be a friend of mine, so that I know about it. Of course he has a medical staff who attend to all the medical work; and there the system appears to work very well.

17,891. It has never been tried, has it, in any mental hospital?—I am not aware that it has ever been tried in a mental hospital. Of course in the large mental hospitals the medical superintendent delegates a good deal to the steward.

17,892. No doubt some medical superintendents could delegate very much better than others?—Yes.

17,893. And many of them would have a natural leaning towards administrative work; others, on the other hand, would have a very strong dislike to it, and they would manage somehow or other to get it into other hands under their control?—Yes.

17,894. It would depend very much upon the personality of the medical superintendent?—No doubt.

17,895. Do you think there is any good ground of complaint that there is not sufficient medical superintendence by the assistant medical officers?—No, I do not think so; they seem to me to be always about the wards.

17,896. I suppose a great many of the patients would have a sort of idea that their case was of great importance, and that the medical superintendent should be constantly seeing them?—That is very common indeed.

17,897. Then you come on to the final complaint which is more or less universal, the complaint of detention?—I should like to say that I am not quite satisfied sometimes as to the amount of medical supervision in private institutions. You do find cases in which a medical officer may have a general practice, and is the proprietor of a private institution.

17,898. Are you thinking of the licensed houses?—Yes, licensed houses. Of course there is a provision that no licensed house with a licence for a number exceeding 50, I think, may be without a resident medical officer; but I am not sure if it would not be a good thing if there were some provision in the case of a private institution above a certain number that it should have a medical officer in constant attendance.

17,899. Is there some section of the Act that covers that, Lord Sandhurst?—There is a section of the Act which requires that there shall be a resident medical man in the case of a licensed house licensed for a certain number of the patients.

17,900. "In every house licensed for 100 patients or more there shall be resident as the manager and medical officer thereof a medical practitioner. Every house licensed for less than 100 or more than 50 patients shall be visited daily by a medical practitioner"?—Yes.

17,901. That is Section 228?—Yes.

17,902. "Every house licensed for less than 50 patients (in case the house is not kept by or has not a resident medical practitioner) shall be visited twice a week by a medical practitioner." That was the section probably that you were referring to?—Yes, that is the section I was thinking of. I do not know whether there is any means of enforcing it by law, but it has struck me. I am thinking of one particular asylum where the complaint has been made to me so often, both by people in the asylum and people who

have left it, that they do not see enough of the medical officer.

17,903. Was that an asylum where there was a resident medical officer?—Yes, and I have felt that there must be something in it. It is rather difficult to see what the remedy is.

17,904. *Mr. Snell*: Have you found that that particular medical officer against whom the complaint has been made has had many administrative duties to do?—No; I think he has things to do outside.

17,905. Outside the institution?—Yes, outside the institution.

17,906. *Deputy-Chairman*: Lord Russell calls my attention to sub-section 4 of Section 228. "The visitors of any licensed house may direct that such house, and the Commissioners may direct that any licensed house shall be visited by a medical practitioner at any time or times, not being oftener than once a day"—instead of twice a week?—Yes.

17,907. But those visitors would be the justices' visitors of course?—They would.

17,908. And the Commissioners would act upon a suggestion by you, or they might act.

Earl Russell: No, I do not think so; I think the Commissioners have a free hand under that surely.

17,909. *Deputy-Chairman*: They have a free hand but I meant if Lord Sandhurst in one of his visits came to the conclusion that there was not sufficient attention by the medical officer he might draw the Commissioners' attention to the fact?—The trouble arises really from the idiosyncrasy of the medical officer. He may go through the wards and visit the patients, but then again he may not give the patients the opportunities that they like and even that they perhaps ought to have of talking to him.

17,910. *Earl Russell*: You mean it may be perfunctory?—It may very easily be perfunctory.

17,911. *Mr. Snell*: Does sub-section 4 mean an additional medical practitioner?—An independent medical practitioner.

Deputy-Chairman: I should have thought not. The words used in each of the sections are "a medical practitioner." It might mean the same or another one.

17,912. *Mr. Snell*: One would assume that there would be a regular medical practitioner attached to the place and that this would be someone additional appointed for the purposes of checking?—That appears to be supplementary really to sub-section 3 which requires a visit twice a week, but the Commissioners may direct more frequent visits.

17,913. *Deputy-Chairman*: Yes. I think, *Mr. Snell*, that the words are perfectly general; it might be the same medical practitioner or another one. (*To the Witness*). Have you had reason to call the attention of the medical practitioner in any case to slackness in seeing the patients or to complaints made by them?—I think in this particular case I have called attention to it.

17,914. *Sir Ernest Hiley*: What has happened then, Lord Sandhurst?—The answer has been "Oh, but there is Doctor so and so; when I am not here he sees the patients." I think that has been the sort of answer. In the particular case I think the medical superintendent's wife was really better known to the patients than the medical superintendent himself; and as I say there is very little one can do to prevent the work being done in a perfunctory manner except not advise people to send their friends there.

17,915. *Deputy-Chairman*: You are up against the personal equation again?—Yes.

17,916. Now the final complaint which has been constantly made to you is the one of wrongful detention?—Yes.

17,917. That is extremely common, so common that it might be called almost universal?—No, I should not say it was almost universal. The vast majority of patients in asylums, of course, are really chronic cases of dementia and they live a perfectly contented, more or less, animal life. Then again there is a considerable number of patients, particularly of

25 May, 1925.]

The LORD SANDHURST.

[Continued.]

the melancholic type, who may suffer from recurrent attacks, or are generally permanently in a melancholic condition, and they feel safer in an asylum than they do anywhere else; they make no complaint. The patients who most frequently complain of detention are patients suffering from mania, either chronic or recurrent mania—they do not feel any sense of ill-being at all, and think they are perfectly entitled to be at large. But the patient who raises the most difficult questions is the paranoiac, the man who has some delusion, some fixed series of delusions, generally of persecution, which render him potentially unsafe to be at large, and whose mind remains perfectly clear to the end of his life probably; he does not sink into dementia except with regard to this one series of delusions; nothing will satisfy him that his beliefs are not wellfounded, and of course nothing will satisfy him that he is not a proper member of society to be at large. It becomes very difficult in those cases, and it must be very difficult to determine whether his delusions are such that they really ought to entail his detention in an asylum, or whether he ought to be at large. I may mention a particular case. I went to see a gentleman who had been detained in Camberwell House. I had great difficulty in finding him; my colleague had failed to find him altogether. On making enquiries I found a gentleman in the house who more or less answered the description, and I had an interview with him, and he told me that he knew the gentleman I was seeking for, that he was not the gentleman himself. Then I got him to tell me something about him, and I said, "Are these comfortable lodgings that you have got here?" "Oh yes," he said, "the lodgings are all right, but they do peculiar things." I said "What is it that they do?" "Oh," he said, "they pump electricity into you." Then, of course, I found I had got hold of my man. He has escaped from Camberwell House, and he has been at large now for a considerable number of years doing no harm to anybody, living rather a restless life because when he has been for a couple of months in a lodging he believes he is subjected to this persecution, and moves on to another, but he has certainly justified his escape. This was after his escape that I had difficulty in finding him; my colleague failed altogether because he was living under an assumed name. It was only by accident that I found him myself.

17,918. It sounds as though you had detective work as well as ordinary visitation?—In this case one had.

17,919. *Mr. Snell*: His delusions were apparently harmless to other people?—His delusions were harmless, but if he got it into his head that a particular person was causing him trouble he might become dangerous. That is the reason why medical superintendents are so reluctant to discharge a patient of that kind.

17,920. *Earl Russell*: Yes, that is the trouble, that they may fix persecution on some individual, and then get an animus against that person?—Yes; they always regard them as potentially dangerous.

17,921. *Deputy-Chairman*: In the course of your visitations and your experience have you ever met with any case you thought was wrongfully certified or wrongly detained?—I have never met a case which I thought was wrongfully certified, but I have met with cases where I thought the detention had been longer than necessary.

17,922. Do you mean you have come across any cases where a patient has clearly recovered, and has yet not been discharged?—No, I do not think I could say that even. In some cases which have been discharged I think that probably a medical man would very likely form the opinion that the patient has not really recovered, although the discharge has never resulted in any harm.

17,923. Of course discharging a patient is a great responsibility on the medical superintendent?—Yes, a great responsibility.

17,924. And it involves the determination of a very difficult question, does it not?—It does.

17,925. But have you come across any cases where you have considered that the patient was what I may call wilfully detained, that is to say detained when the medical superintendent had formed an opinion that he was safe to be out?—Those are two rather different questions, I think. I have never found a case in which a person was wilfully detained in the sense that the medical superintendent would regard him as safe to be out if left to himself; but I think there are many cases in asylums in which the medical superintendent would gladly grant a discharge, if only some responsible person could be found who would undertake to keep an eye upon the patient.

17,926. Yes—you mean that a patient may not have fully recovered soundness of mind?—The mind remains permanently deteriorated to a certain extent.

17,927. The patient is in the position when he ought to have some after care and he cannot get it, and there the medical superintendent has, you think, kept him longer than is necessary for his own safety or the safety of the public?—The medical superintendent is very often begging the relatives, or suggesting to the relatives, that they might safely take them away, but the difficulty he is up against is that he cannot find anybody who will take the responsibility, or, perhaps I ought to say, face the trouble.

17,928. What possible remedy is there for that—nothing but the extension of after care provision, is there?—Nothing but the extension of after care provision, and bringing home to people the responsibility which they ought to face. Of course one does meet with great nervousness on the part of relations, and where there are no near relations, I was going to say, great reluctance to take trouble. One always has a case, I suppose, in one's mind—I have a case of a lady who was for a long time in St. Andrew's Hospital at Northampton; she was very eccentric, and whenever I went there she begged me to take some steps to get her out. Her property was administered by a brother-in-law who lived in Liverpool, and has since died. I think I am right in saying he took no interest in her. It could not be said she was not lawfully detained, and as long as she was there she was perfectly safe and well cared for, and from his point of view no doubt that was the end of his responsibility. Well, the medical superintendent, probably quite rightly, did not feel justified in discharging this lady because he did not think she could take care of herself, and her property is still administered under the direction of the Court. One of her friends who suffered from recurrent insanity had had an unusually long remission and the medical superintendent gave her leave of absence on trial. She wrote to her friend and said: "Why do not you come here?" and it was arranged that she should go to the same house. When she was there the clergyman of the place interested himself in her and he found her another lodging. As a matter of fact her trial was extended from time to time. Eventually I think a brother turned up who took an interest in her and finally she was discharged. She has a brother who has taken over her affairs and with whom she is *en rapport* and she now leads a very happy existence. There is still some mental infirmity left no doubt, but that just illustrates the sort of case that one is up against.

17,929. In this connection you think that Section 72 of the Act is not altogether satisfactory?—Is that the section which gives the petitioner the control of the person?

17,930. The right of discharge. Section 58 is the first section which deals with moving from one institution to another?—Yes.

17,931. "A person having authority to order the discharge of a private patient from an institution for lunatics, or of any single patient may, with the previous consent in writing of a Commissioner, by order in writing direct the removal of a patient" to another institution. Then Section 72 is "A private

25 May, 1925.]

The LORD SANDHURST.

[Continued.]

patient detained in an institution for lunatics, or under care as a single patient, shall be discharged if the person on whose petition the reception order was made by writing under his hand, so directs"?—Yes.

17,932. I gather that your view is that that is not altogether a satisfactory provision?—I do not think it is altogether satisfactory. The person who files the petition may really do so in consequence of an accident. It is almost an accidental matter and it certainly does seem a very large power to place in the hands of the person who merely presents the petition.

17,933. It would not be so usually, would it? Usually it would be one of the near relatives who would present the petition?—That is so, but the trouble is you cannot always trust the near relatives. They are saved an immense amount of trouble by a patient being cared for in an institution. In my opinion a very serious question might arise if the recommendation of the majority Report on Divorce Law was carried out. I can quite imagine a very serious conflict of duty and supposed interest if residence in an asylum for a certain period were to entitle the other spouse to divorce.

17,934. *Earl Russell*: Before you leave that illustration you gave us, I rather wanted to pursue what I think was at the bottom of it. Is that sort of patient really actually happier, do you think, outside the institution, than in it?—The individual that I am thinking of is infinitely happier.

17,935. Is that due to the sense of freedom?—To the sense of freedom and to the sense of responsibility and to the absence of stigma.

17,936. All those three things?—Yes.

17,937. So that really if you can get them outside the institution, it is to their advantage?—Of course that depends upon the patient.

17,938. I mean, supposing that no harm will come to them?—Yes. I should still say that it is not only no harm coming to them, it is a question, no doubt, of the degree of their mental stability; but if they are capable of appreciating the advantages of being free agents, well, then I should say, undoubtedly, they are happier out of an institution.

17,939. *Deputy-Chairman*: It depends upon the patients and upon the surroundings to which they can come?—Yes, very largely upon that.

17,940. *Earl Russell*: I was thinking of cases in which possibly a well managed institution might be more comfortable than the home of a particular relative who might like to have you?—More comfortable very often, but that is not the whole story.

17,941. *Sir David Drummond*: What does Lord Sandhurst feel with regard to Section 77. The exercise of a certain right by the visitors to discharge a patient possibly against the wishes of the superintendent?—Of course that only applies, I think I am right in saying, to an asylum, to a public institution.

17,942. That we understand?—As a rule one meets with no reluctance on the part of medical superintendents in the public institution to discharge patients as soon as they are fit for discharge, because there is such a demand for accommodation that they are really only too glad to discharge a patient if they can.

17,943. I know, but this is a discharge which three visitors can grant?—Yes—I am afraid I cannot throw much light upon that. I imagine that is a power which is very rarely exercised.

17,944. *Earl Russell*: We should have thought never, but as a matter of fact Sir David and I have come across cases where it has been exercised against the advice of the superintendent?—Yes. I am afraid I cannot throw any light upon that; I have no experience on that subject.

17,945. *Deputy-Chairman*: Lord Sandhurst, may I go back to Section 72 for a minute. You think that that may not be the happiest provision that could be made, and I gather you think in cases which have come before the Master and orders have been made for a receiver and so on, that probably it would be better to let the receiver have the right of discharge rather than the petitioner?—Yes, I have thought so.

17,946. But may I put this to you? It has struck me before that with regard to Section 72 it may be doubtful whether this throws any responsibility at all upon the petitioner—whether it is not merely inserted in the Act in order to give him some right, if he chooses to exercise it, to be some protection for the person in the asylum. But is not the real responsibility for discharge upon the medical superintendent under Section 83? You see under Section 83: "The manager of any hospital and licensed house, and a person having charge of a single patient, shall forthwith, upon the recovery of a patient, send notice thereof in the case of a patient not a pauper to the person on whose petition the reception order was made, or by whom the last payment on account of the patient was made, and in the case of a pauper to the guardians." Then sub-section 3 is: "In case the patient is not removed within seven days from the date of the notice he shall be forthwith discharged." Is not the responsibility really for discharge and the sole responsibility upon the medical superintendent?—That is upon the recovery of a patient.

17,947. Yes, that is "discharged recovered"?—Yes.

17,948. But until the patient has recovered is there any obligation or responsibility upon the petitioner to obtain his discharge?—The responsibility, I take it, upon the petitioner, is to provide as far as possible for the happiness and welfare of the patient. Now if the patient is in such a condition mentally that he or she might be at large under some degree of supervision, it seems to me that the petitioner is under very serious responsibility if, to the unhappiness of the patient, he keeps the patient in an asylum longer than necessary, or in an institution longer than is necessary although he may not have recovered. The difficulty arises with the patient who is lawfully detained. I cannot say in any of these cases the patient was not lawfully detained. I do not think I have ever met with a case in which the patient was not lawfully detained beyond, probably, a certain period necessary to ascertain whether recovery was really established.

17,949. But in most cases the petitioner himself, or the receiver in the case where an order has been made by the Court, would have very little opportunity, would he not, of judging whether it was a case for discharge or not?—If the petitioner does his duty or the individual who is responsible for the person of the patient does his duty and visits and makes the proper enquiries, and says to the medical superintendent "Now, how is the patient getting on? She begs me to take her out. Can it be done?"; then the medical superintendent may say: "Yes, it can be done, if you will undertake to see that she is cared for; put her in a nice home and see that she is cared for."

17,950. *Earl Russell*: My objection to Section 72 is rather on the ground of public policy, that is to say giving a private relation the right to turn a lunatic loose upon the world?—Of course, it is always open to the medical superintendent to refuse permission for discharge in the case of a patient who is dangerous, either to himself or to others.

Deputy-Chairman: That is under Section 74.

Earl Russell: Yes, that is true.

Deputy-Chairman: Dangerous or unfit to be at large.

17,951. *Earl Russell*: The superintendents would be reluctant to give their barring certificate, would they not?—I do not know that they would. Of course there are not many patients who are really dangerous.

17,952. Then there is another objection it seems to me, that the petitioner might desire to remove a lunatic for improper purposes, either for the purposes of starving them or shortening their lives because they were an expense, or to get possession of their money by undue influence, or some reason of that sort?—The cases I am thinking about are cases in which the

25 May, 1925.]

The LORD SANDHURST.

[Continued.]

patients' money is in safe keeping. The possible suggestion that I make is that there shall be one authority, namely the receiver, who is necessarily responsible to the Master and who should have the control of the patient's person as well as of the patient's money.

17,953. *Deputy-Chairman*: One always thinks of a receiver in a different connection from that. I mean the idea that the receiver should have any personal control over the lunatic, seems remote from the idea of a receiver rather?—He gets it in a good many cases because in every case in which a patient is originally a pauper patient, there is no petitioner, and if it turns out that he has got money, a receiver is appointed and the receiver makes the last payment, and then he is the petitioner.

17,954. *Earl Russell*: A receiver would not be discharged from the care of the property without satisfactory evidence of the care of the patient?—No; that is an entirely different proposition. The Master is not at least bound by the discharge of a patient.

17,955. *Deputy-Chairman*: In all those cases there would be a formal visit by yourself?—Yes, unless the Master is not satisfied with a medical affidavit, which he sometimes is, of course.

17,956. Then there is another matter which you think is not quite satisfactory, the visitation by the petitioner. Do you think the petitioner ought to pay more than one visit in six months?—Yes.

17,957. The section is Section 5 of the Lunacy Act, is it not?—I do not say that the petitioner should visit more than once in six months necessarily; but as a matter of fact it provides that undertaking and no human being knows how that is to be enforced; and after all it is a very flimsy undertaking. He has to visit either personally or by someone specially appointed by him. There is no provision that any authority is to be satisfied that the person who visits is a proper person to visit, and as far as I know there is no means of enforcing the undertaking. I think Sir Henry Theobald in his book suggests that it might possibly be a subject of contempt of Court. I have known of an action being commenced against a petitioner for not visiting. I do not know what would happen to that action.

17,958. You do not remember the form that action took, do you?—I do not know, but I suppose it was based upon *Ashby v. White*, in Smith's "Leading Cases."

17,959. Was it a motion to commit for contempt?—No; it was an action for breach of duty (at least. I presume so; I have not seen the pleadings) on the ground that there was no wrong without remedy.

17,960. It would be a little difficult to prove damages, would it not?—That is another matter; if he could prove that he would have been discharged earlier if he had been visited.

17,961. Can you suggest any remedy for this—any better form of provision for this?—I think it certainly would be desirable that there should be some means of enforcing the undertaking, and I think that the person appointed to visit should be approved by some authority, by the Board of Control or somebody. You see there is no protection to the patient; there is nothing to show that the visitor is to be agreeable to the patient.

17,962. But the Act provides other visitations for all these patients?—Yes; they are all by officials. The object of this section, I presume, is that a patient should have a visit from somebody that he really knows, somebody that he can confide in.

17,963. There are also dangers there, are there not? A person he knows may be an unsatisfactory person to visit him?—He may be.

17,964. And always assuming that there has been anything in the nature of collusion to get a man away or anything of that kind?—I am very much struck by the fidelity of the relations in the poor cases. They are constantly visiting; they visit once a week, many of them, and the patients welcome the visits of their relations.

17,965. But does not that obtain with the wealthier patients?—I do not think it obtains to the same extent. The friends of the wealthier patients have more calls upon their time, I think. I do not think that the wealthier patients are visited as frequently as the poorer ones.

17,966. *Sir David Drummond*: Are they not at a greater distance?—That may be; that has something to do with it, no doubt. There may be reasons. I mean I do not want to make any charge, but I do notice, or I think I have noticed, that the poorer people visit their friends in asylums more regularly than the well-to-do.

17,967. *Deputy-Chairman*: Now, Lord Sandhurst, we should be very glad to get your view about the licensed houses. That is a matter to which your attention, I think, has been specially directed: whether there should be any amendment of the Act in that respect and whether the numbers should be increased?—I think it is a misfortune that no licensed house can be created.

17,968. You think they perform a very useful function and are wanted?—I do. There are two or three I could name. I have named one of them already, Camberwell House for instance, Peckham House which is its neighbour, and Ticehurst; there are numbers of them which perform most useful functions.

17,969. Which are really required—there is really a demand for them?—Yes. At Camberwell House the difficulty is to get the patients admitted.

17,970. *Earl Russell*: They are not allowed to increase the number of beds?—They are not allowed to increase the number of beds in the licence, and you cannot have a new licence, and I do not think you can move a licensed house (I think I am right in saying that) out of its district into another. That is a difficulty which Chiswick House, which is an excellent house, has been up against; they would like to move into the country, but they cannot do it because they would lose their licence.

17,971. Yes, and we have heard that there have been difficulties in places where they can go for convalescence, the final stage at the seaside.

Deputy-Chairman: I think that is a misapprehension, that the house cannot be moved. Under Section 207, subsection 3: "If at any time it is shown to the satisfaction of the Commissioners or the justices, as the case may be, that it would be for the comfort and advantage of the patients in any licensed house that another house should be substituted in place thereof, the Commissioners or justices may grant to the licensees of such first mentioned house a licence in respect of such other house upon and subject to the same conditions and restrictions as may have existed in respect of the first mentioned house."

17,972. *Earl Russell*: Yes, but it has to be in the same licensing district?—Yes, that is the trouble. The Commissioners have the control of the licensed houses within a certain area of the Metropolis, and the justices within the area of their jurisdiction. The difficulty arises when you want to move a house from the jurisdiction of the Commissioners into that of the justices or from the area of one set of justices into another, and that, I understand, cannot be done.

17,973. Is that clear under that section? I should not have thought so. Still it would give you a very considerable area of change?—It gives an area of change, but that is what I was told at Chiswick House, that that is the difficulty they were under.

17,974. Are they under the Commissioners?—Yes, they are under the Commissioners.

17,975. They could not remove at present to the sea?—I think that was with regard to Christchurch; they used to rent a house at Christchurch to give their patients the benefit of it in the summer and I think their wish was to move down there, if I remember right.

17,976. Of course it is a question of the construction of the section. I should have thought there might have been some doubt about it?—I think it follows almost from the words of the section: "the Commis-

25 May, 1925.]

The LORD SANDHURST.

[Continued.]

sioners or justices may grant to the licensees of such first mentioned house a licence in respect of such other house." Now it is clear that the Commissioners could not give a licence for the house outside and the justices could not give a licence to remove from the present house.

17,977. You mean that the justices would be confined to their particular area?—To their jurisdiction. You see it is "the Commissioners or justices may grant".

17,978. There is a double jurisdiction. What the authority is there respectively, I have no idea?—Except that the Commissioners do not have jurisdiction in the justices' area for licensing houses; that is under Section 208 (2).

Earl Russell: You see if you read the section this way, the Commissioners could not grant a licence for a house outside the Commissioners' area. That in itself would prevent it moving.

17,979. *Deputy Chairman:* Yes, that may be the true construction of the Act; I daresay you are right?—I think you will find that is the view the Commissioners take of it.

17,980. *Mr. Snell:* What do you suppose, Lord Sandhurst, was in the mind of the Legislature when it imposed these restrictions forbidding the increase of licensed houses?—It was when people were very anxious about the liberty of the subject. They thought more about the liberty of the subject, I think, in those days, than they did of the treatment of the patient. There was a sort of panic.

17,981. Is it not reasonable to assume that the Legislature must have had evidence before it which at least impressed it with the fact that these houses were subject to abuses?—There was no doubt a very strong public feeling on the subject. Was it not a Charles Reade novel, and "Valentine Vox" was another one, which were full of the troubles of patients in licensed houses? There certainly was a very strong feeling about licensed houses at that time.

17,982. I mean the Legislature may do foolish things and probably still does, but it does not do a thing without provocation, so to speak?—No.

17,983. *Earl Russell:* What should you say on the question of the feeling now about this conflict of duty and interest; do you think that would be a reason for limiting their numbers or do you think that hardly applies any longer?—No, I do not think it applies very largely. Certainly in these days the anxiety of licensed houses is to be regarded as up-to-date and to have a good recovery rate.

17,984. It has also been put to us by witnesses—I do not know what you would say to it—that there is some sort of moral obliquity involved in making a profit out of the afflicted?—You might as well say there was a moral obliquity in a medical man earning his fees.

17,985. *Miss Symons:* You do not feel that people are more inclined to be suspicious whether rightly or wrongly? I think that does happen to a certain extent but you meet with that you know in other places as well as licensed houses; you meet with the same suspicion even where a patient is a private patient in a public institution, and you meet with it in the registered hospitals, and you cannot persuade patients that nobody is able to make a profit out of them.

17,986. You do not feel that this demand could be met by private accommodation provided say, by the County authority?—Well, I should think it was rather a question of providing the money.

17,987. *Earl Russell:* But you come in touch with the class of patients to whom this applies and with their relations?—Yes.

17,988. Now it has been put to us that that kind of private patient does not wish to go into any accommodation however well equipped and however private, which is furnished by a local authority, that they do want a private house. Has that come within your knowledge?—I think that would be the feeling certainly of a great many relations.

17,989. Many doctors have said to us nothing run by a public authority would do, no matter how well it was run—what do you say with regard to that?—Well, I do not think I should say that that was a proposition without exception. Of course there is one public asylum which has a very large and very up-to-date private wing, Herrison at Dorchester; and one has met with people of quite good social position there and apparently they and their relatives are satisfied. I do not think it obtains to the same extent as it did, but one felt that the high fees charged there were not quite what ought to be charged in the case of a public institution. They were thinking too much of assisting the rates and not meeting the requirements of the middle classes.

17,990. There are cases where secrecy is very much desired, where it is desired that nobody except the official visitors should have access to them?—There are many cases in which relations are sensitive.

17,991. Yes, that is what I mean?—I do not know that the danger of publicity would be any greater in an institution run by a public authority if it was properly run.

17,992. People might think it would be?—They might think it would be.

17,993. *Miss Symons:* We were told of another at Morecambe Bay I think? Yes, that is the Lancaster Hospital?

17,994. Yes?—That is run on rather different lines from Herrison. I think there the fees are extremely moderate. They get extremely good accommodation for very very moderate fees.

17,995. *Mr. Snell:* There is one point I want to ask you about. I gather from your *précis* that the chief feeling in your mind about the private house is that there is no inducement to detain patients there because the competition to get into them is so great?—Certainly, with what I should call the middle class private house.

17,996. One argument is that there is a natural tendency for the medical proprietor to detain his patients?—Yes.

17,997. Your argument is that because of the restriction of the number of those places there is always a demand to get into them; therefore his inducement would be to get rid of one patient and to admit a new one?—Yes; I think that does apply in the majority of the licensed houses, but there are cases (I have felt it myself once or twice) of course in licensed houses, where a patient occupies a villa or half a villa and pays a very large fee; and such a patient is not easy to replace, and one can conceive that in a case of that sort there may be a conflict of interest and duty. The ordinary patient, the five guinea a week patient and the seven guinea a week patient can easily be replaced, but when it comes to thirty guineas a week one can imagine there might be a conflict of interest and duty.

17,998. *Earl Russell:* And that conflict would be increased if you had a larger number of licensed houses and therefore not the same rush for accommodation?—Yes it would.

17,999. *Mr. Snell:* There is another problem that is very much on my mind. It is not only this difficulty of conflict of interest and duty, but there is little security that the patient gets what he is paying for; he may be paying a reasonable fee and yet be half starved, let us say, at least deprived of certain comforts that he ought to have?—I do not think that occurs.

18,000. *Earl Russell:* I will tell you one particular thing that was put to us in evidence, that carriage drives were paid for and not given?—There, again, I have not heard of their being paid for and not given.

18,001. *Mr. Snell:* Suppose you had a regular fee in which those were included, and then not given. You might get that?—I have often been surprised to find that patients who are not paying specially for

25 May, 1925.]

The LORD SANDHURST.

[Continued.]

carriage drives do get them. As a rule carriage drives are an extra and you pay so much for a particular drive.

18,002. *Deputy Chairman*: Have you ever had any complaint of this kind brought to your attention?—I have never had a complaint that carriage drives were paid for and not enjoyed.

18,003. I mean any complaint that patients were really paying for things they were not getting in these houses?—No, I do not think so.

Sir Ernest Hiley: Mr. Snell said "starvation"—I do not know whether he meant deficiency of food.

18,004. *Mr. Snell*: What was in my mind was that you might get a table, a food supply, which was restricted. "Starvation" was too severe a word. What guarantee have we that the standard of comfort provided is equal to the prospectus?—If you come to that I suppose you have only got really the protection which is afforded by the Commissioners and the Visitors, and the interest of the proprietor, because after all a great many patients have sufficient intelligence to complain to their friends if they are not getting enough to eat; and also, of course, you could see by the appearance of the patients to a great extent whether they were well nourished or not.

18,005. *Deputy Chairman*: Your own view is that on the whole it would be an advantage if the number of licensed houses now could be to some extent increased?—Yes, that is my view. We have lost several very useful homes in late years.

18,006. You have lost six licences in the last 15 years?—Yes.

18,007. *Mr. Snell*: Why was that?—The house that I am thinking of at present was called Dinsdale Park, in Durham, I think.

18,008. *Sir David Drummond*: Beside Darlington?—Yes I think it is near Darlington.

18,009. It is north Yorkshire?—I rather think it is Durham. However, that was one which was a very useful house, and I cannot now recall why Doctor Kershaw gave it up; I think he found it was not paying him or something. It was during the war if I remember right. Then another very nice house was River Head House, near Sevenoaks, and there a certain Doctor Munro took it over and he had it a very short time. I think Doctor Munro was very indignant because he said that the principal alienists were all taking commissions on the patients they recommended to various licensed houses, and he was not going to have anything to do with it; at any rate he let the licence lapse. He had views of his own on the treatment of patients and on the methods of alienists generally. Whether for conscientious grounds or not I am not prepared to say but he let the licence lapse, and that disappeared. Another one was Redlands House in the same neighbourhood which was near Tonbridge; there that licence lapsed through some technicality as far as I remember; Doctor Sergeant, I think it was, of the licensed house on Tooting Common acquired the house and I think it was through some mistake on his part that the licence lapsed. He had the house and had not got the licence; he took over one or two of the patients and some of the patients went elsewhere. That was the third. Then another one, which was a very cheap licensed house very much used by the lower middle classes, was the Bethnal House near Bethnal Green Station. There the licence lapsed because they were not making it pay, if I remember right. But all those places reduced the area to which you could send patients, very considerably.

18,010. *Deputy-Chairman*: They covered a very considerable number of beds?—A very considerable number of beds and in all classes too.

18,011. *Mr. Snell*: None of them was closed because of any irregularities?—Not that I am aware of. No.

18,012. *Miss Symons*: I was wondering whether there were any cases in your experience in which you have been obliged to move patients to another place because you were dissatisfied with the care they were getting?—No. I have often recom-

mended that patients should be moved, but I cannot recall a case in which I recommended that a patient should be moved from one asylum to another because I was not satisfied with the care he was getting. But in deference to their wishes I have very often recommended that a patient should be moved, sometimes because, although I thought that the grievance he may have complained of was not well founded, I yet thought it would be good for the patient to go to somewhere where he thought he had a better chance.

18,013. *Earl Russell*: Of course it is an element in their recovery to remove a grievance even though it is an imaginary one?—Yes. I think there have been cases in which I have not been satisfied with the care of a patient in a private house where I have suggested removal.

18,014. That is single care?—Yes.

18,015. *Miss Symons*: Have you ever found cases where perhaps they were economising in the patient's food and amusements?—I think in single care there is sometimes a tendency not so much to economise on the patient's food but to economise generally, poke him away into a small room and let a better room to another tenant—that kind of thing. I do not think you often find a case in which a patient has not had enough to eat; in fact I cannot recall a case.

18,016. *Mrs. Mathew*: I wanted to ask if you have any view about aftercare. Could we have your views about that?—The subject is of the greatest importance and I think if the After Care Association could have State assistance it would be a very useful thing. I mean the After Care Association is doing an abundance of most useful work. I do not know whether you have had Miss Vickers before you.

18,017. Yes?—She has told you all about it probably, but it cannot undertake all the work that it usefully might undertake if its funds were larger. Doctor King of Peckham House for example, who deals with a number of very poor patients, has got one or two ex-nurses with whom he is in touch, and when a patient is fit for a trial or perhaps is on the verge of being discharged, or even has been discharged, he will get one of these nurses to take him as a boarder. That is his practice and it certainly is a very useful practice. In some cases one is astonished at the fees at which these patients are received.

18,018. You mean they are so low?—Yes. I was going to say this, with regard to licensed houses, if I might. I think Doctor Edwards has suggested that it would be well if the superintendents of licensed houses were required to have some mental qualifications. I mean as things stand at present any medical man may run a private house and may acquire a licence, one of the existing licences.

18,019. *Earl Russell*: Indeed a layman may be the licensee.

18,020. *Deputy-Chairman*: Or a company?—Yes; a layman must have his patients visited by a medical man, but the only requirement is that he should be a medical man in practice, and there is no guarantee that he should be a person who is specially qualified to deal with mental cases. Of course some of the licensed houses one knows of are excellent institutions for the care of chronic patients, but one does not feel that one would advise that a patient should go there if there was a prospect of recovery.

18,021. *Sir David Drummond*: But the same obtains in connection with public asylums: there is no special qualification?—That is true, but those who have the appointment of the medical officers of public asylums generally take care to get somebody who is qualified.

18,022. *Earl Russell*: They should do?—They have not got to take the first person who comes along.

18,023. *Sir David Drummond*: He is often qualified on account of his administrative ability and not his

25 May, 1925.]

Mr. G. M. HILDYARD, K.C.

[Continued.]

medical abilities at all, for a public asylum, I mean?—You may know more about that than I do, but you often find a medical superintendent is appointed from the staff of some other institution where he has been dealing with mental patients. I am very much struck in this connection with the number of Scotsmen that I find acting as medical superintendents.

(The Witness withdrew.)

(After a short adjournment.)

THE RIGHT HONOURABLE H. P. MACMILLAN, K.C. (in the Chair).

Mr. G. M. HILDYARD, K.C. (Master in Lunacy), called and examined.

18,025. *Chairman*: Mr. Hildyard, we have had the advantage of reading your *précis*, which you were good enough to send to us, and I think we might profitably occupy a little time in going into some of the questions which your *précis* raises. First of all, could you tell us the precise nature of your office and the duties which you discharge—I do not mean in detail, but just to indicate your status in the lunacy administration?—The Master's Department administers the estates of lunatics and other persons who are incapable of dealing with their own properties. They do it by appointing a receiver, who is an agent of the lunatic and who deals with the property under the control of the Department.

18,026. Your contact, from the lunatic's point of view, is primarily in connection with their property rights?—Yes, primarily.

18,027. And only incidentally are you concerned with their welfare otherwise?—Yes.

18,028. I further gather that you do not take action on your own initiative, but you are always invoked in some form or other?—Yes. Of course we can take action if somebody, not necessarily the relations of the patient—it may be the Board of Control or somebody else—tells us that a patient has got property which needs looking after; then we take action through the Official Solicitor.

18,029. But in the normal case your Department is set in motion by someone acting on behalf of the lunatic?—Yes.

18,030. Then what is the nature of your office—I mean its organisation and equipment?—There is a Master and an Assistant Master and then a number of departments of clerks dealing with particular numbers of patients. It is divided into six sections: each one has a certain number of clerks, and they deal with the administration of the property of so many people, who are allotted to them alphabetically.

18,031. That is the administrative department?—Entirely.

18,032. So far as you yourself, as Master, are concerned, I gather that you pay personal visits to cases with which you are concerned?—Yes. Of course there is a separate jurisdiction by inquisition. The Department, representing the Chancellor, deals with what are called inquisition patients, of whom there are now only a few.

18,033. There seems to be only a couple of hundred?—Yes, and those are dying out.

18,034. Are your duties in relation to the persons so found by inquisition different from those where a receiver has been appointed?—A little bit, because the patients so found do not come in any way under the jurisdiction of the Board of Control, so that both mentally and in regard to their property they are entirely under us.

18,035. *Earl Russell*: Are you the judicial authority to whom application is made?—No. On a petition the Judge orders an inquisition, and then the Master decides on enquiry whether there is a case or not.

18,036. *Chairman*: There is a very useful summary of your office in Sir Henry Theobald's work?—Yes.

18,037. Was he your predecessor?—Yes

18,024. So we have heard.—I attribute that to the fact that the Scotch have got such fine schools of mental science; Edinburgh and Dumfries send out some of the ablest men for the purpose of mental work.

Deputy-Chairman: We are very much indebted to you for your evidence.

18,038. And one can see that the procedure is altered from time to time?—Yes.

18,039. Your duties really fall into two compartments: those that relate to lunatics so found by inquisition, and those with regard to the lunatics of whose estates a receiver has been appointed?—Yes.

18,040. Apparently resort to the former procedure is dropping out?—Yes.

18,041. Do you advocate the retention of inquisition?—Yes, there are a few cases for which it is necessary. Whether it need continue to be necessary I do not know.

18,042. It seems a pity to have two systems in operation unless they both serve some distinctly useful purpose?—We cannot deal with some property in Ireland unless there has been an inquisition.

18,043. That could easily be remedied by legislation?—Yes, if Ireland would agree; it is Ireland that makes the difficulty.

18,044. Then I will withdraw the word "easily"?—Yes. Then there are some people who are not quite satisfied with the treatment they are getting under the Board of Control; sometimes their relations would rather get away from the Board of Control by coming into direct relation with the Lord Chancellor instead. Whether that is a good thing or a bad thing I do not know.

18,045. *Mr. Micklem*: Are there not cases where it would be wise to decide the question of lunacy by a jury, which you can have on an inquisition, of course?—Yes.

18,046. You never have that safeguard, except on an inquisition?—On an inquisition, if the patient is well enough to demand a jury, which he very seldom is, he may demand a jury, and then it is heard before a jury; that is only if he demands it, and there is something to try.

18,047. *Earl Russell*: Do you find a jury is a suitable body to try this sort of thing?—I have not known a case for a great many years; I do not know; I do not quite know why they should not be.

18,048. *Chairman*: It is rather interesting to notice that the development in England has been practically on parallel lines with the experience which we have had in Scotland. There we have a formal process of cognition, which is equivalent to your inquisition; we also have the system of the appointment of a judicial factor, who is the opposite number of the receiver in England, and almost all the administration in Scotland is done by such officials. I have not seen more than one case of cognition in 20 or 30 years' experience?—Yes. On the other hand, in Ireland they are still found by inquisition—even in quite small cases.

18,049. The actual figures at the present moment are 219 inquisition cases on the Visitors' books, as Lord Sandhurst said?—Of course those are almost entirely the residuum of previous years. Two a year is about the average now.

18,050. It is manifestly a diminishing quantity?—Very much.

18,051. I think it is for consideration whether the whole of that elaborate machinery should continue—whether it is now of practical value or not I do not know?—I have had very few inquisitions since I was

25 May, 1925.]

Mr. G. M. HILDYARD, K.C.

[Continued.]

appointed, but there are cases in which a lunatic has managed to get married. In the case of a lunatic found by inquisition, the marriage is not valid.

18,052. The marriage could probably be annulled on the ground that there was no legal consent if the person was really a lunatic?—There is not a very large mentality required to know that you are being married.

18,053. *Earl Russell*: Is that so? A lunatic so found by inquisition cannot contract a marriage?—No—by statute.

18,054. *Chairman*: Now, just taking your topics in order, Mr. Hildyard, I note in the first place that in the course of your experience you have not actually come across a case in which relatives have endeavoured to get the weak-minded person certified in order to get control of his property?—No.

18,055. Although you have not personally come across such a case, I gather you recognise the great desirability of safeguards being maintained to prevent such a possibility?—Yes, I do, because of course, although one has not had proof of the existence of such a case, it may have existed.

18,056. Therefore the important thing from our point of view is to see that the safeguards are retained and, if necessary, improved at any points at which they may be shown to be inadequate?—Yes.

18,057. Now you have a very important suggestion really running through your *précis*, directed to the desirability of the property and estates of all lunatic persons being brought into charge or control?—Yes.

18,058. Apparently the position is rather haphazard at present?—Yes.

18,059. And have you found in experience that resort has been had to the appointment of a receiver often at too late a stage—after some mischief has been done with regard to the property?—Yes, frequently.

18,060. You might just illustrate that by the different ways in which you have found that disadvantage to the patient has arisen?—The two main ways are that sometimes relatives, thinking that they are doing the best they can for the patient, spend his money too rapidly; they think he will be unhappy, and they spend as much as they can on him to make him happier, which perhaps to some extent makes him happier, and then the patient gets better, comes out, and finds his money all gone; it has been done with the best intentions, but he might have got well just as soon if he had been kept a little less extravagantly, and had something to live on when he came out. Then, on the other hand, one does find that patients are kept at an uncomfortable place, or at an uncomfortable rate of maintenance, with the idea of spending as little upon them as possible; and after some years they come to us, and we find that really on their income they could have been kept very much better and have been private patients instead of pauper patients, or even have been out of an asylum in a home or with a doctor, and during those years they have had an uncomfortable time quite unnecessarily; whether the relatives have done that so as to get the benefit themselves one cannot say.

18,061. Of course, one could see a motive there on the part of relatives, that they might wish to save as much as possible out of the income of a lunatic in order that it might ultimately reach their own pockets.

18,062. *Mr. Micklem*: Or that it might reach his when he came out?—Yes; but I think undue economy would be more likely the other way. I think there is a feeling with some of these people that "the poor thing is a lunatic; he will not understand; he would not be any better if we spent money upon him; let us keep it."

18,063. *Chairman*: That has been in the case where there has been no receiver appointed, before the case has come to your cognisance, and after money has been spent or has not been spent. In contrast with that, when a receiver is appointed, either the Official

Solicitor may be appointed or another person. How is the estate then administered on behalf of the lunatic?—When a receiver is appointed I have to decide what shall be spent upon the lunatic, and how he should be maintained; of course I may be wrong, sometimes, like the relatives are. It is very difficult to know how far it is wise to spend a man's money while he is a lunatic, and how far one ought to keep it for him.

18,064. But your judgment is entirely immune from any suggestion of bias. Your only interest is the patient's welfare?—Quite; it must be an honest mistake, anyway.

18,065. And in deciding how you will dispose of the capital or the income of an estate, what considerations do you have in view generally—I mean how does the problem present itself to you?—Well, of course, there are so many difficult circumstances. One has got so often to consider not only the patient, but also his family, his wife or children, or other people who are dependent on him, and the way one looks at it as a rule is: spend the whole income in such a way as to do the best for everybody. Spend as much on the patient as can be comfortably enjoyed without waste, and spend the rest of it on his family. That is simple as long as there is enough income.

18,066. You would not wish to break up the home, of course, because a patient might recover and go back to his home?—Quite. He does owe a debt to his family.

18,067. The difficulty is where there is not enough?—That is the great difficulty. Where you have not enough to pay the guardians' rate, then you are not entitled to use the property for any other purpose—even for the wife and children.

18,068. *Sir David Drummond*: Does the question of diagnosis come in here—the precise nature of the mental affliction?—I do not know that it does. I have to be satisfied on the evidence that the person is a lunatic: either that he is fit to be detained in an asylum or is unable to manage his property. To that extent the diagnosis comes in.

18,069. You do not concern yourself with the question of whether he is a general paralytic, do you?—Of course, one does consider the question of how long he is likely to live. I get from the doctor in every case, under the new form we now have, a statement as to his opinion of the bodily health of the patient, and as to the prospects of recovery, and those two things must enter into one's mind in dealing with property.

18,070. *Earl Russell*: In the case which you have mentioned, where the income is not enough to pay the guardians' rate, you do not have anything to do with it, do you; the guardians take it out of your hands?—No. If a receiver has been appointed the guardians have no longer any powers. Generally we are always bargaining with the guardians, but they are entitled to be paid not only out of income but out of capital.

18,071. Who is the master of the situation?—I am, fortunately.

18,072. *Mr. Micklem*: They have the first charge for his maintenance?—I must say most guardians are very good, and they will very often allow quite a small payment, subject to being given a charge on the capital; then if the patient recovers and there is anything left, the guardians have a first claim to it.

18,073. *Earl Russell*: Of course as a rule when the guardians have a free hand they sell up everything the patients have to pay their charges?—I think they vary very much. I think some are very good to the patients, and some more good to the ratepayers.

18,074. *Chairman*: You speak of the persons being lunatics, in answer to Sir David. Of course you have persons who are not certified lunatics, but of whose estate a receiver has been appointed, a person therefore whose mental state may vary very much in degree?—Yes.

18,075. I should imagine that many persons who are incapable of managing their affairs, although not certifiable, might have a certain amount of intelli-

25 May, 1925.]

Mr. G. M. HILDYARD, K.C.

[Continued.]

gence, enabling them to co-operate with you in the administration of their affairs?—Some do; to take an extreme case: although a patient might not be able to manage his capital, he might be able to manage his income, and you might appoint a receiver to pay the income directly into the patient's own hands, or you might allow the receiver to pay the patient pocket money.

18,076. *Earl Russell*: Once the receiver is appointed, the capital would be quite safe from any charge the patient tried to impose upon it?—Yes. Of course you do get these great difficulties with the sort of people the Chairman has been mentioning, where they are not shut up in any way, where they go about and incur very large debts; and although strictly in law you may say to the creditor, "No, we are not going to pay this; we have got a receiver," you cannot do it altogether. We are bound to recognise their debts to some extent, if they can afford them.

18,077. *Chairman*: Is the estate of the lunatic technically vested in you?—No, it is not vested in any person.

18,078. I was thinking of the distinction which one knows in another sphere of the law?—Yes.

18,079. You are not vested with the actual title?—No. We have the power of vesting it, and what we do with large inscribed stocks, for instance, is to transfer them into the name of the Paymaster; they go into Court. We can authorise the receiver to execute deeds, or we can make vesting orders; but if we do not do either, we just leave the certificates for the stocks in a bank, and the property remains in the lunatic.

18,080. But I suppose the matter has often come to your cognisance first of all because of the difficulty of carrying out a transaction?—That is what brings it to our notice in most cases. Really what I think has made such a large increase lately is that so many people with very small means hold war stocks. They cannot deal with the inscribed stocks at all except by getting the authority of the Court. Where it is only a question of small house property, the tenants will pay to anybody.

18,081. *Mr. Micklem*: Do you mean because they are not capable of signing documents?—Yes. The bank needs such a perfect authority that they will not act on anything else; sometimes there are powers of attorney which the banks act upon, although they might have lapsed through certification.

18,082. *Chairman*: Now I think we might get on our note a summary of the various ways in which a lunatic's maintenance is at present paid for. I think first there is the case of the guardians paying out of the rates?—Yes.

18,083. That is in the case of the pauper patients?—Yes.

18,084. Then secondly the friends or relatives may pay out of their own pockets?—Yes.

18,085. Thirdly the trustees acting under a discretionary trust, and who hold property under such a trust, may apply property for the maintenance of the lunatic?—Yes.

18,086. Then you may have friends or relatives doing it out of the lunatic's property without any legal authority at all?—Yes.

18,087. Then you may have the case of the payments being made by friends or relatives out of the lunatic's property under authority other than that of the Court of Lunacy?—Yes.

18,088. Then I think the last case is where the payments are made by a committee or receiver out of the lunatic's property under the authority of the Lunacy Court?—Yes.

18,089. The first two cases, the guardians and the friends or relatives paying out of their own pockets, are cases with which you have nothing to do?—That is so.

18,090. And similarly with regard to discretionary trusts, I think you have no powers to interfere?—No.

18,091. Is that the class of case where a father leaves a sum of money to trustees to be expended on an insane child?—That is the class of case; of course, they are sometimes very difficult of construction. If the testator says, "Trustees to apply all or so much as they think fit," then no one can interfere with them, but we do interfere where there is merely an apparent discretion; we threaten them we will take them to the Chancery Court to construe the will to see whether they are exercising a discretion at all.

18,092. It would be a little difficult to deal with that class of case, because there are as many different ways of conferring these powers as there are testators, and one knows the vagaries of testators?—Quite. The only thing one can suggest is that you might say that some notice of the trust should be given to some authority, or some check should be imposed to see that it is being carried out.

18,093. Of course the case might be so grave as to be one of breach of trust?—Yes, it might be so.

18,094. And as the beneficiary would not be in a position to call the trustees to account, they would not be subject to the same restraint as in the case of a sane beneficiary?—Not at all; we have to represent the beneficiary for that purpose.

18,095. *Mr. Micklem*: Would you have to take proceedings in that case in the name of the lunatic?—Yes; we should appoint a receiver and authorise him to take proceedings in the name of the lunatic.

18,096. *Chairman*: And give a proper maintenance allowance, I suppose?—Yes.

18,097. *Earl Russell*: Are your receivers that you would appoint officers of the Court, or are they solicitors, or people likely to be interested in the thing?—I should think they are more often relations than anybody else. There is the Official Solicitor, if necessary.

18,098. *Chairman*: Curiously, we mostly appoint chartered accountants in Scotland?—There are difficulties. So many of these cases are very, very small. Chartered accountants are all right for biggish estates, but they open their mouths too wide sometimes; it is their business, and they must charge for it.

18,099. *Earl Russell*: The same, of course, would be true with solicitors?—The same would be true with solicitors. We do not appoint solicitors very much, because there is the question of legal costs.

18,100. *Chairman*: And the Official Solicitor is really a kind of public trustee?—He is of that nature, yes.

18,101. You note in passing, the case of the rules of co-operative and provident societies, which seem to have caused trouble sometimes?—Yes.

18,102. Have you experienced that?—Yes, there is that difficulty.

18,103. You mean the benefit ceases during incapacity?—Yes. Sometimes the provision is that the benefits shall accumulate until the patient comes out. There is a good deal to be said for that; sometimes they are allowed to use them for their wives and children; there is something to be said for that; sometimes they merely cease. Of course, it is part of the contract.

18,104. After all, the constitution of any co-operative or provident society represents the contract between the society and its members, and it may vary infinitely, of course?—Quite.

18,105. But you think it is an unfortunate rule to have, that benefits should cease during mental incapacity?—I think it is, because the maintenance costs a considerable amount while the patient is incapable. After all, the patient has subscribed so as to be kept when he is ill, and this particular illness is not provided for.

18,106. *Earl Russell*: Are you talking about a benefit society or a trading society?—There are various co-operative societies; they all have different rules.

18,107. The ordinary kind of thing one thinks of is a sort of co-operative stores?—No, I mean friendly and benefit societies—things of that kind.

25 May, 1925.]

Mr. G. M. HILDYARD, K.C.

[Continued.]

18,108. *Chairman*: Friendly and provident societies?—Yes.

18,109. Their rules have, I think, to be approved by the Registrar?—Yes, they have. In that way, if it were thought proper that any other rules should be made, no doubt there would be some hold upon them. No doubt it is a matter of contract. There is one point I should like to mention. I do think there is one great hardship on lunatics, rather of this same nature, and that is that the Government always, when they can, as far as I can see, put burdens upon the rates rather than upon the country. There is a provision, for instance, in the Old Age Pensions Act that no pension shall be payable to anybody in an asylum. The idea no doubt was that when they were in an asylum they were kept by the guardians, and there was no reason to pay the pension to the guardians. Of course the result at present is to take away from the patient his 10s. a week, and the hardship is very much accentuated now, and will be still more so if the new Pensions Bill goes through; an ordinary person, although he may have £30 or £40 a year, is still entitled to his old age pension, and the two together would be quite sufficient to maintain him. He goes into an asylum and he does not get it.

18,110. Does that mean that his pension is applied for his maintenance through the medium of the guardians?—No; he becomes a person not entitled to a pension.

18,111. *Earl Russell*: Are the ordinary inhabitants of Poor Law institutions also disentitled to receive a pension on that footing?—Yes.

18,112. So he is on the same footing?—Yes; he is on the same footing; but where it comes in undoubtedly is that an ordinary person is not an inhabitant of a Poor Law institution if he can pay for his maintenance. In this case these people, because of their illness, have to go into asylums, and they are paying their maintenance very often. Under the new Bill I suppose you might have £50 or £60 a year and still get your pension.

18,113. The 10s. a week might just make the difference as to whether he was solvent or not solvent in meeting the claims of the guardians?—Yes; under the Old Age Pensions Act you can have £39 a year.

18,114. The whole of that, and your 10s. a week, would go in the maintenance of the asylum?—Yes; but now a man with £39 a year has to use the capital of that to make up the pauper rate; if he is going to pay the guardians he has got to make up the difference between the £39 a year and his maintenance out of his capital, and he ought to be able to be getting that from the Government as his old age pension. He has got capital producing £39 a year, and I understand under the new Bill it does not matter how much you have got, you are to get your old age pension, unless you are a lunatic.

18,115. He is deprived of 10s. a week?—He is deprived of 10s. a week.

18,116. I thought it was a question as to whether this 10s. a week was to come out of the rates or the taxes?—No, it is not that.

18,117. That is the question which was present to the mind of the Chancellor of the Exchequer when he made this provision?—Yes. I am trying to get it altered by bringing it to the minds of the people who are drafting the new Bill.

18,118. Did you find the Treasury at all sympathetic?—I would not say "sympathetic."

18,119. *Chairman*: It is not an epithet one commonly applies to the Treasury; but we are obliged to you for mentioning it. Then next I appreciate the point you are making regarding the undesirability of forcing administration by the Court upon all cases. At the same time, surely there is a great deal to be said for all cases where there is any property involved being brought to the notice of your Department?—I think so, very much. What I had in my mind about the undesirability was that you cannot keep any legal proceedings of this kind from being somewhat expensive, and you have a great many cases where

the lunacy lasts a very short time. A man may be ill only three or four months, or something of that kind, and it does seem a little hard—possibly it may be necessary—that you should put those estates to the expense of legal proceedings merely for a three or four months' administration.

18,120. *Earl Russell*: I should be very glad to have some figures about the expense. Suppose a man has £60 a year, and you have to appoint a receiver for about three months, what would it cost him altogether, from first to last?—It is almost impossible to say, really, because it depends very much on how it is done. If he has got relatives who are sufficiently energetic and sufficiently understanding in business matters to do it themselves without a solicitor, it costs very little.

18,121. Of course, if it were a case of managing small house property, I take it the cost would only be the cost in your Court?—Yes, but it is that initial cost which is the heavy cost.

18,122. What sort of amount is it?—It is very small for persons who apply in person—say it is a London case, and they are here, and the estate is worth less than £50 a year: we can make what is called a no-fee case, and it only costs them a few shillings. On the other hand, if you have to have stamps on the order, if it is over £50, it would cost three or four pounds. Once you bring a solicitor in it may cost anything from £10 to £50.

18,123. *Chairman*: I wonder if you could give us a few selected instances. I should like to see a few bills of costs?—Yes, I will get them out for you.

18,124. *Earl Russell*: It would be very interesting to know the actual sum that a man has to waste, so to speak, on the necessary machinery?—Yes; it is so difficult, as I say, to give anything like an average case. If you have got to have inscribed stocks lodged in Court it costs something.

18,125. *Chairman*: Often a very small asset is a very difficult one to administer?—Yes.

18,126. *Earl Russell*: Suppose a man is away from London, can he do all his application by post, or must he necessarily come to London?—No; I tried to get extra staff and things to make a sort of poor persons' correspondence department; the Treasury would not hear of that. We do do a great deal through correspondence.

18,127. You could not do it through the existing Poor Persons' Department?—No; I think that has broken down without us.

18,128. *Chairman*: I think your suggestion later on is the County Court?—Yes.

18,129. *Mr. Micklem*: What fee is payable to the receiver?—The receivers may be appointed, and generally are, if they are members of the family, without any remuneration at all.

18,130. What do you make a receiver do in the way of giving security?—We get a guarantee society to support him.

18,131. That costs money?—That is one of the expensive parts of it, and I am afraid that does lead to one appointing them fairly often without security, which is perhaps dangerous.

18,132. *Chairman*: It is not a legal necessity that you should have security?—No; I can always waive it.

18,133. *Earl Russell*: How is the application made to you?—A summons, which has to be served upon the patient and supported by affidavit.

18,134. *Mr. Micklem*: So that it may be opposed?—It may be opposed.

18,135. That may be the entire proceeding. On that you may be able to pronounce your necessary order?—Yes. If it is a certified case we get a certificate from the Board of Control to say it is a certified case, and that is sufficient.

18,136. *Chairman*: In Scotland we simply present a petition to a Judge, which narrates the circumstances, states the amount of the afflicted person's estate, asks for the appointment of a curator bonis, and then has appended to it two printed certificates

25 May, 1925.]

Mr. G. M. HILDYARD, K.C.

[Continued.]

from doctors who certify on soul and conscience that A.B., whom they have seen, is incapable of managing or of giving directions for the management of his own affairs; and upon that a Judge appoints; there is a service of it upon the person?—Do you need the two doctors if there is already a certificate?

18,137. I am assuming the case of a person who is not certified, simply having a receiver appointed of his estate.

18,138. *Earl Russell*: Would you be able to do without the doctor's certificate if the person was a certified patient?—Yes. As a matter of fact we always do get some information from the doctor as to the prospects of recovery, and things of that sort.

18,139. But it need not be an affidavit, need it?—No; we make it as cheap as we can, but it is difficult. Then of course, talking of expense, there is the percentage levy. The State takes a certain percentage of the income of all cases that are under jurisdiction.

18,140. Like the Public Trustee's charges?—Yes; although we exempt the very small cases; but that is a burden on any case.

18,141. *Mr. Micklem*: They are considerable?—Three per cent.

18,142. *Chairman*: But if you gave us one or two typical instances that would show us the cost at each step?—Yes, quite.

18,143. Then you draw attention to one or two of the provisions of the Act of 1890 which are related to this matter. First of all, Section 132, where provision is made for small estates: the County Court Judge may apparently authorise any person to take possession of and sell and to give directions for maintenance of the person affected. Is that without a receiver at all?—That is without a receiver; but I think that is only on the application of the Poor Law authority, is it not?

18,144. "May upon the application of the clerk of the guardians, or a relieving officer"?—That section is hardly used at all.

18,145. Section 299 is another to which you refer us?—That is used to a certain extent, but only in very small cases.

18,146. That, again, is a method of making lunatics' property available without the appointment of a receiver?—Yes, for the purpose of the Poor Law authorities.

18,147. And, again, Section 300 provides for an order by a County Court Judge for payment of expenses incurred by guardians of a union?—Yes.

18,148. *Mr. Micklem*: Under Section 299 is the application made by the guardians?—Yes, I think it is. The section says a justice may direct a relieving officer or the treasurer or some other officer of the local authority to seize and sell so much of any other personal property, and so on, as shall be sufficient to pay the expenses of maintenance. Nobody is so anxious about the expenditure on maintenance as the guardians themselves, so I do not think anyone except the guardians applies under that.

18,149. *Earl Russell*: What is the reason for retaining that power in Section 300? I thought the recovery by guardians was always done before justices. My recollection is that you went to the justices and asked them to make any necessary order for payment?—Yes.

18,150. *Chairman*: It might, however, afford some precedent for bringing in the County Court Judge in the matter of receiverships of small estates?—Yes.

18,151. Then there is a general section, Section 335, relating to pensions or allowances?—Yes.

18,152. That is a section which authorises the Public Department concerned to pay as it may think proper; again, I suppose, without the necessity of a receiver being appointed?—Yes.

18,153. Then I take it you are referring to these to show us that there are also other means by which the estate of a lunatic may be administered?—Yes.

18,154. You also draw attention to the Postmaster-General's position, where no receiver has been appointed?—Yes.

18,155. I rather gather that you do not look with favour upon his powers?—No, not entirely. It is a sort of co-ordinate jurisdiction in a way. The Post Office deals with anything acquired through the Post Office without the appointment of a receiver.

18,156. *Earl Russell*: They do it merely on enquiry made by their own officers without anything in the nature of a legal procedure?—Quite, and without any of the safeguards of the Lunacy Acts.

18,157. And without the expense?—And without the expense. That is why I do not say I think definitely it ought to be changed in any way, because it may be what is required in very small cases, but I do not think the lunatic is really properly protected.

18,158. *Chairman*: I understand, however, that you do not think the Post Office jurisdiction should be affected unless a simpler method of appointing a receiver is instituted?—No. I think it does meet the requirements of very small cases, and it would be very unfair to take those facilities away, unless you could provide something equally cheap for the very small estates.

18,159. *Mr. Micklem*: Does it apply where a person of unsound mind has other property than War Savings?—It does not apply to other property, but the Post Office can deal with everything that has been acquired through the Post Office.

18,160. Do they make enquiries with regard to other property?—In most cases I think they do.

18,161. *Chairman*: Is the danger of the present system this, that taking War Savings Certificates, they might be paid over by the Post Office and, in the absence of a receiver, possibly extravagantly used?—Yes.

18,162. You have not to administer it after payment?—No. Somebody comes and says: "We need a couple of hundred pounds for the maintenance of this patient" or possibly "We have spent it"; and the Post Office will cash the War Savings Certificates without going into the circumstances of the patient.

18,163. *Earl Russell*: Have they not got an officer who would make some sort of enquiry to back up the story?—I do not think they go into the indirect details. I think they would require to see that it was being spent; but not that the patient was being properly maintained at that rate.

18,164. But they would satisfy themselves that it was a relation and that they were connected with it, would they not?—I think so. I am not saying that they do this badly at all; but I think there is not quite enough control over them.

18,165. *Chairman*: They have not the machinery available?—No; only, as I pointed out, there are a great many of these cases; they have a couple of thousand cases a year.

18,166. *Earl Russell*: And I suppose many of them are small cases?—Yes.

18,167. *Mr. Micklem*: Still, if all those cases came into your Department and you have your other cases of which you have spoken, you would want to go back to the old system of two Masters?—We should want four, at least.

18,168. *Chairman*: Of course, this is all coupled with your suggestion of some simpler method for small estates?—Quite.

18,169. Then I think we have already covered the point that you do not act of your own initiative—I mean you have to be brought into operation by the application of somebody or by the state of matters being brought to your notice by some interested person?—Quite.

18,170. The practical suggestion which seems to lie at the back of much of your *précis* would seem to be this, that there should be intimation made in every case by the person who has charge of the patient to your Department, that there is such a patient under care and that that patient has means?—Yes.

18,171. You suggest that that should not necessarily be done until a period has elapsed, possibly six months you suggest, because recovery might take place and procedure might be superfluous?—Quite.

25 May, 1925.]

Mr. G. M. HILDYARD, K.C.

[Continued.]

18,172. But in any cases where there is likely to be a prolonged detention, you should be notified?—Yes.

18,173. But then how is the institution, which naturally would be the notifying authority, to know whether the patient has means or not? Of course, in the case of a pauper I can understand the guardians taking steps to find out whether there is any money?—Quite.

18,174. But the institution, I take it, would not busy itself with such enquiry, would it?—No; I do not think it would. It was rather in my mind to make it a duty on the petitioner.

18,175. There is no petitioner in the case of the pauper, of course?—No. Of course, a pauper in a sense is not so likely to have property. I think there would be a difficulty in finding the person.

18,176. A pauper may be a peculiar person in law; he may be only a pauper because he has been put through the machinery of the Poor Law; at the same time, he may have some small means of his own which are just as valuable to him?—It might be so.

18,177. *Mr. Micklem*: But your idea is that where you have an ordinary petitioner, the petitioner might set out in every case not only the bodily condition of the man, but his material circumstances, so to speak?—Without going into details, yes.

Chairman: That is exactly what we do in Scotland.

18,178. *Earl Russell*: When a petition is made to you it has to disclose everything known about his assets?—Yes; but this is to meet the case where the people do not want to have a receiver appointed.

18,179. *Mr. Micklem*: It would seem reasonable where you are going to certify a man that you should not only refer to his bodily condition, but that you should set out what he has got, as far as you know it?—Quite.

Chairman: I wonder what sanction could attach to that, in order to secure that the disclosure was complete; a relative would not always know.

Mr. Micklem: You would not always want it to be complete.

Witness: This would merely show that the patient had property. Then the petition might also contain an undertaking by the petitioner that he would apply to the Lunacy Department if the patient was not dead or better within six months; then you would get your details of property when actually required; you put an obligation upon him.

18,180. *Earl Russell*: Indeed, would you not want to know, whether he made application or not to the Master in Lunacy, that there was such a case in existence?—Either that, or you would do it through the Board of Control on the certificate.

18,181. Still, if you have any suspicions, you can always put the Official Solicitor in motion?—Yes, quite.

18,182. *Chairman*: This might fall into line with certain other recommendations we have received, namely, that persons, before certification, should be subjected to some form of provisional detention and, possibly, observation; and during that period, which would be a temporary detention, it would be unnecessary to have anything to do with the estate, because it would all be provisional?—Quite.

18,183. But that, on formal certification, which means that the case has declared itself as one requiring treatment for a longer period, you should be notified of the estate of the patient?—Yes.

18,184. *Earl Russell*: Do you happen to know what happens to the estates of persons convicted of felony?—Yes.

18,185. Of course, as a rule, there are not many, but in that case there is the administrator appointed under the Act, or ought to be?—Do you mean the Broadmoor cases?

18,186. I was thinking of ordinary convictions for felony. I mean in every case the property devolves upon an administrator while the man is in prison?—Yes.

18,187. That is somewhat similar, because I should imagine in a good many cases nothing is ever done. It is only in the big case?—Of course, they are not lunatics; if they are lunatics they are not convicted. Broadmoor cases are people detained as lunatics who are criminal lunatics, and there they have receivers in the ordinary way.

18,188. They are of course not necessarily convicted felons?—No, they would not be. They are a very happy class, in a way, because there the Treasury are most generous; they always let them use the whole of their property for their comforts; they seldom want anything for maintenance.

18,189. Are you brought into contact at all with the voluntary patient?—Yes, a certain number of our "D" cases, the uncertified ones do go as voluntary patients to various institutions.

18,190. When you say a "D" case, you are referring to Section 116, of course?—Yes, the uncertified cases.

18,191. You may have an uncertified case becoming a voluntary inmate of a registered hospital?—Yes.

18,191A. And that person has a receiver?—Yes.

18,192. But not all voluntary patients possessed of means would necessarily have a receiver, would they?—Oh, no.

18,193. Only such persons as desire to become voluntary patients and are incapable of managing their own affairs would have a receiver appointed to them?—Yes.

18,194. Would you not also require to consider the possibility of a voluntary boarder reaching such a stage in his or her illness as to require the appointment of a receiver? The voluntary patient might quite well start in a state capable of giving instructions for his or her affairs, and the illness might become more accentuated later?—Not only the voluntary people; there may be a great many people who are incapable but who are not certified; I do not see how you are going to get any machinery under which you can interfere unless the matter is brought to the court voluntarily.

18,195. It looks as if any order, whether for the pauper or the private patient, contemplating a more or less continued period of detention, should perhaps be accompanied by an intimation to you if there is any estate?—Yes, I certainly agree to that.

18,196. Then further, to complete your proposal, you suggest that the case of estates under a limit, say, of £500 of capital value, or £50 per annum, should be under the jurisdiction of the County Court Judge?—Yes.

18,197. Then you would give a kind of lunacy jurisdiction to the County Court Judges?—I think probably that would have to be limited in some way, because there is no machinery now. Probably such of the County Court Judges as have now bankruptcy jurisdiction could do it; but I do not think that would help matters; it does mean new machinery of course.

18,198. And I do not quite see how the County Court Judge could discharge the functions that you discharge in looking after the welfare of a person. The County Court Judge would appoint a receiver and the small means would be in the control of the receiver; but who is to look after the receiver and find out whether he is applying the money properly and whether the patient is getting the benefit of his money,—things which I understand you in your Department look after, so far as receivers appointed by you are concerned?—Yes, I suppose County Courts would have to do that; and of course certified cases have the Board of Control to look after that; the County Courts might be limited to the certified cases; after all, most of the small cases are certified cases.

18,199. *Earl Russell*: We do not want anything to make the voluntary system more difficult by limiting this to certified cases where there is property?—Quite.

18,200. Of course, a person who is a voluntary patient may be always subject to undue influence.

25 May, 1925.]

Mr. G. M. HILDYARD, K.C.

[Continued.]

It is not desirable that they should manage property?—Quite. After all, in a certified case notice is given to everybody in a way by the certification; in the other case people may not know, and a hoard of people may be battenning on him; but I do not see how you can get at it.

18,201. *Chairman*: I should have thought that some machinery for dealing with the property of insane persons is very desirable in all cases, because apart altogether from the point of view of their personal welfare, I can imagine that many afflicted persons would be worried and anxious about their affairs and that the course of their cure might actually be impeded?—They are very much; we find that.

18,202. What I am thinking of is this, that a person who is worried, not a very acute case but a mentally disordered person, might have his or her worries greatly increased by the thought that his or her business was going to the dogs while they were in an asylum, or that their affairs were getting into the hands of undesirable persons, and so on?—Quite.

18,203. Whereas, if they knew that their affairs were in responsible hands and would be looked after by a responsible and neutral person, that particular anxiety would be allayed?—Quite.

18,204. *Earl Russell*: You cannot get over the trouble of a personal business; you cannot continue to run that; I mean a fried fish shop or an auction room?—No; that is very difficult.

18,205. *Chairman*: I think we have now covered the points which you have been good enough to put before us in your *précis*?—Of course, some of your detention points are of great interest to me. You may say that primarily I am interested in the property, but, secondarily, I am interested in seeing that the property is used in the best way for the patients. I have no doubt you have already considered the sort of things that trouble me; I mean the difficulty of dealing with these patients who have got some delusions but who are not insensible, who quite understand their position, and have not got enough money to be kept entirely on their own, people who have to be sent to an asylum because there is nowhere else to send them; and one cannot help doing that even when you are providing about £60 or £70 a year for the person's benefit. They are living in the same wards as maniacs very often, and they are having a very bad time. I do not know whether you have been able to devise any method of classification, which would enable one to secure that patients who felt the unpleasant part of their surroundings could be put, without great expense, into a place where they would be better looked after.

18,206. On the occasion of your visits to patients, have you encountered that sort of thing?—I do not visit much myself, you know; I have too much work to do up here; I cannot get away. My Visitors report, and I do see some of these people after they have got better, when the receiver is discharged, and they tell me these things; and, again, I see the relatives; and, without accepting everything one is told, it is common sense. One of the great difficulties even of certification is that there are some of these patients who are perfectly fitted to be out of the asylum if they had only got someone to take care of them; they do not think they are lunatics, and they are not lunatics in many senses; still, owing to the lack of space and money, they have got to consort all their time with people who are in a very much worse mental condition.

18,207. *Earl Russell*: Is not the only way to improve that by an extension of the open door and the parole system, which the doctors are now trying to do?—Yes; but the difficulty is that a person in that state is not thoroughly capable of looking after himself.

18,208. Neither are those who are given parole?—No.

18,209. *Mr. Micklem*: Does not that point to the necessity of further after care provision for these people?—Yes; I think that is of great value.

18,210. *Sir David Drummond*: Or a more perfect classification?—That is what was rather in my mind.

18,211. *Chairman*: We have heard a great deal on the possibility of better classification; it is very interesting to hear your experiences, too. It becomes in the end of the day of course largely a question of money?—I can understand that.

18,212. Because to have very discriminating classification obviously means more accommodation?—Yes.

18,213. *Earl Russell*: Small wards and many attendants must cost more?—They must. I suppose it is impossible in any way to disturb the County system and to say one asylum for one type and another asylum for another type?

18,214. Possibly, if you had the Lancashire and Cheshire combination you might do it?—If it is for the good of the country, the county must give way.

18,215. *Mr. Micklem*: Your suggestion rather was that classification might depend to some extent upon the amount they are paying. I rather gathered that you suggested that, but that is not the view you press, is it?—No, I did not really mean that. I really did feel rather that if you were paying for your maintenance you would be supplying some of the money that would be necessary to improve classification.

18,216. *Chairman*: I quite see your point: that a person who is paying a small but still a reasonable sum of money is not getting value for it, if he is receiving no better attention and no better privacy than the person who is there as a pauper and who is purely rate-aided?—He is not getting value for his money.

18,217. *Earl Russell*: And from his point of view it is a large sum of money, of course?—Yes, possibly using up his capital which, after all, is very hard. It does seem to me that classification, if it can possibly be improved, is of enormous importance.

18,218. *Chairman*: There is one other small matter. The receivership continues until it is terminated by a discharge, of course?—Yes.

18,219. What is the position of the patient after he or she has been set free from the asylum (I am taking a certified case) but the receiver is still in the saddle?—As far as I am concerned, the decertification makes no difference at all; that is to say, the receiver continues as receiver until the application is made for the discharge of the receiver.

18,220. *Earl Russell*: You take no official notice of the other?—No.

18,221. *Chairman*: Therefore, that person, who has been actually discharged cured from the institution, would be unable to touch any part of his income or capital until such time as the receiver had actually been discharged?—That is so. In that case, if he has really been discharged cured and recovered, it is automatic almost; he has only got to apply, and there is an end of it.

18,222. But the person, having recovered, knows what steps to take for his own protection?—Yes.

18,223. *Earl Russell*: Do you mean to say that if he came to you and produced a certificate which said "Discharged cured," that would be sufficient?—Yes.

18,224. *Chairman*: If you had a "Discharged cured" case, you would yourself proceed to relieve the person of the burden of the receivership?—Quite.

18,225. But until the receivership is actually removed by a formal step, the patient, whether recovered or not recovered, cannot touch any of his means?—No. Of course, one is bound to realise that if a person has been for some years without any control or authority, without any responsibility, and not looking after themselves at all, in an asylum, it is not a bad thing to have a short period when they come out in order to let them get used to the world before they do take over their property.

18,226. Suppose they wanted a little money right away?—They would get it.

25 May, 1925.]

Mr. G. M. HILDYARD, K.C.

[Continued.]

18,227. From whom?—From us, in the same way. They might apply and say: "I want to start a business and I must have a little bit of my capital."

18,228. Have you a discretion?—Yes, we have the widest discretion in dealing with everything, capital and income.

18,229. *Earl Russell*: Supposing a person is discharged at the request of the petitioner, what do you require then to discharge the receivership?—The medical officer, and if there is any doubt, one of the Lord Chancellor's Visitors goes to see the patient. Of course, it is in a sense rather a suspicious state of circumstances; one has to be careful.

18,230. I am thinking of a case that is going on in which the receivership was discharged some years ago rather under those circumstances?—Yes.

18,231. *Chairman*: Now have you had any experience of licensed houses?—Yes.

18,232. Have you any observation to make to us upon their utility?—Well, of course I have a very great difficulty always in finding the maintenance I want at the cost which I can afford. There are people of every kind of varying incomes, and without an enormous variety of institutions, you can never get places for them. I do not know really quite how the licensed houses differ from some of the other hospitals; I do not quite know what their position is; but we want them all, as far as my part of it is concerned.

18,233. *Earl Russell*: The essential difference is that a licensed house is run for private profit?—Yes, but it does not make a very great difference from our point of view. If a licensed house will provide maintenance for a patient at a sum which he can afford, it does not matter to us whether they make a profit out of it.

18,234. *Chairman*: The licensed house has rather come under the suspicion of the Legislature as being a place where people make money out of the afflicted, and because there is a possible conflict between interest and duty—duty to the patient and their own interest in such cases. Have you ever come into contact with abuses in connection with licensed houses?—I do not think so. Some of them charge more than one thinks they ought to charge and obviously they are anxious to make money out of it, but I do not think there are real abuses. One cannot help realising that a medical superintendent must be a little biased by the fact that a particular patient is providing a great proportion of his income; but I cannot say that I ever knew of anyone who had been kept in a licensed house who ought not to have been kept there. After all, the Board of Control has power; and if anybody thinks the patient is all right, the medical superintendent ought not to be able to put his spoke in the way.

18,235. *Sir David Drummond*: Then you see no reason why licensed houses should not be increased?—No. Of course, it would be better, I suppose, ruling out that particular difficulty anyhow, if you could take their places by other houses; if you could have Government institutions doing the work they are doing, without making a profit out of it. If you merely provide nothing, I do not know where my patients are going.

18,236. *Chairman*: You see, it is thought that they cater for a particular demand, namely, a place where patients can go, who dislike being in State institutions. There is a class of people who prefer to be in some place which is the equivalent of a nursing home, and merely because they happen to be mentally afflicted, it is a licensed house; it is thought that that class of person prefers the licensed house?—I do not know; I am not quite clear about these licensed houses. Do you include places like St. Andrew's and Holloway Sanatorium?

Earl Russell: Holloway is not run for profit.

18,237. *Chairman*: The licensed house is really an institution where patients are received and housed for gain. The registered hospitals are all maintained out of endowments or from payments made by private patients which are utilised for the benefit of the establishment, but never go into any private person's pocket?—I cannot quite see why it should make any difference to a patient or even to his relations.

18,238. There is this element, is there not, that in the one case there may be a temptation to exploit the patient?—Yes; but you were saying, I thought, that they were necessary because patients would rather go to a licensed house than to St. Andrew's or to the Holloway Sanatorium; they would obviously rather go there than go to a county asylum.

18,239. The distinction does not exist in Scotland either, and we have only one small licensed house?—Quite. I have never realised anyway that there was any feeling either in the patients' or their relations' minds as between the two classes of place.

18,240. But have you found that there are sufficient registered hospitals in the country?—No; you would have to take their place by something else.

18,241. At present the class you have in mind is catered for by the licensed house and the registered hospital?—Yes.

18,242. I suppose even with both, you often have difficulty in getting accommodation?—We have not much difficulty with a rich patient; the difficulty is with the patient whose income is up to £200 a year.

18,243. That, again, points to this, that the monetary side of the transaction may be unduly prominent?—Yes, I think that may be so. Of course, one realises that £100 a year is not very much to keep anybody on, whether it is in an institution or anywhere else.

18,244. *Earl Russell*: No; that is below the guardians' rate—£100 a year?—Below a great many guardians' rates, yes; but that is why so many of the small estate people have to go into asylums; the private side of the county asylum is the only place you can get for a person with £120 a year; a nursing home is impossible.

18,245. *Chairman*: Of course, they could not live out of an asylum either on that amount?—They could not.

18,246. They cease to be wage-earners when they become inmates of an institution?—Quite.

18,247. The £100 a year eked out with what they earn would be adequate?—Yes.

Chairman: We are very much obliged to you Master Hildyard, for your contribution to our evidence.

(The Witness withdrew.)

(Adjourned to Friday, 19th June, at 10.30 o'clock.)

5, OLD PALACE YARD,
WESTMINSTER, S.W.1.

THIRTY-FOURTH DAY.

Friday, 19th June, 1925.

MEMBERS PRESENT:

THE RIGHT HON. H. P. MACMILLAN, K.C. (*in the Chair*)
THE EARL RUSSELL.
SIR HUMPHRY ROLLESTON, BART., K.C.B., M.D.
SIR ERNEST HILEY, K.B.E.
SIR DAVID DRUMMOND, C.B.E., M.D.
MR. W. A. JOWITT, K.C.
MR. NATHANIEL MICKLEM, K.C.
MR. H. SNELL, M.P.
MRS. C. J. MATHEW.
MISS MADELEINE SYMONS.

MR. P. BARTER (*Secretary*).

MR. W. FAIRLEY (*Assistant Secretary*).

Evidence of Mrs. F. M. GLANVILL, Mr. GEORGE HILL (Wandsworth Board of Guardians), and
Dr. R. W. GILMOUR, M.B., B.Sc. (Durham), M.R.C.S., L.R.C.P. (Physician in Charge of St. Luke's Clinic).

Mrs. F. M. GLANVILL and Mr. GEORGE HILL, called and examined.

18,248. *Chairman*: This morning our witnesses are two members of the Wandsworth Board of Guardians, who are good enough to attend to put before us the views which they entertain in relation to the administration of the Lunacy laws from the point of view of the guardians. We have had the advantage, Mrs. Glanvill and Mr. George Hill, of reading your short note of the points to which you desire to draw our attention. I need scarcely say that at this stage of our inquiry we have had a great volume of evidence on all questions affecting the Lunacy Acts and, among other things, affecting a good many of the points to which you allude; but we should much appreciate any observations you would like to make in expansion of the topics you refer to. You first of all draw our attention to the matter of grading of patients. We should be happy to have an expression of opinion coming from a responsible body such as yours.—(*Mr. George Hill*): I think my first duty is to apologise to you if we put you to any inconvenience by being late.

18,249. We have retaliated by keeping you waiting a little time, because we had some business to transact, so we are quits.—Thank you. Well, Sir, I want you to bear in mind the friendly attitude with which we meet you this morning, with a view of suggesting as laymen any points that we think in regard to visiting might be helpful either to the Lunacy Commissioners or the committee that might attend. We thought in visiting these various asylums as guardians it was futile, simply useless, to go there year after year and be shown a number of patients who we were not even sure were our patients, only by name; they were not able to answer for themselves; we took it for granted they were our patients. But it struck me personally it was useless to go round unless one looked into the welfare of these poor things from our point of view.

A committee was formed with the view of making surprise visits. As I say, to view them on a special day when they are brought into you with their best clothes on, you did not see their inner life, and, in making a surprise visit, one had an opportunity of coming into contact with the life of the patients.

18,250. Just before you pass from that, you were of course visiting in pursuance of the right which you possess under the Lunacy Act, 1890, Section 201?—Yes.

18,251. The right at any time "between eight in the morning and six in the evening, to visit and examine any pauper lunatic chargeable to the union confined in any institution for lunatics, unless the medical officer of the institution delivers to the person or persons intending to make the visit a statement signed by him certifying that for the reasons set forth in the statement the visit would be injurious to the lunatic"?—Quite.

18,252. You have, therefore, a statutory right as guardians to enter at any time you please between the stated hours any lunatic asylum in which any paupers for whom you are responsible are resident?—Yes.

18,253. Now you exercise that right, I understand, by visiting from time to time, but it has been your practice to announce your visit beforehand?—Previously, yes.

18,254. You talk about instituting surprise visits; it had been your practice before to announce your visits?—Quite.

18,255. You are under no obligation to announce your visit?—Some five or six years ago when I first became a guardian, I was told I was not allowed to go unless I announced it first. I looked it up for myself; I think you will find that very few guardians, even in London, know the powers they have.

Earl Russell: Of course it is when the whole board of guardians see fit, I take it.

19 June, 1925.]

Mrs. F. M. GLANVILL and Mr. GEORGE HILL.

[Continued.]

Chairman: Yes.*Witness:* Does that mean "guardians" or a "single guardian"?

18,256. The expression of the statute is "the guardians of any union shall be permitted whenever they see fit between eight in the morning and six in the evening, to visit and examine any pauper lunatic chargeable to" their union. However, we need not go into the legal question.—It is nice to know.

18,257. We are not going to give gratuitous opinions. In point of practice you had always announced your visits beforehand?—Yes.

18,258. You were not satisfied with those visits, and wanted to pay surprise visits, and, accordingly, instituted a series of surprise visits?—Yes, I thought it was useless.

18,259. When you were visiting on other occasions, that is to say, announced visits, did you get facilities for investigating any case that attracted your notice?—When one came to interview 300 or 400 patients, it did not give you much time.

18,260. What was the sort of programme?—You would receive a list. You would tell the doctor you had come to visit so many patients; they would be brought into a room, and the guardians would form themselves into a committee and sit there and interview each one individually, and just have a cheery word with them; that is all one can do in the space of time.

18,261. Did they make any complaint to you?—Yes, but one has to be very careful; as a layman one would not be in a position to go into difficult cases; one will always get complaints.

18,262. *Earl Russell:* But if you got a complaint of ill-treatment you would take some notice of it?—We should come to our own conclusion; you get used to that sort of thing when you are going round. When their plea is good, you can tell by the patient, more or less.

18,263. *Chairman:* What we are concerned with is this: the visit of the guardians is one of the safeguards for the patients?—Yes.

18,264. And one would like to know whether it is to any extent an effective safeguard, and whether a person who has a complaint, either on account of ill-treatment or undue detention, has an opportunity of interviewing a guardian and putting his case to an outside person interested in him, independently of the institution in which he happens to be?—We should take that up; we should report that. We should interview the doctor and ask the reason and report to our board.

18,265. Have you had any such cases in your experience where you went into the matter, investigated the matter yourself?—No. You are referring to the guardians as a body?

18,266. Yes?—(*Mrs. Glanvill:*) I consider we have.

18,267. You pay a visit to an institution; a patient there makes a complaint to you. What I want to know is whether you have had occasion to investigate any case?—(*Mr. George Hill:*) My point is this: as a body going round we have so many to see that we could not go into it. We should take notice of that complaint and report it; but where we go as a special committee, a surprise visit, we have found complaints which we will give you.

18,268. What one is anxious to know is whether an opportunity is afforded by the visit of the guardians to the patients to bring before an independent body like yourselves any matter which ought to be investigated. One wants to know whether there is contact maintained between the patients in the institution and the board of guardians interested in the patients' condition?—I will give you a case which Mrs. Glanvill will substantiate later. We might take the grading of patients. Our committee is not satisfied with the herding up in dormitories of, say, 100 patients together; we believe in sections according to the various complaints. I know I am touching on a wide subject now.

18,269. Classification?—Yes. Personally in my experience I see no difference between the mentally unsound and the mentally ailing. If there is a case of mental ailing, and they are all packed together in one dormitory, I do not see where the patient is going to benefit; and it seems a home of detention rather than a home of cure. In my view in going through crowded asylums, the rooms are uniformly decorated; but every room should be different, so that the patient is not always looking at that blue corridor, or that blue dormitory. The eye being an avenue to the brain, I submit that would have an effect, and anything that can be pleasing to the eye is pleasing to the brain. There are times when these poor creatures have their sane moments, and they must get tired, and they tell you this, of the same old walls. I submit this, that each ward should be decorated with something fresh, and that there should be sections—classification and sections. It is a big question I know, but we feel at the present moment that some of the institutions are doing a great work. Take, for instance, Horton or Long Grove—there is a beautiful villa system there.

18,270. Of course the amenities of life are one thing; the classification of the cases according to their degree of insanity is perhaps a little different. We have heard a great deal of evidence upon the desirability of segregating the cases and preventing the graver cases being brought into contact with the slighter cases, or the violent cases being brought into contact with the quiet cases. Upon that matter you may take it that we have really had a great amount of responsible evidence which has made a considerable impression on our minds; but you as a guardian will have necessarily in view the financial aspect of the thing?—I appreciate that on that point, but, on the other hand, is it going to be cheaper in the long run? I am speaking now with an experience derived from conversing with medical men, who tell me it is a big question, but it would be the cheapest for the country in the long run, certainly from a humane point of view.

18,271. There may be no question about the humane point of view; but are you thinking that, from the economical point of view, you might attain a larger percentage of recoveries if you had better surroundings?—Yes. I think the figures given by the London County Council of the recoveries are appalling. I do not see what there is at the present institutions to enable them to recover. There is more or less the same food; you do not get that in a private asylum; there one is studied more or less.

18,272. I am not sure, you know, that the percentage of recoveries in private asylums is so much better than those in the London County Council asylums?—I cannot speak with authority there, but I should say there are more facilities for getting more cures. Take a young girl, for argument's sake. I believe in the after-care. A girl, to my mind, through confinement ought never to go into an institution of that kind; I would treat her as an imbecile, not as of unsound mind. Many have asked me if they could go into an after-care home so that they could get some light work. When you get patients talking to you like that it must impress itself upon you. I am quite aware they have their rational moments, and one always allows for that sort of thing.

18,273. A suggestion has been made that patients should be moved from one institution to another after a stated interval of time, in order that they might have a change of surroundings such as you have suggested. You make a particular point in the note you have sent in of the patients being brought together, good and bad cases alike, on the visiting days?—And they also live together in common life.

18,274. This is not confined to the question of their all being brought before you together, but you are referring to the larger question of their living together?—That is right.

19 June, 1925.]

Mrs. F. M. GLANVILL and Mr. GEORGE HILL.

[Continued.]

18,275. When they are brought before you, the whole of them would be brought before you, I suppose?—Our patients, yes.

18,276. And do you suggest that when they are brought before you they should not mix good, bad and indifferent, but that there should be some classification at that time also?—I do not mean when we see them.

18,277. The note is in that respect perhaps just a little misleading, because it suggests they were brought together at the time you were visiting; and does not necessarily mean that at other times they were living together; but your point is that the system of classification both on admission and after they have taken up their residence in the institutions should be more exhaustive?—Quite so.

18,278. Upon that we have heard a great deal of evidence and the point is fully before us?—Quite.

18,279. *Earl Russell*: Do you have the opportunity of going round the wards and seeing the patients in the surroundings in which they actually live?—We have not done hitherto, until the special committee was instituted. I did not know my powers until the committee was instituted.

18,280. Of course it is obviously more important that you should visit them and see how they live?—That is just my point, and I saw it was futile to go round as a body of men and say: "We visited this institution and we find it as well as can be expected,"—some such stereotyped reply as that.

18,281. I notice you say here something about your not being allowed to visit where you desire?—I will come to that, if I might, with the Chairman's permission.

18,282. *Chairman*: But whatever be your existing powers, what you would desire, I take it, in this matter is that the guardians should have an unrestricted power of visitation and of enquiry in any institution where the paupers for whom they are responsible are living?—That is right.

18,283. That any guardian should be entitled to go as a member of the board of guardians as and when he pleased and to see over the whole institution—is that what you would desire?—That is right.

18,284. *Earl Russell*: Did you say any member?—A member of the guardians.

18,285. Without the authority of the board of guardians?—It is out of courtesy. Even then, as the Chairman puts it, he would walk through as a guardian.

18,286. But do not you sometimes have irresponsible members whom it might be undesirable to allow to go and visit an asylum whenever they wished?—Do you mean undesirable guardians politically?

18,287. *Chairman*: No. Visitation is a most useful thing if it is conducted by discreet persons, but I think any of us who have had experience of public life know that not every one engaged in public life is necessarily discreet. Therefore the board of guardians themselves might say, "It is undesirable for us as a responsible body to have one of our members, who may not be the most discreet of our members, occupying himself in this matter and possibly causing trouble"?—I quite agree with you. Of course this committee is composed of chosen men and women; they are chosen by the board.

18,288. Lord Russell's point may be picked up in this way: that the guardians should as a board, or through any specially appointed persons, have the opportunity of visiting. Perhaps I put it too broadly when I suggested that any guardian at any time might go, because you might upset the routine of the institution very much indeed if you had people moving about at all times?—I quite appreciate that point. (*Mrs. Glanvill*): I suggest a committee of three.

18,289. The important thing is to ensure that the responsible body of guardians should have access at all times by proper representatives to an institution?—(*Mr. Hill*): Without giving notice.

18,290. Certainly, without giving notice?—That is my point.

18,291. If that were assured, you would be content?—You will bear in mind with regard to grading, the special care of women, if I might force my point there, that they should be put in an aftercare place instead of being put with the unsound.

18,292. What type of case have you in mind?—Childbirth.

18,293. Puerperal cases?—Yes. I take this very seriously and I feel it when I see these poor girls. There are other cases which one could mention but as you know it is a big question. But that is one of the vital points I would like gone into, because I do consider that they are more or less harmless. I am speaking now from experience, and having had conversations with various superintendents, and they agree with me upon this point.

18,294. You consider that this type of case requires special consideration?—I do. (*Mrs. Glanvill*): My idea would be this (of course it may not be possible):—but take Epsom, we have four large asylums there, Banstead and Horton, and so on, all within a three mile radius—would it be possible to have one set apart for the extreme cases, and so grade them up until they finally reach West Park, which is the most up-to-date one on the cottage principle, to be then set free to their homes? Of course one realises one would want a tremendous lot more attendants for the extreme insane; but you do not seem to have got sufficient staff to be able to cope with the extreme cases, and if they were in one building perhaps one could have more money spent upon that building and more attendants. I am only taking Epsom because there are four institutions in quite a small area; a few patients could be moved on until at last they reached the last one where they are almost in home surroundings; but if you could sort them out till they got to the last one, I think if it could be done it would be money well spent.

18,295. Where you have an authority which has a group of institutions under its charge it would be possible; indeed, it has been suggested that instead of each institution containing all classes of cases one institution might be set apart for one class, and another for another?—That is my point.

18,296. And it is one worthy of consideration?—(*Mr. Hill*): Of course they are all more or less poor patients; the other thing is to bring them as near home, as near their friends as possible. I came across a case the other day—a woman had to work nearly all night washing to be able to get her money to go to a certain institution; and she has applied for her relative to be brought as near home as possible to save the railway fare. She was a widow woman. One cannot always meet them to help them, but it is a tragedy when a woman has to go out working all night for that purpose.

18,297. *Earl Russell*: That is very true; but you see the geographical grading would just interfere with the other grading you are talking about?—Yes. Then there is the punishment of patients. We have evidence that there is punishment existing and going on at the present moment. If it had not been for this special visiting committee we should not have known of this case. We were told this man was in the infirmary, they said "Oh yes, you can go along to the infirmary." We saw him in bed; we interviewed him and asked him how he came by his injury. He had been kicked by an attendant; we spoke to the doctor. He said he did not notice it till five days afterwards when he was having a bath. I said: "It is strange; should it not be brought to your notice immediately the patient is injured?" "Well," he said, "we did not notice it till he was having a bath five days afterwards; we found he was ruptured." We immediately held an inquiry. We found on going through and interviewing the attendants and nurses they hardly knew how it was done. It was not done in a scuffle, or in pulling

19 June, 1925.]

Mrs. F. M. GLANVILL and Mr. GEORGE HILL.

[Continued.]

him off a chair; and the point which we want to force home is that we are not satisfied with the evidence of this committee, which we consider is contradicting itself. On the one hand they say that it is impossible to take any notice of a mental person; they wind up by saying that he tells them himself that he did this 11 years ago on a bicycle. If you cannot take any notice in the first instance, why take notice of the suggestion that he has injured himself on a bicycle 11 years ago; it is contradictory; we could get no satisfactory evidence. Sir Frederick Willis gave us a very patient hearing, and we were transferred back to the institution again. The doctor was most courteous and he gave us every facility, but we could not get to the bottom of the evidence; we could not get at how the man was injured; no one would come forward and say how he was injured; no one knew. On our next surprise visit to that man we found him in a most acute ward with a black eye. I said, "Why is he put in this acute ward?" They said, "He has got worse." On the next visit we found him well cared for and in the recreation room. Of course, I am going to submit evidence to you that these men are put in acute wards, not actually punished by the attendants; that is the last thing I should say about the noble profession, the medical profession; they are doing all in their power, but I feel they are handicapped, so I would like to disabuse the mind of anyone who thinks we have a feeling against the medical profession.

18,298. Of course, you must remember this, that investigations on questions of fact into occurrences taking place in any institution whether it is an institution for the insane or not are often attended with great difficulty?—But they are judges of themselves. There are the institutions and the Board of Control, and they are sitting in judgment on themselves all the time. Who is to judge? I want an independent inquiry.

18,299. *Earl Russell*: What do you suggest could have been done that would have enabled anybody to arrive at a judgment in this case?—I was coming to that point.

Chairman: What kind of inquiry do you say would necessarily have led to a conclusive result, because even in the Law Courts results are not always conclusive?

18,300. *Earl Russell*: And presumably with sane witnesses?—I submit this. Who have more grounds to look after their patients than the guardians themselves? I submit that immediately one of our patients is injured we should be notified and enabled to go down and visit. They have not given us any report; in fact, I think, if I remember aright, that they object to us attending when an inquiry is being held on our own patients. I ask: why should not your asylums be like the hospitals—an open door?

18,301. *Chairman*: Take this particular case you have in mind. You tell us that every facility was given you. Did you go down yourselves, and through your committee interview nurses and so on?—I asked for that, and I was refused, and we asked then to go before the Board of Control, and Sir Frederick Willis said he did not think we had that right, as he thought that the visiting committee would have gone into that matter, and he did not think the guardians ought to ask for that, but in this case he did not wish to burke anything at all; he would write to the superintendent and ask for us to have another interview and have the attendant there.

18,302. Then you did interview the attendant?—No; we interviewed the doctor, but the doctor had heard from Sir Frederick and the attendant was missing that day. That is quite usual, when we want to find an attendant he has always got the day off. We had no opportunity of interviewing the nurses as you suggest.

18,303. *Earl Russell*: Was an inquiry held by the Board of Control themselves in this case?—No; the Mental Hospital Sub-Committee held an inquiry.

18,304. What do you suggest, supposing you, or the Chairman here, held an inquiry, could have been done more than that inquiry did to get at the facts?—We ask that the guardians should be allowed at the inquiry when an injury occurs.

Chairman: To a pauper patient under your charge?

18,305. *Earl Russell*: Do you think anything more could have been got out?—We do; we are not satisfied. I think the doctor and Sir Frederick were perfectly honest about it; but I think the whole evidence was wrong. (*Mrs. Glanvill*): May I suggest here that I really think that had we been present (either of us that had found the man in bed in the first instance) we should not have agreed with these two reports as we got them. They may have satisfied us; but, as it is, coming to our knowledge from outside that there are punishments going on and that you can punish a patient without a mark showing, we thought it would have been more satisfactory if we had seen the attendant. We found these two reports did not quite agree.

18,306. *Chairman*: Again, looking at it from the point of view of improving the procedure, would the guardians be satisfied if, on any occurrence taking place in an asylum in relation to one of their pauper patients which in their view required investigation, they were allowed to take part in the formal investigation?—(*Mr. Hill*): Then we should be satisfied.

18,307. If you have a *locus standi* to be represented at an inquiry relating to one of your patients?—That is the point.

18,308. In order that you may put forward your views and have attention drawn to matters which you regard as important?—That is the point. We were told no punishment ever exists. A week after I made a special visit to Hanwell; I asked a certain doctor there if they ever had any cruelty there, bearing this case in mind. They knew who we were when we visited, there was a stampede; they knew all about the case at Epsom. He said, "We have just discharged a nurse now. A mother came in to visit her son and found both his eyes blacked"; there was a case, then, of prosecution. It does exist, and the doctor found it; probably we should not have known that, unless the mother had asked to see the doctor because her son was injured.

18,309. The records of all institutions show that a certain number of attendants are discharged because they do not fulfil their duties properly; that is an inevitable incident. The important thing is to see that these cases do not escape investigation?—That is just our point.

18,310. *Miss Symons*: I suppose apart from actually ascertaining the facts you are likely to be asked about cases of that kind, and are not able to deal with them if you have not access to all the facts?—Quite.

18,311. *Mr. Snell*: Do you find that relatives of patients make complaints to you as guardians?—Yes. I suppose I have 100 letters. This committee are not in the least advocating release; we are simply laymen, and we leave that to the medical side. Some of the officials have thought that our main purpose was to get these poor things released.

18,312. *Chairman*: That would be futile, of course. I think, if one may put your general point, it is this: that as guardians you have certain responsibilities towards those pauper patients, and that the existing system does not give you the facilities which you would like to discharge that duty?—That is our point. I have got another case which I am investigating now of a girl; her hair was pulled entirely out of her head, and her father went and fetched her away; so that cruelty does exist, and we think special visiting committees will act as a check. They tell us the Commissioners had not seen them that year; it may have been that the year was not up and they would come the next day, but they had not seen them. There should be an independent body. This special visiting

19 June, 1925.]

Mrs. F. M. GLANVILL and Mr. GEORGE HILL.

[Continued.]

committee to my mind would be a kind of check; they would know there was someone round about.

18,313. *Mr. Jowitt*: Mrs. Glanvill used the phrase about punishments without leaving a mark, and you were saying you had had about 100 letters, and then you broke off. Is it frequently suggested that this punishment does take place?—It is.

18,314. And what is the nature of the punishment? Is it some physical violence, or is it suggested that they are made to drink drugs, or are they deprived of food?—Yes, there is a case of punishment in that way—I do not want to go into details.

18,315. That is a common complaint, is it?—That is so. I will substantiate it in this way: there is a City merchant who did well, and who was in a well established business, and who, through the war, through the bombs, went temporarily deranged. His wife thought he was not quite sound, so had him put away; he had not been there long, and he felt himself that he was well, and he said to the superintendent, "I feel a different man altogether." He was released after about nine months, but he said that during the six months he was there he had seen untold cruelty: where a patient had pushed an attendant or even hit him, they took him into the lavatory and both punched him. He saw it himself, and the doctor saw them taking him, and said, "What is the matter?" They said, "Oh, he is a terror; we have just shut him up for a little while." Then, of course, they reported this. If they do not punish the patient themselves, the way they have got of getting them punished is to put them into an acute ward where they are bound to be punished by other patients. I have proof of that at Hanwell, where, when I went in what I call "Dante's Inferno," it was an appalling place; there was a young fellow there near the gates looking through the bars of the steps as we went through, who said, "May I have a word with you?" He spoke quite rationally; he said: "I have been put here because I have tried to escape." I said: "You should not do that." He said: "I have been put here amongst these chaps, and they often give me a good thrashing." I spoke to the assistant doctor, and said: "You heard what that young man said?" He said: "Yes, he is put there for punishment; he will not want to escape again." I said: "That is wrong, to put patients into an acute ward purposely to receive punishment." That is a case.

18,316. Do you say the assistant doctor admitted it?—Yes; we have got witnesses of this.

Earl Russell: What was the name of the doctor; I think we must have it now we have had this statement?

18,317. *Chairman*: There is a point of view, you know, which one must keep in mind in visiting these places: the refractory ward is, of course, the ward in which, as you tell us, the more violent patients are kept; it is the ward in which the largest number of attendants are available?—Quite.

18,318. One has heard this explanation given of a violent patient being put into the refractory ward, that it is not so much from the point of view of punishment as to enable that patient to be properly taken charge of, because in the other wards there are fewer attendants, and a violent patient there would be very disturbing to the other patients.—Appreciated. I say a fairly normal patient is put into this acute ward to receive punishment because he did something wrong.

18,319. May it not be because, having become violent, he will probably be best treated there in the sense of having most supervision?—Quite. I have made a statement. I am quite prepared to go to Hanwell. It was the young assistant doctor who showed us round, and he said: "Oh, yes, he is put there for punishment." Various members of this committee will prove this. I say it is wrong. If that system does go on, it is not right, and should not be allowed.

18,320. *Mr. Snell*: Did you have any evidence as to the time he had been in the courtyard?—He had only just been put there. In trying to escape he had given the attendant a severe kick. He had been there three or four days, I believe.

18,321. Was any indication given as to the time he would be likely to be kept there as a punishment?—No.

18,322. *Sir David Drummond*: What action did you take when you heard that?—Reported it to our board.

18,323. And what action did your board take?—That is the whole cause of this enquiry; we have simply led up to it; we have written to you and asked you to receive us.

18,324. That is all you have done?—We are powerless.

Sir Humphry Rolleston: It is very important to ascertain how much evidence there may be as to what part of the necessary treatment can be interpreted as being a punishment.

Chairman: I was anxious that that point of view should not escape notice.

18,325. *Sir Humphry Rolleston*: I am sure the witness would strengthen his contention if he had a certain number of statistics. I mean, we have heard one or two examples, which may be capable of interpretation in another way; but if he could give some statistics of the number of cases in which it appeared to him that definite punishment had been meted out to patients because they have manifested some evidence of insanity, it would be even more valuable than the evidence we have already had?—Of course, this committee has only just been appointed; we have not had much experience with the committee.

18,326. *Mrs. Mathew*: How long ago was this incident?—I suppose, roughly, about February. We have got the record of it, if you would like to have the record.

18,327. *Mr. Snell*: February of this year?—As far as my memory carries me.

18,328. *Sir David Drummond*: You have only referred to one case which would admit of proof—that is to say, we could call the doctor before us and have proof. That is the only instance you have, is it not?—I quite agree, that is sufficient for me. On the other hand, as I say, it is not fair for us to receive letters and submit to you cases of cruelty which are unfounded.

18,329. *Chairman*: Here was a patient, I understand, for whom you were responsible?—In Hanwell Asylum. I do not say we were responsible.

18,330. You were visiting as guardians, and your attention was attracted to the patient. I understand you to say that the patient had recently tried to escape?—That is right.

18,331. He had been foiled in his attempt to escape, and is then found in the refractory ward?—The acute ward.

18,332. At any rate in that special ward. That in itself was quite right?—It may be. I am simply telling you of our experience.

18,333. On the other hand, you said that patient told you he had been thrashed?—No, I said he had been put there for punishment, and the patients were knocking him about, not the doctor or the attendant. He was put into this particular acute ward so that he would get knocked about, and they do. (*Mrs. Glanvill*): They fight amongst themselves, that is what it is; and a man who is recovering from it, we take it, is put back, graded back, and then the punishment is quite sufficient, to be put back with maniacs—it would be to me if I was nearly sane.

18,334. *Mr. Snell*: When you left the asylum you were probably asked to make some comment in a book, to say that you had been a visitor?—Yes.

18,335. Did you register anything in this book showing your disapproval?—(*Mr. Hill*): No; what happened there was that, unfortunately, there were two committees; we happened to go, to save expense,

19 June, 1925.]

Mrs. F. M. GLANVILL and Mr. GEORGE HILL.

[Continued.]

in the same car; the ordinary visiting committee went there and we as a special visiting committee went the same day. The ordinary visiting committee saw the details, and they wrote in the book that they found everything satisfactory.

18,336. On the female side?—Yes. We signed with them, because we took our colleagues' word that the females were properly looked after. The ordinary visiting committee had not seen this acute ward that we had seen.

18,337. What I want to know is whether you, having seen and heard—We signed nothing in the book at all.

18,338. You did not even say you were dissatisfied?—I certainly did to the assistant, whoever he may be.

18,339. You did not write in the book?—No, we made no report at all.

18,340. *Sir David Drummond*: The important point is that the doctor admitted that the patient was put in the acute ward for punishment?—When I say the doctor, it was an assistant who showed us round, who I assumed was an assistant doctor.

18,341. *Chairman*: Do you know his name?—No, I should know him by person. They would have a record as to who showed us round.

18,342. We cannot get nearer to it than that at the moment.—I am not even going to say it was a doctor; I assume it was the assistant doctor who showed us round.

18,343. Can you give us the date of your visit?—Yes, I will send it to you.

18,344. The upshot of it is this, that that matter was not more fully investigated by you at the time, and what I understand you desire is that the guardians should have further powers of investigation?—That is right.

18,345. And I understand that your board attach value to those powers, because you think it would be an additional safeguard to your patients if such powers, under proper regulations, were confided to you?—Quite.

18,346. And you find at the present moment that your powers are inadequate for the purposes you have in view, which you think are important public purposes.—Yes.

18,347. Then you draw our attention to the condition of the padded rooms at Cane Hill Mental Hospital.—I submit on behalf of my committee that again this is in a very dark spot, and I am submitting again also it may be for a reason it is put there, but my submission is that although you have a padded cell, and a very acute case, there should be sufficient fresh air. In my opinion there was an insanitary padded cell.

18,348. *Earl Russell*: Did it smell?—It was not any too fresh. Just imagine when a patient comes to find herself in a place like that, like the Black Hole of Calcutta; there may be a reason that they should be put in a dark place, but I say there should be plenty of fresh air there.

18,349. *Chairman*: I venture to suggest that your language is quite exaggerated, because I have seen this padded room myself, and I certainly would not describe it as a Black Hole of Calcutta. It seems to me a great deal of harm can be done by using language of that sort in public?—It is a very dark place, it is a dark hole, of course it is, it is a padded place.

18,350. But that is the class of language which is seized upon by the public and gives the impression that public authorities dealing with suffering humanity are treating them inhumanely?—With great respect I withdraw that, regarding that particular phrase, but I wish to emphasise the darkness. Do not think for a moment that this committee intend to expose anything that is not true, or want to expose things with a view of causing a sensation. We want to help if we can.

18,351. Very often the cause of reform is injured by language of that extreme type, which is seized upon by the public and made the basis of allegations which are unfounded?—I hope no notice will be taken as to that particular phrase.

18,352. On the other hand any suggestions that can be made as to the improvement of these places are most helpful to us.

18,353. *Earl Russell*: Had it got shutters which could be opened?—No; what struck me was the insufficient air.

18,354. But how was it lighted?—Just a ray of light, as I saw it; when the door was shut there were simply four dark walls.

18,355. *Sir Humphry Rolleston*: What time of the day did you go?—About 3.30 or 4 o'clock.

18,356. What season of the year?—That would be in the winter time.

18,357. *Earl Russell*: What you say is it was dark. Were there any shutters there which were shut and which could be opened?—I did not notice; one of our lady guardians went in.

18,358. You did not make a very careful examination of this before condemning it?—The position was sufficient. I have been in a great many of these padded cells.

18,359. *Chairman*: It is right that we should inform Mr. Hill that, without any warning whatever, one or two of us went to this institution for the express purpose of looking at those rooms.—This particular room?

18,360. This particular room, and you may take it that it was absolutely a surprise visit. There was no intimation whatever made beforehand. While I quite agree that I should not care to have been in that room myself, I did not notice anything about it that seemed particularly objectionable. True there was nobody in it, therefore there may not have been such smells as I am afraid sometimes do occur, but it is very difficult to have the lighting arranged satisfactorily. A padded cell assumes a violent patient; the light must be introduced from fairly high up; otherwise the patient may do himself or herself damage by smashing glass. Also so far as the artificial light is concerned, they are in process of installing a better system there, and they are getting in electric light?—I am pleased to hear it. This was brought up by the ladies that went there, and I went and saw it, and I thought to myself: "It looks a very bad place, and seems very badly ventilated."

18,361. *Mr. Snell*: Was it by any chance a padded room reserved for what they call dirty cases?—It might have been.

18,362. Which would make some difference?—Yes. (*Mrs. Glanvill*): I was at Cane Hill last week on the women's side, and there was nothing to complain of there at all. I did ask: "Can you show me the cell that has been complained of?" They said, "It is probably one on the male side that opens out on the corridor."

18,363. *Chairman*: It was on the male side that I went to see the padded room. I went expressly to see it, because I wanted to see for myself. However, we may pass from that. Then we have dealt with the question of procedure on your visits, and also with the question of improvement of procedure when a case arises for investigation. I think the only remaining topic is the question of the clothing of the patients?—(*Mr. Hill*): It was a very cold day; we had all got our overcoats on. These poor fellows you could see had bare chests, were very thinly clad, and they came up to us and said: "Oh, we are cold." The doctor said: "These are very acute cases, and if you put good clothes on them they might tear them off."

18,364. Do you supply the clothes as guardians?—No, we do not supply them.

18,365. What do you pay for your patients?—It all depends; there is a uniform rate governed by

19 June, 1925.]

Mrs. F. M. GLANVILL and Mr. GEORGE HILL.

[Continued.]

the London County Council. (Mrs. Glanvill): It was 24s. 6d.; I think it has gone up. (Mr. Hill): I could not give you the exact figure.

18,366. *Earl Russell*: 24s. 6d.?—Yes, and, of course, so much as is collected from the patients' relations.

18,367. *Chairman*: That goes in relief of the burden on the guardians if a patient is able to pay himself?—(Mrs. Glanvill): I do not think we get any of that.

18,368. But do not you investigate cases chargeable to the rates?—Yes. I am chairman of that particular committee, but as to the money we get from the patients—I do not think we benefit from that; I think the London County Council get that, do not they?

Earl Russell: What you collect from the patients' friends goes into your poor rate.

18,369. *Chairman*: If the patient's means are sufficient to pay the charges then the patient is transferred to the private list, and is not treated as a pauper patient any longer?—We do not often get those.

18,370. You have a duty, of course, to investigate whether a pauper patient has or has not means?—We sit about seven hours every week on that. (Mr. Hill): We bring him before a magistrate to make an order, which we have done recently. (Mrs. Glanvill): On the clothing, the thing that struck us was this, that in many other asylums we had been to at the same period they were very well clothed indeed, and our point was: why could not those patients at Hanwell (it was a terribly cold day) have their overcoats issued? We had been a day or two before and seen very bad cases, but they all had overcoats on.

18,371. The matter of clothing is a very interesting question, and has a considerable effect upon the mind, as one knows. Are you in favour of the patients being allowed to have their own clothing, if their own clothing is suitable?—I am myself. (Mr. Hill): You must not interfere with the regulations.

18,372. Are you also in favour of the patients not being in uniform, so that even if they have clothes supplied to them there may be a certain amount of variety?—Yes, I am in favour of it.

18,373. You have visited a number of them yourself?—Every one of them under the London County Council.

18,374. As regards clothing, are your criticisms confined to one of these institutions only?—(Mrs. Glanvill): Because it was so cold; we thought that the poor creatures looked so perished.

18,375. This is a particular case that came under your notice?—(Mr. Hill): At Hanwell.

18,376. But as regards the other institutions where your patients are, were you satisfied?—Yes, the institutions differ so, that is what I cannot understand; we would like more uniformity. Then again, if they were cold I should have liked to have seen them have a place where they can retire to. You get a strong man who is very strong and never feels the cold—others, the least little wind and they put a light coat on, so it must apply to the unsound as well. Of course that is drawing the line very fine.

18,377. I think you may take it that we are alive to the importance of the question of clothing and of diet, and the treatment of patients?—Yes; those are my points. Ours is a committee instituted with a view of helping rather than causing anything in the nature of scandal or being dictatorial at all.

18,378. I think you will appreciate my observation, because one has to remember that there is a large public service engaged in a very difficult task. Reform is, of course, desirable in many departments in public life?—We shall always be very cautious not to express any words which we think will be hurtful to the relations—that is your point?

Chairman: If you please.

18,379. *Earl Russell*: You said you were coming back to that point I asked you, but you never did, whether you were prevented from visiting the whole of the institutions?—On our first visit to a certain institution we were told: "I do not know that you can go; you have not given us any notice; this has never been done before, walking in without giving us notice, and I doubt whether we can allow you to look over." I said: "I must refer to the section of the Act which gives us power." "You are a special visiting committee." "Yes." "I am sorry; I will show you over." We go to another one, and we are questioned for possibly 10 minutes or a quarter of an hour; there is such confusion. We do not consider it necessary; we do not want to waste the doctor's time. We consider that when we enter an institution and say who we are, one attendant can show us round. We do not want anything put in order; it should be in order before we get there.

18,380. That is all it comes to?—Yes.

18,381. *Miss Symons*: Do you ever drop in at dinner time?—We have been at meal times. (Mrs. Glanvill): My point is when we go as a visiting body we have so many patients, somewhere in the region of 400 at Long Grove. If you visit them you must notify them, or else the men may be out on the farms, or the women washing; you could not possibly do it. But if this little committee is allowed to continue as it is, and can just pop in and ask to see five, six, or seven patients, then that is how we really get more information than all the years we have done the visiting, when they have simply passed by the table, with "This is So-and-so, and this is So-and-so." It is true that we have been able to find out things, and we hope to be able to get them quietly put right.

18,382. *Sir David Drummond*: How much time do you spend when you make your visit?—Taking Long Grove the women are all on one side, and the men are on the other side; the two ladies take the women, and the two gentlemen take the men. They just file past the table. You use your own discretion. Sometimes they are too bad, but if there is anybody who wishes to speak to you they do speak to you, and it is all over. That goes on, and that will probably take you at Long Grove two to three hours.

18,383. That is an average?—You can see in that two or three hours perhaps 200 or 250 patients, as the case may be, but if we go with the small committee we go much slower.

18,384. *Mrs. Mathew*: Have the guardians power to demand an enquiry of themselves?—No, I am afraid not.

18,385. *Chairman*: No; I think you could only make representations to the Board of Control regarding any case, and if they treated it as a serious case necessitating investigation they have the power, of course, to conduct a formal enquiry, and they do from time to time conduct such formal enquiries?—(Mr. Hill): We do not wish to be officious in any shape or form. If you wish to see a model house you should go to the Flower House at Beckenham.

18,386. *Sir Ernest Hiley*: Can you tell us whether the guardians adopt any means of classification of the patients in their own workhouse?—Yes. We have workshops, and outdoor gardening and such like, they are all dissected. If we have an acute case it is sent away at once.

18,387. And what do you do with the old senile cases?—They are put in comfortable quarters by themselves.

18,388. Not with the acute cases?—No. That is what we advocate now, we maintain that many, many patients could be brought into an aftercare place.

18,389. You are satisfied with your own classification?—We are at our particular institution.

(The witnesses withdrew.)

19 June, 1925.]

Dr. RICHARD WITHERS GILMOUR, M.B., B.Sc. (Durham),
M.R.C.S., L.R.C.P.

[Continued.]

Dr. RICHARD WITHERS GILMOUR, M.B., B.Sc. (Durham), M.R.C.S., L.R.C.P., called and examined.

18,390. *Chairman*: Dr. Gilmour, you are Physician in charge of St. Luke's Hospital Clinic and of the wards for functional nervous diseases of the Middlesex Hospital?—Yes.

18,391. I think you can best assist us by telling us a little about your clinic itself; it is a topic which we are naturally very much interested in?—Should I read what I have written?

18,392. I think that would be quite a good plan, if you did so, and add any matter that occurs to you as you proceed?—The St. Luke's Hospital, which was one of the registered hospitals for mental diseases and which, of course, stands on the same basis as the general voluntary hospitals in mental work, closed in 1916, as its leasehold interests in the site were sold. After the war efforts were made to reopen, but owing to labour troubles and the increased cost of building it was decided to open in London a clinic, comprising an out-patient department and a few beds for the treatment of functional nervous and uncertified mental cases.

18,393. Up to that time had the hospital received certified cases in the usual way?—In the old days, yes, and then we took in voluntary boarders, ten years before it closed.

18,394. This was really a new departure?—This was a new departure; we had no regular out-patient department. Great difficulty was found in securing a site for this clinic, and at last a suggestion was made by Dr. Bond, on behalf of the Board of Control, that an effort should be made to get into touch with one of the large general hospitals in London, with a view to starting the scheme in conjunction with an existing neurological department. The Governors of St. Luke's Hospital readily agreed to this course, as they were anxious to avail themselves of any facilities which the present laws allowed them of treating cases without the necessity of certification, and away from the popular prejudice attaching to the name of Mental Hospital. With the kind assistance of Dr. Bond, of the Board of Control, the Governors got into touch with the Board of Governors of the Middlesex Hospital, and with their co-operation the present scheme was started as a part of the Neurological Department of that Hospital. Work commenced in the out-patient department in November 1922, and the wards were opened in June of the following year. Our ward block consists of two small wards with three beds each, with separate bathrooms and lavatories, a small treatment room and a ward kitchen. It is just a block on a floor by itself. The nursing staff is supplied by the St. Luke's Hospital authorities. The four principal reasons for having such a clinic as this at a general hospital appear to me to be these: that the patients at the present time will come readily to the out-patient department of a general hospital, very many of whom would not go to a mental hospital on account of the name. That I think applies to those patients who know nothing about mental hospitals; those who have been for the first time to the Maudsley, go at once freely and almost sooner than to a general hospital, I believe; but those who never have been to a mental hospital shirk the name, though they would go at once to a general hospital. The word "mental" to some people calls up the word "insane", they do not realise that the word "insane" is no more a medical term than the word "illness". "Insane" is really a legal or medico-legal term. They also picture all sorts of horrors which are usually supposed to go on in the asylums. The second point was that the knowledge that they have been admitted to a general hospital for treatment makes patients realise that they are considered to be really ill in the ordinary sense of the word, and not that they are peculiar and are being shut up or being put away. That is good for two reasons. In the first place, it helps very

much in treatment, and, in the second place, it helps them to realise what their illness is when they are treated like that, and when they see other people about them who are truly physically ill. Then the third point was that in the very large majority of mental cases it is found that expert examination or treatment is necessary, such as for eyes, ears, and various things, and also some special laboratory facilities for examination and diagnosis. Those, of course, were at hand at a general hospital at once; and I have found that that is a most extremely useful thing; because the majority of patients I get in require their teeth, ears or something seen to; I merely send them downstairs to the special department, and they are done at once. Then the fourth point is this: when it is realised that mental affection often gives rise to physical symptoms and that physical illness probably always causes mental alteration, it is easily understood that many purely functional cases come to a general hospital complaining of physical symptoms, and also that others come complaining of indefinite mental or nervous symptoms, which on careful examination are found to have some physical disease as their cause. The functional nervous and mental cases which come to the general hospital complaining of physical symptoms would naturally never go to a mental hospital to seek advice, since they do not realise that their trouble is mental, and think that it is physical.

18,395. May we pause there just a moment? I understand that by your clinic you have provided an establishment for the treatment of in-patients and out-patients who are suffering from mental disorder but not certified?—Yes.

18,396. And that it is run by you in association with the Middlesex Hospital, which is a general hospital?—Yes.

18,397. And that you are really carrying on the work of your original hospital on those new lines at a new place, and now in association with a general hospital?—Yes, at a general hospital.

18,398. Therefore you are able to illustrate to us a type of institution which has been commended to us, namely, an institution for the treatment of mental disorder in association with a general hospital, and where both in- and out-patients are treated?—Yes, we have both.

18,399. Then has it gone the length of amalgamation with a general hospital, or are you, so to speak, a separate unit in association with it?—That I am afraid I cannot tell you really, because it did not lie within my province, but it is associated in this way: we work at the Middlesex the wards which were supplied to us; I think the St. Luke's authority pay something towards the decoration of them, and so on.

18,400. Do you conduct this clinic under the same roof as the Middlesex Hospital?—Yes, it is under the roof of the Middlesex Hospital.

18,401. Then certain wards were allotted to you?—One little ward block; I only have six beds, but it is in the Middlesex Hospital above one ward, and under some sleeping rooms for some of the staff.

18,402. You have an in-patient department consisting of a ward in the Middlesex Hospital dedicated to your particular purpose?—Yes.

18,403. Then you have, I suppose, an out-patient room for receiving patients?—I see out-patients together with the neurologist; we see them in the same out-patient department at the same times.

18,404. Then you are, I take it, the visiting physician there, are you?—Of my wards, yes.

18,405. Of your department?—Yes.

18,406. Who is the resident?—The wards are looked after by the house physician, and one of the physicians as well.

18,407. As part of his work?—Yes.

19 June, 1925.]

Dr. RICHARD WITHERS GILMOUR, M.B., B.Sc. (Durham),
M.R.C.S., L.R.C.P.

[Continued.]

18,408. In that way you will have quite an intimate association between that ward and the other wards in the general hospital?—Yes.

18,409. On the patients' side of it, I take it, a contribution is made from the funds of St. Luke's Hospital?—They pay practically for the upkeep of it.

18,410. In recognition of the fact that you are getting that accommodation and are enabled to carry on your special work under the roof of the Middlesex Hospital?—Yes.

18,411. Now on the general policy you commend that type of institution to us as being likely to attract cases which otherwise might be repelled by the existing system?—I think many are attracted.

18,412. Are they incipient cases mostly that you receive?—Yes, mostly.

18,413. All slight cases?—Some are slight. The first man that I took in—I may say I was not resident in London then, and I wondered what was going to happen, my hand was rather forced on taking the case in. I found that a very suspicious young strong upstanding man came in who had had very great business troubles which caused his breakdown; and he was looking in an extraordinary suspicious way, and was I thought on the verge of acute mania. His father who was, I think, an Ex-Inspector of the Metropolitan Police, told me it had taken six of them to keep him in bed the night before and look after him. However he had agreed to come to the Middlesex Hospital and he came. I said, "You know where you have come to?" He said, "Yes." "You see exactly what the wards are; I will take your word you are not to escape, if you will give it me." He gave me his word. For three days I wondered whether he was going to break out. He settled down; he was with us, I think, for six or eight weeks, and he comes up now often to see me. But the night before it was a question whether they would have to certify him to remove him.

18,414. *Sir David Drummond*: You took considerable risk?—Yes, but my hand was forced, and I had to take it.

18,415. *Chairman*: You must have a very considerable measure of discretion as to the class of cases you receive?—Absolutely.

18,416. All cases would not be adapted to treatment in such a clinic?—Certainly not; I was going to say few truly insane would be.

18,417. But you desire to attract the class of person who for the moment is repelled by the existing institution, in order that you may, if possible, cure such cases, and prevent their ever reaching the stage of certification—that is the aim?—That is the aim absolutely.

18,418. Have you found in experience that there is quite a considerable number of patients of that sort, who can be benefited by such treatment outside the existing asylum treatment and escape altogether from certification?—I think from what I have written on the work done here you will see that that is so.

18,419. Perhaps you might give us a little of your experience?—The conditions of admission under which patients come are that they shall be capable of understanding and be fully aware that they are coming into a general hospital, and then that they come in by their own desire and expressed wish; that is essential. Further I just tell them that they must obey the rules of the hospital, and the friends of the patient must agree to remove the case if called upon to do so.

18,420. These cases are entirely voluntary?—Yes; they do not even sign a paper, I simply see them when they come in. If I am taking in merely a functional case I do not trouble to talk to them like that, I take it for granted as one would a patient in a general ward; but in the case of anyone who is apt to give trouble I take their word for it, and there is no paper signed at all by the friends or the patient,

18,421. Do you find they come alone or in company with friends or relatives generally?—To the out-patient department they very often come alone; coming in they are almost always accompanied by a relative or friend.

18,422. Do you reject some as being unsuitable?—In the applications for admission?

18,423. Yes, or those who have come to you as out-patients whom you might have transferred to the in-patient department if you thought fit?—Very often. I have taken patients in from Peterborough without seeing them, on the letter of a doctor.

18,424. If you find that the case is unsuitable for your institution what do you do?—Then, as I point out further on in what I have written, I have to call on the friends to remove the patient.

18,425. But you take no written obligation from your patients at all, so that they may leave, if they please, at once, just as a patient in a general hospital may do, subject of course to the doctor's advice?—Yes, I remark here that I have never had any trouble with it.

18,426. *Mr. Snell*: Would you mind telling us what the results of this freedom from restraint are? Do you have accidents or any increased proportion of suicides?—No, I am glad to say I have had none so far of any kind. Of course there are two things that I want to impress upon you, one is that one is not dealing with the insane.

18,427. *Chairman*: You have rather a selected class of patients to deal with?—Certainly.

Mr. Snell: But you did take in a man who had been very obstreperous 24 hours earlier?—Certainly.

18,428. And he might have broken out then, and you would have exercised restraint?—There are two female nurses on night duty, and the house physician was within call.

18,429. *Earl Russell*: Those female nurses could not do much with a strong man?—No, but he was an early case.

18,430. *Chairman*: I think, Dr. Gilmour said this was an exceptional case, and he took an exceptional risk?—Yes, I did; from the way he spoke to me I could see he was a man who would probably give notice if he was going to be rowdy.

18,431. *Mr. Snell*: What I wanted to get was your opinion—is it worth while taking extra risks in regard to violent or suicidal cases?—I think it is foolish. I think the patient has a perfect right to turn round afterwards and tell you you had no right to do so, and I think then it is very difficult to answer him.

18,432. But you are aware that at an institution like the Maudsley they do take certain additional risks?—Yes, I was only looking on my own particular wards, where, of course, you could not do it. Our building is not put up for these cases specially. We have got a ward which existed before.

18,433. *Mr. Jowitt*: Do you devote your whole time, apart from out-patients, to these in-patients?—I go up there generally every day.

18,434. It makes a very great difference?—If you had 20 you could do it.

18,435. But you could not run a thing like yours on a big scale?—No, it is bound to be limited in numbers always.

18,436. *Mr. Snell*: Are they male or female?—At present they are all female.

18,437. *Sir David Drummond*: Do you think it would be feasible to suggest that what you are doing at the Middlesex should be carried out throughout the country in connection with our general hospitals?—I think that would be a very useful thing, most extraordinarily useful.

18,438. Do you think it would be practicable—have you thought of it from that point of view?—Yes, I have, and I think it would be practicable where there is a mental hospital near. This scheme must be, I think, run by arrangement with a mental hospital in some way.

19 June, 1925.]

Dr. RICHARD WITHERS GILMOUR, M.B., B.Sc. (Durham),
M.R.C.S., L.R.C.P.

[Continued.]

18,439. But you recognise the many and great practical difficulties in inducing committees of general hospitals to take this matter up?—I think there will be very great difficulties. It is done at Oxford, I think, too.

18,440. *Chairman*: The interest of your case to us is that it is an illustration of a mental department being run in association with a general hospital. You have made the experiment on a small scale, and you have found, apparently that it is a useful function?—I am convinced of it.

18,441. The question is whether it is feasible to extend it more largely; but do you ever find that any of your patients get worse in your wards and reach the stage when certification is necessary?—Yes, I do indeed; I have one or two where it is necessary.

18,442. You have a few statistics, have you not, of your recent patients; perhaps you might give us these?—Yes. In the case of out-patients, last year the average number seen each week was 14. I had 111 new cases. It is not a big out-patient department, I know. Since the opening of the wards on June 12th, 1923, to December 31st, 1924, 12 males and 30 females were admitted. Of these 17 were cases which on admission could have been certified, though willing to come in for treatment, and if they had not been admitted to our ward would fairly certainly have been certified—could have been certified.

18,443. That is to say, you would have been prepared to certify them?—Yes, had there been nowhere else for them to go, and no other place could have taken them in; that is to say they would not have been, I think, taken into any nursing home or anywhere else except under certificates, and further, they could not have been looked after at home.

18,444. *Sir David Drummond*: Do you think an out-patient department connected with a general hospital without an in-patient department, would be of much service?—Yes, I do, Sir David, indeed. I am sure of it from what I have seen.

18,445. We have heard evidence that it would not?—My reason for saying that is that one gets principally the neuroses and psycho-neuroses coming to the out-patient department, but those do pass to genuine psychoses. I know it is said they never do pass from one to the other, but personally I do believe it; I have seen it, and I feel sure of it, and those neuroses and psycho-neuroses are treated with quite good results.

18,446. You think it would be advantageous to have an out-patient department even when committees will not undertake the in-patient department?—Yes, I do; I do not think you can teach neurology unless you teach the functional and the mental side as well as the physical side.

18,447. *Chairman*: Just proceeding with your statistics, you told us that 17 of those cases would have been certifiable?—They certainly could have been certified when they came in, though willing to come in for treatment, and if they had not been admitted to our ward they would have been certified; the rest were admitted showing mental symptoms. Of course all the cases I take in do show mental symptoms of some sort. Several of these developed such mental symptoms after admission as to render certification possible.

18,448. How many?—I am afraid I cannot give you that particular number, but there were several of them, who although they were not certifiable when they came in, were certainly certifiable later.

18,449. Did you ask the relatives to remove those cases?—No, I did not, except in one or two cases; those I could keep who were not troublesome and I was able to look after, I did. One or two became noisy and apt to be violent and disturbing, distressing to either the rest of my patients or the rest of the hospital, and I was forced to ask the relations to remove them.

18,450. Can you say of any patient you have had under your charge that you were keeping them against their wishes?—I certainly cannot. It is another point I put to the patient. I say "You are at liberty to go when you like; the only thing is do not get up at 3 in the morning and say you want to go, because it is unfair to us." One man did; he went at 6; he did not know what he was doing.

18,451. Did you let him just go off?—Yes; they knew he could get home; he had his clothes given to him.

18,452. *Earl Russell*: He knew enough to get home?—Yes, quite; he would not otherwise have been with us.

18,453. *Chairman*: I was thinking you might well have an embarrassing case of a patient who developed suddenly acute symptoms, and desired to go away. What are you to do with such a case?—If relatives are within reach I should wire or 'phone, and get them at once, and in the meantime keep the patient till such time as they came. You can only keep patients like that for a bit anyhow by diplomacy; otherwise if I could not get hold of the relatives I should send for the relieving officer, I think.

18,454. *Earl Russell*: Would you not adopt any other method than diplomacy for keeping them?—I was going to say we have not any other method to employ. Cases who suddenly develop like that are excessively rare.

18,455. *Chairman*: One generally can judge?—Yes.

18,456. I understand it is part of your policy that no patient should be certified in your wards?—That is very distinctly a part of it; I will not have it, and I think it would be wrong to do so.

18,457. You desire to maintain the voluntary aspect of it?—Because you assure the patients when they come in that they will not be certified, and they trust you, but the moment you certify one you can no longer give that assurance.

18,458. You attach importance to the reputation of your ward as a place where no person ever will be certified?—I think that is essential.

18,459. The ticket of admission to your ward is that one should be suffering, and that is all that is required?—Yes. I know a great many people hold that finally wards like this should take in certified cases. Personally, the more I see it the less I believe that.

18,460. Have you any more statistics to give us?

18,461. *Mr. Micklem*: The 17 out of the 42 in-patients were certifiable. What was the result of the treatment?—I am afraid I have not them here; that was one of the things I should have put down.

18,462. *Chairman*: Of your total figures, what was the result of the treatment received? You have given us the total admitted. What happened to them?—I can give you the results for last year for the whole thing. Last year the admissions were 5 men and 20 women.

18,463. In-patients?—Yes; and of the 20 women 6 were remaining at the end of the year, which make really 19 that one was dealing with.

18,464. What happened to them?—Of the 5 men, 4 recovered, and of the 20 women, 7 recovered.

18,465. And of the residue, what happened to them?—Three were removed by the friends at my request, and the rest were discharged, either relieved or not improved. But I should like to say that giving figures of recoveries from a ward like mine is quite different from giving them in a mental hospital, because in a mental hospital the patient is discharged on trial for a month or so, and then they come back for final discharge. I have to discharge outright, and put down for the benefit of the Middlesex Hospital how that patient is discharged. Now, in these cases it is very difficult to say when you send them away that they are going to hold up under the former stress as well as they have done whilst in hospital. I have discharged many "improved" which I have found afterwards have completely recovered.

19 June, 1925.]

Dr. RICHARD WITHERS GILMOUR, M.B., B.Sc. (Durham),
M.R.C.S., L.R.C.P.

[Continued.]

18,466. Did none of those cases pass to asylums under certification?—Not straight from me.

18,467. Of the three whom you had to ask the relatives to remove?—One was taken home; he was a case of general paralysis, who was certified two or three days later. Another case had some relatives in this country, they were distant relatives. Her father was in South Africa; her mother was dead. The child was a case of dementia præcox, and she did get suddenly violent. She was a girl of 16 or 17. I then communicated with an aunt and the relieving officer came along at the aunt's request, and she was removed to the infirmary.

18,468. *Mr. Micklem*: When you discharge them improved why do not you wait for recovery?—Because I cannot. I have got to do it as soon as my bed is empty, as soon as the papers go down; that is rather a handicap on me really.

18,469. *Chairman*: Could you utilise more accommodation?—Yes. They are going to rebuild the hospital, and I hope when they do I shall have room for 15 patients anyhow. The point about the general hospital is this: the number of beds which are occupied by the St. Luke's cases have to be limited. If you take them beyond a certain number you sink the Middlesex into St. Luke's, and, of course, the general hospital has to avoid that; but I think one could get 20 beds without anything of that sort.

18,470. Then would you advocate the institution of such wards in association with our general hospitals throughout the country?—I think they would be very excellent things, at all events at the present day.

18,471. Do you find you can work quite satisfactorily in association with the general staff of the Middlesex Hospital?—Yes, most friendly.

18,472. Do you take your part in the general administration of the institution, or are you treated as a separate branch, so to speak?—No. I am on the school committee there; and I am sent for if anyone wants me to see any case in any of their wards. Yesterday I took in a case under the senior physician there with some abdominal trouble, and with a drug habit. I took her into my ward as she was unable to go into the general hospital ward on account of the drug habit.

18,473. Is the point you wish to emphasise this, that very frequently mental disorder is associated with physical disorder, and if the patient is in a ward under the same roof as the general patients, or ordinary patients, you then are able to invoke all the specialised skill of surgeons and physicians in the general hospital to treat the physical ailments of the patient?—Yes, a most extraordinarily useful thing.

18,474. Equally I suppose on the general hospital side where a patient incidentally to a physical disorder may take some mental aberration, you are at hand with your ward for a specialised treatment of that aspect of the case?—Yes. I have taken three cases like that from the other wards which have been sent in to me. One, a woman with acute hallucinations came in to me and she did very well indeed.

18,475. So the allocation of the case to your department would depend to some extent, would it not, upon the predominance of the mental symptoms?—Yes.

18,476. *Sir David Drummond*: Would you advocate, if it were carried out generally, the principle you are suggesting, that the mental department should be separate, though connected with the general hospital—should not just be a ward in the same block, as it were?—That is a matter, I think, entirely of administration.

18,477. Would it not admit of very much greater liberty if it were a separate block, so that a noisy patient would not necessarily disturb the other patients?—Yes, quite right. If you are going to take

in noisy patients and these people who are really troublesome and give annoyance to other patients, you are going to get the general hospital stamped as a mental one, and that is what one wants to avoid. One is really out to take in the earlier cases, the mild cases.

18,478. But some of these puerperal cases are noisy, as you know, and in three or four weeks they are well, and you do not want to certify them. These are the sort of people we should like to see admitted into an institution such as yours?—I think you will have to in a general hospital, as far as I see.

18,479. *Chairman*: Do you take in puerperal cases?—We had one sent in from the maternity ward which I was not able to keep because I had no bed.

18,480. *Earl Russell*: Although it would have been noisy?—Yes.

18,481. In spite of that you would have kept it?—I would have done my best.

18,482. *Sir David Drummond*: If you had a block 50 yards away?—Yes, but then you have got a mental hospital. We are rebuilding St. Luke's, and I have at present pointed out to my committee that the ground we have at Gerrard's Cross is too far away; that they should get some small place nearer and put up an acute hospital.

Mr. Snell: Suppose you had a place constructed like St. Thomas's across the way, separate buildings joined together with corridors, that is really what you want?

18,483. *Chairman*: Would you like to have one of the pavilions of St. Thomas's at your disposal for the purpose of mental cases?—I do not think you want one of those full blocks, if you had a floor of it.

18,484. *Mr. Snell*: That would satisfy you?—Quite.

18,485. *Mr. Jowitt*: Do you attach considerable importance to having small dormitories with only three or four people in them?—Yes; certainly it should not be more than three or four at the very most.

18,486. What occurs to me is, as I said before, that the value of your scheme is the fact that it is run on a small scale; you can give your skill and attention to comparatively few people, and it is run as a private affair. At the same time that is the drawback in applying the scheme throughout the country, that you really only tackle the fringe of the problem by doing it?—Yes, because I think the functional cases are so enormous in number, coming into the general hospitals, and they are very seldom treated fully. Of course the time each case takes is tremendous, if you are going into it.

18,487. I know it is. I should think 20 would be the outside, would it not?—I am taking it that I could look after my ward of 20, and also look after St. Luke's Hospital as well, needless to say with assistance. I think that they can be run in that way quite easily. Then small wards, I may say, are so important for this reason, that with these neurosis cases, and the early mental cases you find that symptoms seem to be contagious at times. Place three people together, and in a few days they are all exactly the same, you cannot tell which from which, whereas they were all different when they came in. Now if you could take patients and move them from one ward to another, you will find that suggestion again comes in very strongly, and that you can get very great results from that and help by that.

18,488. *Chairman*: There is only one question I want to ask you in conclusion with regard to the staff which you employ. Do you find that you require a specialised staff of nurses?—We have had up to the present nurses all with mental training.

18,489. How many nurses have you for your ward?—We have to have, I think it is, about five; it is a most expensive experiment.

19 June, 1925.]

Dr. RICHARD WITHERS GILMOUR, M.B., B.Sc. (Durham),
M.R.C.S., L.R.C.P.

[Continued.]

18,490. Five women nurses?—Yes.

18,491. No men?—No, no men. Only once has there been the necessity for a male attendant, and then the Middlesex Hospital have some men that they employ as male attendants when necessary.

18,492. In the ordinary course women nurses attend on both the men and women patients?—Quite.

18,493. Have you found that satisfactory?—Quite.

18,494. Then you have a staff of six nurses—there will be a head nurse, I suppose?—Yes, that is done in this way. The St. Luke's Hospital authority have a private nursing staff that they are able to call on, if necessary. I think there are five nurses that we have.

18,495. Are they on the books of the Middlesex Hospital as ordinary nurses?—No, they are on the books of our hospital, but whilst they are at the

Middlesex Hospital they are under the Middlesex Hospital matron.

18,496. They are, so to speak, seconded?—Yes; they are kept by the St. Luke's authorities, and they sleep at St. Luke's House; they are all mental nurses.

18,497. That is to say, they have had training in mental institutions?—Yes.

18,498. Have they had general hospital training as well?—Most of them have as well.

18,499. Do they share the ordinary life of the Middlesex Hospital, do they use the Nurses' home?—No, they do not use that, they feed at the Middlesex Hospital.

18,500. Mr. Micklem: Are you re-building St. Luke's?—We hope to.

Chairman: We are very much obliged to you for coming to-day.

(The Witness withdrew.)

(Adjourned to Monday next at 2 o'clock.)

5, OLD PALACE YARD,
WESTMINSTER, S.W.1.**THIRTY-FIFTH DAY.****Monday, 22nd June, 1925.**

MEMBERS PRESENT :

MR. NATHANIEL MICKLEM, K.C. (*in the Chair*).

THE EARL RUSSELL.

SIR HUMPHRY ROLLESTON, BART., K.C.B., M.D.

SIR ERNEST HILEY, K.B.E.

SIR DAVID DRUMMOND, C.B.E., M.D.

MR. H. SNELL, M.F.

MRS. C. J. MATHEW.

MISS MADELEINE SYMONS.

MR. P. BARTER (*Secretary*).MR. H. FAIRLEY (*Assistant Secretary*).

The Countess of CHICHESTER and Dr. HELEN BOYLE, M.D. (Brux.), L.R.C.P., called and examined.

18,501. *Deputy-Chairman*: This afternoon we are to have the pleasure and advantage of the evidence of Lady Chichester and Dr. Helen Boyle, given on behalf of the Lady Chichester Hospital; and, I think, Dr. Boyle wishes to add supplementary evidence dealing with her views on the general subject. I think, Lady Chichester, you are the President of the hospital?—(*The Countess of Chichester*): Yes, I am.

18,502. Where is the hospital situated?—In Hove, Sussex, near Brighton.

18,503. I see there is some reference to a dispensary at Brighton. It succeeded the dispensary did it not?—Yes, it is the natural outgrowth from the dispensary. The dispensary originally started and then the hospital with beds came afterwards.

18,504. And Dr. Boyle is the senior physician at the hospital?—Yes.

18,505. Perhaps at this point, Dr. Boyle, I might take your other qualifications. You are a Fellow of the Royal Society of Medicine; a member of the Council of the Medico-Psychological Association, and of its Parliamentary and Educational Committees; a Member of the National Council for Mental Hygiene, and of its Executive Committee; a Member of the Council Central Association for Mental Welfare; Medical Referee for the National Association for the Feeble Minded; late Chairman of the Brighton Division of the British Medical Association, and Senior Physician to the Lady Chichester Hospital. Those are some of your qualifications?—(*Dr Helen Boyle*): Yes.

18,506. Your hospital was started, we gather, in 1905?—It was.

18,507. It is only for women and children?—Yes.

22 June, 1925.]

The Countess of CHICHESTER and Dr. HELEN BOYLE.

[Continued.]

18,508. And it is suggested that it was the first hospital to deal specially with early nervous and borderland cases?—Yes, it was. The only thing that existed before was Dr. Carswell's wards in connection with the Poor Law in Glasgow.

18,509. Then it was apparently incorporated as a corporate company in 1921?—Yes.

18,510. You have given us some details of the hospital. It has 39 beds, and an out-patients department?—Yes.

18,511. There is no endowment; it is really a voluntary hospital just like any of the general hospitals?—Yes.

18,512. And it differs from some of them perhaps in that you have no large benefactions; they are numerous I suppose but not large?—Yes.

18,513. You have given us in an appendix some information as to the class of patient that you take, and the cost at the hospital?—Yes. As a matter of fact I think that should really have come on at the end of the Lady Chichester Hospital evidence.

18,514. Not at the end of your evidence?—No.

18,515. You give there an analysis of 100 consecutive cases under several heads: those that have recovered and returned to normal life and occupation, improved, not improved, dead, and still in hospital?—Yes.

18,516. And on the next page you give the analysis of the nature of those 100 consecutive cases—is that so?—Yes, more or less.

18,517. You set out the types of cases, organic nervous cases, physical disabilities plus neuroses, early psychoses and psycho-neuroses. I suppose the distinctions are perfectly clear to the medical members of our Commission.

18,518. *Sir David Drummond*: It is a very large supposition, Mr. Chairman.

Deputy-Chairman: But I think we appreciate generally what the distinction means. We may take it that the whole of these cases are either nerve cases or early cases of mental disorder?—Yes, really very early cases. It seems to me that it has been a little bit difficult (I have read all the evidence up till now) to know exactly what people mean by "early cases." "Early" may mean several things; it may mean an early case of certifiable mental disorder, that is to say when the disorder has become certifiable and has only just become so, or it may mean a very early case before there is any question of certification at all.

18,519. I take it you really refer to those cases?—Those are the cases we are most interested in.

18,520. I see there are some cases of delinquents, I do not know which of the types they come under?—They may come under almost any of them.

18,521. You do not get very many of those cases, but there are some?—Yes.

18,522. Then perhaps we might just deal with the next page. You set out the cost for each patient; the average cost for the in-patient per week is £1 19s. 7½d., and you set out the different details under which those figures are made up?—Yes.

18,523. Your average number of in-patients resident daily is 43.

18,524. *Sir Humphry Rolleston*: That is very interesting because they have 39 beds?—It does look rather odd, but we have several temporary beds which we can put up. Another thing that makes a little confusion is this, that we have to return for the purposes of expenses the patients who have all their meals in hospital; we have a certain number who live out, and who spend the whole day with us. It is in order to economise accommodation. The accounts are kept according to the rules of King Edward's Fund. This particular page I am not responsible for, but the secretary, who keeps it according to the rules of the Fund, is responsible for it.

18,525. *Deputy-Chairman*: What is the general income of the hospital? Working out these figures and treating it as though there were 42 beds, I

gather that the expenses would be about £4,500 for the in-patients?—(*The Countess of Chichester*): We have no endowment at all; that has to be raised annually.

18,526. How much do you raise annually?—We raise what we have to have to cover this and rather more, because we have capital expenses, the purchase of the house which we are paying off gradually.

18,527. You are not in the unfortunate position of having a large debt on the hospital?—Yes, from the point of view of the mortgage on the house.

18,528. *Earl Russell*: That is only for capital expenditure?—Yes.

18,529. *Chairman*: Do you usually meet the current expenses year by year?—Yes, we meet them, but our capital debt is a thing that really hampers more than anything. (*Dr. Helen Boyle*): We paid off the mortgage last year. (*The Countess of Chichester*): But having borrowed from the bank we have created a debt in order to do so.

18,530. And you have found that this hospital is required in the neighbourhood—you are always full?—(*Dr. Helen Boyle*): Yes, we always have a long waiting list.

18,531. Do your cases come mainly from Brighton and Hove, or do you get them from a distance?—We get them from anywhere—we do not put any check on where the case comes from.

18,532. Where, in fact, do the cases come from?—We have had one from Nigeria, one from Egypt, one from Dublin, one from Scotland, and a great many from the London hospitals.

18,533. Do you mean sent down to you for after-care?—Sometimes they come from the out-patient departments; they had not got any beds in the London hospitals for this kind of case. London has had no provision whatever until quite recently.

18,534. But where would they be—out-patients at the general hospitals in London?—Sometimes. One I was going to tell you about that came to us from St. Thomas's was a case of attempted suicide.

18,535. Sent down from St. Thomas's?—Yes.

18,536. Would the local police court be likely to remand a case of suicide to you if they thought there was a mental complication in it?—Yes. Possibly.

18,537. Your accounts are kept on the system advocated by the King Edward Fund; and we have a list of your officers. Lady Chichester is the President; and the Vice-President is Dame Henrietta Barnett. There are medical officers and others, and all the medical staff officers are honorary appointments?—Yes, except the house physician.

18,538. *Sir Humphry Rolleston*: Is not the price very low—you do it under £2?—(*The Countess of Chichester*): It is very low. That is partly accounted for by the fact of our very small staff. Owing to the nature of the cases that we deal with they are able to co-operate in the working of the hospital a great deal, which of course reduces our domestic staff, and that is, I think, largely accountable for it; that is why you see such a very low charge made.

18,539. In many of the general hospitals it is double that?—Of course, it is very, very carefully run, but I think that partly explains it (*Dr. Helen Boyle*): Yes. Of course, on the other hand, the salaries are fairly high, because they have to be very specialised people.

18,540. I suppose you have to have 12 to 15 nurses altogether?—Yes. The difficulty about the nurses is that they are always varying. Supposing we have two or three threatened suicidal cases, or anything very difficult, we may have to get a nurse in for two or three weeks, and we do not keep on the staff the full number that we often employ.

18,541. *Deputy-Chairman*: What do you reckon your staff at?—I can get it out of the latest report; may I send you that?

22 June, 1925.]

The Countess of CHICHESTER and Dr. HELEN BOYLE.

[Continued.]

18,542. Yes; you might perhaps let the Commission have a copy of the 1924 report?—Yes, I will send you a copy of the report.

18,543. Under which head do you put lighting and heating here?—That again is the King Edward's Fund system. (*The Countess of Chichester*): It is under "Establishment," I think, is it not?—(*Dr. Helen Boyle*): No, "fuel, lighting and domestic." (*The Countess of Chichester*): Yes, it comes under "Domestic."

18,544. You make no saving on food? Are the patients well supplied with all manner of provisions?—This is the entire charge, but, of course, owing to the nature of the case again the feeding has to be good; and then there is also, apart from this, Pound Day, which brings in locally from the inhabitants around a good deal of help. We live on Pound Day for some time.

18,545. Are those gifts in kind?—In kind—nearly entirely in kind.

18,546. Were you, Lady Chichester, to some extent responsible for the origin of this place—were you one of the founders?—I can hardly say that. I think I can say that Dr. Helen Boyle was the founder of the place, but I was connected with it from the beginning, from the very early days, being particularly interested in this type of case, and the extraordinary difficulty that was experienced in finding any place where they could be sent. There was a most curious deficiency, almost I might say vacuum; you could not get them treated anywhere.

18,547. Without certification?—You had to wait till the case was certified.

18,548. And your hospital was started with a view to meeting the need of these early cases?—Yes, and not at all to meet them locally only, but to meet cases from any part of England. We have daily applications from every part of the country.

18,549. You mention some things which, as you suggest, are obvious, that this incipient mental trouble was treated inadequately or not at all—there were no places?—Yes.

18,550. Then you suggest "that the conditions and environment were conducive in many cases to its development, and that patients often needed to be removed from them"?—That was a development from the out-patient department.

18,551. It was no good sending an out-patient back to his home?—No, you had to move some cases.

18,552. And then you suggest, as I gather, that your hospital is used for after-care cases, is that so?—Well, no, not entirely; it is only when they develop nervous symptoms again. I think Dr. Helen Boyle will give you more technical information about that. (*Dr. Helen Boyle*): What we do is this—we do not take any cases from the asylum, for this reason, that there is an After-Care Association which deals with them. Where we are helpful in after-care is that we have an out-patient department, to which any ex-patient who is feeling herself troubled can come and talk over it and see if we can suggest anything to help her. It is not really in one sense after-care in the way that the After-Care Association does it, but it is, we feel, an essential part of after-care.

18,553. It is giving them an opportunity to come as out-patients if they want further advice, is it not?—Yes, and if it is a considerable length of time afterwards, we might advise the case for a time again as a fresh patient.

18,554. You wish to make some suggestion as to the extension of after-care work?—Yes; I think it is essential to after-care to have clinics at the out-patients' department to which patients can go when they are beginning to feel unwell again, to which they can go without any particular notice being taken about it, or saying anything much about it.

18,555. *Earl Russell*: Just as they might go to any other hospital?—Yes.

18,556. *Deputy-Chairman*: I gather you think there should be some such institution as yours in every

considerable centre?—Yes, absolutely; and preferably in connection with a general hospital. We would like to have been connected with a general hospital, and when we started it we offered ourselves to the Royal Sussex County Hospital at Brighton, but they were not then prepared, in 1905, to contemplate it at all. I do not think very many hospitals in those days would have done.

18,557. Do you think that they would possibly take a different view now?—Well, I am inclined to think so. Certainly some of them do. Whether it would be possible for the Sussex County Hospital to start the thing or not I could not, of course, say at all.

18,558. But your view is that it would be a desirable thing, if possible, that it should be in connection with the general hospital?—Yes. We are connected in one sense, because we have consultants who are also consultants of the Royal Sussex County Hospital; we can use their laboratory also. We send laboratory specimens up to the Royal Sussex County Hospital, and we utilise (though purely of course apart from their organisation) a great many of their facilities.

18,559. While you would like them to be, if possible, in connection with general hospitals, you would desire that these clinics should have no connection at all with mental hospitals?—Absolutely none; I think that is essential.

18,560. Now, your Council has directed its attention mainly to the importance and feasibility of very early treatment in the prevention of mental and nervous disorders; and in your *précis* you point out that that is a policy which has been advocated for a long time by the Medico-Psychological Association, and you refer to what has been done in other countries. Especially you refer to these cases: "At the International Congress of Medicine in 1914 the whole subject was ventilated in the Medico-Psychological section by papers from Professor Adolf Meyer from the Johns Hopkins University, Baltimore, and Professor Somner of Giessen, who described their clinics. The latter has stated that 'owing to the benefits derived from the treatment of mental disorders in the early stages the province of Hesse has been able to postpone the building of a new asylum for ten years.'" That is rather a remarkable and striking statement?—Yes.

18,561. "The French Committee of the National Council of Mental Hygiene at a Congress in 1923 stated: 'We start from the principle scientifically established, that insanity in a large number of cases, is an avoidable and curable illness'?"—Yes.

18,562. After your experience of the last 20 years you have come to very much the same conclusion, I gather?—Yes, certainly.

18,563. You find that a large number of patients show signs of nervous or mental disorder a long time before they become certifiable?—Yes.

18,564. And many of them never do become certifiable at all?—Yes. I have also been to clinics and mental hospitals in America, France, Belgium, Germany, Austria and Canada.

18,565. You yourself have visited them?—Yes.

18,566. Could you tell us shortly what your general conclusions are about them?—Well, there is no doubt whatever, I think, that all over those civilised countries the same idea obtains, that if we could treat the mental cases early before they become certifiable, we could in very many cases prevent them becoming certifiable and insane.

18,567. And is it your experience that in other countries they are in advance of us rather in that respect?—They certainly were. We are pulling up a little now, but when we started it in 1905 there was absolutely nothing here at all, and no interest taken in it much; but in Germany they had some rather good places; they had quite a new one near Berlin, and an exceedingly good one at Göttingen. They have also had for some considerable time places in America, the Phipps Clinic in Baltimore was one

22 June, 1925.]

The Countess of CHICHESTER and Dr. HELEN BOYLE.

[Continued.]

of the first, and that was started by the National Council for Mental Hygiene; you had their evidence recently.

18,568. Yes?—Because they attracted so much attention to it—Phipps gave the money for the Phipps Clinic.

18,569. Were your visits paid to these places before you came into connection with the Lady Chichester Hospital, or after it?—Some of them were in existence when we began, but the ones in Germany were. I saw those. There is one in Utrecht which is very good. The thing that struck me, if I may say so, as a result of seeing them all and comparing them with ours, is that in nearly all the places they tend to do a thing which I think wrecks it, and that is, they take cases which are too bad—the Phipps Clinic at Baltimore has locked doors; Utrecht has locked doors, and a good many of the places that I have been to have had locked doors. Where you get locked doors, that is where the patients' liberty is interfered with, it seems to me that you tend to neutralise the chief advantage of the early clinic.

18,570. You do not want to get your place if you can help it associated with the insane at all?—No, and you cannot help that if you interfere with their liberty. They told me before I went to the Phipps Clinic, when I wrote, that it did not impede the work at all; but no sooner did I get to Baltimore than a doctor in the town volunteered to me "We cannot get our patients to go till they are really quite bad," and I said "Why?" "Because they think it is an asylum."

18,571. Do you know if in America there is the same or some similar system of certification to that which we have?—Yes, it is rather various, because of different States, different methods, more or less, but they have definitely certified cases in asylums.

18,572. Perhaps we will deal with that a little later on in your *précis* in connection with the question of acute cases. May I just refer back to the kind of cases which you have, those that are showing early signs of disorder and many of whom will not become certifiable? You deal with patients who are not likely to become certifiable, but who show mental aberration leading to mischief of various kinds. There you are dealing with the boys and others who become criminal?—(The Countess of Chichester): Well, of course, those come into our hands.

18,573. How do they come to you?—(Dr. Helen Boyle): We have had some from Courts. (The Countess of Chichester): And, of course, they come from their own homes, the desperate parent who cannot cope with the child brings it to us. We have very often had cases from London where the child has been sent down to us to deal with.

18,574. Are those children what I should call medically treated, or what is the treatment that they have?—(Dr. Helen Boyle): For instance, stealing is not at all an uncommon thing for us to have, and I could tell you about several cases. One was a little child who was quite young, I think she was about eight or ten—I am telling you this from memory. She was the daughter of a clergyman and a very good little child indeed, so good that she never liked to say anything that was disagreeable to anybody or of anybody; her parents had to go abroad, and I came across her at school.

18,575. Earl Russell: A boarding school?—Yes. She enjoyed being there immensely, and was exceedingly good and no trouble at all. Then for the holidays she went back to a lady she disliked. This lady owed her a grudge, and the child who had no other means of expression at all paid her back by taking her things. She had never stolen from anybody else. She felt that words would not express her feelings of fury, and so she used to go and take her money whenever she could. She did not use it particularly, and she did not want it particularly, but she always took it. We took the child away and I explained to the child what she had been doing,

and I let her abuse the lady as much as she liked to me, encouraged her to, in fact.

18,576. She did permit herself on that occasion to do so?—It was extraordinarily difficult to that child to say anything. The end of it was she was taken away from the lady and she has never stolen anything since; but if that child had been badly handled, it is quite possible that her mentality and her adjustment to life might have been very seriously damaged.

18,577. Miss Symons: Do you get some children through the Children's Courts?—I do not know whether they actually came from the Children's Courts; I suppose they did. We have had one or two girls sent to us on probation.

18,578. Earl Russell: This stealing in your view was merely an expression of revenge, nothing else—it was a personal matter entirely?—Yes; it very often begins like that.

18,579. I mean the object was not the theft?—No, but it very often begins like that. If you enquire about the girls who have suddenly taken to it and used it in other ways—it usually begins in some simple way.

18,580. Deputy-Chairman: I suppose those are cases hardly for medical treatment; they are cases where you want some wise person to have a personal influence over the child?—There was a very wise woman at the head of her school, but she did not know what to do with her. It is not always easy to investigate the mentality of a small child; in fact it is notorious it is one of the most difficult forms of psycho-therapy.

18,581. Did you take that child as an in-patient for a time?—No, I saw her as an out-patient.

18,582. Earl Russell: The functions of the priest and the doctor are very much interchangeable now?—Yes. There are quite a lot of maladjustments in early youth which, if they are not understood and dealt with properly, may become confirmed, and if you can get those children when they are ten or twelve you do not find them criminals at twenty.

18,583. What you treated her with was advice, but advice which one would say could not very well have been given without a medical diagnosis—that is rather your view, is it not?—Yes, that is so. Then we get a fair number of suicidal cases. I thought, if you would like it, I would give you one which was sent down from St. Thomas's.

18,584. Deputy-Chairman: We might like to have the details?—That was a patient of 51; she was married and a widow, in fact, twice a widow, and she was an ironer, and she was suffering from the exhaustion psychoses that Sir Maurice Craig called attention to a good many years ago. She had been 16 years in one place, and she was 26 years in the same house, and she was born in the same street. She was never a minute late at work, and she worked from nine till six daily, at times overtime till ten or eleven, she said. She did her own work and her washing before she started in the morning; she was up at half past five daily, and she was in bed about ten or eleven. Lately she was working in a room alone. Her recreations were looking at the paper on Sundays, and she looked out of the window, she said. It is an odd thing that that should be regarded as a recreation. Occasionally she went to church—usually she was too tired; seldom she went to friends.

18,585. Was that under "recreation"?—Yes, I have put it under "recreation." Her brothers have children, she says, and they do not need her. Her son is a finisher. Her first husband probably committed suicide on the railway, he was found cut up on the railway; her second husband died suddenly in bed of heart failure; her daughter had been married for two years. She had cramp at night; her blood pressure was 104, which is abnormally low. She had some dental sepsis, and she was very sleepy. One night, without any warning, having been at work the day before, she got up and cut her throat extremely

22 June, 1925.]

The Countess of CHICHESTER and Dr. HELEN BOYLE.

[Continued.]

badly; she very nearly died; she was taken into St. Thomas's Hospital, and they sent her down to us. In the three months with us she put on two stone four pounds. She has been doing well now for two years in Brighton, and she is now so well that she stood the loss of her son very well; he died. She is probably quite stable now.

18,586. *Sir David Drummond*: What is her blood pressure now?—I have not taken it; she was with us two years ago. (*The Countess of Chichester*): She went back to work. (*Dr. Helen Boyle*): Yes, but she works in Brighton, and she can come to the club night at hospital. She made a good many friends there. She is now in touch with some human society; that accident was when she was working in a room alone, and had few friends.

18,587. *Deputy-Chairman*: One of your main class of patients are married women, are they not?—Yes, we mention them particularly.

18,588. Those are cases of what you call unstable and nervous mothers who come to you?—(*The Countess of Chichester*): Usually, very much overdone with a large family to look after, who develop some form of nervous trouble, some nervous symptoms; and those are cases which, if they can be got quite early, can, as a rule, be absolutely reconstructed and returned to their own surroundings; but if the surroundings are not changed, and no help is given, it is a disaster to the patients themselves and to the family.

18,589. I suppose at your hospital there is no difficulty in getting these people to come—I mean they come willingly?—Absolutely.

18,590. You are not looked upon as a mental hospital?—That is our great desire, to avoid anything of that sort. No one need stay if they do not want to; it is entirely free.

18,591. *Sir David Drummond*: Are you not aware that there are few general hospitals in this country able to admit these cases?—(*Dr. Helen Boyle*): I think they do admit some without any special treatment.

18,592. Pardon me, I think they do treat some?—They do treat some.

18,593. I think it is a mistake to assume that our general hospitals do not take any notice of these cases?—I would not say they do not take any notice of the cases. But if you are asking me if they are equipped with proper methods for dealing with them, or that their staff is picked from that point of view, I think I should be right in saying there are not a very large number all over the country who do do that.

18,594. *Deputy-Chairman*: Do you think there are cases that would come to you that would not go to a general hospital?—No; I do not think they have any fear of a general hospital at all.

18,595. I did not mean through fear, but who, for some reason or other, would not be likely to go to a general hospital for advice, yet, knowing of your special hospital, would come to you?—What happens is that they often, and generally, in fact, go to a general hospital; and they are given a bottle of medicine, and they are told to go home and not to worry, and they will be all right; and after doing that for some time, sometimes a woefully long time, they hear from someone, "Oh, well, why do not you go along there and try that?" I am bound to think that the general hospital treatment is not altogether satisfactory to the staffs themselves, for they send us the cases; we have had cases from nearly every general hospital in London, I think.

18,596. Do you get cases from the Sussex Hospital?—Yes, we have got one in now.

18,597. If they have got some special nervous cases or mental cases they would send them on to you?—They do sometimes. I wish we had a larger hospital and could take them in at once. When they come to us they often have to wait, because we have a long waiting list. Another thing I feel very strongly, and

that is that there are a large number of these cases amongst the chronic cases that go to hospitals for years; I think there are a large number in the out-patient department of probably every general hospital, cases which, if they had been recognised early (chronic dyspepsia and all sorts of curious little difficulties), could have been cured. We are bound to think that, because we get them after they have been attending perhaps for five years, or even ten years, at some general hospital; then they develop finally, after waiting for a long time, and come to us; they get better, and they do not have to go back as a chronic patient to any general hospital.

18,598. *Earl Russell*: Chronic dyspepsia itself is not a mental symptom at all, is it?—It may be, it is often a symptom of fear. I am drinking water now, because I am afraid, which shows quite well how easy it is for fear—and my fear is not comparable to theirs—to upset ordinary secretions.

18,599. *Deputy-Chairman*: What do you do in cases that come to you which are marked cases of mental disorder, and that really want to be detained—I mean ought to be detained?—We generally say to them when they say they would like to go away, "Oh yes, wire for your people, and go away at once," and they say, "Go away now, but I have only just arrived," and are very much taken aback; so I say, "Yes, but you want to go." Then they say, "Yes, I want to go." Then I say, "Wire to your people and tell them to come and fetch you to-morrow"; they say, "I do not know whether they can come to-morrow," so I say, "You should have thought of that before you let them go." Then they say, "They are coming on Sunday," so I say, "Oh well, if you don't want to stay you must go to-morrow." Then they say, "Well, doctor, may I stay till Sunday?"

18,600. *Sir David Drummond*: I think the Chairman is referring to cases that develop rather suddenly, their mental trouble develops suddenly. What do you do then?—You mean if we get a case developing into an acute mental case?

18,601. *Deputy-Chairman*: Yes?—We wire for their people and they take them home, and I give them a letter to the relieving officer.

18,602. *Earl Russell*: So that, if necessary, they are certified at once?—Yes. If necessary we send two nurses with them.

18,603. *Deputy-Chairman*: You would not allow anybody to be certified in your hospital?—We do sometimes, because it may be impossible to send them so far as their relations would need. Some of the places I have mentioned; you can see it would be impossible to send them such tremendous distances.

18,604. I suppose those cases you would not have undertaken if you had known what they would be likely to develop into?—It is impossible in the early stages to be certain a case will never become certifiable; we are bound to have a few of those; of course we do not like them. Another thing is that sometimes we take cases in as the other voluntary hospitals do, on the recommendation of a medical practitioner; and in the case of some of the medical practitioners I am bound to say the descriptions they give of their cases are very limited. We sometimes get them when they are not really suitable for us at all.

18,605. So far as you are able you would keep all these acute cases out of your hospital?—Yes.

18,606. You think it is too great a price to pay, to be regarded as one of the establishments for the insane; you do not want that?—I think it entirely nullifies the use of our hospital.

18,607. *Sir Humphry Rolleston*: Have you been able to work in any social service, so to speak—are you able to do anything in the way of improving the environmental conditions in their homes?—Yes, we do a bit, but, of course, the social service side needs a tremendous amount of development at present. Our social service is very much limited.

22 June, 1925.]

The Countess of CHICHESTER and Dr. HELEN BOYLE.

[Continued.]

18,608. I wondered whether you would have funds and helpers to enable you to do it at Hove?—(*The Countess of Chichester*): The difficulty is that cases come from all over the country; it is not a local hospital necessarily—I mean it would mean ramifications everywhere.

18,609. But still I suppose a very large proportion of your cases necessarily come from near by?—I should hardly say a large proportion—a certain proportion. (*Dr. Helen Boyle*): We do do social services in various ways. For instance, we have a club night, and a magazine. Any patient can come at any time to the hospital if they like, and to a certain extent they are visited in a small way, but we do hope that our social service side will develop very much more.

18,610. *Mr. Snell*: Is that an open evening once a week or once a month?—Once a week. (*The Countess of Chichester*): We find that the old patients very much cling to that. One old patient once said to me she was going to take up some work in Hove. I said, "Why not go right away and forget all about this"? She looked at me in astonishment; "Forget! The one thing I want is to be nearby and walk past the hospital." That is the one thing you want to get rid of—a feeling of fear with regard to the hospital.

18,611. *Deputy-Chairman*: Your view is that these recoverable acute cases should not go to the clinics at all?—(*Dr. Helen Boyle*): I should like to see places provided entirely for them.

18,612. To maintain special places for acute recoverable cases?—I beg your pardon—you mean to say the acute mental cases should not go to the clinic at all?

18,613. Yes?—That is my feeling; they should be excluded. I personally think that the mental hospital should be of such calibre and so carefully graded, and so well run, that any acute case that requires to have her liberty taken away from her should be able to be safely and comfortably sent there.

18,614. *Sir Humphry Rolleston*: But you draw a great distinction between an acute case, and an acute case which is certifiable?—Well, I think what you mean is this, is it not, that there are some acute cases of certifiable mental disease which, if they are put under suitable treatment, will recover in a short time.

18,615. Yes?—I personally think (I know I am at variance with a great many people over it) that all such cases where the liberty has got to be interfered with (that is the main point I think) should be in mental hospitals, and I think it is detrimental to the mental hospital to take them out of it.

18,616. *Sir David Drummond*: Should be in an asylum you mean?—Yes.

18,617. That is contrary to the evidence we have heard from many people?—Yes, it is. Most people feel that they should be put into the clinics, and I have had a great deal of discussion about it with a great number of people. I went to Utrecht entirely to see that, but the Utrecht clinic is not in the least what I think we most want. It is a clinic which is really a clearing house. They take the cases in there and sort them, and they send the cases that I think should be in the clinics to a place called Zeist, a little way out of the town, which is much more run on the lines of our hospital, and is the department which I think will be more suitable for the general hospital, than the Utrecht clinic itself is.

18,618. *Earl Russell*: You would not see any objection to these cases being under a provisional certificate, wherever they are treated?—No. Personally there again I do not think the public will see very much difference between a provisional certificate and an ordinary certificate, or a provisional order and another kind of order.

18,619. Not if the man is able to say he never was a certifiable lunatic?—I think they will get to the bottom of that in about five years quite easily.

18,620. *Sir Humphry Rolleston*: You would not certify a case of delirium tremens, of course?—I am

not at all certain that it would not be a very good thing if they were certified.

18,621. *Sir David Drummond*: You would not certify people with pneumonia?—No.

18,622. *Deputy-Chairman*: In the quickly recoverable cases do not you think it would be of advantage that they should not be certified if they could possibly be saved from it?—I do think so in a sense, but I am not prepared to sacrifice the clinic to them. I am very anxious that those acute recoverable cases should not be removed from the asylums. I think our asylums and mental hospitals will become the most terrible places of despair, if we do not put any of the recoverable acute cases into them. I do not think you will get a good staff there, and I do not think there is any reason to suppose that because a case will not recover in three or four months it is to be deprived of the highest possible skill. I think you will perhaps notice at the end of the *précis* I have analysed the cases that were discharged within the last year at our local county mental hospital.

18,623. Yes, that is on page 6?—You will see that very few of them got well within three months.

18,624. Only three out of a total of 23?—Yes. The consequence is that I do not think that the number of cases who would be easily recoverable in three months is so enormously great as is often described. I do not think the hardship on them is nearly as important as it is to get your really early case to come to you.

18,625. You do not want people in your clinics too long?—No.

18,626. You mean this might be a question of 9 or 12 months?—It would be, according to these cases here; we should have only got three well in three months.

18,627. Your view is that if a patient is taken to an asylum you think it would make very little difference whether he was taken under a certification order, or under an observation order?—Personally, I think almost none, as far as the public is concerned.

18,628. *Earl Russell*: We have had a good deal of evidence the other way—you have read it, I understand?—I have read every word of it.

18,629. It has not impressed you?—*Dr. Goodall* has had a great deal of correspondence and talk with me about it. It was at his instance I went to see Utrecht the other day again. I said I thought we could compose our differences to some extent by allowing the university hospitals, the hospitals that serve a university, to have clinics to take any kind of case they wanted, that is to say, the acute case that requires interference with liberty, and any other case they want for teaching purposes, but not to extend that to the clinics in connection with any other kind of hospital, and *Dr. Goodall* said he thought that was quite a reasonable idea. I think they would be making a bitter mistake myself, because I think anybody can be taught quite easily on an acute mental patient, and there are a great many reasons why (even in the teaching school) the cases that you want to teach on are the cases that we have, the ones which are so difficult to recognise, but which every practitioner has in his practice every day. They are the most difficult of all, and they are the ones it seems to me you most want to teach on, and though you may get plenty of them, you will not get as good a variety as if you did not take the acute manias. Also, I think every student should go to a mental hospital; I think it is a mistake for him to have it so conveniently brought to his door that he will not have to go and see the cases in the mental hospitals; I think he should go round and see all sorts of cases.

18,630. In your *précis* on page 6, just after the figures you were dealing with just now, you say, "The Council, while recognising that special hospitals may be necessary, have come to the conclu-

22 June, 1925.]

The Countess of CHICHESTER and Dr. HELEN BOYLE.

[Continued.]

sion that there should be a special department in every general hospital for the treatment of these patients"?—Yes.

18,631. I do not quite follow what you mean by saying "special hospitals may be necessary." Do you mean some hospital between the clinic and the asylum, so to speak?—No; what I meant was: we are a special hospital in my view, and while I think that ultimately the special hospitals will not be required (I hope that ours will be improved out of existence, or annexed by a general hospital) till that day, there will be I am afraid all over the country a good many general hospitals which will not be induced to do this special work; and, where that is so, it seems to me that then the town should provide itself with a special hospital like ours.

18,632. Your view is that if possible your hospital should go or be absorbed, for instance, in the Royal Sussex County Hospital?—Yes, or the Hove Hospital. I do not know whether it will be done in my lifetime.

18,633. You are suggesting that the work which your clinic does should be done in every general hospital?—I think so. Why should this class of case be omitted?

18,634. *Sir David Drummond*: And be treated?—There are a great number of cases that you do not want to have to put to bed.

18,635. I think a great many could benefit from a spell in bed?—So do we, but there are a great many who do not want it for very long, and who are certainly not well when they get up.

18,636. Quite true.—We have had one or two acute certifiable cases, but we do not keep them.

18,637. *Deputy-Chairman*: You recognise the difficulty there might be on the ground of finance, and you suggest that in connection with these clinics there should be some special Government support, as there is in certain other health departments?—Yes.

18,638. You point out that it is an expensive form of treatment needing a specialised staff, and it would be impossible for the general hospital to maintain it unless they could get some further grant?—Yes, I think so; bribe them into it.

18,639. *Earl Russell*: "Persuade" is what I expect they call it in departmental circles?—Yes.

18,640. *Deputy-Chairman*: Then you lay stress on the fact that there should be no obvious connection between the clinics and mental hospitals?—Yes; that does not necessarily mean that none of the personnel should take an interest in any case. For instance, the Superintendent of Hellingly goes down to the Eastbourne Hospital, and has an out-patient clinic there.

18,641. Yes, but what you mean is that in the mind of the patient there should be no connection between the two?—Yes, that is the case.

18,642. So far as the doctors and officials are concerned, the closer the union the better, possibly?—Yes.

18,643. Then you sum up your recommendations, and you point out that "efficient social service should be developed in connection with patients suffering or liable to suffer from mental disorder, and should work with the mental hospitals and clinics." . . . I think the necessity for that would generally be recognised, but it is a difficult work, is it not? I do not know whether you could make any special suggestions with regard to that?—About social service?

18,644. Yes?—I should think that it might be developed really by the Central Association for Mental Welfare. They have voluntary associations over the greater part of England now, and they have begun in Scotland too; they have just started a branch in Glasgow. I should think that that might form a nucleus for this kind of work, probably. They do it to a certain extent even now.

18,645. Now, I think we have got the main points connected with the Lady Chichester Hospital. I do

not know, Lady Chichester, whether you would like to add anything?—(*The Countess of Chichester*): I think most of the points have been dealt with. Simply from an outside point of view, I feel that you cannot lay too much stress on the difficulty that arises in the minds of the patient's friends with the idea of any connection with a mental hospital. They are very ignorant, and there is an almost ineradicable difficulty over that. If you can impress upon them that the thing is part of general health, just like going to any other hospital, you catch the cases before they are conscious of it, and the thing is straightened out, especially with mothers of families; because, I think, naturally, their husbands and children very much dislike the idea of any sort of suggestion of mental trouble. This occurs with very young children too. We have had these cases almost of infants, children who have not been taught, and who cannot walk, and we have been able to persuade the parents to let them come into the hospital, and they have been dealt with from the nervous point of view in a way that their parents would not have suggested.

18,646. Taking them as in-patients?—Yes, taking them as in-patients, and perhaps re-educating, or putting the thing straight, whereas no parent would have allowed even the suggestion to be made to them that they should have been dealt with by anything that in their minds had any sort of taint, and for that reason the importance of not having acute cases is very, very great. One acute case may do your other people endless harm.

18,647. It might give you a bad name for all time?—Yes; you have to get over that difficulty again; you have to begin the whole thing over again.

18,648. *Earl Russell*: You have lost your character you mean?—Yes.

18,649. *Mr. Snell*: But I understood Dr. Boyle to suggest that the elimination of the acute recoverable case from an institution would do it harm?—(*Dr. Helen Boyle*): The elimination of recoverable cases from mental hospitals will do them great harm.

18,650. But you do not mean in such hospitals as you own?—No, we do want to eliminate them from our hospital. Another reason we think acute cases should be excluded is that I believe we shall get our general hospitals to accept the work very much more readily, if they think there is no question at all of their having to deal with anybody who screams or has to be locked up, or anything of that sort.

18,651. *Deputy-Chairman*: Taking your in-patients, what would be about the average time that you can keep them?—About three months. The average, when I worked it out last year, I think it was about three months; and you will see that was why I got the returns from the nearest mental hospital, from which you see we should only have got three out of 23 well. It took, I think it was, nine months to get 19 well.

18,652. Dr. Boyle, you are tendering some further very interesting evidence of your personal views. Perhaps before we pass to that, other members of the Commission would like to ask you and Lady Chichester further questions on the Lady Chichester Hospital.

18,653. *Miss Symons*: In connection with the stress you lay on the juvenile delinquents, advocating correlating the work of prisons and rescue homes, I wonder if you have any special proposal in that connection for children. I mean, do you advocate any system of examination of children in the Children's Courts to prevent children who are possibly suffering from some of these disorders going to places where there is no special attention for them?—Absolutely; what I feel about that is what they feel in America, that there ought to be psychiatrists in connection with every single Court. I once attended at the Lewes Assizes; I had to give evidence in a case; I saw quite obvious patients there. I went over Holloway Gaol a little while ago; I was asked to

22 June, 1925.]

The Countess of CHICHESTER and Dr. HELEN BOYLE.

[Continued.]

lecture there, and I said I could not lecture without knowing whom I was lecturing to, and the Home Office very kindly allowed me to go and see anybody I liked. I went round, and I expect people think I am very biased, but I saw "patients" in most of the cells.

18,654. *Mr. Snell*: Would you say that there is any considerable proportion of people detained in prisons who are mental cases?—Of course there are the definite prison returns which the National Council gave you, and there is an enormously large number of them, obviously, from the prisons returns. But, if I may so submit humbly, I think those returns only represent probably a small number of the cases which, if they were taken early in the time that we want to get them, would never get to prison at all.

18,655. That is to say, if they were treated as cases of mental illness or irregularity?—Maladjustments—the beginnings of stealings, and so on.

18,656. *Earl Russell*: Of course you could perfectly well say that a man if he is a sensible man, would not be a burglar?—Exactly.

18,657. But when he is a burglar, what are you going to do with him?—If you could get the burglar, when he is beginning, that is at 16, 14, or possibly 10, like the little child I told you about, if you could get him then and see that he is adjusting to life in that way, you would find that most burglars begin by having a "grouse" against life generally: "Why should certain people be well off and why should I be poor?" and he adjusts to life in that way. He says, "Well, I will get a bit of my own back; I will see if I cannot get some of this money that is floating about."

18,658. *Deputy-Chairman*: You would have to extend your clinics enormously to get in all persons of that class?—I do not know. I think if there were clinics all over the country, people would get to see the differences of mentality so much more readily. A young person who was very bad tempered, or very secretive, or something of that sort, would be noticed sooner; the very good little boy in class, who becomes a dementia præcox, the egocentric young, and so on.

18,659. *Earl Russell*: Temper is a very difficult thing to get over, is it not?—We have had very many cases of violent tempers that we have got adjusted, and they have been able to take a place and keep it. We have had a number of young girls who have been sent to us because they were in and out of places all the time, never would keep any place, and there again one may say, "Well, that child wants a horsewhipping," or "That young woman wants to be shut up in prison," or "She wants to be penalised"; but, as a matter of fact, we find if we can discover why they do the things and explain it to them and keep them with us long enough for them to understand that it is really quite fun to get to know people and to like them, then you can send them out and they will stay in their places.

18,660. Sometimes, in the case of a boy a whipping is effective, is it not?—Yes, there are some who want it.

18,661. *Mr. Snell*: Did you have any opportunity of finding out what particular crimes these prisoners in Holloway had committed; I mean those who you thought were mental cases?—Yes.

18,662. What kind of offences were they?—A great many of them, stealing.

18,663. And drunkenness?—Yes, some of them drunkenness, but the ones that stand out most clearly in my mind were stealing, some stealing food for the children.

18,664. They were more or less poor people. Poor people do not have kleptomania?—I am sure they often do.

18,665. *Earl Russell*: What would you say of a confidence trickster; would you say he also had a diseased mentality?—What I will say about it is that if you began at 14 you would see the beginnings of

why he was trying to trick everybody—probably somebody tried to trick him to begin with.

18,666. *Mrs. Mathew*: Dr. Boyle, I want to know which country, in your opinion, has the best method of mental treatment?—No country has a monopoly. I think, at present. The boarding-out is best at Ghel, in Belgium, so much so that I found an English doctor among the patients, and I said to him, "Do you like being here?" He was boarded-out in a cottage, and he said, "Oh, yes, much better than anything they can do for me in England." He had been there several years. I think that the clinic that I saw under Professor Cramer at Göttingen was the best, early treatment which I know of in the world. Cramer was a very modest man and hardly anybody knew about him, but I happened to hear about him. It was an extremely good clinic, no locked doors, and one half of the building was for men, and the other half for women, and they had some association rooms for entertainments; I think that was the best one I have seen, but there is a good one too at Zeist, outside Utrecht, to which that kind of case is referred by Professor Winkler's Clinic, which is a magnificent place, but they do not keep the cases there any time at all. I will tell you what makes me think that it is not altogether satisfactory. I was attending out-patients, and a girl came in with a very bad arm and hand, and they said, "Oh, that is a girl who is hysterical; she has done it herself." So I said, "But you have hardly seen her." The doctor said, "Oh, that is true, but we know her. She comes up here periodically with this," and I said, "But why is she doing it?" The out-patient doctor said "We do not know." So I said, "What is the longest time you have had her in?" "Oh, I think a week or two," she said. "Two or three weeks perhaps;" so I said, "How often have you had her in?" They had had her in two or three times; and I said, "Are you going to take her in this time?" and she said, "No, I do not think we can be always taking her in." Now that, to my mind, is wholly unsatisfactory. That patient is being disabled for a great part of her life, and there is not any reason why she should be. They took her in and entirely altered her surroundings, and talked to her nicely; it goes away, it gets quite well; she goes out in a short time and comes back again. They have never really got to the bottom of that, chiefly because the clinic is so crowded with the huge number of cases of every sort, and it is very hard to find room for her. She is a case who is incapacitated for a certain part of her life, because it has not been found out why she is doing this. She is doing it for some reason or other. It seems to me that illustrates what one feels about the clinic; that once you get away from the very early case, the very early case is apt to be regarded as less important than the acute ones. They seem to me to be more important, and not less, because they can be returned and be useful and valuable members of society. If I may add another thing, it is this, that I do not want the Commission to think that we are entirely obsessed with psycho-therapeutic measures, because a great number of the cases that come are dependent upon physical conditions. We have a large number of dental cases, for some of which treatment has been extremely successful. I remember one patient who came in with neurasthenia, and the only thing we did for her was to put four inches on to her chest measurement; she was not getting enough air to do anybody any good, and she was always feeling weakly. We have a large number of consultants, and we go into the cases as carefully as we can, in a sort of team way.

18,667. Have you had any opportunity of observing the effect of routine employment?—Yes, we have an occupational clinic.

18,668. Yes, but I was thinking of the effect of just putting labels on boxes, and things like that. It has a mental effect?—You mean a harmful effect?

18,669. Yes, monotonous employment?—Yes. We had a girl who suffered from that, who worked in a

22 June, 1925.]

The Countess of CHICHESTER and Dr. HELEN BOYLE.

[Continued.]

jam factory; there is no doubt that a very monotonous life does lead to nervous trouble, and that case I quoted to you had been 26 years in the same street, the same house, and born in the same house. That was no doubt a contributory factor.

18,670. At what did she work?—She was working at ironing, and it was when she got to the monotony of doing it in a room alone that she broke up altogether.

18,671. *Sir Humphry Rolleston*: I am not quite sure why you think it desirable to take in early cases of disseminated sclerosis; I should have thought you had your hands quite full with the psychological cases. Is it because you think disseminated sclerosis is very often an additional factor?—No, Sir, it is not. Even if they showed no functional disturbance and no brain disturbance, which, of course, you often get, I should still be strongly in favour of admitting any kind of nervous patient for the reason that I believe, if I may say so, that our present system of dividing the nervous system into groups, and giving it to different people, is very damaging for the general outlook on it. I do not think any other country does it as much as this one.

18,672. You are admirably adapted for improving mental control, but you would not say that you were so well equipped as a general hospital for looking after pathological details and investigating and treating them, would you?—I hope that we should be able to investigate any pathological detail that could be investigated at the Royal Sussex County Hospital. The Ralli laboratory there is open to us, and we send any cases we wish to. Dr. Farquhar Buzzard is consultant at the Hospital.

18,673. But you have no advantage over the Royal Sussex Hospital?—No, not specially for that case itself; but, personally, I think it is extremely important that we should take them all in, for this reason, that it abolishes the idea that there is something different between that and neuritis, and a case that is functionally paralysed from hysteria.

18,674. You take in organic cases to keep the nervous system together?—Yes, treated as a whole. Some of the disseminated sclerosis cases, I would like to say, are cases which have perfectly definite functional and mental trouble.

18,675. *Sir Ernest Hiley*: Dr. Boyle, am I right in thinking that you disapprove entirely of the suggestion of the provisional order? You would send an acute case direct to the asylum?—No, it would not be true to say I object to it. I do not object to it; I think it is perfectly harmless, but I do not think that it will do all that is expected of it.

18,676. Then any recommendation of such an order would be, in your opinion, rather a futile thing?—Well, there is such a strong opinion in favour of it that, personally, I should vote in favour of it if I were asked, I think; but I do not think the success of it will last longer than a comparatively small number of years. I mean, I think the patients will not care more for that than the other, and they will avoid it just as much.

18,677. Then you would be equally opposed, of course, to the extension of any such order from time to time, an order to avoid absolute certification?—I would like it to be possible not to certify the people, and to keep them out of an asylum; I am strongly in favour of that, but I doubt if the provisional order will help very much towards it—that is what I mean.

18,678. What would you suggest in place of a provisional order?—Personally, I do not see any reason why one should not do very much as they do in Scotland; let the doctor say: "This patient should be treated for three months and looked after properly." I do not think that there is any real objection to that, because apparently the Scotch do not find it work badly. They do not have abuses, and the doctors do not get into collusion with the nursing homes or do anything very terrible, as far as I can hear.

18,679. Would you do that without any outside confirmation, such as a magistrate's order?—I would, because, you see, you cannot get your patients to submit to the magistrate's order. If people only knew the difficulty there is to persuade them to allow themselves to have anything of that kind done—they do not mind going to a doctor's house or a nursing home, and they are not the least bit afraid of being badly treated there.

18,680. *Earl Russell*: Legal restraint on the doctor's order?—They find it work all right in the north, and, if it does, I should be prepared to agree to it here myself.

18,681. Yes, but would the public?—I do not believe they would.

Deputy-Chairman: Sir Ernest is trenching a little on a subject of special interest to us, when you come to your own personal evidence.

Sir Ernest Hiley: I did not mean to, Sir; I rather had in mind a remark of Dr. Boyle's earlier on.

18,682. *Deputy-Chairman*: Quite, but I think we shall get it out a little more fully now. You have some very strong views, apparently, Dr. Boyle, which are certainly not those that are commonly held, I think, about treatment?—I am afraid so, yes.

18,683. Your main idea is that there should be greater freedom both for the doctor, as I understand, and for the patient?—Yes, specially for the patient.

18,684. You think that the doctor should be free to treat a willing patient where-ever he considers it desirable or possible. I suppose he is now; that is not new, is it?—Yes.

18,685. Any doctor can treat any patient in his own house, surely?—If he does, he lays himself open, if the patient is a certifiable patient, to possibility of fine.

18,686. Not in the patient's own home?—Quite so, yes, that is true.

Earl Russell: That requires money, of course; you cannot do that in the case of the poor.

18,687. *Deputy-Chairman*: That is so; but I mean as between a doctor and a patient in his own house, he is free enough, of course?—Yes, but very often that is not at all a good place for him.

18,688. Quite so. The second point is that you want the patient to be free to go where he wishes to be treated, or where the doctor sends him; that is to say, you would allow, as I gather, an unlimited number of licensed houses?—Yes, open competition.

18,689. Open houses or licensed houses?—Any house.

18,690. At the present moment, as we know, there are only a very limited number of licensed houses, and, as the Act stands at present, they cannot be enlarged or increased. Your view is that the line which has hitherto been taken by the Legislature has been a mistaken one?—Yes.

18,691. It might have been perhaps necessary in the darker days, but now you think that to be entirely changed?—I do.

18,692. And you would have an unlimited number; you would have no monopoly of licensed houses, but free competition between those who are prepared to carry them on?—Yes; I think you get better results with free competition than in the other way.

18,693. Do not you think there would be a great public feeling against giving doctors or relatives the right and power to dispose of their patients, who are suffering from mental disorders, where they liked without any supervision?—If the patients are willing to go, there is no interference with their liberty.

18,694. But there is always a difficulty in these cases, at all events in serious cases, in saying whether the patient is willing to go or not. You do not know how far you can take the assertion of a person who is suffering seriously from a mental disorder; I mean he may say, "I am prepared to go," but he may not know what he is saying, and may not be able to form any opinion of where he is

22 June, 1925.]

The Countess of CHICHESTER and Dr. HELEN BOYLE.

[Continued.]

going, or what his surroundings may be?—Personally I would risk that. I think that the really trying part to the patient is that he is not allowed to say where he will go, or, if he dislikes it, that he would like to leave that place. I do not believe we should have any trouble, comparatively speaking, with anyone if they were not compelled to stop in places that they do not like. I think that is where most of the trouble arises.

18,695. For those who can afford it, I suppose there is a reasonably limited choice now. One knows of cases, of course, where persons of means constantly go to a particular home that they choose, and that they like, within limits?—Yes, but even then (if we are talking now about the certified cases) they may choose a home, but can they get out of it again? It is very difficult to get them out of it.

18,696. You do not mean that they are forcibly detained there?—I mean certified cases—yes, of course, they are.

18,697. I was thinking of cases that were not certified, where they go as voluntary patients, as boarders?—No, I am afraid I have got mixed up. Supposing they went to a licensed house voluntarily and they wanted to get away again, if they are voluntary boarders they can get away again probably at the end of 48 hours. If the patient is not a suitable person to go, he may then be certified; and I am not denying for a moment that the person is probably quite suitable to be certified; but supposing he says, "Yes, well all the same I would rather go somewhere else, even if I am certified," then you get the difficulty of moving him. It is extremely difficult to get a certified patient moved from one place to another, even when they have plenty of means.

18,698. *Earl Russell*: Why—who makes the difficulty?—The last one I have had a difficulty with was the petitioner, and it very often is the petitioner. It has taken two doctors from London, two of us went up to York at great expense, and a great deal more had to be done before we could get that patient moved. It took me nearly two and a half years to get a patient moved from a mental hospital here down into the country.

18,699. Who is the person who has to give the actual consent, the Board of Control?—The Board of Control can overrule it, or they can supersede the petitioner, but it takes such an interminable time; it is such a cumbersome business.

18,700. *Deputy-Chairman*: But you were acting as the medical adviser, of course, of the person suffering from the mental trouble?—Yes.

18,701. If you had made a case to the Board of Control, would they not see that the removal took place?—They do ultimately; but, as I have said, it took me, with one thing and another, nearly two and a half years, I believe it was, to remove one patient into the country.

18,702. *Sir David Drummond*: Surely you are speaking of an exceptional case. I happen to have had some experience in this matter, and it has never been found a difficulty in my case?—In some cases it may not be, but I do think the difficulty of moving them is a serious matter. It is always rather accepted, I think, that if a patient is in a suitable and thoroughly comfortable and well run and properly managed asylum or home, it is unreasonable of him to wish to move away from it; and always, when I have wanted to move patients, I have been asked, "What is there the matter with the place that they are in?" Well, sometimes there is not anything at all the matter with the place that they are in.

18,703. *Deputy-Chairman*: But have you in cases suggested the removal, or has the patient suggested it to you, Dr. Boyle?—In the last case in which I was concerned it was the sister who came to me and wanted to have the patient removed. It is not that anybody is really trying to be disagreeable about it, it is that it is such a cumbersome business to get it done. The Board of Control are quite

willing to help, and so on. In this particular last case I admit the petitioner was difficult.

18,704. *Earl Russell*: But this is a certified patient. Somebody has got to give leave for them to be moved—who do you say it should be?—If the petitioner will not move the patient, and the Board of Control think that the patient has been there a long time, and wants to come away, I do not see why the Board of Control should not say that that patient should be moved somewhere, and find another place for him.

18,705. So that the Board of Control is still to be the authority; but you mean they should act more readily than they do?—Yes. I do not know what limitations there are on their actions with regard to the petitioners; but it seems to me it should be a comparatively easy thing if patients are unhappy anywhere to get them removed to another place, even if they wanted to be moved to their own house.

18,706. *Deputy-Chairman*: May I go back to a point? You say you think the licensed houses should be allowed generally—not have them restricted at all?—Yes.

18,707. Would you have them under control?—Yes, where they take certified cases certainly.

18,708. But not the other cases?—Well, unless the case is certified I imagine they have no jurisdiction.

18,709. *Earl Russell*: You were not asked this, but are you under any kind of control at the Lady Chichester Hospital?—None whatever. (*The Countess of Chichester*): They do not take certified cases.

18,710. *Deputy-Chairman*: You say they are not under control in certain cases where the patients are not certified. All the licensed houses will be under control at the present moment although they can take cases which are not certified?—(*Dr. Helen Boyle*): Yes.

18,711. Do not you think that should be an essential feature of these houses, that there should be some control?—Yes, certainly.

18,712. I mean, you would not allow a house to be set up anywhere to take persons mentally unstable without any supervision, or without any control?—If the patients are mentally unstable, possibly; but not, if they require their liberty interfered with. I feel myself that the chief *raison d'être* of legal supervision is to see that the patient's liberty is not taken away from him. If their liberty is not taken away from them, I would leave them to go where they liked and do what they liked.

18,713. You would never have anybody certified who was not dangerous to himself, or dangerous to other people?—Yes, practically that is what it amounts to.

18,714. And then you would say that that is the only person who is to be under any supervision?—I do not quite understand.

18,715. I gather that you think that unless the case is certified there should never be supervision?—Yes, no supervision for uncertified cases, because they are free.

18,716. If possible you would prevent certification as long as possible, and in every case where it was possible, would you not?—Yes.

18,717. So that you would have, outside the class whom you certify, a large number of people who were suffering from mental trouble?—Yes.

18,718. Do not they require some protection, do you think?—I am inclined to think that they would suffer less and do better if they were not supervised by any particular authority, until you have to take their liberty away.

18,719. There has been a very strong expression of opinion by many witnesses that it is a mistake to allow licensed houses—shall I put it in this way—to make large fortunes out of people suffering from mental trouble. You have no sympathy with that at all?—No, none at all. If you have free competition it is very unlikely they will make large fortunes, I think it is almost impossible for them to make very large fortunes.

22 June, 1925.]

The Countess of CHICHESTER and Dr. HELEN BOYLE.

[Continued.]

18,720. You mean the good houses will survive and the bad houses will fall out?—Yes.

18,721. And that the doctor and the patient can really look after the whole thing without any legislative interference at all?—As long as there is no interference with the liberty, I think they can certainly. But you will see that I suggested that if nursing homes are not registered, which is a possibility in the future, I believe it might be possible to suggest that any nursing home taking patients of any kind, should be obliged to furnish the names of the doctor in charge of the case on demand.

18,722. You say that, because you do not want to draw any distinction between mental illness and any other form of illness?—Yes.

18,723. But you think it might be desirable in these houses. When I say licensed houses, I suppose you would not have them licensed at all, but simply run as private nursing homes?—Exactly. If they want to take certified cases let them take them, and the Board of Control looks after those certified cases. Those are the ones you would have to control.

18,724. But apart from certified cases, no control—that is your view?—Yes.

18,725. You see one cannot help feeling that there are many cases of mental illness which you do not need to be certified, because they quickly recover; yet you want to detain them, and you want to see that they are not detained longer than they ought to be; you want to see that they are properly provided for, and that no advantage is taken of their mental condition; and up till now these cases have been under a certain supervision or control. Do you think all that is a mistake?—I really feel myself that it just amounts to this, that I do not believe it is any use postponing certification if you have to interfere with the liberty of the person. I think that is the thing that the people do not like, and I think that is the thing that gives rise to the trouble. If you have to interfere with their liberty, I do not believe there is any way of getting round it and making it anything but hard. I think a certificate is no harder than a provisional order.

18,726. I quite follow that; it is only calling the thing by another name; but apart from its duration an observation order is just the same as a final order—that is your view?—Yes, I feel that. I think you will have the same difficulty in getting the patients to be treated.

18,727. *Miss Symons*: Dr. Boyle, there is one point on what the Chairman has just been asking you which still puzzles me rather. You are not contemplating the certification of all the so-called non-volitional cases?—No; I would leave those without certificates.

18,728. You do not think that in cases of that kind where the patient really has no will power, there is a danger under your proposal, that they might either be put away, or be put upon by designing relatives, or possibly not receive proper treatment if there were no supervision?—I do not believe there is any more danger than there is now. You do not supervise the non-volitional case of any kind. I mean to say, you do not insist upon a patient being certified who is, as I know one now, paralysed and cannot speak. She has had a clot on her brain and she is not a mental case, but you do not insist upon her being certified; yet she is immensely less capable of looking after herself than most of the mental patients.

18,729. When you were making the point about the difficulty of moving the patient, you do not mean, do you, that the medical superintendent objects to the patient being moved. Was it the petitioner objecting in most cases, or have you found the medical superintendent unwilling to have patients removed?—As a rule the medical superintendent is quite co-operative about it; but I remember one case where the medical superintendent said that he would not have a case back if she was taken away, and that gave rise to a certain amount of trouble, because they

were rather afraid that, if they took her away, they might not find another place to take her for that same money. That gave rise to the trouble I had with that case which took me such a very long time to get moved, but I think myself it is really more an attitude of mind to it. People do not think of moving their mental relations very much, nobody thinks of moving them, but I think they want a change as much as the rest of us do, and as I have said here, I think the poor do too. If we could exchange them between asylums a bit, I am sure we would have immensely less trouble on the part of the chronics. Give them a bit of change now and then. We should not be so hidebound about settlement. Sometimes their settlement is miles from their friends, and they do not want to go such a long way away.

18,730. *Deputy-Chairman*: Do they remove them to their settlement, or do they simply charge the place of settlement with their expense?—No, they transfer them.

18,731. I thought they simply charged the place of settlement?—No. For instance, we have had one or two patients who went away from us and were certified. They would like to have stopped at Hellingly which is a mental hospital near us, where one or two of the other patients and friends they have made could go and see them. Then they have been drafted off to some place in the Midlands where they happened to have a settlement.

Earl Russell: This new rating Bill will make a lot of difference to that?

Deputy-Chairman: Yes, quite.

18,732. *Earl Russell*: Dr. Boyle, have you any experience of the procedure in rate-aided cases, and how it is carried on?—Not very much of course. We see the cases that we occasionally certify, and I have certified a certain number myself.

18,733. In view of what you have been telling us this morning, I should like to know whether you think if a case is certified, it had better go direct to the asylum and not stop in the workhouse?—I think it would be much better to go straight, and I am bound to say that with us in Hove as a rule they do. They are taken by the relieving officer from their house straight to the asylums.

18,734. One of the difficulties now is that the asylums cannot take them in until they are certified, but the workhouse can?—But they are certified before they go.

18,735. Have you got any view about the dietary scale in the rate-aided asylums—do you know anything about it?—Practically nothing; it is years since I was there.

18,736. Now to come to what you say yourself, your No. 3 on page 8: "Freedom for any person who desired it to take in one or more patients for gain." I think as it is, a doctor may take in one patient for gain provided he notifies the Board of Control?—Yes, nearly always, and they can generally get permission to have two, and in rare cases three.

18,737. Do I understand from what you have been saying to the Chairman, that you think the Board of Control ought not to be notified, or is that only in uncertified cases?—Only in uncertified cases.

18,738. I do not want to pursue that because the Chairman went into it at some length, but I gather you think that they might be looked after without any notification to anybody except the doctor or their friends?—The uncertified, yes.

18,739. I think if I may say so, at the bottom of that page, this is rather a false antithesis that you make, is it not—you say that "The sane are often treated by those whom we regard as quacks, faddists and charlatans," and then you say "if we do not guard them why should we guard those who are not sane." Surely the answer is that the sane, even if they are fools, are supposed to have some sense, whereas the other people *ex hypothesi* have none?—I do not think it is true of the insane that they have

22 June, 1925.]

The Countess of CHICHESTER and Dr. HELEN BOYLE.

[Continued.]

none. If they take several mental cases, at any rate, it is very rare to find that there is not one of them who will make it his business to investigate how the home is run in a way that any sane person might. It is very rare to find a mental home which could do some of the things I sometimes come across in the ordinary nursing home. I remember a patient of mine who came and began to get well with me, and then had to be moved; she got well with startling rapidity when she went to an extremely bad home. I think it had every single thing it ought not to have had; she was removed there entirely for economy, and she was so horrified at what went on there that she constituted herself into a sort of private detective, and she was so interested that she got quite well. That is the curious thing about these cases, that you cannot tell what will get them well in the way you can with the others, and that is why you want freedom for them more than for sane people—not less.

18,740. In these things, as you say on page 9 about private asylums, I understand you are in favour of having no monopoly, and of everyone being able to run them; but does that apply to institutions for the certified as well as the uncertified?—Yes, it does.

18,741. Only in the case of the certified you would have notification to the Board of Control?—Yes.

18,742. And no licence from the Board of Control?—I do not really see the reason why. But the Board of Control would visit the certified patients. As a matter of fact, the public and the friends and the servants and the nurses, and all those kind of people, are better protection than any sort of outside supervision can be. A nursing home with a breath of suspicion against it cannot survive, and does not; people get afraid of it.

18,743. I am very glad to hear that.—I have never known a bad one survive except one.

18,744. You trust to competition?—I trust absolutely to competition, because as soon as there is anything against them they get squeezed out. But any form of supervision, again, may guarantee that home in a way that is dangerous. The only one that I know of was the case of a nursing home which was under supervision. It did harm rather than good, because it gave a sense of security when that should not have been given.

18,745. You remember we are dealing with a suspicious public. Will you tell me whether you think this is a thing which is likely to make them less suspicious; you suggest at the bottom of page 9 "Private houses afford freedom for trying out treatments in a way which would be difficult in a public institution"? Is not that the sort of thing that the public might seize upon, and say that the poor are being experimented on?—They are not necessarily poor to begin with, but, on the other hand, if the patient is able to choose her home and the friends are able to choose her home, and they go there in that way, those people will be satisfied. It may not be, in your opinion or my opinion, at all a good method of treatment, but the people would be satisfied with that because they have chosen it.

18,746. Even a sane patient does not choose her treatment?—Do not they? I think very often they do. They go to a doctor because they know what his sort of line is very often.

18,747. I agree you may be able to try experiments, but I doubt whether that would reassure the public?—It is possible, put like that, that it would not; but I think it is true that if they tried it they would like it better, because they would be able to choose a home that would suit their particular type of ideas.

18,748. Now I see on page 11, your No. 5, you go so far as to say that these private houses, which are to be unlicensed and unregistered, and subject to no supervision, are to be allowed to take any patient if his doctor wishes it, although he is certified?—That is what they do, roughly speaking, in Scotland.

18,749. It is a little revolutionary, though, in this country, is it not?—I think if a patient is not obliged to stay there, and can come away when he likes, he will not mind; there is nothing to be afraid of.

18,750. *Miss Symons*: Can you be quite sure that he is not being obliged to stay?—I think you can. There may be very rare cases possibly where a patient is not as comfortable as he might be, but you have got very few people who have no friends, where there would be no servants, no nurses in the house, and where the head of it would be really thoroughly bad. I do not believe you would get that place to survive at all—certainly not if there was any competition about.

18,751. *Earl Russell*: Then you suggest that the public asylums should be allowed to take voluntary boarders at the discretion of the medical superintendent?—Yes.

18,752. But his discretion would rather have to be limited to the case being suitable in a rate-aided institution?—Yes. Also, I think, there are some cases who would like to stay rather longer than they ought.

18,753. Then there was only one more question I wanted to ask you, and that was on page 12, where you analyse your 100 cases?—May I say before I go to that, that with regard to the non-volitional cases in homes, I think a great many of them will go to places chosen by themselves and their families, and their doctor. Then I think the doctor being made responsible more or less for the home is a good thing. Some of my colleagues do not agree with that at all, but I think as a matter of actual fact at present the doctor is really, and does regard himself as, responsible very largely for the nursing home his patient is in; and if he thought they were not being properly looked after, I think he would inevitably move them. I believe that is the case actually at the present moment.

18,754. That is the practice now with ordinary cases?—Yes, and these would come under the same heading; if we insured their having somebody looking after them, I believe it would be quite safe. Another thing is this, that at present with the law you get a certain amount of secrecy about it which is bad. Often the cases I have discovered, which have been defectively treated, have been the cases where the friends do not want them to be certified, and the nursing home dare not let them go out, or dare not let them appear for fear they should be forced to certify them. Now that drives the thing underground, and then you are much more likely to have faulty treatment for that reason than for the other.

18,755. May I just direct your attention to page 12 where you give this analysis of 100 cases? Among the hundred there are 12 with no improvement; six of those were discharged to be certified subsequently. I want to know what happened to the other six—were they just turned loose on the world?—Those did not become insane; they were either neurotic cases—

18,756. No improvement does not mean they were insane; it means they were just as little ill as they were when they came in?—Yes, that is it. They may have had to be sent away because they were difficult or tiresome—something of that sort.

18,757. *Mr. Snell*: Dr. Boyle, reverting for a moment to that question of removal from a place after a certain time, is it your opinion that staying too long in a place may actually encourage a chronic condition?—Yes.

18,758. That is to say, after a certain period they sink into a hopeless torpor, which a change of institution or some break in their lives might prevent?—Yes, I think so, and not only that either; I think they are often converted from peaceable members of an asylum into very difficult chronics, because they get across some member of the staff or some other

22 June, 1925.]

Dr. EDWARD MAPOTHER, M.R.C.P., F.R.C.S.

[Continued.]

patients, or they mix the staff up in some delusion or other.

18,759. It is probably impossible to fix a time; that would vary considerably with the state of the patient?—Yes, and some of course like being there.

(The Witnesses withdrew.)

(After a short adjournment.)

THE RIGHT HONOURABLE H. P. MACMILLAN, K.C. (in the Chair).

Dr. EDWARD MAPOTHER, M.R.C.P., F.R.C.S., called and examined.

18,760. *Chairman*: Dr. Mapother, you are Medical Superintendent of the Maudsley Hospital?—Yes.

18,761. Perhaps we might take from you very shortly your previous experience. Were you, for three years after you received your qualification, *locum tenens* at three of the London County asylums?—During periods over the first three years, yes.

18,762. And the Metropolitan Asylums Board's Darenth Institution?—Yes.

18,763. In alternation with these appointments, you held other appointments which gave you general experience in medicine, and especially in organic neurology?—Yes.

18,764. In 1908, I think, you were appointed Junior Medical Officer at Long Grove Asylum, then recently opened, and you had reached the rank of Deputy Medical Superintendent there when you were appointed to your present post in April, 1922?—Yes.

18,765. During your last two years in the Army did you serve at various hospitals which were treating war neuroses?—Yes.

18,766. And were you finally in charge of the Neurological Section of the 2nd Western General Hospital, Manchester?—Yes.

18,767. Then I think, from September, 1919, to November, 1920, you were seconded to act under the Ministry of Pensions as Medical Superintendent of the Maudsley Hospital, which was then treating neuroses and mental disorders which had arisen during war service?—Yes.

18,768. I think you have visited a large number of neurological and psychiatric clinics abroad?—Yes.

18,769. Associated with the Universities of Amsterdam, Cologne, Munich, Utrecht, Vienna, and Zurich?—Yes.

18,770. And have you especially investigated the administrative arrangements at those places?—Yes.

18,771. Now, in addition to being Medical Superintendent at Maudsley, are you also Physician in charge of the Department of Psychological Medicine at King's College Hospital, and Lecturer on that subject there?—Yes.

18,772. And you are Lecturer also on Morbid Psychology in the course for the Diploma for Psychological Medicine at Maudsley Hospital?—Yes.

18,773. And you are, I understand, permitted also to engage in practice as a consultant in psychological medicine?—Yes.

18,774. You were a member, were you not, of the Committee of the Medico-Psychological Association which prepared the evidence given before us recently?—Yes.

18,775. I think, for the purposes of your evidence to-day, you are assuming that we have before us what was said by the representatives of that Association, and also the British Medical Association, on the reform of the law and of the administration generally?—Yes.

18,776. For the present purpose, although you have received permission from the London County Council to give evidence, I think you desire us to regard the opinions expressed by you as personal?—Yes.

18,777. We shall do so. It may be useful to put it on the note that the Commission had the advantage of

I know one old man who was in a place for 18 years, and they had the greatest difficulty in getting him to go away.

Deputy-Chairman: Thank you; we are very much obliged to you.

paying a visit on Friday afternoon to your institution, when you were good enough to show us round the establishment and to explain its different departments. May we take it generally that the hospital has three functions, namely, research, teaching, and voluntary treatment?—Yes.

18,778. You have recently issued, have you not, the first Annual Report of the Maudsley Hospital under its present régime?—Yes.

18,779. Copies of that report have been supplied to us all, and we have read it with much interest. A considerable amount of information may be derived from that report upon the initiation of your present system and the progress made up to date?—Up to about February of last year, yes. I am just on the point of issuing another report, but I have only outlined facts to give you about the second year. I will give you some further facts if you wish them.

18,780. We shall be very glad to receive that report when it has been prepared. In supplement, then, of the evidence which we have already received from the Medico-Psychological Association and the British Medical Association, and the information which is before us in this report, Dr. Mapother, I think you desire to put before us your views on general lines with regard to the reform of the existing system?—Yes.

18,781. Having brought you up to that point, perhaps now you might indicate to us the points which you specially desire to bring before us this afternoon?—I think that I might say they are really summarised on page 4 of my *précis*. I think there are four main kinds of reform needed. Firstly, the adaptation of the legal formalities required to the patient's attitude towards his treatment; by that I mean the question of whether he is desirous of treatment, or incapable of expressing an opinion upon it, or definitely objects to necessary treatment.

18,782. That is the first aspect?—That is the first aspect. Then the second, upon which I lay most stress, is the provision or approval of specialised types of institutions, which would deal separately on the one hand with the chronic and the recoverable cases, and in each of those classes with the patients who were objecting or objectionable, as I have put it, and on the other hand with those who are neither objecting nor objectionable. Then the third aspect, I think, is the provision for teaching and research—the extension of the present provisions for teaching and research.

18,783. With regard to the first matter, do you regard the classification of patients, from the point of view of the degree of volition which they possess, as very important?—I think it is very important indeed. I think these formalities attending reception are very important as an accompaniment or as a condition of their treatment in specialised institutions. I do not lay as much stress as perhaps some people do on the effect of merely altering the formalities and treating the patient in the same type of institution; but I think that if they accompanied treatment in specialised institutions they would be very important.

18,784. I gather your view is that the main classification, from the point of view of administrative arrangements for patients, is this: first, those who

22 June, 1925.]

Dr. EDWARD MAPOTHER, M.R.C.P., F.R.C.S.

[Continued.]

are able to co-operate in their treatment; secondly, those who are merely negative, and, thirdly, those who are actively resistant to treatment?—Yes, that is the main classification, with this proviso, that in speaking of those three classes I am speaking of certifiable patients. I would put outside of those classes the patients who are uncertifiable, the merely neurotic, for example, whom I regard, and I think it is very important to regard, as simply suffering from another degree of mental disorder.

18,785. These are persons whom you would relegate to medical treatment as persons suffering from a certain form of ailment, namely, a mental disorder?—Quite. I think no questions of legal arrangements should arise in the case of the entirely uncertifiable. Of course, in the first two classes of certifiable cases I think the legal formalities associated with their treatment should be very greatly reduced.

18,786. The difficulty of course occurs to one that the type of case you are referring to first of all, that is to say, the mentally ailing as distinguished from the certifiable case, may at any moment pass into the latter category?—I quite agree they may, and for that reason I do not suggest that there should be any exact correspondence between the institution in which you treat them and this classification for the purpose of legal formalities. For example, at the Maudsley we have patients who are certifiable but willing, and those who are entirely uncertifiable; and I think that that is inevitable, for the very reason you mentioned, that at any moment a patient who enters your institution entirely uncertifiable may become certifiable, though still a willing patient.

18,787. But you would have no patients in Maudsley who are resistant to treatment, whether certifiable or uncertifiable?—None; they are all entitled to discharge on giving just sufficient notice to communicate with their friends.

18,788. That is the statutory 24 hours under the Act of Parliament?—Quite.

18,789. Of course, there is always the difficulty of the value of the consent, and the continuing effect of a consent, particularly in the case of a progressive mental malady. You may say that at the inception there may be a degree of intelligence sufficient to appreciate the situation and to co-operate in treatment, but if unfortunately there is not progress and the case becomes worse, then the consent, however reasonably taken at the outset may cease to be really an effectual consent?—I quite agree; but that raises the whole difference of principle, which I think put shortly is this: at the present time there is an excessive tendency to consider that certifiable patients are to be regarded as unwilling, unless there is definite evidence to the contrary; whereas I would put it that a patient is to be regarded as willing, unless there is definite evidence that he is unwilling.

18,790. You would only bring in the legal compulsion where it was necessary to use restraint against the wishes of the patient?—Exactly.

18,791. May you not have the type of patient who is rather volatile in temperament, and says quite cheerfully, "I am quite willing to come into your institution," and when in your institution as a voluntary inmate proposes to do quite outrageous things? You would have to restrain that person, would you not?—We should not keep a case of that sort; I would put that patient among the objectionable; I would not keep a patient in a clinic who is unmanageable.

18,792. Even though that patient said, "I want to stay on at Maudsley," would you say to him, "You may wish to stay, but, you know, we cannot have people like you, who will not conform to our rules"?—I think there is a definite limit to the usefulness of the clinics. They are a supplement to and not a substitute for mental hospitals and other arrangements. That type of patient would, I think, be treatable in the observation hospitals to replace the observation

wards; but a patient who for that reason or any other is objectionable to others or unmanageable in the clinic must go, I think.

18,793. In your own practice at Maudsley, patients reach you, I understand, either through coming first of all to your out-patient department?—Three-fourths come that way.

18,794. Or are recommended to you from other sources—no doubt by their medical advisers?—Yes; most of them coming from their medical advisers come to the out-patient department. We generally require their attendance at the out-patient department, unless they are recommended by an expert of some kind.

18,795. Then you really exercise a certain measure of selection at that stage?—Yes, that is the function of the out-patient department, very largely.

18,796. You are able to judge which patients are likely to be benefited from your institution, and are appropriate for treatment there?—Yes.

18,797. The others, I suppose, you find it necessary to reject?—Yes.

18,798. And in other cases, because they are resistant and for other reasons, it will be necessary for them to be certified and sent to an asylum?—Yes.

18,799. Do you attach importance to having no certifications carried on in Maudsley?—Yes, I think it is very important indeed. I think the willingness of people to approach it voluntarily depends upon that—upon a knowledge that they will not, without their consent, be certified while they are there.

18,800. You are, of course, the person who can speak with more authority than anybody else, because you have carried out the experiment on a larger scale, as far as England, at least, is concerned; and you think it would be a deterrent to patients' willingness to avail themselves of such a clinic as yours, if there were a possibility of their being certified under your roof?—I not only think it, but I have had experience of the other aspect. I was in charge under the Ministry of Pensions, and in those days we did certify at the hospital. In my opinion, the atmosphere was entirely different; and I may say, from my own point of view, that I had to be one of the certifying doctors, and it made my relations with the patients very unsatisfactory—I mean, in going into certain wards, I think my visits were regarded as rather terrifying.

18,801. Rather ominous, shall we say?—Quite.

18,802. *Mr. Micklem:* Do the patients who come to you now know they will not be certified?—Entirely.

18,803. How is it brought to their knowledge?—It is an understanding that is given to them; it is widely known; everybody knows it.

18,804. *Chairman:* Perhaps it is that they are all informed that they are voluntary patients?—And can leave at 24 hours' notice; they are given written notice of that, of course.

18,805. Do you find that all those who enter your institution voluntarily really appreciate that they are voluntary patients?—I think all of them do, except those who have become rather clouded in their consciousness since they came in. There could not be any ignorance on the subject, because everybody else in the ward knows it. I mean, if any patient was reluctant to stay, and said so aloud, several people in the ward would immediately inform him, "You have only got to write a note to the doctor."

18,806. Would you approve of taking any obligation from a patient at the outset to submit himself for treatment for a stated period, say three or six months?—I do not think it would be so useful in the clinics as in certain other types of hospital. I think it would be a very useful thing in certain cases; of course, such a power does exist under the Inebriates Act, and there are a number of cases, drink and drug cases, where such a thing would be useful; many of such cases, of course, would be uncertifiable.

22 June, 1925.]

Dr. EDWARD MAPOTHER, M.R.C.P., F.R.C.S.

[Continued.]

18,807. I was thinking of the bracing effect of a resolution, and assistance to keep that resolution, such as you get when you are brought into the well-regulated establishment?—I quite agree. There are a number of patients who from day to day can hardly make up their minds whether they want to go or to stay. Solve the problem for them, and they are easier in their minds. But I do not think that such cases would generally be suitably treated at the clinic, for the reason that if the patient complained after giving a six months' undertaking, we will say, and became reluctant and was protesting against detention, it would not be favourable to the atmosphere of the clinic.

18,808. And I can see, also, that an obligation of that sort manifestly could not be enforced?—It could not, in the clinics.

18,809. Therefore, it would only have a certain moral value?—I think it might be useful in some other institutions where some of the patients were compelled to remain.

18,810. But it is very important, I think, to note your considered opinion that institutions of this sort, where uncertified persons are treated in clinics, should be places entirely dissociated from the process of certification?—Yes, entirely.

18,811. And if a patient unhappily in your institution becomes worse, so that certification is necessary and confinement in an asylum is appropriate, you then, I suppose, inform the relatives, or the relieving officer, if there are no relatives?—Practically always the relatives; we adopt the same measures as one would adopt at a general hospital; simply give advice to the relatives, tell the relatives that they should go to the relieving officer.

18,812. And consequently the patient, if ultimately relegated to an asylum, is not relegated to that asylum by any action of yours?—No.

18,813. That is valuable for preserving the voluntary atmosphere of the institution?—I think it is essential.

18,814. What view do you entertain on the subject of the non-volitional patients? I can understand the comparatively simple case of the voluntary patient and I can understand the resistant patient, whose liberty you must infringe for his own good; but I have more difficulty with regard to the intermediate case, the non-volitional case, as to how he should be treated. Have you any views as to that type of case?—I think they should be dealt with in the clinics, provided they are not objectionable to others. I think one has got to bear in mind that they include a great many of the most recoverable cases, a great many of the people who are very seriously ill, a great many of the puerperal cases, and so forth, and that they are the cases with regard to which it is specially desirable to keep them out of an asylum. They are the cases who most permanently recover, in many instances, and I think it is very important indeed. We do not take them at the Maudsley Hospital at present, because, of course, a definite application for admission is a condition of admission, but I think that in the future clinic they should be admissible.

18,815. Therefore, this type of case, the non-volitional case, which you have in mind, is, of course, not the idiot, who has no power of volition, but a person whose powers of volition are temporarily in abeyance?—Quite.

18,816. I am not thinking of the mentally defective, but we are talking about the person who is ordinarily rational, but whose volition is for the time being really in abeyance?—Quite; personally, I would apply the term to the people where it is chronically in abeyance; but I think the important class is the one I have mentioned, the confusional case really.

18,817. How would you suggest that that case should be dealt with as regards procedure? It is manifest that the patient himself, or herself, cannot apply for admission. Do you suggest that it should

be done on behalf of the patient by a representative or relative?—Yes, backed by a recommendation from the doctor.

18,818. Do you think that would be a sufficient safeguard?—I think so.

18,819. Then have you any view as to keeping in touch with the Board of Control or other central authority in the case of patients who are under voluntary treatment?—I think that every institution that ever receives any certifiable patient of any kind should be approved by the Board of Control, and that every admission to such an institution should be notified to them, and that they should have the power of visitation of such institutions. I would suggest that institutions which take nothing but uncertifiable cases should not be subject to any such control.

18,820. Should not even be required to report?—Not if they are purely confined to uncertifiable cases.

18,821. *Mr. Micklem*: How are you going to draw the line between certifiable and uncertifiable; it is not a clean cut, is it?—No; it is a practical distinction based upon whether the patient is prone to conduct which is seriously detrimental to himself or to others, or whether he is incapable of looking after himself or being looked after by his friends or relatives.

18,822. *Chairman*: Of course, it is still the difficulty which I think the medical profession feel at the present moment, of determining whether they are or are not infringing the law; because the present law is that you must not have a person who is certifiable in your house for treatment for gain. I can imagine that it may be most embarrassing to a practitioner to say of a particular patient whether he is really a certifiable case or not, so that at a particular moment he becomes guilty of an infraction of the law. As *Mr. Micklem* says, the edges are not definite?—They are always bound to be ill-defined. It is a matter of opinion, of course. At the present moment the determining opinion is that of the Board of Control, and I think that would necessarily remain so.

18,823. Can you suggest any protection for the doctor? Let us assume a medical practitioner, skilled in mental treatment, desirous of conducting a nursing home in his department, just as a surgeon conducts a nursing home in his department. The surgeon has no menace hanging over him of legal prosecution. The other doctor has. He is never quite sure whether at any given moment he may or may not be breaking the law?—He would have the option which is exercised by a certain number of people running homes for uncertifiable cases now, of writing to the Board of Control, describing the case, and asking their opinion upon it. That is actually done at the present moment, if there is any doubt in the mind of people.

18,824. Do you not think it might be met by the system of approving the houses or nursing homes: registration of them and approval of them?—I do suggest that: that every home that ever takes a certifiable case should be registered. I think if a universal registration of nursing homes could be instituted, it would be a very valuable thing; but in such a case would the homes which took these neurotic patients be liable to visitation by the Board of Control, because it is the Board of Control's opinion that will necessarily be the determining opinion? Unless every home is liable to visitation by the Board of Control, I do not see how it really helps.

18,825. Of course, you could not very well expand the functions of the Board of Control to make them visitors of every nursing home?—Quite so; otherwise, I do not quite see how it helps to have universal registration.

18,826. You would not have registration confined to a particular type of nursing home which takes cases of nervous breakdown or nervous cases generally?—I think the universal registration of nursing homes is a desirable thing, but I do not

22 June, 1925.]

Dr. EDWARD MAPOTHER, M.R.C.P., F.R.C.S.

[Continued.]

think that is particularly relevant to the question of the avoidance of illegal detention.

18,827. *Mr. Micklem*: What is the good of registration unless there is some supervision?—I think it should involve some supervision. My suggestion is that every approved home would have to notify every patient admitted to it and would be liable to visitation by the Board of Control.

18,828. As a nursing home?—Every institution that took any certifiable cases.

18,829. Do you mean only those that took certifiable cases? I rather gathered you thought it should be all nursing homes?—I take it that elsewhere it would be a question of visitation by some officials of the Ministry of Health other than the Board of Control.

18,830. *Chairman*: Registration accompanied by supervision under some regulations, no doubt. I think that is a very difficult department of our investigation: the question of the treatment of the non-certified case by the private practitioner in a nursing home, to ensure the necessary protection for the public without depriving the patient of the benefit which is to be got from a private nursing home?—Yes, it is very difficult. At the present time, of course, the treatment of uncertifiable cases is extensively carried on, and the treatment of certifiable cases is carried on, too, though illegally.

18,831. *Lord Russell*: We have had evidence from Dr. Boyle that they ought to be treated without any supervision or any report at all?—Dr. Boyle goes farther than I do.

18,832. *Chairman*: The difficulty in this problem is that on the one hand you have the advocate of the case being looked at from the purely medical point of view; on the other hand, you have the legal point of view, which is always emphasising that aspect of it; and this is a department where these two aspects appeal one to one class of mind and the other to the other. We have to do our best to reconcile these views. You, naturally, look at the problem from the point of view of the patient whom you hope to cure?—Yes. I entirely agree to rigid legal control in every case where there is objection on the part of the patient.

18,833. Where for the treatment of the patient it is necessary to invade the liberty of that patient's will, there should be legal formalities preceding such invasion?—Yes, I think it is absolutely necessary.

18,834. I am much impressed with the general proposition you put forward—that, as matters stand just now, certification is the preface to treatment?—It is for the certifiable poor, absolutely.

18,835. Whereas, what you would aim at is that treatment should be the means of avoiding certification?—Certainly.

18,836. That really puts your position in a sentence?—Quite.

18,837. But then, if you are to have treatment which is to result in the avoidance of certification, you must provide the means for achieving that end?—Quite.

18,838. At present, you point to this, that there are no means, or almost none?—Practically none.

18,839. Your institution is in that respect a pioneer, because it does treat with a view to avoiding certification?—Quite. The general hospitals do not treat as severe cases.

18,840. As long as the case is willing and recoverable?—Yes, those are our two demands.

18,841. *Mr. Micklem*: Rather on a smaller scale they are working in the same direction?—Yes, but they are not legally authorised to take as severe cases as we are. Those should be the two criteria: the willingness and the recoverability.

18,842. *Mr. Snell*: If you decide, having admitted a patient, that he or she is not recoverable, then you do not retain them?—No; we notify the friends.

18,843. *Chairman*: I am not keeping entirely to the order of your *précis*, because I am taking advantage of your presence here to put to you one or two

of our general difficulties. From your experience of asylum treatment, apart from Maudsley, do you think it is desirable to eliminate from our asylums the irrecoverable chronic cases?—I should suggest that they are what asylums are for.

18,844. You would rather keep that class of case there?—That is almost all I would have at the asylums eventually; but I am not suggesting that it is practicable at once.

18,845. The reason why I put that question was this: that we have had some evidence to this effect, that asylums ought to be places of hopefulness and places where cure may be looked for, and that if you have a large proportion of the population consisting of senile demented, persons for whom all that you can do is to give them shelter and comfort until they die, you are distracting the staff from the task of treatment and making them really hotel keepers for a class of person for whom they really can do little or nothing medically.—In a sense, I suggest that that is the situation now, that the presence of the extremely chronic elements in the asylums is rather detrimental to the new case, and that the new case and the recoverable case in their own interests should be treated apart. I do not believe myself as a matter of asylum experience that the discharge of others has any stimulating effect upon the chronics who are left behind on each committee day; I have never noticed any cheering effect in that. There are a large number of institutions for mental defectives and so forth where discharge is practically non-existent, and they are quite contented institutions.

18,846. We shall need to have, and probably we may have in an ideal state, quite a number of institutions; because there is your type of institution where the voluntary patient is to be treated but where there is to be no certification; then you require institutions where certified and resistant patients are received; but they in their turn are different, or may be different from those for chronic cases?—Yes. I have spoken of them in my *précis* as observation hospitals, replacing the present observation wards of workhouses.

18,847. Yes; I appreciate that you are telling us of what you think would be desirable rather than what may be immediately practicable?—I think progress has got to be gradual, but I think that particular step, the institution of observation hospitals, should come very soon, because I think it is so essential to the success of the clinics. I think it is the co-operation between those two types of hospital that is going to make the difference. We are not getting at the Maudsley Hospital by any means all the cases we might, and many cases that go into the observation wards and thence to the asylums could come to us. If there were better co-ordination between a few observation hospitals and a few clinics, I am quite certain that a great many cases would never need to go to the asylums.

18,848. *Earl Russell*: Is there anything against such observation wards being in the asylums themselves?—I think it is undesirable to treat a new case in contact with the chronic case. I am suggesting that most cases in the observation hospitals would be under the provisional order.

18,849. I should have thought you could have had a separate wing, with separate access, which would do at least as well as the observation wards of workhouses?—As well perhaps as the observation wards of workhouses, but not as separate observation hospitals. The idea of observation hospitals or "receiving houses" has been mooted for 20 years; the London County Council favour it.

18,850. *Chairman*: Would your scheme involve really the staging of the matter first of all in the voluntary clinic, in-patient and out-patient; secondly, the observation home, where patients who had ceased to be voluntary or were incapable of being managed in a voluntary clinic, should for a period be under observation and treatment; and thirdly, only as a

22 June, 1925.]

Dr. EDWARD MAPOTHER, M.R.C.P., F.R.C.S.

[Continued.]

last resort, the asylum?—Yes. I do not mean that it would necessarily be a progress step by step.

18,851. Some of the cases would have to be taken to the asylum right away?—I think they should all pass through the observation hospital, though they might not wait there very long if they were hopeless.

18,852. If you had a senile dement, I suppose such a case would pass to the asylum straight away?—Yes.

18,853. That provision might be a consummation devoutly to be wished, but it would be a very expensive matter administratively, would it not? Your establishment, which at present deals with a relatively small population passing through your institution, is costly per head, is it not?—Yes; but I would like, if I may, to say something on that question of cost.

18,854. Please do.—There is, to a certain degree, a fallacy involved. I am not denying that it is costly and is bound to be costly, because when you are dealing with a small number your central charges are bound to be high; the salaries of the superintendent, matron, clerk, and house steward, and people like that, are spread over a relatively small number of patients, so a small institution is always expensive; but one has got to remember that one is comparing the cost of a hospital like the Maudsley with the cost of an asylum as a whole. It is strictly comparable to the cost of the admission wards of the asylum, and that is a very different figure. We have got a nursing staff that is high in proportion to the number of patients; it is out of all proportion to that at an asylum taken as a whole; but it is exactly the same proportion of nurses to patients as that in the reception ward of a mental hospital. I happen to know, for example, that at Long Grove the number of nurses per patient in the reception hospital is exactly the same as at the Maudsley; so that your reception hospitals at the asylums, which are the comparable things, are far more expensive of course than the asylum as a whole.

18,855. That particular department of a general lunatic asylum may be as expensive as yours?—It is not quite so expensive, because, of course, we have a much higher proportion of medical staff, and I think on the whole we feed our patients better, and so forth; and our central salaries, of course, are high. Those points come in, but if the clinics were doing the work which is now done by the reception hospitals at the asylums, the rate of the asylums or the expenditure at the asylums would be correspondingly diminished.

18,856. There would be a set-off in that respect?—Yes, a considerable set-off.

18,857. Mr. Snell: The cost of the pathological laboratory is added?—It is separate now.

18,858. Earl Russell: And the costs ought to be distributed among all the asylums?—They are.

18,859. Chairman: You are doing work for them all there?—Yes.

18,860. Would you wish to see similar clinics established in all large centres of population throughout the country?—Yes, everywhere; and more than one in London.

18,861. And do you think it would be possible to work them on a larger scale; because, if I may say so, it did strike one that a great benefit to the patients was the relatively small size of the institution, in enabling each patient to have the benefit of your personal supervision as head of the establishment, as well as the attention of your subordinates?—I think they might be reasonably cheapened by about doubling them. I think that it would be workable to have a "Maudsley" of about 300 to 400 beds; but I think they would lose efficiency if they were much bigger than that.

18,862. How far do you carry that view in regard to the size of lunatic asylums generally? Do you think you can have adequate medical supervision of

a large asylum of possibly 2,000 or 3,000 inmates, male and female?—I think the supervision as regards chronic cases is perfectly adequate. I do not think size matters so much. It is the mixed character of the asylum that is the drawback; and if they were institutions for chronics, I think the large size has many advantages.

18,863. You spread out the on-cost, of course, and perhaps the patients are not so sensitive to their being brought together?—It is economical; and you can make many arrangements of a practical kind for a large number of patients that you cannot make for a small number; organisation of industries, and so forth.

18,864. But if you are dealing with patients who may reward your treatment by becoming cured, you cannot possibly handle anything like these large numbers, can you?—No. I do not say the supervision is ineffective at the asylums, but it is only as effective as it is because relatively few patients are recoverable. Of course, a very large proportion of the attention of the medical staff is directed to just those few; the senior medical officer probably deals personally with only about 100 cases.

18,865. In your case all your patients may repay treatment and therefore receive attention with that hope?—Yes.

18,866. Would you put the figure at just about double the existing accommodation at Maudsley as being the limit of personal supervision?—Yes. I have not thought it out accurately; but I think that would be as large as one would care to go in an institution of that kind.

18,867. I think we have your point upon the classification of the different types, and your point upon the desirability of treatment with a view to avoiding certification rather than certification as the passport to treatment?—Yes.

18,868. Then I think you have a view as to the desirability of assimilating procedure and place of treatment in the case of poor patients and paying patients?—Yes, I have. There are one or two ways in which I view that. I have suggested private institutions rather analogous to what I have spoken of as the clinic and observation hospital for the poor. I think the really desirable places for the treatment of the paying patient would be analogous institutions, some on the lines of the Maudsley, taking the uncertifiable and the quiet, willing and non-volitional cases, and others rather, perhaps, on the lines of the observation hospital, taking again the recoverable case, but those who were objecting or objectionable. A very rough comparison would be a place like Bethlem, for the objecting and objectionable, and a place rather on the lines of Swaylands, but taking some certifiable cases, which, of course, places of that sort cannot do at present. Curable private patients should be treated in such places as far as possible, rather than in scattered nursing homes, for the reason that in the case of paying patients adequate treatment, laboratory investigation, and so forth, becomes very difficult and expensive, if it is not conducted in a place with its own laboratory. I do not say that it should be compulsory to put patients in such places, but I think that the institution of private places on those lines is very desirable. Then, again, another point of assimilation that I would like to emphasize is that I think the quiet, willing but certifiable patient in the well-to-do classes should have the option of voluntary treatment in a doctor's home, in the same sort of way as a poor patient might be boarded out. At the present time, an insane patient cannot be a voluntary boarder in private care. I think that is a very serious weakness in the law. It is the most desirable kind of single care there is, I think.

18,869. Mr. Micklem: I think the doctors could take one patient, or two patients?—Under certificates, Sir, but there is no such thing as a voluntary boarder in private care. If insane, a person can only be a voluntary patient in a registered hospital or licensed house; but you cannot get private care.

22 June, 1925.]

Dr. EDWARD MAPOTHER, M.R.C.P., F.R.C.S.

[Continued.]

18,870. *Chairman*: Unless the case is certified?—Unless the case is certified.

18,871. *Mr. Micklem*: Do not the Board of Control make some exceptions there? I thought Dr. Boyle was telling us that by application to the Board of Control you could get leave to retain a private patient, or more than one?—There is no provision for it in the Act; of course, the matter does rest with the Board of Control; but I do not think there is any regular provision for it in the Act.

18,872. No. The only provision in the Act is that licensed houses may take boarders, or registered hospitals apparently may take boarders, although it is not so expressly provided?—There is no provision for a voluntary boarder in private care. I do not know what the Board of Control may do in the matter.

18,873. *Chairman*: Do you think that it would be an advantage to enable that class of case, that is, the uncertified case, to be treated in a doctor's house?—I think so. I think for a great many quiet, harmless cases, it is the happiest sort of surroundings they can have.

18,874. They have the advantage of medical supervision at hand?—Yes.

18,875. Of course, one has always to bear in mind the possibility of abuse?—Again, it should be subject to supervision and control.

18,876. And visitation?—Yes.

18,877. You referred to the fact that there is the system of boarding-out of poor cases?—Yes.

18,878. That has obtained to a considerable extent in Scotland, where patients are sent out to cottagers' houses throughout the country and are visited by Deputy Commissioners of the Scottish Board of Control?—Yes.

18,879. You would figure the same type of visitation by some Commissioner, or Deputy-Commissioner, of patients in single care?—Yes, possibly you would require decentralised visitation.

18,880. You could hardly expect the Commissioners themselves to go round all the individual cases if this was taken advantage of largely?—No; of course, you could not do that, though they now have to visit the same patients if they are certified; but I think that the thing might spread and become a bigger problem.

18,881. *Mr. Micklem*: I suppose you think that the present licensed houses might well be increased and that registered hospitals might well be increased?—I would say especially registered hospitals.

18,882. *Chairman*: But the registered hospital is not an institution one can call into being at once very well, because it is really a charity; it has its own foundation?—It has been, of course, but there is no reason why a registered hospital should not be just self-supporting—self-supporting and not profit-making. In the past registered hospitals were always endowed; I do not see why they should be; I can imagine a registered hospital which was just self-supporting, without endowments.

18,883. That would mean it would have to support itself either by the fees charged to patients, in which case it simply becomes a non-profit-making concern?—Yes, under the management of disinterested people, of course.

18,884. Or it might be assisted by contributions from the public, which makes it a charitable institution?—Yes; it is difficult to imagine getting contributions from year to year. I do not think that for a registered hospital you would get charitable contributions for the well-to-do every year.

18,885. I do not think you would. That rather tends in this direction: that you would like to see the type of institution which we know at present as a licensed house, which is conducted for profit, transformed more into the likeness of the registered hospital, which is comparable in treatment, but which is not run for profit?—Quite. I do not want to be taken as suggesting any criticism of the licensed houses at all. It is more a matter of theory and principle.

18,886. We quite understand. Do you think that some relief might be got by dedicating one institution to one type of case and another kind of institution to another type of case, where you are dealing with large centres of population, like London? At present each of the large asylums has all types in it?—I think that is very important indeed.

18,887. Do you think it would be better to distribute the cases among the institutions available, so that each institution would have its own type?—I think that would have a great effect in promoting contentment, especially if the voluntary system of admission to asylums was authorised. In that way you would get the discontented and protesting people largely confined to certain institutions; the rest would be happy and content. I think you would again have to separate them out, because the worst feature of the mental hospital of the present time is the presence of the noisy and refractory patients; I think it must strike everybody.

18,888. I think that is a very impressive fact. You think of the patient who is brought in, possibly excited and nervous and apprehensive, and finds himself for the first time in a place where he has gone for treatment, exposed to noise and disturbance; one can well see what a harmful effect that would have.—Yes, and to some extent it goes on later. Classify in your wards as you may, you have a relatively small number of gardens, and you will find in a garden adjoining quiet and well-conducted people, and reaching them from a little distance the obscene screams of the noisy, refractory patient, who either utters filth or howls like a wild beast. That sort of thing going on day after day must be rather trying to quiet and well-behaved people.

18,889. What is your solution of that?—I suggest chronic, noisy patients in one institution. I agree it would be a hideous institution, but I think it is better that they should be concentrated in one place than that they should make life unbearable to other people.

18,890. *Mr. Micklem*: Would you put the chronic noisy cases with the chronic quiet cases?—No. I suppose it is possible really to get them isolated in very remote villas. It might be done (I do not know) by keeping them in one institution, but my opinion is that, once they are unfortunately so—I mean the case that year in and year out is like that—the concentration of those and their separation from others would be a considerable improvement.

18,891. What about the type of case which is very violent but of short duration—not an uncommon type of case?—Quite. I think you would have to treat those in an institution where there were quiet patients, and have a special villa for them. If the improved periods were relatively short they might have to be at the institution for the chronic refractory cases; but you should have a villa there in which the temporarily quiet people would be kept.

18,892. I understand it to be your view that it is most undesirable that mental cases should live together without discrimination?—Yes.

18,893. And that you ought particularly to protect the quieter cases from disturbance by the noisy cases?—Yes.

18,894. Because medically you regard the noise and disturbance and violence of such cases as very detrimental to the cure?—Yes, and it is intolerably unpleasant to the quiet chronic case.

18,895. Then the ideal classification, I take it from you, would be that the noisy patients and disturbing patients should be in one institution, and the quiet patients in another institution?—Yes.

18,896. But you cannot achieve that because temporarily some quiet patient may become noisy; then you should have means of isolating any noisy patient while noisy?—Quite.

18,897. *Mr. Snell*: Do you not always tend to have noisy and refractory patients in an admission ward?

22 June, 1925.]

Dr. EDWARD MAPOTHER, M.R.C.P., F.R.C.S.

[Continued.]

—Yes; a move has been made by providing for two admission wards in some of the mental hospitals, and it is a very good one.

18,898. *Chairman*: It is a pretty rough classification, is it not, simply to say "quiet" and "noisy"? —Yes.

18,899. It is not merely the noise that may be detrimental?—I have used in my *précis* the word "objectionable" to include all sorts of offences. I do not mean only noise; there are many other forms of offensiveness.

18,900. But you think no harm would arise to the offensive cases *inter se* if they were all together?—I do not think so. As a matter of practical experience, one comes across a great many nurses who are devoted to the nursing of that sort of patient and who will threaten to resign if you move them out of a refractory ward. There are a great number of nurses with a special gift for that, and a real devotion to it.

18,901. That is a most remarkable statement?—It is a remarkable fact, but I think it is a fairly well known one. I think they are the best kind of nurses, those who have a real sense of their vocation. There are a large number of nurses who hate that spell of their duty.

18,902. *Mr. Micklem*: Are you speaking of male or female nurses?—Both. I have in my mind a couple of female nurses, but I have known a good many.

18,903. *Chairman*: I think you will probably find the vocational sense stronger among women than among men in that work, do you not?—I do not know that that is so. At the present time there is a tendency rather for the female nurses to come in in a very transitory way, whereas the male nurses do come to regard it as their permanent calling and settle down to it.

18,904. We have heard about a large number of young women who just pass through, but I was thinking rather of those who become permanently settled in the institutions?—I am a very ardent advocate of female nursing of male patients.

18,905. That was to be my next question. You have had considerable experience of that—would you recommend the use of female nurses in all cases?—Yes, in the clinics. In one ward we have three male nurses. The ward is in charge of a sister, and a staff nurse, but we have no ward that is not really run by women.

18,906. Have you some male attendants who are under the lady matron?—In one ward, yes.

18,907. Do you find that causes any friction?—No; we have had no trouble.

18,908. *Mr. Snell*: Then your patients, if I may say so, are selected; you do not retain those who are specially refractory?—No, that is perfectly true. I am not for a moment saying you could do the same universal female nursing in mental hospitals; I only say you can spread it much further than it has gone. It does of course cause a very slight restriction of the cases we might take but it is a much smaller restriction than one might think, because a great many unmanageable patients are more manageable by a woman than a man.

18,909. *Chairman*: You add that the attendance of a woman nurse is of itself therapeutic?—Yes, I think it is undoubtedly.

18,910. *Mrs. Mathew*: Your nurses are trained in both branches?—All except our probationers; that is more than half our staff. All our sisters and staff nurses are trained in general nursing.

18,911. *Chairman*: We have not been taking your points exactly in order, because so many of the topics you have touched upon have proved so attractive as we went on. There is one observation that you made which is of interest to us. From your considerable experience of public asylums, you inform us that the defects which you have observed do not lie in the

direction of unjustifiable detention, neglect or ill-treatment, but rather in other directions?—Yes, quite.

18,912. Let us consider those other directions where you think the disadvantages of the present system lie. You have summarised these on page 9 of your *précis*?—Yes.

18,913. Is it first of all, the mixing up in one institution of cases of different types?—Yes, I think that is the real drawback. The results, I think, are those that I have mentioned there also.

18,914. First of all, you have under the same roof the curable cases, the incurable cases, and those who need detention but are resistant?—Yes, quite.

18,915. And is classification under those types inevitably imperfect?—Yes, I think that it is. It is somewhat a matter of what I was mentioning just now. Classify as you may in your wards they are rather apt at any rate to hear each other, and they are bound to some extent to mix in central arrangements like church, the visiting room, at occupations and at entertainments, and so forth; it is almost impossible to avoid it.

18,916. The social environment of the patient is a very material matter, I should think?—Very. Of course, every mental hospital does its very utmost to render the classification as perfect as possible, and most of them are provided with an admission hospital and a convalescent ward, which are entirely separate from the main building. In spite of that, there is a certain amount of contact.

18,917. This feature of asylum life in our country at the present time under the existing system, I gather, in your view, deters people from taking advantage of such institutions, and also deters the best class of nurse or attendant from selecting that work?—I think that is so.

18,918. These are both unfortunate features?—I would point to what I was saying about half our staff being trained nurses. I do not think in any asylum in the country you could get that state of affairs.

18,919. Now let us consider with you a little what you would wish to see established in any large centre of population. First of all, there must be a number of "Maudsley" institutions, obviously?—Quite.

18,920. You must have a clinic to which people would be attracted at the initial stages of the ailment?—Yes.

18,921. And where they may receive treatment in a clinic?—Yes.

18,922. That is an indispensable part of your system as you envisage it?—Yes.

18,923. Then the observation hospital. I have a little more difficulty in seeing its role. Perhaps you might develop that idea with us a little, Dr. Mapother?—I imagine them as replacing, as I have said, the present observation wards, and having three or four in London, associated with an equal number of clinics, perhaps one associated more or less with each clinic. The patients who would go into the observation hospitals would be the new patients that were unsuitable for the clinic. They would be unsuitable because they were either objecting or objectionable.

18,924. Let us assume that one has arrived at your clinic; the case has been seen by you, or by one of your assistants, and found to be a case unsuitable for reception at Maudsley, but suitable for this observation hospital; the relatives would be recommended to take the patient to the observation hospital?—Yes, and a certain number might leave our wards, and in the same way the relatives would be recommended to take the patient to the observation hospital, as they are now recommended to approach the relieving officer.

18,925. But this is to be an intermediate stage before certification, and which may possibly result in avoiding certification also?—Yes.

18,926. For such a case, I take it, you would want compulsory powers for retention?—I think you might

22 June, 1925.]

Dr. EDWARD MAPOTHER, M.R.C.P., F.R.C.S.

[Continued.]

want a provisional order. I do not think it should be a definite certification, in the first instance.

18,927. It would not probably require that the patient should be certified as of unsound mind, but should be certified as a person whom it is desirable to restrain in the meantime?—Quite; though some of them might be willing or non-volitional cases that were objectionable, as well as those who were definitely objecting; because, of course, we have to turn out patients who are even willing to remain but are too noisy—I mean the melancholic who shouts at the top of her voice; she has got to be turned out.

18,928. *Mr. Micklem*: You suggest an observation order?—Yes. The name "provisional order" rather suggests to me that it is almost inevitably going to pass over into a certificate, and is a merely provisional arrangement.

18,929. *Chairman*: Another word that might be more attractive is a "temporary" order?—Yes.

18,930. But its object would be to secure that patients who were the subjects of such orders should receive treatment in special institutions, and to confer upon the persons who had charge of them certain powers with regard to them?—Yes.

18,931. You must obviously have some powers with regard to such patients?—Exactly.

18,932. What I understand you would like would be that the doctor should not commit himself to a diagnosis of the case as a case of insanity, but the treatment of the case should be coupled with powers of detention, if necessary, for a limited period?—Yes.

18,933. Have you any idea of the period which you would recommend?—A month would probably suffice. A month would suffice in the type of hospital functioning essentially as a clearing house; but, of course, if you had no other hospital for the curable unwilling case, then I think there should be powers for longer than a month.

18,934. There has to be some formality at this stage. You are contemplating there should be power of detention?—Yes.

18,935. What procedure do you contemplate; who is to pronounce the order, the provisional order, or the temporary order?—At the beginning of the month?

18,936. Yes?—I think the procedure would be that the patient would be admitted, say, for three days on the application of a relative and the recommendation of a doctor, and that at the end of three days there should be an observation order or a temporary order signed either by a magistrate, as has been suggested, or preferably by a member of the visiting committee of the institution.

18,937. You would contemplate at that stage the introduction of the layman and the law?—Yes. I think you clearly must. I mean some of these people will require detention against their will, and I think at that stage you have got to have legal authority.

18,938. Would you have the observation hospital worked in association with the clinic?—Yes; I think it is very essential. There would be a good deal of coming and going between the two, necessarily.

18,939. *Mr. Micklem*: Are you not in danger there of getting the clinic into trouble, so to speak; I mean, getting it connected with the mental hospital?—I think they should be connected in one sense, in the way that Maudsley is connected with the mental hospitals of London; and it is connected with the observation wards, to some extent.

18,940. Not in the mind of your patients?—No, and I do not know why it should be in the future any more. It is, as a fact, connected now; we get patients from the mental observation wards; we send patients to them. We are under the same governing body as the mental hospitals in London, but there is a large distinction in the patient's mind.

18,941. Would there not be some danger of losing that distinction which you think is of value now?—I do not see why one should lose it, but, of course,

the condition of affairs exists in the case of Maudsley; it exists in the highest degree.

18,942. *Chairman*: But without that operating as any deterrent to patients?—It does not operate in the least as a deterrent.

18,943. In connection with the establishment of those clinics, do you favour the idea of their being established, where you cannot have an independent establishment like your own, as part of a general hospital?—Where you cannot have an independent clinic, yes, but I think it would be an inferior substitute.

18,944. We had evidence on Friday about what is being done at the Middlesex Hospital just now, on a very small scale no doubt; but in your experience do you find that hospitals would be willing to afford accommodation for mental clinics?—I think it is inevitably bound to be on a very small scale. I am entirely in favour of a sample of patients being treated in general hospitals for various reasons, because I think the public and the medical profession will take a more reasonable view of mental disorder when it is treated in the general hospital. But I do not think the general hospital could ever deal with the whole of the problem, even as regards numbers, and I do not think they could ever deal with anything except what I may call a Bowdlerised sample of it; they are never going to be able to afford three or four wards for each sex, to classify all the patients, and if you do not have that your ward is going to be either chaos or a clearing house; it cannot carry out treatment to a finish.

18,945. You really seem to contemplate a sort of service of mental hygiene with a series of institutions comparable, let us say, to the special service that is given for the treatment of tuberculosis, which would be the subject of Imperial grant, and supported possibly also by local rates?—Exactly.

18,946. And in the series of institutions which you contemplate, you would have the clinic, the observation hospital, and the asylum each playing its own definite role in the general service of the mentally afflicted?—Quite, and there are other items that I have mentioned, specially perhaps convalescent homes; and the reason I suggest them is that I think they will prove a very large economy, because a number of your patients that would otherwise be occupying beds in expensive hospitals could be cheaply treated in convalescent homes, during the later stage of their illness.

18,947. Of course if you catch your case early, you may prevent it ever becoming an acute case?—Quite. Not all cases, however, begin insidiously; many cases begin quite abruptly.

18,948. I believe, to put it colloquially, you may go in off the deep end very suddenly?—Exactly.

18,949. Now you contemplate further development in what you call the hospital for extended observation. What have you in mind in that?—I have in mind that there would be considerable pressure on the observation hospitals that I have spoken of, replacing the observation wards, and that there would be a number of curable cases who were unwilling or objectionable, and yet whom it was very desirable to keep out of the asylums; and if you had a special hospital to which such cases could be sent (and I have one in mind, one institution in London, where it could be done), those cases could without going into an asylum be treated to recovery.

18,950. Would that not be achieved by enabling the observation order or the temporary order to be renewed in suitable cases? The trouble I feel we might encounter would be this, that if you have too many different types of institution, the public would not appreciate the differences among them, and they might be difficult to administer. One wants to have simplicity, because one of the things that has impressed us is the complication of the existing system?—I think what you say would meet the case

22 June, 1925.]

Dr. EDWARD MAPOTHER, M.R.C.P., F.R.C.S.

[Continued.]

perfectly if there were not too much pressure on the observation hospitals; but I can conceive they would have to function as clearing houses, and, if you were not careful, you might get a number of beds that might treat 12 new cases in a year blocked by one hopeful case for the whole year. I think that would be a difficulty.

18,951. Then you only propose to get over it by setting up another type of institution. It might be better to have a larger observation hospital to start with?—Yes. A large proportion of its beds would tend to get silted up with recoverable cases. One has to think of all the acute manias. In practice, the acute mania is not a case that one finds easy to deal with at the voluntary clinic, they are often too noisy or objectionable, and others become intolerant of discipline and demand to go, and yet they are a highly recoverable type of case—frequently a case that is an episode, and one which one would like to keep out of asylums—there are a lot of them, and I think such cases would rather tend to block your beds in your observation hospital.

18,952. And although the treatment might take longer, you think that case ought to have a chance of avoiding certification?—I do.

18,953. Then at the other end, convalescents should be dealt with, in your view, by the provision of some kind of homes, I take it?—Yes.

18,954. That must be one of the difficult stages in treating your patients—the return to normal life again?—Yes, it is. Of course, with us the return is gradual. The patients are allowed out at week-ends with their friends; they go out a good deal; first, perhaps a single day a week, and then week-ends. The process is very gradual with us.

18,955. And you have not, of course, the same problem as the superintendent of an asylum has, who knows he ought not to detain a person who has ceased to be certifiable, although it may be in the interest of the person that he or she should remain, after having got past the stage of certifiability on the road to recovery?—Quite. Of course, we discharge many patients who are not by any means fully recovered, with a view to their attendance at the out-patients' department. In this way treatment, although expensive while it lasts at the clinic, may ultimately be cheaper than treatment in the asylum.

18,956. What about the home surroundings and circumstances of the patient? Do you not find that the return of a patient to the home circumstances may merely bring on the ailment again?—That may be so, and it is really those cases I had in my mind when I mentioned the institution of hostels in my *précis*.

18,957. A case reasonably recovered, but which might lapse again if subjected afresh to the conditions to which it was originally subjected?—Exactly. Matrimonial troubles and troubles with parents may be the cause of the breakdown.

18,958. *Mr. Micklem*: Do you find a great number of your patients are in-patients for a time, and then come back later for advice?—Yes, a large number. Even though they may go out against advice, very often they clamour to come back the next day.

18,959. *Chairman*: If we had both the power and the money, many of your suggestions would be very desirable, but we have to cut our coat according to our cloth, and one is anxious to see what are, in your view, the most clamant reforms at the present moment. Suppose we were to ask you what are the matters which, in your opinion, just now, call for reform most urgently, and what are the means you would suggest should be taken?—In the way of provision I think the most important thing is the institution of clinics and observation hospitals. I think that is the most important side of it. Of course, it must be accompanied by legal changes, but, as regards provision, I think those are the most important.

18,960. And if you had institutions of that sort, you anticipate that certification would be avoided in

a substantial number of cases?—A very large number of cases.

18,961. And then you would make the asylum, as we have known it hitherto, the home for the chronic case?—Eventually.

18,962. And you do not think that would have the effect which some witnesses have rather laid stress upon, a sense of hopelessness in those who become inmates of asylums?—There might be some effect in that direction, but I think it would be a drawback that would have to be faced for the greater gain of the separation of the acute cases.

18,963. In connection with the observation hospital which you have in mind, would you grade it in turn—I see you make a reference to the system going on now at Ewell?—Yes, there would be internal classification. I would have classification inside the observation hospital itself.

18,964. Have you something to say to us on the subject of the relations of local authorities to voluntary hospitals?—I think it is desirable that the main arrangements dealing with the mass of cases should be under the local authorities. I do not think it is practical that the general hospitals should undertake the bulk of the work, though I am strongly, as I have said, in favour of their undertaking treatment of some cases for educational purposes, and for the effect in producing a reasonable atmosphere towards the whole subject.

18,965. So as to assimilate the mental ailments to other ailments, to remove the line of demarcation which exists just now?—Exactly.

18,966. But, on the other hand, the special circumstances of mental disorder rather suggest, just as the special circumstances of tuberculosis suggest, that you should have separate institutions?—Yes.

18,967. After all, it is an incident of the treatment of tuberculosis that you must have fresh air to a degree that is not necessary in the case of other ailments; therefore, you have to have out-of-door places for the treatment of patients. Similarly, with regard to mental disorder you require a certain type of treatment that is special to that disease?—Yes. There is no line of demarcation. Where you have one disease that grades in different patients, and in the same patient at different times, into eligibility for one of these different institutions, I think you must have co-ordination between them.

18,968. And a patient might, therefore, pass from one to the other, according to the conditions?—Yes, exactly, and it can best be arranged if they are in the hands of one authority, I think; and for teaching and research I think that co-ordination is extremely important, too.

18,969. Suppose it were possible to have clinics and observation hospitals on a scale which you would desire, would you place those under the local authority, or would you place them under the Board of Control?—Immediately under the local authority with a central supervision by the Board of Control.

18,970. You would really make a local health service, but, because of the specialty that it deals with, mental disorder, you would have the Board of Control superior in the end?—Yes, general supervision.

18,971. I think, Dr. Mapother, we have covered most of the topics, but we do not want to part from you if you have any other points, which I may have omitted to bring up, which you would like to put before us?—I think when you were at Maudsley Hospital the other day it was mentioned to me that you might possibly ask me about research and teaching, and those topics; I do not know whether you would like me to say anything upon that subject.

18,972. I think we should. I personally have been asking you questions almost entirely about certification and treatment?—That of course is what my own *précis* deals with.

18,973. We have had the cause of research advocated to us by Sir Frederick Mott and others, but, as you are carrying on that work, we should like

22 June, 1925.]

Dr. EDWARD MAPOTHER, M.R.C.P., F.R.C.S.

[Continued.]

to hear you, and Mr. Snell has a question to ask which may afford you the opportunity of telling us what you have to say upon it.

18,974. *Mr. Snell*: First of all, have you written anything, or is there anything written on these psychiatric clinics abroad?—I do not think there is any general work on the subject. There was a discussion at the Royal Society of Medicine about a couple of years ago, and I spoke on the subject. I have a small paper that I could let you have.

18,975. I think I must have seen that?—I have extensive notes taken when I was at these clinics.

18,976. On the matter of research, you have a small research fund of about £10,000 have you not?—Yes, we have; that is part of the money left by Dr. Maudsley.

18,977. What is the position of that fund at the present moment?—Up to the present it has not been very extensively used, it has been accumulating to some extent; it has been dipped into a small extent to buy apparatus, and so forth, but at the present moment arrangements are really contemplated for the employment of the interest on the money for studentships and scholarships.

18,978. What I really want to ask is, is it your opinion that useful research work could be done with an ultimate saving to the community if the funds were available?—Undoubtedly.

18,979. *Chairman*: Just to follow that up: do you approve accordingly of the proposal in Lord Onslow's Mental Treatment Bill that the local authorities should be empowered to provide funds for research?—Yes, for research and teaching.

18,980. *Mr. Snell*: I wonder if it is possible to indicate what sort of research work could usefully be done and in what directions?—What medical directions?

18,981. Yes?—I think continuous research work should go on in all directions, every subject that is allied to this. To some extent, it might be psychological research and anatomical and chemical and bacteriological; and I would rather stress especially research dealing with treatment, dealing not merely with the pathological side; such researches sometimes become a little academic; I think that research should be largely directed towards treatment, and that brings out the point that I think research should always be conducted in connection with a clinic and where the living patient is available.

18,982. That is to say, that there are promising opportunities for the expenditure of money on research?—There are indeed.

18,983. That would repay the community for a reasonable expenditure?—Yes. Of course results must not be expected in the immediate future—I mean there is no question of reducing the rates in 10 years or something of that sort, but that ultimately research pays is certain.

18,984. I may put it then, may I not, that £10,000 is not enough as the basis of a research fund?—No, it is not. Of course that £10,000 is quite independent of the maintenance of our laboratory, and the payment of all the salaried officers connected with it. The County Council in London does support the laboratory and pay the salaries, quite independently of this £10,000 which is going to be used for the endowment of scholarships and studentships.

18,985. Then you would urge finally that if the community saw fit to provide sufficient money for research, it would derive a substantial benefit?—Undoubtedly, I think.

18,986. *Chairman*: Is it a department in which there has hitherto been comparatively little research?—Very scanty, and mainly, I believe, because of the absence of the clinic or some such place to serve as a centre. I do not think myself that research work carried out in isolated local laboratories of asylums will be very productive; I think it must be research carried out in laboratories associated with a central school and associated with a university and in touch

with that; and, of course, that condition of affairs does not exist, except in the case of the Maudsley and in one or two other places.

18,987. And perhaps the very obscurity of the disease has hitherto been a deterrent in the exploration of it?—Quite.

18,988. You think now that we are entering upon more hopeful days, do you?—I do, indeed. I think the activity and general interest, and the whole attitude, of the medical staffs of the mental hospitals towards their work has changed out of all knowledge, in my own time. The sort of criticism which is sometimes levelled at them is very much out of date, in my opinion.

18,989. *Miss Symons*: Dr. Mapother, in putting this scheme before us do you think it would be necessary to encourage local authorities, and possibly, in order to secure efficient control, to have a 50 per cent. Exchequer grant?—I should like to see the central grant made as large as possible; I do not know what the limit is, but I should like to see it put up to the limit.

18,990. Both in order to bring this about, and in order to secure more control?—To bring up efficiency. Not all local authorities are like the London County Council, and there are local authorities which need, in my opinion, stimulation very badly.

18,991. In connection with the observation hospitals that you advocate, do you contemplate entirely new buildings, or do you think it would be possible to make use of any existing buildings by a redistribution of the patients now in them?—It might be possible; I am not sufficiently acquainted with them. I think on the whole it would probably mean new buildings mostly. It might be possible, if certain boards of guardians were willing to give up one of their institutions, to adapt it, because the accommodation at some is good, but at some it is not.

18,992. There is one other question which I think Lord Russell was anxious to put to you. He wanted to know what your opinion from your experience is of the present dietary in public mental hospitals—whether you think it is adequate and sufficiently varied for the needs of the patients?—My view is this, that it is physiologically adequate (speaking of the chronic patient) but dull, and that it has been considerably improved of late years. As regards the acute patients, it has to be always borne in mind that medical extras are very largely given, and that the standard diet is not what the acute patient lives on. Our dietary cost at the Maudsley is very much higher than the mental hospital dietary; but it must be remembered that here, again, you have got the same fallacy I spoke of before, that they are not comparable. Our dietary cost is comparable to the admission hospital of an ordinary asylum, and that would be found to be very much higher because medical extras are largely given. With regard to the chronic patient, some improvement, I think, is desirable. It is a question of money purely. I think one has got to bear this in mind; I believe it is the fact that 5d. a day per certified patient represents £1,000,000 a year to the country, and, in order to make any large improvement, you would probably have to spend a good many millions a year. If the community is willing to do it, I am in favour of it. It is not a medical question. I think the diet is physiologically adequate, because most of them gain weight, and seem to maintain their health on it, but I think it is dull.

18,993. *Mrs. Mathew*: I only want to ask you whether you are satisfied that we have the very best design for our asylums—they seem all to be on the same principle?—I think I should like to see an extension of the villa principle, though they have certain practical difficulties in getting about from one to another in bad weather, and so forth. I should like to see that, and, in that connection, would come in what I mentioned about the proximity of gardens for different types of patients. If you had the villa

22 June, 1925.]

Dr. EDWARD MAPOTHER, M.R.C.P., F.R.C.S.

[Continued.]

principle carried further, there would be less of that. The villa principle, of course, is carried very far at Ewell which you have seen, Sir, but the other is cheaper; I think the block system is cheaper, and these things generally turn on questions of money.

18,994. But you think the improvement would be almost worth the expenditure?—I think it certainly would, in the case of the acute recoverable patient. Ewell is the place I have in mind for the "extended observation hospital." But one may have to cut one's coat according to one's cloth in that matter.

18,995. Of course we could move out our asylums a little further; we need not have them on such expensive ground; but it seems to me that certainly the old ones leave a good deal to be desired?—I quite agree.

18,996. And even the new ones seem to be on the same principle?—I think there is only one cure for some of the old places, and that is to pull them down.

18,997. *Chairman*: I suppose it is desirable, as far as possible, to remove the element of the institution in places where patients reside?—Yes, quite.

18,998. Because you want to make the people feel, as far as you can, that they are still human beings, not separated off from their fellows, and merely receiving treatment for the time being?—Yes; that is the whole aim, I think.

18,999. You do not want them to be institutionalised more than you can help?—No.

19,000. And, of course, the large type of barrack building, to which Mrs. Mathew refers, has all the savour of institution about it, and not the feeling of normal human life which is conducted in separate houses by separate families?—I do not think you get it to the same extent where you have villas.

19,001. It helps to mitigate that feeling very much?—I think it does.

Chairman: Then may we thank you for your attendance here to-day, and for your kindness in showing us round Maudsley on Friday.

(The Witness withdrew.)

(Adjourned.)

5, OLD PALACE YARD,
WESTMINSTER, S.W.1.

THIRTY-SIXTH DAY.

Friday, 10th July, 1925.

MEMBERS PRESENT :

THE RIGHT HON. H. P. MACMILLAN, K.C. (*Chairman*).

THE EARL RUSSELL.

SIR HUMPHRY ROLLESTON, BART., K.C.B., M.D.

SIR ERNEST HILEY, K.B.E.

SIR DAVID DRUMMOND, C.B.E., M.D.

MR. NATHANIEL MICKLEM, K.C.

MR. H. SNELL, M.P.

MISS MADELEINE SYMONS.

MR. P. BARTER (*Secretary*).

MR. W. FAIRLEY (*Assistant Secretary*).

The Hon. WILLIAM SIDNEY, J.P., and Mrs. ROSE DUNN GARDNER, J.P., called and examined.

19,002. *Chairman*: This morning we have with us representatives of the London County Council in the persons of the Hon. William Sidney, J.P., and Mrs. Rose Dunn Gardner, J.P., who have been deputed to present certain aspects of the law and administration regarding lunacy for our consideration. I think, Mr. Sidney and Mrs. Gardner, you were appointed by the London County Council on the 26th May, 1925, to state to this Royal Commission the views of the London County Council on the matter of our remit?—(Mr. William Sidney): That is so.

19,003. As we know, your Council is the authority responsible for the care and treatment in its mental hospitals of no fewer than 18,500 patients?—Yes.

19,004. And one, of course, recognises how intimately your Council is concerned in any proposals affecting the treatment of these patients?—Yes.

19,005. As you are aware, we have had the advantage of paying a visit to the Maudsley Hospital, and also of having the evidence of the Medical Superintendent before us recently, and we are therefore familiar with the pioneer work which the London County Council has done in the matter of the treatment of incipient and uncertified cases. It might be convenient, I think, if we just touched, first of all, upon that topic. I think your Council considered the question of dealing practically with the matter in consequence of Dr. Henry Maudsley's gift of

10 July, 1925.]

The Hon. WILLIAM SIDNEY, J.P., and
Mrs. ROSE DUNN GARDNER, J.P.

[Continued.]

£40,000 for the establishment of the Maudsley Hospital?—Yes.

19,006. And did your Council give its general approval to the provisions of Lord Onslow's Bill, the Mental Treatment Bill of 1923?—It did, yes.

19,007. Which, as we know, deals with the temporary treatment of patients without certification in approved institutions?—Yes.

19,008. May one take it that the Maudsley Hospital, which has been founded and is conducted by the London County Council, is an experiment in that direction?—That is so, yes.

19,009. It was necessary, was it not, for your Council to obtain special statutory powers to establish such an institution?—It was.

19,010. And you obtained those powers, I observe, under the London County Council (Parks, &c.) Act of 1915, Part III?—Yes.

19,011. We are familiar with Section 6 of that Act which we have all studied, and it appears to adumbrate, if one may say so, the system regarding the advantages of which we have heard so much?—Yes.

19,012. Perhaps it might be useful, for the purpose of raising some discussion, to look at the terms of that section, first of all, if you please. I notice that the persons who are to be the beneficiaries, if I may so call them, of the scheme, are those who are suffering from incipient insanity or mental infirmity, and are desirous of voluntarily submitting themselves to treatment?—Yes.

19,013. Do you regard the word "incipient" as qualifying both the insanity and the mental infirmity, or are the two categories distinct? Do you receive incipient cases of insanity and cases of mental infirmity whether incipient or not, who are prepared to submit to voluntary treatment?—Yes.

19,014. There are two classes, as you will appreciate; there is the incipient case where you hope to arrest the progress of the malady at an early stage, and there is the other class of case who is willing to submit to voluntary treatment?—I think both, yes.

19,015. Therefore we do not qualify the second category as necessarily incipient cases—they may be more established cases?—Yes, certainly.

19,016. The essence of the matter is that the patients are voluntary patients?—That is so. (*Mrs. Dunn Gardner*): And I think, also, they must be suitable patients.

19,017. Yes, but I was thinking for the moment of the general categories of patients who are eligible, in the first place, for this mode of treatment. The incipient case is one class of case, where you hope by treatment without certification to arrest the progress of the malady and cure the patient?—(*Mr. Sidney*): Yes.

19,018. On the other hand, you have cases where patients, whether incipient or not, are willing to submit to treatment voluntarily without certification?—Yes, of course, with the limitation mentioned by *Mrs. Gardner*. (*Mrs. Dunn Gardner*): If they are suitable patients, Maudsley take in the voluntary cases. The fact of being voluntary would not by itself gain them admission to Maudsley.

19,019. But all voluntary persons are eligible—that is how it stands?—Yes.

19,020. I suppose one may take it that there are two aims disclosed in this provision; one is the aim I have already indicated, of providing treatment for cases in their early stages without certification at all, in the hope of achieving recovery?—(*Mr. Sidney*): Yes.

19,021. And the other is, even in cases which may be well established, to avoid the stigma of certification (such as it is) where it can be avoided, in consequence of the patients being willing voluntarily to submit to a measure of restraint?—Yes, that is so.

19,022. And the consequence of the success of the scheme would, of course, be a large diminution probably in the number of certified cases?—I think it must be. That is the hope.

19,023. That is the objective of the whole thing?—Yes, that is so. Experience only will tell whether that is so or not, of course.

19,024. Quite; but I suppose your Council has recognised that under the existing régime patients are not able to get the advantage of institutional treatment until they are first certified?—That is so.

19,025. Therefore, until they have reached a more or less advanced stage of their malady?—That is so, of course.

19,026. This provision at Maudsley is in line with the general conception of modern medicine: that prevention is better than cure?—Yes.

19,027. Which is in conformity with the good old adage as well?—Yes.

19,028. Then looking at the second sub-section, you deal there with the question of the expense, and you take power, I see, to pay the whole or any part of the expenses of maintenance and treatment in the hospital of any such person as a voluntary boarder. In practice, do you exercise that discretion?—Yes.

19,029. And are some patients in Maudsley treated free?—Yes.

19,030. Could you give us any indication, first of all, as to who exercises that discretion, and what are the classes of cases where you give this privilege?—The Committee exercises that discretion. Of course the lady almoner obtains all the particulars; then each case comes before the Committee.

19,031. With the facts ascertained?—With the facts set out.

19,032. You observe there is a statutory discretion imposed upon you there—you may, if you think fit, defray the expenses?—Yes.

19,033. That means you must think fit upon information, of course?—Yes, and a considerable number are so dealt with.

19,034. Cases are selected for free treatment, after investigation and consideration of their circumstances by the Committee?—Yes, that is so.

19,035. Then you decide that such and such a case is a proper case to be treated free?—That is so.

19,036. Is such a case, when treated free, placed in the category of a person in receipt of Poor Law relief?—No.

Earl Russell: No, because the charge is on the county rate, not on the poor rate.

19,037. *Chairman*: That is a very interesting feature of it. These patients, although they receive the benefit of the institution free, are not in any sense pauperised?—No. (*Mrs. Dunn Gardner*): But we do have some cases which are paid for by the guardians—which are sent to us by the guardians, at any rate.

19,038. That is another category, but I am interested in the type of person whom you treat in Maudsley who is unable to pay for the treatment, and who at present could only get treatment really as a pauper in a London County Council institution. This provides a method whereby such a person may receive treatment free, if a deserving and proper case, without becoming a pauper?—Yes.

19,039. And the charges are defrayed out of what fund?—(*Mr. Sidney*): The county rate.

19,040. To what extent, could you tell me, have you exercised that discretion? How many of the patients are free?—I do not know that we have got the figures with us.

19,041. They could easily be got, no doubt?—A fair number.

19,042. Quite substantial, is it?—A fair proportion, I should say.

19,043. Then, on the other hand, you have the ordinary paying patient who is able to pay on different scales which you will have for the purpose?—Yes; five pounds is the ordinary standard charge.

19,044. Some less and some more?—Yes, and a paying patient very often becomes a free patient after a period.

19,045. They have come to the end of their means?—Yes.

10 July, 1925.]

The Hon. WILLIAM SIDNEY, J.P., and
Mrs. ROSE DUNN GARDNER, J.P.

[Continued.]

19,046. *Mr. Micklem*: What do you pay for the free patients?—(*Mr. Sidney*): What do they cost?

19,047. Yes?—£5.

19,048. *Chairman*: It arises in this way, I think, *Mr. Sidney*; you will have the cost of running the institution?—Yes.

19,049. Then you will have receipts from paying patients?—Yes.

19,050. Then you will have probably a deficit on the undertaking if you have a considerable number of free patients. Do you merely rate upon the deficit for the conduct of the institution, or do you fix a standard for each free patient and rate for the accumulated amount of these sums?—We could give you the figures for the cost of running the whole institution. Do you mean per head?

19,051. We wanted rather to know what it costs you to keep a patient free in Maudsley?—It costs about £5 a week, which includes everything.

19,052. Establishment charges and everything else?—Yes.

19,053. Of course that is a figure very much higher than the ordinary asylum rate?—Yes. Of course it is a very costly institution. It is very heavily staffed, and the number of patients is small.

19,054. We have to keep that in view, of course, in any recommendation that we may make?—Yes. It is very very costly. If you are going to increase the number of "Maudsleys," it would be a very heavy cost on the rates indeed.

19,055. *Earl Russell*: You do not charge the whole laboratory cost to Maudsley, do you?—No.

19,056. But you allocate that among all the asylums?—Among all the asylums, yes.

19,057. *Chairman*: All your institutions are, of course, entitled to use the service of the laboratories at Maudsley?—Yes.

19,058. I think it might be interesting to us to have a short abstract of the finance of Maudsley, that is to say, what it costs to run it, and any detailed figures you have taken out for the purposes of your own information; because this type of institution is naturally very attractive, but one has to consider what it costs, and we have not before us as yet, I think, any figures as to what it actually costs?—We will supply you with all the figures; we will show you the cost of the institution.

19,059. And perhaps it could be shown to what extent the paying patients come to the relief of the non-paying patients. It is a system on which they bear each other's burdens to some extent, and one would like to see what the net cost to you is of treating patients free there?—All the figures will be supplied to you.

19,060. Then provision is next made in subsection (3) for rules, and that makes reference to Section 338 of the Lunacy Act of 1890.

19,061. *Earl Russell*: Maudsley is an asylum under the Lunacy Act, I suppose, is it?—Yes.

Chairman: Yes, with a special code in the 1915 Act applicable to it.

Earl Russell: Generally it is subject to the 1890 Act?

19,062. *Chairman*: Yes. Then subsection (3) is really a matter of machinery; it provides for the rules which are made under subsection (1) of Section 338, prescribing the books and entries and notices and so on. Then we come in subsection (4) to a very important matter, which emphasises the voluntary aspect. Any patient, I understand, with you may leave on 24 hours' notice?—Yes.

19,063. And I take it that all patients on entering the establishment are made aware of the fact that if they please they may leave at 24 hours' notice?—Yes, it is on the form. Whether 24 hours is long enough is rather a question, or will be in the future, I think, if we are going to extend the voluntary system. It is rather short notice.

19,064. Lord Onslow's Bill suggested, you remember, 72 hours?—I think it did.

19,065. The real point of the length of the period is this, that you want to have time to communicate with the relatives?—Yes; even 72 hours seems to be rather short. On the Continent they have to give several days' notice.

19,066. Of course, the more you prolong the period, the less you have the atmosphere of liberty?—Yes, I know that it is a difficulty.

19,067. It seems to me the practical point is that if you have a patient who ceases to be voluntary and becomes resistant and may be a danger, you must have some power to detain for a short period, in order that the relatives or the authorities may be communicated with and the right steps taken?—Yes, and also to protect the public.

19,068. You might have a suicidal case, who says, "I want to go out at once"?—Yes.

19,069. Have you found in experience any difficulties of that sort owing to the shortness of the period of 24 hours?—I do not think so; I have not heard of any, but I do think the 24 hours' notice is too short.

19,070. What is the procedure you adopt in the case of a voluntary patient desiring to leave you, where you think that there is risk?—We notify the friends.

19,071. I take it that whenever any patient enters Maudsley, it is done with the concurrence generally or at least with the knowledge of some responsible person who will probably sign some paper, and with whom you would naturally communicate regarding the case?—Yes.

19,072. You are always in touch with someone?—Always in touch with the relations or friends.

19,073. What happens in the case of a patient who has no relations? Who stands guardian, so to speak, if there is no sponsor?—I do not know that we have had any case. The relieving officer would be communicated with, of course, as a last resort.

19,074. Take the category that Mrs. Dunn Gardner referred to, of which you have some, namely, patients sent to you by boards of guardians: in their case, I suppose, you communicate with the board of guardians?—Yes, certainly; they give an undertaking.

19,075. I would like to know a little about that class of case. If it is a case sent to you by a board of guardians, it must be a case which has come within the purview of the Poor Law, manifestly?—Yes.

19,076. On what basis are such patients sent to you. Do they merely write and invite you to receive a patient?—Yes. (*Mrs. Dunn Gardner*): They write and ask, and then they pay at the rate which the patients would be costing in the infirmary from which they came.

19,077. Do these cases come to you from boards of guardians all over the country?—(*Mr. Sidney*): No, only London. (*Mrs. Dunn Gardner*): And only a few in London.

19,078. These must be uncertified cases which are known to the board of guardians, paupers, and persons who the board of guardians think might benefit by Maudsley treatment?—(*Mr. Sidney*): Yes.

19,079. And they invite you to receive them?—Yes.

19,080. And they pay the asylum rate and you make a loss on every case which you take?—They pay the infirmary rate.

19,081. That is much less than the £5 of which you have been speaking?—There would be a loss, yes.

19,082. But not quite the same loss as if it were an absolutely free patient?—No; we get the infirmary rate.

19,083. These are really Poor Law infirmary cases which have developed mental symptoms, and where it is assumed the Maudsley treatment might be beneficial?—That is so.

19,084. Are there many such cases in Maudsley?—I do not think we receive many.

19,085. *Miss Symons*: Do you reject any applications from the infirmary?—I should think we take all those that have applied.

10 July, 1925.]

The Hon. WILLIAM SIDNEY, J.P., and
Mrs. ROSE DUNN GARDNER, J.P.

[Continued.]

19,086. *Chairman*: I notice there is no geographical limitation in the Act on the sources from which your patients may be taken. Take your paying patients—do they come from all parts of the country?—(*Mrs. Dunn Gardner*): It is only for county cases. Very exceptional cases are admitted sometimes from outside the county, and they pay, of course, a higher rate than the in-county patients. Very few of them are received.

19,087. It is primarily intended for the London area?—Yes.

19,088. *Earl Russell*: Your discretion under subsection (1) is wide enough to cover the outside?—(*Mr. Sidney*): We take no outside cases at a reduced amount; they have to pay the full amount.

19,089. *Chairman*: That is very proper, because they are charged to the county rate. Then with regard to pauper cases, they are entirely from London Poor Law union areas?—Yes.

19,090. *Earl Russell*: There are some legal questions I would like to ask on this. You see the wording is "a voluntary boarder shall be at liberty to leave on giving 24 hours' notice." Do you interpret it as meaning "shall not be at liberty to leave without giving 24 hours' notice"—because it is not quite the same?—Yes.

19,091. *Chairman*: It is expressed positively and not negatively?—Yes.

19,092. *Earl Russell*: Then I see that, purposely no doubt, the notice does not have to be in writing, or in any formal manner. Would you take it as sufficient notice if a patient in the wards simply said "I want to get out"?—I suppose it would be so under that.

19,093. I suppose you would, at any rate, make him say it to the Superintendent?—Yes, I conclude that is what is done.

19,094. *Chairman*: What Lord Russell has mentioned raises a point which has always troubled some of us, and that is, what really is a voluntary patient? I am sure it must have puzzled you also, because once you have any degree of mental disorder, even incipient mental disorder, there may be some deterioration of the will—I mean, it is not a normal case *ex hypothesi*. The question is, how far you can justly rely on the patient having expressed a real voluntary intention as distinguished from a merely imperfect voluntary intention. Coupled with that, if I may put the whole of the problem before you, a patient after reception may deteriorate; the case may become worse, so that the element of voluntarism may practically disappear; the case may become non-volitional owing to the progress of the malady, and such a patient would not be in a position to appreciate the power to give 24 hours' notice. Have these practical questions presented themselves to you in the administration of the institution?—I do not think they have. I have not heard any. I quite see your point.

19,095. A person may at an early stage of the malady say "I am most desirous and anxious to go to Maudsley," and you may estimate that he has a real desire and intention to go there at that stage; then, after the reception, the malady may progress; the person may really not be in a state to appreciate the right to leave within 24 hours. Is such a case still regarded as a voluntary case, although it has become non-volitional, shall we say?—I suppose if the mind deteriorated to a very serious extent, it would become a certifiable case, would it not?

19,096. Yes, but then, although certifiable, you do not necessarily eject a case because it is a certifiable case?—(*Mrs. Dunn Gardner*): Or still curable.

19,097. That has always struck me and my colleagues as a great difficulty, that you might have a patient as a voluntary patient who, nevertheless, has at least suffered some deterioration of his will power, and may during his residence practically lose his will power by the very nature of the disease. Is he still to be characterised as a voluntary patient, although, if you spoke to him, he would be quite incapable of

understanding what you were saying?—Might I mention a case in a private institution who was admitted as a voluntary patient, understanding, as she says, that it was a sort of a home of rest? Immediately on her giving notice, she was certified in the same institution and kept there as another kind of patient, and from the little I was able to learn there, it was quite an ordinary occurrence; it was more easy to admit cases as voluntary cases and then to certify them in the institution.

19,098. That raises a very large topic. It is most undesirable that certification should be associated with these voluntary institutions at all, lest people may be deterred from going there because of the menace of certification as the ultimate upshot?—I am afraid, if it was largely practised, it would do away with the voluntary patients altogether; they would regard it merely as a trap to get them certified; it is being done.

19,099. It does not quite, if I may say so, meet my difficulty. I always like to look at things from a practical point of view, and I shall assume a patient who has quite sufficient will power to appreciate that he is submitting himself to treatment in an institution for cure, and what he is signing, but after residence for a fortnight or three weeks the malady has progressed rapidly and the patient has ceased to have any will power; would he still be retained in Maudsley?—Would it not be a matter for the Medical Superintendent? If it was merely a temporary phase of the illness, then he would be kept there; but if he had permanently deteriorated, then it would be better that he should be certified.

19,100. Two ways out occur to one. First, you take his voluntary act of entering the institution as, so to speak, continuing on until the patient becomes resistant and says "No, I will not." That may be one way. If the patient says "No, I will not," then he has got to go out. If, on the other hand, he does not take up that attitude, but the case has deteriorated, then the Medical Superintendent may say from the medical aspect, "This case has now become one of those cases in which we cannot hope for cure, and this is a case that should not remain here but should leave us and be certified." That is how it may solve itself in practice?—(*Mr. Sidney*): A voluntary patient may become a non-volitional patient; then I conclude the Medical Superintendent would communicate with the relatives, and they would give their consent to his remaining there.

19,101. Subject always to what Mrs. Dunn Gardner points out, that it may be a temporary aberration. Then, for that purpose, you treat the original voluntary act as persisting over what I may call that gap in the volitional power of the patient?—Yes.

19,102. *Earl Russell*: I appreciate very much the arguments against certifying in a voluntary place like Maudsley, but you have got also to think of the other side, in the interest of the patient. Supposing a patient becomes properly and necessarily certifiable, what steps do you take—do you send him away somewhere and then bring him back?—He is removed.

19,103. Where to?—He is sent to the friends, and then they go to the relieving officer, and they go through the usual formalities.

19,104. Is not that in itself rather undesirable? Supposing a patient is a violent patient; is it not rather undesirable to take a violent patient through the streets to a private house. When you come to think of it from the medical point of view, that is not attractive?—No, it is not.

19,105. *Chairman*: The difficulty is how to bridge the transition from Maudsley to the asylum?—(*Mrs. Dunn Gardner*): The point rather is that the steps are taken not by the authorities of Maudsley but by the friends.

19,106. *Sir Humphry Rolleston*: And, if he has no friends?—Then you communicate with the relieving officer, whom the law makes his friend.

19,107. *Earl Russell*: I am thinking of the physical transfer of the patient, and the bad effect it has

10 July, 1925.]

The Hon. WILLIAM SIDNEY, J.P., and
Mrs. ROSE DUNN GARDNER, J.P.

[Continued.]

upon him, supposing he is violent and resistant?—It happens whenever one of the 2,000 patients are taken into each of the institutions; they always have to be moved from the observation ward where they are.

19,108. Actually, from the point of view of the patient, of course, it would be simpler to put him in an ambulance there and then at the Maudsley and take him direct to an ordinary asylum?—I should very much regret to see that done.

19,109. There is also the medical point of view, of course?—But the friends may arrange for that to be done.

19,110. Direct?—Direct.

19,111. *Chairman*: But the certification does not take place in Maudsley?—No.

19,112. *Earl Russell*: And he cannot enter an asylum until he has been certified?—No. (*Mr. Sidney*): I suppose the voluntary boarders will be taken into our ordinary mental hospitals.

19,113. *Chairman*: Voluntary ones, yes, that is, if legislation were enacted. I think Lord Russell's case is just the kind of case I have in mind. It is the case of a patient who has got steadily worse, unhappily, in your institution, and it is recognised that you cannot do much for him; he has ceased to be a voluntary patient. What is to be done with him? In your desire to dissociate your institution from the process of certification altogether, you say: "We have had this patient, he has been with us, and we can simply send him away now, and he must be subjected to the ordinary process of law." This episode is over, and he is just relegated back to the position of an ordinary case which has to go through the ordinary machinery; the only point which arises is, whether the desire to dissociate your institution from certification may not operate prejudicially to the patient, by relegating the patient at what is an acute stage of his malady to the ordinary machinery, and beginning all over again, in order to certify him for admission to an asylum as a certified patient?—I am sure there will be cases of that nature, where it would be desirable to certify him at once.

19,114. *Earl Russell*: I suppose you might deal with him by hyoscine. I should like to hear the medical views?—(*Mrs. Dunn Gardner*): It is really a question for the Medical Superintendent, as to whether the patient has suffered in consequence of the regulation.

19,115. *Chairman*: Possibly, some of your later suggestions may help to mitigate the difficulty, because if observation institutions are to be set up where patients may be detained provisionally pending final disposal, that might be a proper reception place for a patient who has left Maudsley?—That has been suggested.

Chairman: I was thinking of the ways in which all this difficulty might be mitigated in the interests of the patients.

19,116. *Sir David Drummond*: As a matter of practice, how many in the last 12 months would necessarily be dealt with in that way?—(*Mr. Sidney*): We have not got the figures.

Sir David Drummond: I suppose very few.

Chairman: I think, Sir David, we have the report of the first year's experience in Maudsley, and there are statistics given there of the number of patients who left and who were subsequently certified. I think I remember reading the figures there.

19,117. *Sir Humphry Rolleston*: Does not Mr. Sidney feel that it is really much more important to protect the reputation of Maudsley as a place where certification does not under any circumstances take place rather than to be responsible for what takes place when the patient is handed over to the care of the friends for them to deal with?—I think so as regards the Maudsley; but I was thinking of the position if you are going to take voluntary boarders in at all our mental hospitals. At the Maudsley, I daresay, it is better to keep it free from the taint of certification.

19,118. But at the mental hospitals they must be certified?—I was referring to the proposal to take voluntary boarders into mental hospitals.

Sir Humphry Rolleston: I thought we were really concerned with what took place in Maudsley, and gathered that Maudsley thought it was so important to protect their reputation as a place where certification did not take place, that they were not really so much concerned with what happened to a patient when they handed him over to the friends or the guardians.

19,119. *Chairman*: Yes; the emphasis is on the dissociation of Maudsley from certification?—As regards Maudsley, certainly.

19,120. I think I may read a passage from the report on page 11. The heading is: "Disposal of patients needing certification." That is our exact point, and your Medical Superintendent states this: "As before stated, no cases are certified in the hospital. When a patient about to be discharged appears to require institutional care"—that is an euphemism, of course, for a case requiring to be sent to an asylum—"various procedures may be necessary—(a) If a case has been admitted from a Poor Law Institution, the patient is sent back in accordance with an agreement obtained from the guardians at the time of admission."—you just hand him back to the source from which you got him—"Otherwise the friends are notified and required to make arrangements in accordance with their undertakings to be responsible for care and treatment on discharge. The procedure is very like that at a general hospital. (b) In some cases the relatives arrange for admission either under certificate or as a voluntary boarder to a private mental hospital. (c) In cases where this is financially impossible, they are advised to make arrangements with the relieving officer (of the patient's previous parish) for admission to the observation ward upon discharge from here. (d) In a few cases (at the request of friends) the relieving officer of Camberwell is notified and patients transferred direct to the observation ward of that parish. This is only done where the physical state of the patient requires it or where intense suicidal disposition or hostility to the relatives renders it unsafe to hand over the patient to them even for the necessary journey. The following table shows the relative frequency of these procedures," and then certain statistics are given; so that I think we have a clear outline of the methods which are pursued.

Sir David Drummond: I should like to know what are the figures there?

Chairman: The table takes this form: Cases discharged, Total: with approval 248, against advice 49; of those with approval, 248 in number, 75 were discharged not improved, and 50 requiring institution. That, presumably, means asylum cases.

Sir David Drummond: A very large number.

19,121. *Chairman*: Quite a substantial number. Then the table shows under the letters (a), (b), (c) and (d) how each of those 50 cases was dealt with under one or other form of procedure. Now there is another large matter which you deal with next in your *précis* and upon which we should be happy to have your views. I see your Council is strongly of opinion that the administration of such an institution should be under the visiting committee charged with lunacy administration?—Yes.

19,122. As you know, that is a topic which has been debated to some extent, and debated from the very point of view to which you have been addressing yourself—the question of dissociation of the uncertified case from lunacy administration; and it has been suggested that it might be desirable that this particular work, the treatment of the uncertified case or the incipient case, should be confided to the ordinary health authority in contradistinction to the lunacy authority, with the same object in view, of dissociating cases at that stage from what I may call the stigma of lunacy surveillance. Now, there are reasons for and against that. Do I understand that

10 July, 1925.]

The Hon. WILLIAM SIDNEY, J.P., and
Mrs. ROSE DUNN GARDNER, J.P.

[Continued.]

the London County Council, notwithstanding the drawback to which I have alluded, consider that it is preferable that the incipient case or the voluntary case should be dealt with within the ambit of the lunacy committee's authority?—Certainly; it is more convenient that it should be under the one administration.

19,123. Have you thought of that other aspect to which I have alluded, the desirability of severing, if possible, the pre-certification history of the case from lunacy administration altogether?—It might be desirable perhaps from the point of view of keeping it apart from the taint of lunacy, but from an administration point of view surely it is better that it should be under one administrative body.

19,124. *Earl Russell*: And surely also from the medical point of view. Are you not all the time treating one disease in different stages?—Yes.

Chairman: Yes; I think that is perhaps the most important feature.

Sir David Drummond: I would like to point out that there are admitted into Maudsley quite a number of cases that are not essentially mental cases; they are cases, admitted for mental treatment incidentally, in which mental symptoms may arise, but the treatment consists in treating the original disease, ex-ophthalmic goitre, and St. Vitus's Dance, for example. Therefore they do not quite come under this category. I saw at least five cases there that would be treated in a general hospital for St. Vitus's Dance, or for Graves disease.

Chairman: Yes, I noticed one case myself.

Sir David Drummond: I was going to ask a question upon that point.

Chairman: I think you might ask it just now, Sir David, because it is very relevant.

19,125. *Sir David Drummond*: It is just this: Do all the cases admitted come under the designation of insanity or mental infirmity?—Yes.

19,126. I am afraid that is not exactly the view I should have taken from what I saw at Maudsley, because the cases I saw were essentially cases of general disease in which this mental state arose, if there were any symptoms present at all. Therefore the treatment consisted in the treatment of that original disease.

Chairman: But they must all be cases which exhibit, possibly as a concomitant of another disease, mental disorder.

Sir David Drummond: That may be so, but the essential feature of the case was otherwise.

Chairman: Yes, it is predominantly a physical case with mental symptoms.

Sir David Drummond: That is so, and therefore I ask, is there not another class admitted in which, incidentally, mental symptoms may arise or have arisen?

Chairman: Is your difficulty, Sir David, whether such cases fall under the category of persons suffering from incipient insanity or mental infirmity?

19,127. *Sir David Drummond*: Yes, that is so.—(*Mrs. Dunn Gardner*): They are all admitted to the Maudsley Hospital in consequence of their mental symptoms. The fact that they develop other symptoms—

19,128. *Earl Russell*: I am afraid Sir David's point is that the other symptoms develop first and are the dominant ones?—(*Mr. Sidney*): There may be cases which ought not to have been admitted there.

19,129. *Sir David Drummond*: That is what I ask—are all your cases cases which really come under this designation of incipient insanity?—(*Mrs. Dunn Gardner*): The directions are that that should be so, that they should be admitted for their mental symptoms, but not excluded because they also have other illnesses.

19,130. If you were to extend that, you could fill your hospital with physical disease, in the course of which early mental symptoms had arisen, and cases which do not come under this designation at all?—We can fill the Maudsley Hospital quite well.

19,131. *Chairman*: We had some evidence of a general hospital in connection with this question. In the wards of a general hospital you have patients suffering from various forms of physical ailments, and, as a concomitant of these states of high fever and so on, you may have mental disorder supervening, we were told. I think it was in Edinburgh Infirmary that there was a ward to which cases were transferred when they became unmanageable, although the causation of their state was not strictly mental disease, but it was a concomitant of ordinary special disease. In that case the patient was temporarily transferred to this other ward, which was under the charge of an alienist, who had a staff specially fitted to deal with cases of that sort. It seems a very useful expedient; but in your administration of Maudsley we must take it as we find it; you do not exclude a case of mental disorder merely because the mental disorder has supervened upon, or is a concomitant of, a well-known and defined physical disease?—(*Mr. Sidney*): No, we have not in practice done it.

19,132. Whether it is in within your Act is perhaps another matter, but in practice you have admitted such cases as Sir David has seen?—(*Mrs. Dunn Gardner*): In London, of course, a number of these cases in hospital who develop mental symptoms are sent to an observation ward in the workhouse—a strangely unsuitable place for them always, I think.

19,133. Maudsley, of course, has close association with King's College Hospital?—(*Mr. Sidney*): Yes.

19,134. And I take it in the case of, let us say, ex-ophthalmic goitre or any other well-known disease of that sort, which may have mental symptoms, you are able to pray in aid the assistance of the medical staff, as distinct from the alienist staff, from over the way, to deal with these cases and to prescribe for them?—We have consultants. (*Mrs. Dunn Gardner*): And they send over their cases to us, and we to them.

Chairman: I rather take it Sir David's point would be this, that these are cases of well-known disease which require special treatment from the physical point of view?

Sir David Drummond: Essentially so, if you are to do their mental condition any good.

Chairman: And the proper person to prescribe for such a case would not be the alienist, but the general practitioner?

19,135. *Sir David Drummond*: Not at all—such diseases as kidney disease, brain disease, and so forth, as apart from insanity?—(*Mr. Sidney*): And those are cases which you consider might be in a general hospital?

Sir David Drummond: Most certainly, that is the point.

19,136. *Chairman*: No doubt the London County Council will take note of the point that has been raised. But we are interested in seeing how you conduct your institution, and you do not debar a case from admission for the reason that it is suffering from some perfectly well-known physical ailment, but has mental symptoms really as a concomitant; you take in such a case?—Yes.

19,137. Now, on this general question, however, of administration, I take it that your County Council has considered quite fully the relative advantages and disadvantages of the visiting committee, that is to say, the body charged with the administration of the Lunacy Acts, having charge also of Maudsley and any similar institutions?—Yes, we certainly think it is desirable.

19,138. And you think that the administrative advantages outweigh any drawbacks that may result from the association with the lunacy administration, which is the necessary consequence of the two systems being in one hand?—I think so, yes.

19,139. The idea (one wants just to put to you the idea for your consideration) that has been suggested more than once is that just as tuberculosis and certain other diseases are treated at special clinics and the costs are charged against the ordinary rate in contradistinction to the poor rate, similar institutions for dealing with incipient insanity short of

10 July, 1925.]

The Hon. WILLIAM SIDNEY, J.P., and
Mrs. ROSE DUNN GARDNER, J.P.

[Continued.]

certification might also be a charge against the public health rate?—Yes. (Mrs. Dunn Gardner): It is a point, I think, is it not, that if you only sent to your asylums patients who were practically not hopeful patients it would make it very much harder for the patients whom you did send to the asylums, who would have to abandon all hope on entering, and also for the staff who would have nothing to deal with but the chronics?

19,140. But still this scheme contemplates two types of institutions. On the one hand the institution for the voluntary uncertified patient, and, on the other hand, the institution for the certified patient. These two will go on in future in parallel?—(Mr. Sidney): That is the question that has really not been decided. If you are going to have a very large number of voluntary patients, we should, I suppose, have to send them to the mental hospitals and mix them with the other patients; otherwise we should have to have a large number of institutions similar to the Maudsley, which we should have to set up in London. We should to a large extent empty our mental hospitals.

19,141. Of course you do propose, alongside the Maudsley type of institution, the admission of voluntary patients to the asylum properly so called?—Yes, that we contemplate.

19,142. There might be a certain overlapping between these two categories?—I daresay if we were beginning *de novo* we would start with separate institutions for voluntary patients like the Maudsley, but we have got to take things as they are. We have got our larger mental hospitals, and if we had a larger number of people who entered as voluntary patients, we should empty our mental hospitals.

19,143. Earl Russell: Yes, but if you had voluntary patients at your ordinary institutions, you would have associating with them recovering patients under parole to some extent?—Yes. Classification has been carried very far in the matter.

19,144. It would not be a very sharp line between them?—No. (Mrs. Dunn Gardner.) You see it is not settled yet. We are building villas and we might have villas for voluntary patients.

19,145. Chairman: We recognise that we are at a stage of transition, but it is interesting to know what is the goal of the transition; and if we could reshape the world to our ideal, we could probably solve this problem. Now I do see an administrative difficulty here. Suppose you were to reproduce the Maudsley institution in some numbers, and at the same time were to have voluntary patients going into asylums. What would determine whether a voluntary patient went to a Maudsley institution or to one of the ordinary asylums as a voluntary boarder? What would be the line of distinction between the two cases?—(Mr. Sidney): I do not think we could draw any distinction. We should either have to send them all, except the small number who went to Maudsley, to our mental hospitals, or else send them all to institutions like the Maudsley. You could not have a mixture of the two systems, I think.

19,146. One of the projects that is foreshadowed here, is that you would have places in association with the asylums, villas such as Mrs. Dunn Gardner was referring to, which would be in a sense really Maudsley adjuncts of a mental hospital?—That would be so, if Mrs. Dunn Gardner's idea was carried out. I think that is the better of the two.

19,147. Now, there you are trenching on a very difficult subject, because if the incipient case and the voluntary case went to the premises of the asylum, although no doubt the case would be different in law, would it not be very liable to attract to itself just the stigma that the people would say "So and so has gone to Hanwell," and they would not discriminate between the two?—There is that risk.

Earl Russell: But then you want to aim at making Hanwell a desirable address. It will take time, no doubt.

19,148. Chairman: No doubt it will achieve that. Now I think we might get on our note an important recommendation of your Council which relates to this

matter. I understand that the Mental Hospitals Committee made a recommendation in consequence of which the County Council on the 26th May, 1923, resolved as follows: "That, in the opinion of the Council in the application of the principle embodied in the Mental Treatment Bill, 1923, which the Council has already approved, that there should be power for temporary treatment to be given in approved institutions to persons suffering from mental disorder who are likely to benefit from such treatment, without it being necessary for such persons to be certified, it is desirable that the duty of administering the local authority's mental hospital or hospitals, and the provision of necessary approved accommodation for the treatment of uncertified mental cases, should be dealt with as the work of one and the same branch of the local authority's administration"?—Yes.

19,149. We may take that as your considered view, no doubt, after looking into these various aspects of the problem which I have been putting to you this morning?—Is it not the case, Sir, that in Scotland the voluntary boarders go to the ordinary mental hospitals?

19,150. I believe so, yes.—Has there been any objection?

19,151. I do not know that any has been taken?—I thought that was so.

19,152. That is so. Then you deal next with the case of the patient who is incapable of volition, which is also dealt with in the Mental Treatment Bill, 1923. The principle upon which these cases are proposed to be dealt with by that measure is to substitute the will of some responsible guardian for the absence of will on the part of the patient?—That is so.

19,153. It is really a substituted volition?—Yes.

19,154. Earl Russell: When you say without certificate you mean not certified in the full sense, but of course the Mental Treatment Bill provides for two medical certificates?—It does, yes.

19,155. Chairman: You mean without the certificate of insanity?—Yes.

19,156. Earl Russell: Without the full justice's order?—Yes.

19,157. Chairman: But that type of case is again rather a puzzling one. It all depends, does it not, upon who is to judge as to whether the case is non-volitional or not?—Yes, entirely.

19,158. A discretion must reside somewhere as to the disposal of the unhappy subject?—Yes.

19,159. Earl Russell: You come back again to our modern high priest, the doctor?—Yes.

19,160. Chairman: Personally I have always felt throughout all these discussions that it is extremely difficult to abstract categories; and when one tries by legislation and administration to deal with human people, one never gets precise definitions which will cover every variety of human experience. You can only do it on broad lines?—That is so. It would be simpler, of course, to define a voluntary boarder as a person who has either got the will power or has not got the will power.

19,161. Yes. I have suggested that the wider classification might be better, between simply voluntary and involuntary patients. That is the widest possible classification. Then, again, you can have three classes, voluntary, non-volitional but passive, resistant; and the necessity for restraint arises only in the case of the resistant patient?—Yes.

19,162. But, on the other hand, in the non-volitional case you are undoubtedly subjecting the person of the patient to restraint?—Yes.

19,163. Which the law would not permit unless it were specially authorised?—No.

19,164. You are disposing, in short, of a human being without his will, if you can put it in that way?—Yes.

19,165. Which would be an unlawful act were it not authorised?—Yes. (Mrs. Dunn Gardner): But it seems rather hard to exclude him from the benefit

10 July, 1925.]

The Hon. WILLIAM SIDNEY, J.P., and
Mrs. ROSE DUNN GARDNER, J.P.

[Continued.]

of treatment, because temporarily he has not the will to say he would like it.

19,166. It is not a question of his exclusion from treatment, but a question whether he should be treated under certification or not?—He would be treated in a different place, in any ordinary mental hospital.

19,167. Yes; he would not get the benefit of the special type of institution. The non-volitional case may happen to be perhaps the most curable case, because the period of non-volition may be quite transitory, and it would be hard that such a case, merely on account of the absence of volition, should be certified in order to get treatment.

Sir David Drummond: I think that is a very important point. Curable cases are often the people who are not in a position to state their will in that way.

19,168. *Chairman*: I am afraid if the case is resistant, certification of some sort may be necessary, but that again might be alleviated by your subsequent suggestions for observation and temporary certification, less than full certification?—(*Mr. Sidney*): Provisional certification.

19,169. Now may we pass to certain amendments of the existing Lunacy Act which you propose. You deal first with the voluntary boarders; and I understand that, from your experience, speaking generally, you regard the Lunacy Acts as providing adequate protection for the individual?—Yes.

19,170. But you emphasize the fact that the Act of 1890 is now 35 years old, and that the outlook upon this whole subject, both medically and socially, has very materially altered and, I hope, advanced in the interim?—Yes.

19,171. And the amendments you suggest are in the direction of a recognition of that new outlook?—Yes.

19,172. Then, first of all, you are in favour of the voluntary boarders being received in all mental hospitals administered by a local authority?—Yes.

19,173. Have you considered what safeguards should be attached to that, to prevent, let us say, the abuse of the institution by persons tendering themselves as voluntary patients who, attracted by the new outlook of the mental hospital, regard it as a desirable place to live?—(*Mrs. Dunn Gardner*): Do not we say "suitable cases"?

19,174. Some safeguards are manifestly necessary there. In whom is the discretion to reside? A person may present himself and say: "I desire to live in Hanwell"?—(*Mr. Sidney*): There must be a doctor's certificate; we would have to rely upon that.

19,175. *Earl Russell*: Why must there be a doctor's certificate? Why cannot the patient come as he would to any ordinary hospital? I agree that the medical superintendent should say whether it is a fit case or not, but why must there be a doctor's certificate?—To show simply that he is not a crank.

19,176. But the medical superintendent can find that out?—But after a certain time would you not fill the hospital?

19,177. *Chairman*: There we are right at the heart of the difficulty. As Lord Russell points out, the door of the general hospital, so long as there are beds available, is open to all patients?—(*Mrs. Dunn Gardner*): Who are regarded as suitable.

19,178. Who are suffering. Is not that it? If you have a street accident, the person is taken at once to the hospital; others find their way through the out-patient department, where the doctors say: "This case ought to be admitted". Others come with what we call in Scotland a "line" or recommendation?—But if a patient suffering from cancer were to go across the road to the consumptive hospital, he would not be admitted; he would have to go somewhere else. (*Mr. Sidney*): But, of course, it is easier to detect a person suffering from a bodily disease than from a mental disease.

19,179. *Earl Russell*: It is not necessarily very easy, if he says he is suffering from heart trouble, for instance?—No.

19,180. *Chairman*: You make a very important recommendation, and it is one which has commended itself to us all, namely, that the voluntary system should be associated with the mental hospitals, but we must consider rather carefully what are to be the safeguards?—(*Mrs. Dunn Gardner*): It is a very important point.

19,181. Are people to be allowed to present themselves, as Lord Russell figures, at the door of an institution and demand admission, or must they pass through some preliminary test of suitability, or what is to be the machinery? Has that point been thought out by the London County Council to any extent?—(*Mr. Sidney*): No, I do not think it has, although of course there must be some precautions taken.

19,182. One would like to know, from the practical point of view, how that machinery could be devised?—Yes.

19,183. *Earl Russell*: There is a specific case which has always stuck in my mind since it was given in evidence here by a medical superintendent of a public mental hospital, who said that a woman felt an attack coming on, and she wanted to come in. Could he let her in; and his answer has to be "No." But supposing he could take voluntary boarders, why should he say: "Go away and find some other doctor, and come back with a certificate"? Why should he not be able to say he can take the case in, if he has room?—(*Mrs. Dunn Gardner*): But he would be in a position himself to give the certificate. He would not require a certificate from another doctor who might not have treated her. He for a long while probably had been treating this case?

19,184. Yes, he had in this case, but a person might come, in whom he saw signs of a mental breakdown beginning: why should he send that person out to find another doctor?

19,185. *Chairman*: At the present moment the medical superintendent's task is perfectly simple. The person presented at his door comes with a warrant, and he simply opens his door and the case is taken in: he has no discretion. If the voluntary patient is to be introduced, there must be some method whereby the institution is protected against persons who are quite unsuitable; there must be some sifting process, and the machinery for that is obviously a matter of very considerable importance, or you might have the system abused altogether. There is the case that Lord Russell figures, where the patient should be able to get the benefit of renewed treatment at the earliest possible moment. You are not however going to open the doors of the London County Council asylums and make them agreeable residences for malingerers and ne'er-do-wells?—(*Mr. Sidney*): I think you must have a medical certificate, or you must have some reference from some hospital.

19,186. There must be some ticket of admission, so to speak, some qualification?—Yes; it cannot depend solely upon the medical superintendent's examination of the person who presents himself or herself at the gates of the institution.

19,187. Would it be possible, do you think, for the solution to be found again in the clinic and the observation ward? That would be the first stage—that the patient should go there in the first instance?—(*Mrs. Dunn Gardner*): That would mean that you would have to mix up the voluntary boarders with the certifiable cases, because, as I understand it, the observation hospital is to take the place of the observation ward of the infirmaries.

19,188. Yes, but I think with a rather wider sphere?—Yes; but I mean you would deliberately mix your voluntary boarders and certifiable cases then.

19,189. *Earl Russell*: I do not see myself why the opinion of the medical man who has seen this patient at an out-patient department is worth more than the opinion of the medical superintendent at the asylum

10 July, 1925.]

The Hon. WILLIAM SIDNEY, J.P., and
Mrs. ROSE DUNN GARDNER, J.P.

[Continued.]

when the patient gets there?—I suppose you might have the opinion of some friend who had known the patient for a long time, as well as the doctor.

19,190. But I can imagine cases in which it might be desirable that the patient should be admitted there and then, and not put out for a day or two to get certificates?—Quite.

Sir David Drummond: But in that case the doctor who took the out-patients in the first instance would have very little difficulty in recognising the case, if it were a case requiring admission.

Earl Russell: And you could allow them to come with a certificate from the Poor Law doctor, to whom they had been brought by the relieving officer.

Sir David Drummond: Those requiring admission at once would be recognised by the doctor at the asylum.

19,191. *Chairman*: I think we may leave it at this: that the County Council approve generally of the principle of the voluntary patients being admissible to your institutions?—(*Mr. Sidney*): Yes.

19,192. But you are not at the moment in a position to give us any suggestions as to the machinery that will be necessary in that matter. If, on thinking it over, with the assistance of your officials, you have any suggestions to make to us on the practical side as to the safeguards, you might be good enough to communicate with our Secretary, because the point is well worth consideration. The working of it out is very important, and one would like to have suggestions from a large body such as the London County Council. Perhaps you will be good enough to consider how it should be done in practice, and, if you have anything to suggest, communicate with us?—Yes, I have been thinking about what the channel should be.

Earl Russell: On the lines the Chairman mentions: what is to be, so to speak, the ticket that is to bring them in?

19,193. *Chairman*: Yes; it obviously requires deliberation?—I understand that at Maudsley a great many come through the out-patient department, or else enquire what their doctor thinks about it. They have seen a doctor, probably.

19,194. Maudsley is on a small scale, but I am thinking of the general case of every asylum in this country, if it had to receive voluntary boarders if tendered, and what is to be the qualification?—Yes, we will give you that information.

19,195. Of course, we recognise that the admission of voluntary patients may be of the greatest value in this way, that a person may thus obtain the benefit of the institution without certification, and may therefore be encouraged to go there at an early stage, instead of having first of all to be a pronounced case before the benefit of the institution can be obtained. That is the general principle, is it not?—Yes.

19,196. Now you also point out, as Mrs. Dunn Gardner has already done, that the presence of such patients may infuse an atmosphere of hopefulness, and one sees the psychological effect of that.

19,197. *Mr. Micklem*: In your *précis* on page 4, you say "It is clearly anomalous that authority for what has been allowed for many years to private institutions should be denied to the authorities of public mental hospitals." So far as private institutions are concerned, that has been extremely limited, has it not? They have no general power of receiving boarders?—Yes.

Chairman: Registered hospitals receive large numbers. Bethlehem has more voluntary patients, I understand, than involuntary patients.

19,198. *Mr. Micklem*: But licensed houses only have the boarders under the statutory sanction of the 1890 Act?—(*Mrs. Dunn Gardner*): Yes. They admit voluntary boarders.

Mr. Micklem: But in every case they have to get the consent of the Board of Control, and they have to get the consent for a limited time.

Chairman: Yes; there are certain formalities. They are in the category of voluntary patients, I think, Mr. Micklem.

19,199. *Mr. Micklem*: But it has to be done with the previous consent of the Board of Control, and that consent only runs for a very limited period, and has to be renewed, if necessary?—But the public hospitals have no right to admit voluntary boarders under any circumstances.

19,200. I follow that; but I rather thought from what was stated here that it was assumed that these private institutions could receive voluntary boarders as they pleased?—(*Mrs. Dunn Gardner*): I should very much like to know how many at private institutions are received as voluntary boarders and perhaps, within a week, are certified.

Mr. Micklem: The Act says they may receive and lodge as boarders for the time specified in the consent of the Board of Control, but not beyond that.

19,201. *Chairman*: At the moment no voluntary patients at all can be received in a public mental hospital. In the registered mental hospital, and in the licensed house, such patients under certain formalities are received. That is the actual position?—(*Mr. Sidney*): Yes.

Mr. Micklem: But they are very strict formalities.

19,202. *Chairman*: No doubt, they are, but the fact remains that there are a considerable number of them, subject to those formalities, in the licensed houses and registered mental hospitals. Now on the question of certification you draw attention to the rather anomalous position that in certain cases two medical certificates are required, and in other cases one only. May I take it that the general effect of the Council's views upon the matter is embodied in their resolution of the 26th May, 1925, as follows: "That in the opinion of the Council, it is desirable that in every case in which an order for the compulsory detention of a person of unsound mind is made, the presentation to the judicial authority, who is asked to make the order, of two medical certificates should be necessary before the order can be made, that one of these certificates should be given by a practitioner who has been approved specially for that purpose, and that amendment of the Lunacy Act, 1890, to secure this is desirable"?—Yes.

19,203. First of all, I think that the County Council are in favour of the abolition of any discrimination in the matter of formalities between the private patient and the parish patient?—Yes.

19,204. Then, secondly, as to the method which should be applied to both cases indifferently, the Council's view appears to be that two certificates in all cases are necessary?—Yes.

19,205. I do not want to cover ground that we have covered very frequently before, but have you considered whether the expense of two certificates is necessary in all cases, or whether the resort to two medical opinions should not be confined to cases where there is some room for doubt? I mean, do you approve of two certificates for all cases?—I think it is more desirable.

19,206. You think the value from the public point of view of the protection thus afforded counterbalances the increased cost in which it would result, for it would cost a great deal more?—Parliament has thought it necessary under the Mental Deficiency Act that there should be two certificates, and I do not see how you can draw a distinction very well between the two cases.

19,207. *Earl Russell*: But your experience tells you that in eight out of ten cases there is no sort of doubt?—Yes.

19,208. The admissions into the asylum leave you with no doubt. Is it really necessary to have a second certificate there?—It is more to satisfy public opinion. I cannot say that in my experience it is necessary to have two.

19,209. *Mr. Micklem*: But the Council do not intend this to cover the case of an urgency order,

10 July, 1925.]

The Hon. WILLIAM SIDNEY, J.P., and
Mrs. ROSE DUNN GARDNER, J.P.

[Continued.]

do they? In many cases immediate action must be taken?—Yes, you would have to exclude those cases.

19,210. But you do not mean that in those cases it would be necessary to have two certificates?—In my personal experience I must admit that I have not seen the necessity for the two certificates.

19,211. *Sir David Drummond*: What do you mean by saying that one of the certificates should be given by a practitioner approved specially for the purpose?—That is to bring us into line with the requirements of the Mental Deficiency Act.

19,212. But what was in your mind when you advanced that view?—(*Mrs. Dunn Gardner*): I think we thought it would be a great protection that one certificate at any rate should be given by an expert.

19,213. But that would be impossible in outlying parts of the country?—Of course, we only know about London. (*Mr. Sidney*): We are only thinking of London, where it is possible to carry it out.

19,214. *Earl Russell*: Approved specially by whom?—(*Mrs. Dunn Gardner*): In the Mental Deficiency Act the approval is by the local authority or the Board of Control.

19,215. *Sir David Drummond*: I am afraid it would not be practicable throughout the country?—(*Mr. Sidney*): Not throughout the country, possibly, no. (*Mrs. Dunn Gardner*): But why should it not be applicable to all mental cases? If it has been found to be practicable and applicable for mental deficiency cases, why not for the others?

19,216. *Chairman*: You may point to the Mental Deficiency Act as being the latest pronouncement of Parliament upon the subject, but we want to explore it on its merits; and when it is contemplated that a large additional expenditure might be necessary, it is very desirable to see whether that expenditure will be useful. For the moment I gather that the only merit of it in your view is that it would give the public a greater sense of security?—(*Mr. Sidney*): Yes, that is so. I think that is our view.

19,217. Rather than that it would in fact result in protecting the patient against being detained unwarrantably?—Yes.

19,218. *Sir David Drummond*: I would like to point out to you that these gentlemen who are appointed under the Mental Deficiency Act are not experts at all; they are not in any sense mental experts?—(*Mrs. Dunn Gardner*): They are not mental experts, but they are experts with regard to mental deficiency.

19,219. They are not; they just happen to be appointed; two or three doctors will apply to get permission to do this, and that is acceded to, but there is no question of expertness?—I believe their credentials are inquired into before they are appointed, as to what their experience has been, and that sort of thing.

19,220. This is quite a different point. You are suggesting that they should be medical men who are approved specially to deal with questions of lunacy?—Only one should be.

19,221. *Earl Russell*: You see, in effect at any rate, under the pauper practice there is a second medical certificate almost immediately: that of the medical superintendent of the place where the patient is received?—He has been received then.

19,222. He has been received, it is true, but you do not find that many do have to be sent away because they have been wrongfully certified in practice, although there is only one doctor?—I think I have seen several patients who have been sent to an asylum and, on reception, their illness has cleared up, and they have been at once recommended to the committee to be discharged, but they have to wait until there is a committee meeting.

19,223. *Chairman*: There are two points. The first is: are there to be two certificates? The second is: who are to give the certificates, be they one or two? On the first question, should there be two certificates, the only suggestion we would make for your consideration is this: whether in general one certificate

is not necessary for all cases, private and parish, subject to this, that it should be in the discretion of the judicial authority or the certifying doctor, if he thinks that the case is one of any doubt or difficulty, to call in a second opinion. In ordinary life when cases of difficulty arise in practice you do call in a second opinion, just because the case is difficult, but you do not call in a second opinion generally for a cold in the head. The obvious case can be treated without a second opinion; and, if you take a case of pronounced insanity, is it necessary for two people to go through the process of certifying in such a case? I am putting it argumentatively, to test it. Is it necessary to have two opinions in every case, or would it not be a sufficient safeguard if there were one opinion, coupled with the provision that, if the case were one of difficulty, the doctor or the justice of the peace should be entitled, if they so wished, to be fortified with another opinion?—Until we have discussed the question of receiving houses or observation hospitals, it is rather difficult to say, is it not?

19,224. I agree the questions are related?—Yes, and whether during the time of waiting to see if they should be certified or not the patients will be under the care of experts or whether they will be in the ward of an infirmary or workhouse, makes, I think, a great deal of difference.

19,225. If every patient is to pass through the stage of the observation ward, it may be that one medical opinion would be quite sufficient for admission to that stage. Then the case would be under full observation; and if it was one of any difficulty a second opinion might be obtained before the final certificate was granted. But the suggestion that all cases must necessarily have two certificates is one that requires consideration, in view of the large additional expense which might be unnecessary, and, if its only object was to appease public anxiety, it might really not be well spent money?—(*Mr. Sidney*): Yes, I think that is so, Sir. Personally, I do not think it is necessary to have two. But the idea was more to bring us into line with the Mental Deficiency Act; and also, as regards the private patients, if it is determined that one is sufficient for private cases as well as other cases, I do not think we need insist upon two.

19,226. *Earl Russell*: I think we are all quite with you in getting the two classes into line?—They must be in line.

19,227. *Chairman*: You want uniformity of procedure, and you also point to the fact that the latest expression of public opinion is embodied in the Act of 1913?—Yes.

19,227A. Then let us pass to the next question of whether the medical practitioner concerned should have any special qualification. Here again your resolution is on the lines of the Mental Deficiency Act, Section 5, where one of the medical certifiers must be approved for the purpose by the local authority or the Board. Now that is practically your language, though you put it a little more emphatically. *Sir David* has pointed out quite properly that it does not necessarily mean in the least that the person approved by the local authority shall be a specialist in mental disease; but, on the other hand, it would have this result that if a person were specially selected and approved for the purpose he would acquire experience of the work and he would be a man who knew about this matter?—Yes.

19,228. *Earl Russell*: You would not get a man standing high in the profession applying for a guinea a time; it would not be worth his while?—No.

19,229. *Chairman*: You would not get him in the country either?—As a matter of fact, as regards pauper patients, almost invariably the certificate is given by the medical superintendent of the Poor Law infirmary, who has certain experience, because he is constantly seeing these patients who are brought into the observation ward, and he has a certain knowledge of mental cases.

10 July, 1925.]

The Hon. WILLIAM SIDNEY, J.P., and
Mrs. ROSE DUNN GARDNER, J.P.

[Continued.]

19,230. There is something to be said for this, Mr. Sidney, that the process of certification, being a very important one indeed because of its consequences, should not be left entirely to any general medical practitioner, and, possibly, a very inexperienced one, who at the present moment is as qualified in law to certify as the most experienced doctor?—I think so. It ought to be somebody approved.

19,231. It might be an advantage therefore if the local authorities were to designate a particular medical man, presumably they would select one of some experience, who would then become the recognised person for this purpose, and would acquire experience in his work, as we saw in Glasgow. Dr. Carswell told us he was specially appointed by Glasgow to deal with these cases, and he saw every case?—I think that is so.

19,232. And that again would help to allay public apprehensions by giving the feeling that this was a responsible doctor who was specially charged with this duty and selected for this duty?—I think that is most important.

Sir David Drummond: But you would not expect a man who had a big reputation to undertake this duty; a man whose opinion was worth having might not be the man who would be approved.

Chairman: You could not command the services of the eminent practitioner, but would you not get in the large districts an experienced man?

Sir David Drummond: I do not think it will work in practice.

19,233. *Chairman*: Now we can pass to another topic. I see the County Council is in favour of greater freedom in the matter of boarding-out, and there you refer to the Scottish practice. Apparently, according to your experience, Section 57 of the Act of 1890 has not in practice proved workable?—No.

19,234. Have you found in practical experience that some system of boarding-out of harmless cases would be a desirable thing?—I think so, Sir, yes.

19,235. Do you think you could get the right type of home?—It would be rather difficult, of course, in the case of London.

19,236. You see it is obviously a case where you want to send the person to a rural district?—Yes.

19,237. In Scotland it has been largely done by sending the patients to cottagers in the rural parts of Scotland, where the patient joins more or less in the family life and does a good deal of work about the place, if one may speak colloquially, and leads a more or less happy life as a member of the family. But somebody was good enough to say in that chair some time ago that they thought there was possibly a larger supply in Scotland of responsible God-fearing —(I think was the expression)—cottagers who would undertake the care and could be entrusted with the care of these people. I am not for a moment subscribing to that view, if I may say so, as between the two nations; but the difficulty of course is to get the proper type of home to send the patients to, because the risks of abuse are very great. The patient may be overworked, underfed, improperly sheltered and clothed; but do you think you could command in rural districts round about London a sufficient number of homes in which you could board out suitable patients?—I think so. I think Mrs. Dunn Gardner has rather gone into this question. (*Mrs. Dunn Gardner*): I went over to Belgium and saw the boarding-out system there, but at present I think it is hardly worth contemplating because we have not got enough accommodation for our ordinary people. I mean there is no extra housing available; nobody has got an empty room. Each patient must have a separate room. They could let it to somebody who is not a patient at all.

19,238. Of course, payments are made in respect of such patients?—So is rent. I do not think there is at present any superfluity of accommodation which we can make use of. Where I saw it done in Belgium, in each place there were a great many houses and

a very few people, and they were most anxious to have the boarders. Of course, at Ghel it is a different thing there; because it has been done for so many hundred years, starting on a religious basis, that the whole country becomes the guardian of a boarded-out patient; it is a most wonderful thing to see. At Liewrneux, where I went to, there is not any of that feeling at all; it seems to me that they were depending much more on their central accommodation; each has a headquarters to which patients can be at once removed. At Ghel it was much too primitive to have headquarters, but at Liewrneux they were making the most gorgeous and expensive building I have ever seen in connection with lunatics.

19,239. Do you think the housing difficulties are such in the rural quarters that there are not cottagers at the moment who could take in cases? We have the housing difficulty in Scotland also, and although the boarding-out system has a little diminished lately, there are still a large number of boarded-out cases with us in Scotland.

Earl Russell: In that class of house at the moment I think there are hardly any vacant beds.

19,240. *Chairman*: You think it is hardly practicable at the moment?—For the moment. We are trying to do it more for the mental deficiency cases than we have done for any other patients; of course, they are more easy to deal with than others, but it is most difficult to find anybody willing to become guardians, simply because they have not room for the people.

19,241. *Earl Russell*: The power might be worth having?—Yes.

19,242. *Chairman*: Subject to the difficulty of carrying it out in practice, the County Council is in favour of greater facilities for doing it, and we may, of course, have a happier time hereafter when there is more accommodation in the country?—Yes. There is no doubt that the lives lived by the people boarded out are infinitely happier than the lives lived by the people in the bigger institutions.

19,243. I think one must always recognise that the atmosphere of an institution, however well conducted, is distasteful?—(*Mr. Sidney*): One cannot get away from that fact.

19,244. Then you suggest that any boarded-out patients should remain on the books of the institution, and it will be necessary probably to have some special provision for supervision?—Yes.

19,245. It is done in Scotland by district sponsors. You make reference a little later in your *précis* to various abortive legislative efforts, and I should like to see the series of Bills that have been produced from time to time; they mark the progress of thought on the matter?—I will supply them.

19,246. You refer us, first of all, to an amending Lunacy Bill introduced in 1899 in the House of Lords which dealt with boarding-out; you give us a clause there, and possibly we might just put that clause on our note as it stands, in order that it may be available to us all. The clause is as follows:—

“8 (1) Notwithstanding anything in section fifty-seven, sub-sections one and two, of the principal Act (*i.e.*, the Lunacy Act, 1890) contained, any two members of the visiting committee of an asylum may, without the approval required by that section of the board of guardians, local authority, or a justice, but subject to regulations made by that committee and approved by a Secretary of State, order a pauper lunatic to be delivered over to the custody of some person (not necessarily a relative or friend of the lunatic) who shall be willing to receive him, and who shall be considered by the visiting committee to be a fit and proper person to receive and properly care for the lunatic, and no such person shall have in his charge or custody more than two lunatics at any one time. The visiting committee may pay to the person to whom the lunatic is delivered

10 July, 1925.]

The Hon. WILLIAM SIDNEY, J.P., and
Mrs. ROSE DUNN GARDNER, J.P.

[Continued.]

such allowance as it thinks proper; but the guardians of the union to which the lunatic is chargeable or the local authority liable for his maintenance shall not pay to the committee in respect of the lunatic more than the sum which would have been payable by them if the lunatic had remained in the asylum. In any case, where the expense incurred by the visiting committee of an asylum in boarding-out a lunatic is greater than the amount received for his maintenance, the difference in cost shall be borne by the local authority to which the asylum belongs.

(2) The name of any lunatic who may be so boarded-out shall remain upon the books of the asylum from which he was removed, and a medical officer of that asylum shall visit him from time to time and report the result of the visit to the visiting committee. Two members of the committee may, at any time, order the lunatic to be brought back to the asylum.

(3) When any order has been made under the provisions of this section, notice thereof shall be sent to the clerk to the board of guardians or the local authority, as the case may be.

(4) Sub-section three of section fifty-seven of the principal Act shall apply in the case of any lunatic boarded out under the provisions of this section."

19,247. *Chairman*: That Bill with the clause quoted, passed the House of Lords in 1900, but failed in the House of Commons, and has not been again introduced, but the County Council is in favour of legislation on those lines, I take it?—Yes.

19,248. Now, the next topic is one of very great importance. I see that your County Council has been a pioneer in the matter of the provision of houses to which alleged lunatics could be taken in lieu of the workhouse?—Yes.

19,249. Have you been impressed with the undesirability of what one may call the workhouse stage in the treatment of insanity?—Yes. I do not think it is desirable.

19,250. You think that episode which is the preliminary of the admission of so many patients to your mental hospitals is undesirable, in that it involves passing through the workhouse stage, with the consequent pauperisation?—Yes. (*Mrs. Dunn Gardner*): And the ward may be one where there is no special expert doctor, where there is no expert nurse, no trained attendants, and no means of dealing with the cases.

19,251. Quite. At the very stage when possibly treatment might be most desirable, at the outset?—Absolutely so.

19,252. I suppose the removal of a patient to those surroundings when the patient is upset may just help to accentuate the symptoms?—(*Mr. Sidney*): And the undesirability of keeping them any length of time.

19,253. Is your Council's solution of that the provision of a new type of institution altogether?—Yes, that has been in the mind of the County Council for a very long time.

19,254. So I gather, and I see that so long ago as 1899 in the Council Minutes for the 10th October of that year, approval was given to the provision of such institutions?—Yes.

19,255. And you tell us that support was given to the proposal by the then Lord Chancellor, the Lunacy Commissioners, and the late Local Government Board, now the Ministry of Health. In 1903 you tell us a public Bill was introduced in the House of Lords which passed that House without amendment, but did not make progress in the Lower House for want of time. Attempts were made to reintroduce the Bill in 1904, 1906 and 1907, unsuccessfully. Then the Royal Commission on the Care and Control of the Feeble-minded meantime made recommendations for the provision of receiving houses on lines similar to those of your Bill; and in 1909 your Council again considered the proposal,

but thought that the experiment might be limited to one receiving house. Then the Maudsley Hospital project was under discussion, and it was suggested that a receiving house might be established in connection with that hospital, and there the matter rests. But it is manifest, Mr. Sidney, that throughout, the London County Council has been alive to the disadvantages of the present system, and has been casting about for some solution?—That is so, and I think I may say that most of the boards of guardians have come to that conclusion also.

19,256. And the line on which you think the solution should be sought is the provision of approved institutions of the nature of receiving houses, interposed between the patient and the admission to the asylum?—Yes.

19,257. Let us pursue that a little further. The project included power to provide and maintain receiving houses and ambulance stations, and an ambulance service?—Yes.

19,258. We might just put on our note this summary of your scheme. It included "power to provide and maintain receiving houses and ambulance stations and an ambulance service ancillary thereto; the treatment of out-patients in an out-patient department at the receiving houses; the appointment of a sufficient number of medical practitioners as certifying officers; persons alleged to be of unsound mind were to be removed to the receiving house in place of the workhouse infirmary; justices of the peace were to follow the procedure of the Lunacy Acts when making reception orders, but were to employ the services of the specially appointed certifying doctor; a patient could be detained on the authority of the medical superintendent for three days, during which time the medical superintendent was to bring him before a justice and report to the justice whether the patient should be further detained in the receiving house or sent to an asylum, the justice could order the patient to be detained for treatment for not more than six weeks in the receiving house, and this period could be extended by a justice on the recommendation of two members of the receiving house committee for periods not exceeding three weeks at a time." Does that passage which I have read contain in summary form the procedure which the London County Council thinks desirable?—Yes. It might require amendments in detail, of course.

19,259. But that is the general outline?—Yes.

Sir Ernest Hiley: Might we have the title of the Bill, Mr. Chairman? It does not appear on the note at all.

Chairman: Have you the title of the Bill? There are several Bills, Sir Ernest. There was, first of all, the Bill of 1899, and then there was a Public Bill of 1903.

Mr. Snell: That was the same Bill throughout the years, was it, 1904, 1906, 1907?

Chairman: And then there was one in 1909.

19,260. *Sir Ernest Hiley*: I mean the Bill alluded to in paragraph 20?—The title is "Lunacy Act Amendment (Receiving House) London Bill."

Chairman: I would like, and I think my colleagues would like, to see those Bills which are referred to; but we can easily get them from the Government printers. I think we should see the whole of them, because they evidently represent the line of thought which the London County Council is pursuing.

19,261. *Mr. Snell*: Did the Council promote this Bill?—Yes, they did.

19,262. *Sir Ernest Hiley*: I understood it was a Public Bill?—Promoted by the Council I understand.

19,263. *Chairman*: Was it a private Members Bill, or a Government Bill, or was it adopted by the Government?—It was a Public Bill.

19,264. Then it must have been a Bill which was backed by the Government of the day?—The Lord Chancellor had approved of it.

16 July, 1925.]

The Hon. WILLIAM SIDNEY, J.P., and
Mrs. ROSE DUNN GARDNER, J.P.

[Continued.]

19,265. *Sir Ernest Hiley*: Who introduced it?—I do not know.

Chairman: I think we can get the history of this legislation investigated for us, without detaining Mr. Sidney; all the information is at our disposal. We will get a note on this chapter of legislation. It is new to me; I had not known of this series of Bills.

Earl Russell: I remember the receiving houses being mooted as long ago as 1899.

19,266. *Chairman*: We can get a record of them all. The fact that you have been interesting yourselves in these projects of reform shows, of course, that the London County Council is dissatisfied with the existing régime in this matter?—Yes.

19,267. And that objection, I think, still holds good?—Yes.

19,268. *Earl Russell*: I would like to ask Mr. Sidney on paragraph 20 whether he would approve of somewhat similar powers being given to the justice to make an order for extended observation in existing infirmary wards, pending the establishment of a receiving house, to ensure this interval before complete certification?—Yes.

19,269. Even if you have not got a receiving house you still may avoid complete certification by this method?—Yes. (*Mrs. Dunn Gardner*): For myself I think six weeks without treatment would be a most serious thing.

19,270. Are they necessarily without treatment in the bigger Poor Law infirmaries?—I mean to say expert treatment.

19,271. Of course we have had the other view, that it would be better if they went at once to the mental hospital?—But then you will have experts at the heads of the receiving houses, and I hope many of the people would not have to go to the mental hospitals at all, if they might stop for a time in the receiving houses.

19,272. *Mr. Micklem*: But in the receiving houses you contemplate that they will be certified?—Yes. The justice would give the power to detain them in the receiving house, but the patient would be saved from going to the mental hospital at all, because so many of them get well in so short a time.

19,273. *Chairman*: The patient would not be described as a certified patient at all; the patient would be described as a patient received into this institution for observation and treatment under a temporary order, with as little emphasis on the "order" side of it as possible. But that there will require to be in reserve some power of restraint is manifest?—Yes. The observation wards have padded rooms, of course.

19,274. But it would be under a different category from the certified patient?—Yes, and also they would never have been to the mental hospital.

19,275. And might never reach one?—Yes, that is so. (*Mr. Sidney*): I think on second thoughts it would not do; you would have to wait till you get your receiving houses.

19,276. *Earl Russell*: But we have had evidence that a great many of these cases, even although violent at first, may be discharged in a comparatively short time, and in that case they do avoid the asylum?—Of course a large number avoid the asylum in the present observation wards. Only about half of those go to asylums.

19,277. We have evidence which rather suggested that if the observation period could be extended, you might get better results. I will not press it?—No; that wants a good deal of consideration, I think.

19,278. *Chairman*: Now your Committee has interested itself in the matter of after care, Mr. Sidney, and you point to the existing system under which patients may be allowed out on trial, and receive, if paupers, a money allowance while they are on trial. That, as we have heard, is a very valuable provision, but these are still patients who are undischarged; they are still patients who are certified and on the books of the institution. After-care concerns itself rather with the patient who has

ceased to be on the books of the institution and has been returned to ordinary civil life?—That is so.

19,279. And at present, I understand, that such after care is provided entirely by voluntary associations and private individuals?—Yes.

19,280. We have had the advantage of some evidence from the After Care Association which was very interesting, and satisfied us, I think, that very useful work could be done. Now in Lord Onslow's Bill it is proposed to authorize expenditure for the purpose of after care by local authorities. Has that your approval?—Yes.

19,281. There again, of course, there is this consideration that it is obviously a branch of philanthropic work that requires to be done with great tact, because many patients, I should imagine, particularly the fully recovered cases, desire to be dissociated as quickly as possible from that episode of life and forget it, not to feel that they are under supervision and investigation. On the other hand, there are many cases, although no longer proper to be detained as inmates, who find the stress of resuming life very severe. What kind of work can be done in the matter of after care when you bring it down to real life? Is it visiting or looking out for jobs for people or what is it?—(*Mrs. Dunn Gardner*): In the first place trying to deal with the awful feeling of loneliness of patients who go out of the institution to nobody, or to an old sister, and who may have been for years in the institution and have lost sight of all their friends, no character to go to an employment with, and with practically nothing but the workhouse before them; if they can be placed for a short time in a home, and in a little bit find their feet again before they try to get employment, then they can be helped to get employment.

19,282. You think that one branch of after care work would be the providing of what one might call convalescent homes or places of rest, between the asylum and the resumption of ordinary life?—Yes.

19,283. That I can see might be very useful work. Then visiting, I suppose, in the homes?—If they have got good homes they go home. A girl goes home and nobody knows what is a good thing to do with her, and they get her in a situation where she is at once worked so hard that she breaks down again. You do want a little supervision, I think, in that way.

19,284. Advice?—Yes, and looking at the situation from the point of view that the mother cannot perhaps appreciate, because she does not understand that her daughter is not just the same as she was when she went in.

19,285. That would be an organisation of visitors, tactful persons who could give advice and companionship possibly?—Yes, money is wanted too; for if you advise somebody who is accustomed to earn her own living to rest for a month or more, there is no income coming in; you want money help as well as the sympathetic help which they need; and with men it is just the same,—I mean they want caring for until they can get to a full day's work.

19,286. There is another aspect of it, the looking about for suitable employment, and inducing employers to take them?—Very much so, and that is done very much by the After Care Association.

19,287. These seem to represent the three main aspects of their work: the provision of a convalescent home, change of air, and so on; secondly, visiting and advising and giving a sense that they are still cared for; and, thirdly, the finding of suitable employment?—Yes, and tools and clothes; when they come in, the mental hospital can do that.

19,288. And not the least important and incidental to these is the providing of money?—Yes. When they go out on their four weeks' trial they can have an allowance from the hospital, and they are advised: "You can look for work at once," or "Do nothing for the next four weeks till we see you again."

19,289. Have you considered what organisation will be necessary for this work?—(*Mr. Sidney*): It will be necessary to work through the voluntary Association unless the work became too big.

10 July, 1925.]

The Hon. WILLIAM SIDNEY, J.P., and
Mrs. ROSE DUNN GARDNER, J.P.

[Continued.]

19,290 You contemplate that this should be done by utilising private effort which should be subsidised from private funds?—Yes, that is the idea.

19,291. Your County Council might make a grant to an approved After Care Association whose work you thought was satisfactory?—Yes.

19,292. You desire to eliminate the official element and make it as far as possible a voluntary effort?—Yes.

19,293. *Earl Russell*: At the moment you have no power to subscribe, have you?—No.

19,294. *Miss Symons*: What happens, Mrs. Dunn Gardner, in the case of the Maudsley. Does your lady almoner there keep in touch with patients after they leave to any extent?—(Mrs. Dunn Gardner:) I do not think she could have the time to. I do not know this, but I believe she tries to pass them on to some parish worker or club, in the case of a girl.

19,295. *Chairman*: It is quite manifest that this is an important part of the work, because the whole of the treatment may be undone by the patient being put into unsuitable circumstances or subjected to stresses and strains which he or she cannot bear?—Yes.

19,296. Then you tell us generally about the improvement which has taken place in methods of housing, and in the care and treatment of mental patients since your Council undertook the responsibility of the administration of asylums in 1889?—(Mr. Sidney): Yes.

19,297. Some of us have had the advantage of seeing a number of your institutions, and we have had evidence from medical superintendents and others on the subject. I do not think we should delay with details about this matter, but it is the case, I think, that the history of your administration shows progressive improvement in all those matters of dietary, clothing and medical treatment?—Undoubtedly.

19,298. *Earl Russell*: What is the cost per patient per week of your present diet?—Between 5s. and 6s.

19,299. For that you think the dietary is adequate?—(Mrs. Dunn Gardner): We have brought some of our menus along.

Chairman: We have had a print of the dietary that was approved by the London County Council, but we should rather like to see what the menu for to-day is.

19,300. *Miss Symons*: Are you satisfied with the arrangements by which in some of your institutions there is no evening meal?—That has been dealt with. Sitting up patients have evening meals now.

19,301. Everywhere do they?—(Mr. Sidney): In every case where they sit up; that has been passed by the Council.

19,302. *Chairman*: That is a very important reform; the interval was too long?—(Mrs. Dunn Gardner): Each month they have a menu for the whole month, quite different.

19,302A. *Mr. Snell*: They change from month to month?—They change from month to month—each four weeks they have something different again.

Miss Symons: How does the 5s. or 6s. a week compare with the amount of money spent on the staff diet?

19,303. *Chairman*: Of course, you cannot very well judge of a meal merely from the menu. There is roast beef and roast beef, and there are also methods of cooking roast beef. A good deal depends upon whether the supplies are satisfactory, and whether the cooking is satisfactory?—The Board of Control has laid down what they consider ought to be the amount of vitamins and calories, and all those sort of things, and all the menus contain more than the Board of Control have laid down.

19,304. *Earl Russell*: Do any of the patients ever complain?—(Mr. Sidney): No. We go round at dinner time; I have asked them constantly and we have never had any complaint whatever; in fact they express themselves perfectly satisfied with the food.

19,305. *Chairman*: The matter of course has been under investigation by a Departmental Committee of the Board of Control which has gone into the question of dietary, and I understand your dietary is rather more liberal than they recommended?—(Mrs. Dunn Gardner): Yes.

19,306. But it is a matter which has the attention of the London County Council; its importance is appreciated, I have no doubt?—Yes. Since they have had the so very varied dietary they have been much happier. (Mr. Sidney): I think both the quality and quantity are admirable.

19,307. I imagine in asylum life the meals must be great events in the day, and very important?—Yes.

19,308. *Miss Symons*: Does your new arrangement mean that where they sit up after seven o'clock at night they would have supper?—(Mrs. Dunn Gardner): Yes.

19,309. You feel, do you, that the patients who are up all day and go to bed at seven, in spite of the long interval between tea and breakfast next morning, do not need it?—(Mr. Sidney): I have asked the doctors and they say it is not necessary.

19,310. *Mr. Snell*: What is the attitude of those who are sent to bed early? Do not they wish to stay up and have supper?—No. Those really are not fit; they are in a very bad state. A very large number sit up now; it varies in the different wards.

19,311. It is what one may call the bed cases?—Yes.

19,312. *Sir Ernest Hiley*: You have overcome the kitchen difficulty. We were told the difficulty about having an evening meal was because the kitchen staff wanted to go off?—(Mrs. Dunn Gardner): They have a cold meal, except cocoa in the winter.

19,313. But you have overcome that difficulty? (Mr. Sidney): I think so; I have heard no complaints.

19,314. *Earl Russell*: They can warm cocoa in the wards?—(Mrs. Dunn Gardner): Yes, they have got their little kitchens.

19,315. *Mr. Snell*: Just cocoa and bread and butter?—Yes, it varies; we try not to have it always the same.

19,316. *Sir Ernest Hiley*: At Claybury difficulty was experienced about having supper because the kitchen staff wanted to go off?—(Mr. Sidney): Yes, but I do not think there is any difficulty about what we propose to give them now; I have heard of no difficulty with the kitchen staff.

19,317. *Chairman*: Then in the matter of clothing, I see you pay attention to what is another important matter in preserving the self-respect of patients. You are trying as far as possible to avoid institutional clothing?—Yes. The ladies of this Committee have had this in hand. In the last two or three years they have improved matters very much indeed. (Mrs. Dunn Gardner): They have a modern type of dress instead of the old one, but, in addition to the dress itself we have had little things like bright buttons and bright braid; they can embroider things for themselves; they can make their dresses different from the others; they take a great interest in those little things.

19,318. *Miss Symons*: What is the practice in your institutions about underclothes? I gathered in some places I visited, that though the patients were allowed to wear their own top clothes, where they have them, there have been difficulties about allowing them to wear their own underclothes?—That is so; it varies in different institutions. In some places they can only wear clothes of their own. It is very difficult when patients have to be moved from ward to ward, what happens to their clothes, and what nurses are responsible for them.

19,319. Where the underclothes are to be provided, are they to be produced on rather more modern patterns, because it struck me that I saw (not in one of your institutions) some kind of underclothes I had

10 July, 1925.]

The HON. WILLIAM SIDNEY, J.P., and
Mrs. ROSE DUNN GARDNER, J.P.

[Continued.]

never seen before. I wondered if they had been modernised?—We have taken great pains to modernise them, but to modernise clothes for a woman who has been 20 or 30 years in an institution—nothing would make her more angry.

19,320. *Earl Russell*: Then does not one find this practical difficulty that if they have any separate set of underclothes they get lost in the wards, or lost in the wash?—Yes. We have not succeeded in attaining to it in all institutions. Obviously it would be a satisfactory thing to do if one could.

19,321. To many an individual it would be very satisfactory?—Yes. I cannot say that we have managed it in every institution; we have in some.

19,322. *Miss Symons*: But they are being modernised?—The younger ones were modernised some time ago. There was one lady who took up the special subject of corsets and went into that for a long time. I did not do that myself.

19,323. How many women are there on your Committee?—We have the co-opted members as well as the members of the Council. I think we have ten. Then the co-opted members have more time than the others.

19,324. *Earl Russell*: And with regard to the men, are they allowed their own underclothes. Do they have their own shirts and things of that sort?—We have not gone into the question of men's underclothing. We have to take the things step by step, but they have much prettier patterns to their shirts.

19,325. *Chairman*: On the general question of clothing, one is glad to notice that you recognise the importance of that element in the self-respect of the patients?—(*Mr. Sidney*): Yes.

19,326. There is no doubt that it has a mental effect on men as well as on women; it is not a matter of sex entirely?—Particular attention has been paid to that during the last two or three years.

19,327. That helps further to get rid of the idea of the institutional aspect?—Yes.

19,328. You want them to remain individuals and not merely numbers?—(*Mrs. Dunn Gardner*): Yes, we try to.

19,329. Of course in all this you have to consider expense, Mr. Sidney, and perhaps it is as well that one should remember what a very large household you have to attend to. You bring out a very striking figure here: if you spend a penny a week on each patient does it represent over £4,000, a year?—Yes.

19,330. So that a recommendation that resulted even in London alone in one penny addition expenditure per patient per week would mean £4,000 a year?—Yes.

19,331. It is a very striking figure; therefore you have to look closely to your financial side?—Of course that is so.

19,332. Then on the matter of actual medical treatment, which is a very important thing, have you been able to increase the number of your medical officers in your mental hospitals of late?—Yes, we have increased them from seven to eight.

19,333. In the institutions with 2,000 or more patients, do you allow eight assistant medical officers in addition to the medical superintendent?—Yes.

19,334. And do you give every inducement to your young medical officers to qualify specially in psychological medicine?—Yes.

19,335. Have you lectures arranged for them?—Yes.

19,336. And they are given at the Maudsley Hospital?—Yes.

19,337. Then do you give study leave to your medical officers?—In addition to their going to Maudsley hospital?

19,338. Yes?—We do.

19,339. Or is that all done at Maudsley—do they get their leave for the purpose of studying at

Maudsley?—(*Mrs. Dunn Gardner*) They have three months at Maudsley. (*Mr. Sidney*) They have a separate course.

19,340. *Mr. Snell*: Do they get any experience of treatment on the continent?—No.

19,341. *Chairman*: Do I take it that their leave is given to them to go to Maudsley where they are, so to speak, seconded for the time being?—Yes.

19,342. They get the advantage of seeing this very up-to-date establishment with its pathological laboratories, and so on?—Yes. (*Mrs. Dunn Gardner*): Four assistant medical officers are always at Maudsley now.

19,343. Each having a three months' course?—Yes.

19,344. And these are assistant medical officers drawn from your different institutions?—Yes.

19,345. And that enables them to qualify for the diploma in psychological medicine?—Yes.

19,346. Then, as we know, you have a very valuable pathological laboratory in connection with your mental hospitals at Maudsley under the directorship of Dr. Golla, formerly under the directorship of Sir Frederick Mott?—Yes.

19,347. *Sir David Drummond*: Do you anticipate that before long you will insist upon the medical officers holding the diploma?—(*Mr. Sidney*): We are making a point of that now when the question of promotion comes up.

19,348. That is to say you are promoting men specially who have obtained the psychological diploma?—Yes.

19,349. But you do not make it essential for admission to the service?—No, we could not do that, because they come in very young, they take the D.P.M. a year or two after they come in.

19,350. *Chairman*: But they recognise that the obtaining of the diploma is a passport to promotion?—That is so now. For the last year or two we have insisted upon that. We have impressed upon them the fact that we do not promote people who have not got the D.P.M., to a certain rank.

19,351. Then the pathological laboratory at Maudsley is really a central laboratory to which all the mental hospitals under your charge can resort for aid?—Yes.

19,352. In addition to that, each one has its own laboratory on a less elaborate scale?—We have just set them up; in some cases they have them and in some they have not. Now we are extending it so that every hospital has its own laboratory.

19,353. The central one is engaged in larger matters of research?—Yes. (*Mrs. Dunn Gardner*): Dr. Golla supervises the local ones as well as the big one at Maudsley, and often suggests work that the young medical officers shall do in their local laboratories. (*Mr. Sidney*): It prevents overlapping.

19,354. Now will you tell us a little about your experience in the matter of nurses. Has your County Council any view upon the desirability of the employment of female nurses on the male side of institutions—has that been before your Council, Mr. Sidney?—Yes, we are considering it.

19,355. *Earl Russell*: You have not got any female nurses on the male side, have you, at present?—(*Mrs. Dunn Gardner*): The difficulty in getting female nurses is so very much greater than the difficulty in getting male nurses that I do not think we should be likely for some time at any rate to make a change. We have found the greatest difficulty in getting suitable female nurses.

19,356. *Mr. Snell*: Have you arrived at any conclusion, supposing they were available, as to the advisability or otherwise of having female nurses on the male side?—(*Mr. Sidney*): In some of the hospital infirmaries the male patients are nursed by women already. (*Mrs. Dunn Gardner*): During the war we did that largely.

19,357. *Sir David Drummond*: That is only the infirmary ward?—(*Mr. Sidney*): Yes, only the infirmary ward; we have not thought of the others.

10 July, 1925.]

The Hon. WILLIAM SIDNEY, J.P., and
Mrs. ROSE DUNN GARDNER, J.P.

[Continued.]

Of course, the Maudsley staff are women, but you are alluding to the mental hospitals.

19,358. *Chairman*: Yes, because we have had some interesting evidence on the subject; and it has been thought by some that the nursing by women in the majority of cases had itself a therapeutic value and rather tended to induce the male patients to behave better and show more restraint. But you are not in a position to give us evidence about that?—No. There was a nursing conference the other day at which the matter was discussed.

19,359. You tell us that you have a great difficulty in getting an adequate supply of women nurses?—(Mrs. Dunn Gardner): Yes.

19,360. What is the reason of that, do you think?—This is only my own view, not the view of the London County Council. I think we rather forget that a mental hospital is not the same as another hospital, and very many wards of the mental hospitals are really not hospital wards at all. We expect all our female nurses to pass a very difficult examination now.

19,361. *Earl Russell*: Before you appoint them at all?—No, we appoint them, but it is known in quite a short time by those who have left school that they will be obliged to attend lectures and to pass a very stiff examination. A great many of the young women do not mind that at all, those who are very intelligent, and do it very well indeed. But there is another type of nurse who has the greatest difficulty in expressing herself on paper, and is not really capable of taking in hand subjects that she has to study, but I think some of those nurses are really those who most add to the happiness of the patients; the motherly, kindly, infinitely patient woman who treats her patients more as an ordinary nurse.

19,362. A sort of French "bonne" type?—Certainly who, if we go on and insist upon examinations will be excluded altogether. I think it is essential that we should have as highly trained nurses as we can get; but I think if we put those highly trained nurses into chronic wards where there is no true nursing to be done, but kindness, of course, and looking after very disagreeable cases, there is not enough to occupy the mind of those people, and they will not stop with us. We are by the examination cutting out the kind of women we got in the past.

Earl Russell: I think that is a very significant statement.

19,363. *Sir David Drummond*: Have you any observation to make on the question of the kind of examination which the nurses you are speaking of are submitted to—do you think it is too stiff?—I do not think it is too stiff for those who are going to be head nurses in charge of wards, but I think it is too stiff for the women who are just going to keep the patients clean and be kind to them.

19,364. There are some of them for whom the examination has gone beyond the proper limits?—Yes. I think the Medico-Psychological book is a very difficult book, and if they really do know it, then they are not going to settle down to be a children's nurse to grown-up people.

19,365. *Chairman*: Personally, I would rather have a nurse who was 90 per cent. kind than one who was 90 per cent. efficient in passing an examination?—Yes.

19,366. *Mr. Snell*: Are you suggesting there should be two grades of technical efficiency?—That is what I am suggesting myself. (Mr. Sidney): That is proposed by the Departmental Committee on Mental Nursing.

Earl Russell: That is the best-reasoned statement we have had yet from a nursing point of view.

19,367. *Chairman*: It is an admirable statement; but the fact remains, whether it is due to the conditions of service or not, you do find a difficulty in getting a supply of women nurses?—(Mr. Sidney): Very great.

19,368. Can you suggest any means by which women could be attracted? Is it a question of pay or the

hours of work?—Not hours of work, because we have reduced it in London to 48 hours only.

19,369. Have you improved the conditions of your nurses?—Yes. I do not think the conditions of service are a deterrent. I think a considerable number leave just on the eve of examination.

19,370. *Mr. Snell*: Do you retire them on marriage?—Yes, they have to go if they are married.

19,371. That is a reason, I suppose?

19,372. *Sir David Drummond*: Do you only promote nurses if they have passed the examination?—(Mrs. Dunn Gardner): Practically they are promoted without being given the rank, as it were, because you must carry on your institution. They are made staff nurses and charge nurses, but they are not on the permanent staff of staff nurses and charge nurses. If anybody came who had passed, she would be promoted above the others.

19,373. *Chairman*: Now you have considered, I see, the question of whether the Board of Control should be authorised to set up and enforce standards in the matter of diets, clothing, and so on. At present as we know, they visit and inspect and make recommendations. Has the County Council any view as to whether a more effective sanction should be placed in the hands of the Board of Control enabling them to enforce these matters on a standard basis?—(Mr. Sidney): I think it is better to leave it to persuasion or recommendation. If you have the power of enforcing, it is a question of money; you force expenditure on a publicly elected body.

19,374. Of course you do not want, either, to remove the initiative from the local authority?—No. I should have thought it was sufficient if they recommended; I should think it gradually raises the standard.

19,375. *Earl Russell*: Of course it is always the backward local authorities who want stimulating, but preferably, no doubt, without force?—Preferably without force, I think, unless the central authority is going to find the money. It is interfering with the principles of local self-government, I should have thought.

19,376. *Chairman*: Now, I think, almost the last topic on which we should ask your views is the question of the size of the hospitals, and the position of the medical superintendents. Of course the size of hospitals is related to the question of the cost of hospitals, is it not?—Very largely.

19,377. And you have, I know, under your charge institutions of a very large size, 2,000 and upwards?—Yes.

19,378. There is a feeling that an asylum can be too large for effective administration?—Certainly.

19,379. On the other hand, I suppose that the smaller the institution, the greater the cost per head necessarily?—Necessarily, yes.

Earl Russell: That would not apply below 1,000, I suppose?

19,380. *Chairman*: Probably not. I should qualify that by saying 'within limits,' of course. It has been suggested that 1,000 ought to be the limit of accommodation, but you have many in excess of that number. Have you any view as to the future of such institutions?—(Mrs. Dunn Gardner): We are not contemplating building another one. (Mr. Sidney): I do not think it is likely that the County of London as at present constituted will require another one. We are finishing the West Park, which is the last one.

19,381. Why do you think there will not be any more?—The population in the County of London is falling, and the number of beds applied for last year fell by 300.

19,382. *Earl Russell*: So you have at last got to the top of your curve?—I think so, and we have been able to bring in all our out-county patients. We have very few boarded out, about 300. There were 800 or 900.

19,383. *Chairman*: But if you were not the inheritors of a past system, would you advocate institutions on so large a scale as those you have

10 July, 1925.]

The Hon. WILLIAM SIDNEY, J.P., and
Mrs. ROSE DUNN GARDNER, J.P.

[Continued.]

just now, apart from the financial aspect of it?—I do not think 2,000 is too large for a medical superintendent to keep proper supervision over.

19,384. The objection that has been taken, and to which you allude here, is that the medical superintendent in charge of such an institution cannot possibly know his individual patients, and also must have the distraction of a great deal of administrative work?—Yes. I do not think it is possible even with those 1,000 cases for a medical superintendent to know every case; but if he is properly served by his medical officers it is not necessary that he should know every case.

19,385. After all, the medical superintendent is the person who is primarily concerned with the detention and the discharge of the patient; he is actually responsible for the persons under his charge. Is it desirable that he should be a person who must rely entirely upon his subordinates for information as to the cases, when the fate of those patients is in his hands?—(Mrs. Dunn Gardner): He does not at all depend entirely upon his subordinates. He constantly visits the wards himself; he sees the subordinates every morning, and in the cases where the subordinates feel a little doubtful, the medical superintendent looks into them.

19,386. I put it a little too strongly. Let me put it in this way, that he depends upon his assistants to direct his attention to any particular cases?—He goes through the wards; he spends a good deal of time in his wards. (Mr. Sidney): I was very much astonished by the knowledge of the medical superintendent of the individual cases; I think it is quite wonderful. They seem to me to know all the cases.

19,387. Of course a great many of the cases he may not require to know but, on the other hand, the cases which cause most anxiety, of which there may be quite a large number, and which require consideration and reconsideration from time to time, ought to be under the eye of the medical superintendent, ought they not?—I think they are more or less. I suppose it is impossible for them to be entirely under the eye of one man.

19,388. We have had a good deal of evidence to the effect that the medical superintendent is seldom seen in the wards, and when he is seen he is there for so short a time that he has not much opportunity of studying individual cases. Of course it may vary in different institutions, but we have had a considerable body of evidence to that effect? If it was necessary for the medical superintendent to know every case you would have to have a very small asylum of only 200 or 300 virtually.

19,389. Then it is inseparable from the idea of a large institution that the medical superintendent must, to some extent, rely upon his subordinates for his attention to be directed to particular cases?—That is so.

19,390. Have you any view upon the question of the separation of the medical superintendent's medical duties from administration?—I do not think it is possible to separate them, they are so intermixed. I think he must have the control of everything.

19,391. We have heard all the pros and cons on that subject more or less, Mr. Sidney.

19,392. Mr. Snell: Do you hold the medical superintendent responsible for the administration of the place also?—Yes.

19,393. And that every report which comes to you must be on his responsibility; no subordinate officer reports directly to the Committee?—The medical superintendent is the supreme officer.

19,394. Earl Russell: There is this point on that, and on his administration. Would you regard the medical superintendent as the man to be praised or blamed if the asylum was run economically or non-economically?—I think so, yes; I think he takes the responsibility for everything.

19,395. Of course that does mean that he would have to give his whole time and his whole thought to administration; he cannot depute it to somebody else?—No.

19,396. Mr. Snell: He becomes an administrator rather than a mental specialist?—He is both; I think he must be both.

19,397. Earl Russell: Suppose that your beef or your butter or eggs were badly bought at a higher price than they should be, and sometimes the qualities were not good, would you hold him responsible for that?—No, that would be the stores department. That is centralised now. That was the case in old days.

19,398. He is free of that now?—He is quite free; the stores department supply everything.

19,399. The same remark would apply to clothing and that sort of thing?—Yes.

19,400. Sir David Drummond: About how many of the 2,000 patients do you suppose a medical superintendent can have any intimate knowledge of?—I think he has a general knowledge of all of them, and has an intimate knowledge of some.

19,401. Are you aware that no physician in this country in a general hospital deals with more than 40 or 50 patients, and, if he knows something about them, he does a great deal of work?—The medical superintendent cannot know every detail about them. He has got eight medical officers under him.

19,402. I know. I am speaking of the man who is the expert of the institution, whose knowledge is most valuable to the institution. He can only have an intimate knowledge of 40 or 50 at best?—(Mrs. Dunn Gardner): But he has the initial knowledge of the whole of them because it is he who has to see them in the first place; he sees them when they come in.

19,403. Earl Russell: He certainly has seen them at least once and probably more?—But he knows them quite intimately. (Mr. Sidney): I was very much struck by the medical superintendent's knowledge of the patients.

19,404. Chairman: If you go round with the medical superintendent you find him addressing a great many of them by name; but he has that difficulty that a man at the head of a large institution cannot have the same individual knowledge and must rely upon his subordinates to a considerable extent?—Yes, to a considerable extent.

19,405. In your later mental hospitals I gather that admission villas have been included where recent cases are dealt with?—Yes, and we are extending that.

19,406. That is to have a separate house or villa in which the newly arrived case is dealt with and not at once plunged into the asylum at large?—Yes, that is so. At Claybury and Colney Hatch we are building now.

19,407. And it gives an opportunity of classification, to which no doubt you attach importance?—Great importance, yes.

19,408. There was one matter Dr. Mapother referred to I think, either in evidence or in conversation with us, namely, that in London where you have a large number of institutions, you might distribute your patients among those institutions according to some system of classification. That is to say, you might devote one of your institutions to cases of one type and another to cases of another type, rather than having in each institution examples of all types?—(Mr. Sidney): What he calls a mixed population?

19,409. Yes. Whether you should have a population of one type, or whether you should have a mixed population in asylums, is an interesting question of policy to consider. Has the London County Council any views on that topic?—I think that at one time Banstead had chronic patients only, and that was not found to be successful.

19,410. Was it because the place became too depressing?—I think so. It is better from a medical

10 July, 1925.]

The Hon. WILLIAM SIDNEY, J.P., and
MRS. ROSE DUNN GARDNER, J.P.

[Continued.]

point of view, I think, to have all types of cases in each hospital because of course they vary very quickly. Sometimes a case is acute; sometimes it is not acute, and they are moved from ward to ward; you would have to move cases from one institution to another, which would be very inconvenient.

19,411. I have put to you, I think, all the matters arising in your *précis*. We are greatly indebted to the London County Council and to yourselves for coming here to-day. We have had most useful evidence from you.—Thank you for the way in which you have received us.

(The witnesses withdrew.)

(Adjourned to to-morrow at 10.30 o'clock.)

5, OLD PALACE YARD,
WESTMINSTER, S.W.1.

THIRTY-SEVENTH DAY.

Saturday, 11th July, 1925.

MEMBERS PRESENT :

THE RIGHT HON. H. P. MACMILLAN, K.C. (*Chairman*).

SIR ERNEST HILEY, K.B.E.

SIR DAVID DRUMMOND, C.B.E., M.D.

MR. W. A. JOWITT, K.C.

MR. NATHANIEL MICKLEM, K.C.

MR. H. SNELL, M.P.

MRS. C. J. MATHEW.

MISS MADELEINE SYMONS.

MR. P. BARTER (*Secretary*).

MR. W. FAIRLEY (*Assistant Secretary*).

Sir LEWIS BEARD, called and examined.

19,412. *Chairman*: We have with us this morning Sir Lewis Beard, Town Clerk of Blackburn, who is also Chairman of the Law Committee of the Association of Municipal Corporations, a Member of the Lancashire Asylums Board, and Vice-Chairman of the Visiting Committee of the Lancaster Mental Hospital.

Sir Lewis, you are good enough to attend this morning for the purpose of giving us the views of your Association, I take it?—If you please.

19,413. And the first topic to which you propose to refer is the matter of accommodation?—Yes.

19,414. You have a few interesting statistics which I think we might have from you?—These figures are official, I understand, and have been furnished to me by the Board of Control.

19,415. You might give us the figures which indicate the extent of the accommodation required and the growing demand upon accommodation?—The net yearly increase of patients requiring accommodation for the four years 1920 to 1923 was 3,565. The present vacant bed space in mental hospitals is 4,754. Taking those figures together it is quite evident that the demand is rapidly overtaking the supply.

19,416. May I ask, are these the figures for the whole of England? Do they include London?—I understand so.

19,417. Now if the demand will so shortly overtake the supply, what is the view of your Association as to how that problem is to be met?—The view of my Association is that at the present time it is impossible to deal with the problem in the way which of course would be indicated under the ordinary normal conditions, that is, by increasing the number of mental hospitals, or adding to the existing mental hospitals, because the cost of building is prohibitive. Not only that, but the cost of raising money is very high, and this would saddle the local authorities with an enormous debt which would I think utterly cripple their resources at the present time, conjoined with the other demands which they have upon them principally in connection with housing. Further than that, it would withdraw from housing a great deal of enterprise, money, labour, and material which is urgently needed there; and, taking the two demands together, I think the whole thing would break down.

19,418. What solution has occurred to your Association for this dilemma?—It is only a palliative, if they get over this temporary difficulty, until conditions are more favourable for building. Ultimately no doubt, if this increase goes on, we shall have to build; but at the moment the information in our possession shows that at many institutions which are maintained by the guardians there is vacant accommo-

11 July, 1925.]

Sir LEWIS BEARD.

[Continued.]

dation, which is not required for ordinary purposes, and which is quite suitable with a little fitting, and so forth, for this purpose, and subject to proper supervision, this might be used.

19,419. Do you contemplate, Sir Lewis, that the strain upon the accommodation might be relieved in this way: in the asylums at present there are a large number of people who are really just in a chronic state, but whose physical and mental powers are abating simultaneously?—Certainly.

19,420. These people only require shelter and comfort until they die?—That is so.

19,421. And if these people were removed from the asylums to Poor Law institutions, accommodation would be rendered vacant and available for the really insane persons requiring treatment?—Yes.

19,422. It is an interesting aspect of the problem, because at present I take it that the mental hospitals throughout the country have a large permanent population of aged and demented persons?—I believe that is so. I have not any statistics, but from my own experience I know it is so in the case of Lancashire; and from general information, I get the impression that there are a great number of these people who are really occupying places which are more suitable for the general welfare of persons who require treatment. Of course there is a very highly skilled and highly trained staff at the mental hospitals, and their energies are really wasted in putting to bed poor old people who can do nothing but drowse away their time until the end comes.

19,423. Is it the practice at present where a person in a Poor Law institution becomes senile and certifiable, simply to have him removed to a mental hospital?—I am afraid I could not say what the general practice is.

19,424. I was wondering how these old people find their way to the mental hospital?—They come, I think, principally through the medium of the Poor Law administration. Many of them have been there a long time.

19,425. Your view would be that these people should not have been transferred from the Poor Law institution merely because they have become senile, but that they should rather be retained there?—Under present circumstances certainly they should be retained there. Whether at the time of their removal pressure upon the accommodation was so great, I do not know. There was at one time a strong inducement offered to the guardians to send their patients to the mental hospitals, in the shape of a grant which was commonly known as the 6s. grant; I think it was a 4s. grant to begin with; it became 6s. afterwards. At that time it was evidently the policy of Parliament, it was the desire of the Government to encourage that these people should all go into the mental hospitals as far as possible. I think experience has shown that that has been rather indiscriminately used.

19,426. Then co-incidentally with the anticipated overcrowding of the mental hospitals, you have a depletion of the Poor Law institutions and vacant accommodation there?—There is such accommodation I am assured by those who know. I have no personal knowledge of it.

19,427. We have had evidence from other witnesses that there is a good deal of accommodation in the Poor Law institutions. Have you also this in view—indeed you have already hinted at it—that you have a highly paid and skilled staff in the mental hospitals whose duty is to consider the cases of the patients, and to apply curative treatment to them, and that the time of such persons is largely diverted by the menial duties of attending to patients who cannot hope to be cured?—That is so.

19,428. I wonder if it is possible to get any statistics as to the extent to which the population of our mental hospitals consists of persons of that class?—I think there is no doubt that if the Commission thought proper to send round a questionnaire on that

subject to selected institutions, they would get a large amount of valuable information.

19,429. Have you thought of the other alternative, and that is the aggregation of cases of that sort, cases of senile decay, in a single separate institution—not a Poor Law institution necessarily?—No, because one's mind was directed rather to meeting the immediate deficiency in the accommodation.

19,430. Rather than the question of additional accommodation?—Yes.

19,431. Your province is Lancashire, but I am thinking of the London problem, where there are a large number of institutions in one hand, whether it would be desirable to allocate one institution to one type, and another institution to another type, *i.e.*, classify by institutions rather than within the institutions?—I have not thought of that. Of course, what I was dealing with was how we were to find accommodation for this growing population.

19,432. And your suggestion is that the practical solution, under the present economic conditions, is rather to remove some of the present resident population, and to release space for those who are the proper residents in mental hospitals?—That is it precisely.

19,433. And do you think that in that way a considerable amount of accommodation would be released?—I think so.

19,434. How do you think it would affect these old people themselves, not regarding them merely as pawns to be moved about, but looking at it from the point of view of their own welfare?—May I say that I am very desirous that the human side of this question should not be lost sight of. I do not think really it would affect them seriously. Of course, if there were any serious objection on anyone's part it would be taken into account; but I take it that the selection would be made by the medical staff who were alive to the circumstances of each case, and who would see that no case of hardship was brought about.

19,435. I notice that one of your suggestions points in that direction. You suggest that any arrangements made for the transfer of such cases should be in the hands of the medical superintendent of the mental hospital?—Yes.

19,436. And I suppose it would be necessary to see that this accommodation in the Poor Law institution was suitable, and that the patients would receive adequate attention and proper food and clothing, and so on?—Certainly.

19,437. Assuming that the Poor Law institution was approved for the purpose, you think that this would offer a solution of the immediate difficulty?—Yes. May I say, just following up what you were good enough to put to me with respect to individual hardship, it might very often be the means of mitigating the hardship which is now felt, which is that, owing to these institutions being so large, they are scattered about at great distances in order to command a sufficient area, and the relatives of the patients often have a long journey to take before they can visit them. If they could be removed to institutions which were nearer their own homes it would really be an alleviation to the relatives.

19,438. I wonder whether there is anything in this point: do you think that the relatives would prefer their aged parents, or whoever may be suffering in this way, to end their days rather in a Poor Law institution than in an institution for the insane?—I think your knowledge of human nature is equal to mine.

19,439. It does occur to one that to visit one of these old people in a Poor Law institution, might be a pleasanter experience than visiting them in an asylum?—I think the Poor Law institutions vary very much. I have seen some, and some of them are models; others are not quite so excellent, but they do vary very much, and that matter would be taken into consideration. But I think the question of distance, the expense of visiting, is a real question with many people.

11 July, 1925.]

Sir LEWIS BEARD.

[Continued.]

19,440. It does seem a little hard that an old person who is not suffering from any mental disorder, but is merely suffering from decline of mental powers, should be relegated to an institution for the insane?—Quite.

19,441. I can imagine that that would hurt the feelings of some people?—I think, if I may say so, that what is commonly referred to as the pauper taint, is not nearly so much felt by any of these people as the lunacy taint.

19,442. That was really in my mind?—Yes. My experience, and it is backed up by that of others, is that to go to an asylum puts a far blacker mark against a person than going to the workhouse.

Sir David Drummond: Has Sir Lewis contemplated the fact that it has been proposed, in order to augment the available accommodation for ordinary cases in our general hospitals, to utilise these Poor Law institutions, not for mental cases, but for cases of ordinary disease? That is one of the suggestions. There is a great shortage of beds in our general hospitals throughout the country. We have long waiting lists, and it has been suggested that some of our Poor Law institutions with available accommodation should be utilised for that purpose.

19,443. *Chairman*: There might be a competition for this vacant space by the mental hospitals on the one hand, and by the general hospitals on the other hand. Has that aspect of it occurred to you?—No, it had not, and I am not quite sure whether we are talking about the same vacant space. What I meant to suggest here was the vacant space in what might be called the ordinary wards of the workhouse.

19,444. Not the infirmary wards?—Not the infirmary space.

19,445. The residential wards?—Yes, because the point I want to make is that these cases, which I am suggesting might be transferred, are cases which are really not infirmary cases, not cases which require any regular medical supervision or treatment, but are merely to be waited upon, fed, and put to bed, and so forth.

19,446. Just like the old soul who sits in an arm-chair in a cottage and dodders away the remaining years of her life?—Precisely. Perhaps I might quote a case that I happened to come across where a man was brought up for certification on the ground that he was insane, and the justice before whom the case was brought said "I will visit this man." He found he was an old farmer, as you say, doddering about on his farm and his family were getting a little tired of him, but there was really no reason for sending him to an asylum; but if it had not been that that particular justice took a special interest in the case, he might have been sent to an asylum. And there are many cases which would become simply of that type.

Sir David Drummond: Are you not attaching too much importance to the senile phase of it? There are a great many chronic cases, but still the form of insanity is incurable, that are on all fours with the senile cases.

19,447. *Chairman*: I appreciate that, Sir David. There is, of course, the senile case which we have been specially dealing with, and of which there is a considerable proportion in our mental hospitals as we have seen from our visits; but there is another type, namely, the person who, though not suffering from senility, is suffering from some chronic or harmless form of insanity which is recognised as practically incurable. Would you contemplate the transference of that class also to the Poor Law institution?—I am afraid I could not give an opinion on that. It would be all subject to the discretion of the medical superintendent.

19,448. I think we may sum up your view in this sense, that it is not confined necessarily to the senile case, but that accommodation might be released in our mental hospitals by a review of the cases there, and the selection of a substantial number of those cases as appropriate for return to, or admission to,

the Poor Law institution, where they would receive all that they require; and their room would be available for proper inmates of a mental hospital?—That it so.

19,449. *Mr. Jowitt*: May I just ask this: has it occurred to you that the present residents in the Poor Law institutions might dislike very much their new influx of visitors—I mean they might not like to have these people whose mental powers, at any rate, were obviously defective, associating with them?—My suggestion is not that they should be put into the common rooms with the others. There are many rooms which are empty.

19,450. You would keep them quite separate?—Yes, because I think they must always be regarded as mental patients, and there might conceivably—I do not know, I am not a medical man—be a relapse which would require their being returned.

19,451. *Mr. Micklem*: Have you any statistics of the accommodation vacant in the workhouses?—No, I have not.

Mr. Jowitt: It is a question not of beds; it is a question of wards under these hypotheses.

Chairman: Yes. It means also dormitory accommodation, but the accommodation is generally measured in terms of beds.

Mr. Jowitt: Unless you can clear a ward you can do nothing at all.

19,452. *Chairman*: No. We have had some evidence that there is a considerable amount of vacant space in Poor Law institutions which is not taken advantage of just now; and I can see the motive you have indicated for the transference of those cases from the Poor Law authority to the mental hospital, if there is a pecuniary inducement?—Yes.

19,453. We recognise the value of your suggestion upon that point. We may pass now to the treatment of the incipient voluntary case without certification. What is the view of the Association of Municipal Corporations on that topic?—They support the principle of the Mental Treatment Bill, but I must guard myself there, it is the principle they support; they might have many amendments of detail to suggest as to the machinery, but they are strongly of opinion that there ought to be provision made for the treatment of incipient cases without certification.

19,454. In that connection has your Association considered a suggestion that has been urged upon us from many quarters, that in connection with the treatment of cases before certification or in the hope of avoiding certification, there should be some intermediate observation institution or ward, where cases might be under observation for a period on some provisional or temporary order, during which the patient might be examined and possibly recover if the case is transitory, and so be discharged, or possibly be relegated ultimately to certification in a mental hospital? This conception of an intermediate stage has been advocated before us as a possible solution of many difficulties?—No. My Association has not considered that question. I may say that we have endeavoured in this evidence to avoid in any way trenching upon what might be called medical grounds, or, assuming to ourselves knowledge which we did not possess.

19,455. I appreciate your modesty, Sir Lewis, but this has a practical bearing because it might involve the provision of additional accommodation; and it has been suggested that there is a debit and credit side in this consideration, that you might again get some relief for the mental hospital accommodation, if you had an intermediate institution, where cases could be considered and observed for a period, with the consequence that many of them might recover and never find their way to a mental hospital at all. It might involve the provision of additional accommodation?—Yes.

19,456. But it might be accommodation which would be economic in this sense, that it would obviate the construction of large new mental hospitals, be-

11 July, 1925.]

Sir LEWIS BEARD.

[Continued.]

cause it might diminish the number of those resorting ultimately to mental hospitals?—Yes.

19,457. That topic has not been before you. I am looking at it from the purely financial point of view just now?—No, that suggestion has not been before the Association.

19,458. It is one that has some attractions from the point of view of avoiding difficulties in the way of certifying doubtful cases, by providing an interim period of observation?—Quite. Speaking for myself, if I might for a moment, it is a point that has great attractions for me, and I may say that I hope you will stop me if I am going beyond what I ought to say.

19,459. I think your personal view would be interesting to us. We quite understand you are not speaking for the moment on behalf of your Association?—If I might for a moment speak in that capacity, Mr. Chairman, I have been very much impressed with the ignorance that prevails with regard to the nature of mental disease. I do not mean from a medical point of view particularly, but as to the many aspects of mental disease which force themselves even upon a layman who has anything to do with its administration, and the horror which many people have of seeing their relatives confined to an asylum as we call it now, the fear that possesses them as to the meaning of this taint which they have discovered. They are so afraid of it that they will not tackle it properly.

19,460. They prefer to shut their eyes to it as long as they possibly can?—That is exactly what it amounts to. It is the same with regard to tuberculosis. We have in Blackburn (if I may speak for a moment of that town), started health work in the nature of health education, trying to teach the people what health means, that it does not mean simply waiting till they are ill and sending for the doctor, but living healthy lives so as to avoid the incidence of disease. We have contemplated including lectures and propaganda on mental health, but we have not yet been able to do that successfully; it is very difficult to do, but it may be within the knowledge of the Commission, that a deputation of medical officers of health recently waited upon Mr. Neville Chamberlain on the very subject of educating the public in matters of health, and that he gave them a very favourable reply. It did occur to me, as one who has thought a great deal about this thing, and discussed it with medical officers and others, whether the Commission would consider the desirability of recommending that some effort should be made to spread among the public a better knowledge of what insanity means, and the possibility of its treatment. The public do not know as a rule that many cases of insanity are curable, that many cases recover. They regard the lunatic as a person apt to break out into violence without warning, and as being something apart from human nature almost. I do think that if anything could be done to spread better knowledge of the subject, it would be an immense benefit.

19,461. That is a most interesting suggestion, Sir Lewis. I wonder if you have considered whether powers should be given to local authorities to spend money upon the propaganda in these health matters, or, at any rate, upon instruction in health matters?—Certainly.

19,462. Take this effort you are making just now in Blackburn, how is that financed—is that voluntary effort entirely?—No, we are putting it upon the rates without sanction.

19,463. I admire your courage, if I may say so; you regard that as public health administration?—We do.

19,464. But while you are doing it without sanction perhaps you would prefer that sanction should be given, if possible?—It would give us a much freer hand, if we felt that we had not only the sanction but the encouragement which sanction implies. We can only do a little bit in our corner.

19,465. On this topic of treatment without certification which we were discussing, I see you are in favour of such cases being under the control of the present lunacy authorities, rather than under the control of the ordinary local authority, I gather?—Well, that is a difficult question, but it would require a great deal of re-adjustment and legislation to transfer it.

19,466. The reason why I am raising the point with you is this—it really arises out of what you have been speaking of recently. These health lectures that you speak of, and this propaganda with the object of informing the public mind on insanity, as well as other ailments, would be in the hands of the local authority, and the expense of it would be charged to the public health rate?—Yes.

19,467. On the other hand, this new method of treatment which is proposed without certification for incipient cases, you suggest should be in the hands of the existing lunacy authorities. Has it occurred to you to consider whether, in order to dissociate as far as possible in the public mind the idea that these incipient cases are really cases of insanity, they should be dealt with by the public health authority under the Minister of Health, in the same way, for example, as tuberculosis is now dealt with, or venereal diseases? I want to know whether you favour the idea of having a new branch of public health dealing with incipient cases of insanity, or would you rather contemplate an extension of the existing lunacy organisation. That is a practical problem; it could be dealt with in two ways, either independently of the lunacy authorities or in association with them. I gather your Association thinks it would be better to use the existing lunacy organisation?—I do not think we have applied our minds to that, and, as a matter of fact, this suggestion I have made now is not my Association's suggestion.

19,468. I follow. But the point you put to me is a very interesting one, if I may say so, and a very difficult one; but I would like to remind you that tuberculosis is not in the hands of the health authorities, but of the county councils and county borough councils, and so is venereal disease; and although no doubt in a county borough it does not matter because we are all one authority, it would make a difference to the county as to the authority to be entrusted with it. Generally speaking, where a matter requires large institutional treatment it goes into the hands of the large authorities as a matter of convenience of administration: therefore the county councils would have to continue, I think, the mental hospital authorities; but whether the actual work that I have suggested should be in their hands, or in the hands of the health authorities, I think is a difficult question, and I should like further time to consider it. But there is no reason why it should not be in the hands of the Ministry of Health; it should be in the hands of the Ministry of Health. Now, of course, the whole question of mental hospitals is subject to the general control of the Ministry of Health. The Board of Control is a branch of the Ministry of Health technically.

19,469. It has an independent jurisdiction though?—Yes, but the Ministry of Health is responsible to Parliament for it.

19,470. And one can see a drawback from the administrative point of view of having two authorities in charge of one department, because it might lead to duplication, where you have a staff of skilled persons already at work on this subject; and there is no real distinction between the incipient case and the confirmed case in one sense—it is the same illness in different phases. However, we cannot pursue that topic, because, as you say, you are not speaking for your Association on it; but your Association's view is that this matter of the treatment of incipient cases should be under the control of the present lunacy authorities?—So far as they have gone, they support the principle of the Bill. Whether when they come to close quarters with it, which they have not yet

11 July, 1925.]

Sir LEWIS BEARD.

[Continued.]

done, they will recommend that the power should be given to the health authorities, I do not know.

19,471. Then passing to the visiting committee which is at present really the body in charge of these institutions, I notice that you propose that its name should be changed to that of Mental Hospital Committee?—Yes. I am not wedded particularly to the form of the name, but I think the word "visiting" does mischief.

19,472. There is a great deal in a name, of course?—Very often.

19,473. And the name suggests that these are more or less transient persons who go from time to time and look round and go away again. In point of fact they are the persons by statute really responsible?—Not altogether, because the statute itself gives some duties to the medical superintendent if I am not mistaken, and I do not want to interfere with that; but in practice they are responsible for finance and administration.

19,474. They are more than visitors, in short?—Oh yes, a great deal more.

19,475. They are, so far as the local authority is concerned, the managers on behalf of the local authority, and entrusted with powers which are much larger than mere visiting powers?—Yes, but there again, if I might interpose for a moment, the powers are given by the statute to any two or any three members of a visiting committee, and it is curious that it is not necessary for the committee to meet for these powers to be exercised. It is more than the name, really the substance is there. I mean under certain circumstances the three members of the visiting committee—in fact I think under any circumstances three members of the visiting committee may discharge a patient.

19,476. Against the wishes of the medical superintendent?—Quite.

19,477. Two can do it with his concurrence?—Yes. I venture to suggest that is not really the way things should be administered. There should be a corporate responsibility for the exercise of any duty. If it is thought that a patient should be discharged, when the medical superintendent certifies him "You are recovered," then let them say so, let it be automatic on certificate of the superintendent. But if the committee is to exercise jurisdiction and take responsibility, it should be at a meeting properly called and with due deliberation.

19,478. You object to what one may call the apparently casual character of the machinery?—Two members of the committee act; the medical superintendent says "I think so and so might be discharged" and they sign a certificate, and they sign it simply on his recommendation. Really he takes the responsibility, then let him take it.

19,479. But if the visiting committee is to function, you think it should function with more responsibility and in a corporate capacity?—In a corporate capacity, and after everybody having had a chance of expressing his views.

19,480. *Sir David Drummond*: Do you approve of three members of a visiting committee, independent of the medical superintendent, being able to discharge a patient?—No, I do not approve of it.

19,481. *Chairman*: It is a curious provision of the statute; we have heard that it is not often exercised?—No. I know that in the case of the asylum with which I am connected, the practice is that the medical superintendent certifies A, B, C and D, and he certifies them to the full committee at a meeting, as recovered cases; thereupon an order is drawn up, or rather it is a printed form of order, and it is signed by three members of the committee.

19,482. There is no decision of the committee on the case, is there?—Yes, always.

19,483. The committee passes upon it?—The committee passes upon it, but it is purely formal. I mean to say the *Chairman* says "The medical superintendent has certified these patients recovered; is it your pleasure that they should be discharged?" They

all hold up their hands, of course—I mean they are only too glad to discharge a patient.

19,484. *Sir David Drummond*: But they do not act independently of the superintendent?—I may say we act independently of the superintendent in other cases where the relatives or friends come and ask to have the patient released to them, a non-recovered patient. We have the power to discharge a patient to the custody of his relatives or friends. We get a report from the medical superintendent; if the medical superintendent recommends the discharge we always grant it; if not, we hear the patient's friends; they come before the committee, and they state their case, and they are questioned by members of the committee. They are told what the medical superintendent's report on the case is, and they are asked how they propose to deal with the difficulties which are suggested by that report, and then the committee weigh the matter up, and they decide one way or the other, but they decide on their own responsibility.

19,485. *Chairman*: This is diverging a little from your presence this morning as the representative of the Association, but I venture, having you here, to ask you this question as Vice-Chairman of the Visiting Committee of the Lancaster Mental Hospital and as a Member of the Lancashire Asylums Board. I can understand a case coming before your visiting committee with the medical superintendent's report in favour of discharge. Of course I can see that, very naturally, that is practically dealt with automatically?—Yes.

19,486. But does the visiting committee ever of its own initiative, in consequence of receiving letters from relatives or from the patient himself, set on foot enquiries, as to whether a case should be discharged?—Yes.

19,487. I mean not where it is put before you by the medical superintendent but where the enquiry initiates from the side of the visiting committee?—Certainly.

19,488. I would like to know how you do that because that is an important feature?—We have a rota of visitors, that is to say, in the interval between the monthly meetings of the visiting committee certain members of the committee visit the institution and they go through it.

19,489. I have no doubt you yourself have visited frequently?—Frequently, yes. The practice is this: if there is any case brought before the committee at the monthly meeting by relatives or friends which seems to have any substance in it, or indeed even if it has not, it is referred to the visitors for that month. They go into the case; they see the patient; they discuss it with the medical officer of the institution, and they make a report to the committee at the next meeting.

19,490. So that quite apart from the medical superintendent's normal applications for discharge, you do investigate cases on your own initiative?—Oh clearly.

19,491. Have you found instances in which you thought it proper to discharge cases which have been brought to your knowledge, apart from the medical superintendent's initiative?—Yes, not as overriding him in any sense, but it would be a question of the judgment of the committee as to the convenience and the probabilities of the case, based partly upon the medical superintendent's report as to the condition of the patient.

19,492. Yes, but the important feature at this stage is that you have found that there have been cases which have not been brought to your knowledge by the medical superintendent, but which, being brought to your knowledge from other sources, you have thought proper to discharge?—Yes.

19,493. Has that often happened?—No.

19,494. But it has in some cases?—It has happened.

19,495. Now may we come back to the recommendations of your Association. Passing to the question of certification I see you do not desire to

11 July, 1925.]

Sir LEWIS BEARD.

[Continued.]

deal with the question of the distinction between paupers and non-paupers. You have nothing to say upon that subject, I take it?—No.

19,496. We have heard much about that from others. You draw attention to the different forms of procedure under which patients are certified, and find their way into the mental hospitals?—Yes.

19,497. Would you just give us the points to which you wish to allude in this connection?—In the first place, I should like to call the attention of the Commission to the fact that in consequence of recent legislation the distinction between a justice who is a judicial authority, and a justice who is not, has disappeared. I think I may put that broadly as a proposition.

19,498. In some cases, of course, the whole bench of justices have been appointed judicial authorities, and that obliterates any distinction?—And Parliament has sanctioned that practice, so that Parliament has gone back from the position that it originally took up, that there was to be a distinction between the justice who is a judicial authority, and another. However, that being the case, I think we must take it that all justices are to be considered as potentially empowered to exercise all these powers, and what I wanted to put before the Commission on behalf of my Association is this, without criticising anybody, that it is not right that the newest justice on the bench, without any experience of these cases at all, should have this very great power over the liberty of the subject. In the exercise of his ordinary judicial duties he has the advantage of sitting with a colleague, and he may sit on many occasions on the bench and hear cases dealt with before he ventures to take part in the jurisdiction of the bench itself. But with respect to lunacy he may simply have a relieving officer come to his office one morning and present him with a certificate and say "Will you sign this?" And apart from anything else, the man's inexperience will lead him to do what he is asked to do. He has no other judgment to guide him; he has an independent judgment to exercise. It appears to my Association that that is a state of things that ought not to be. In an ordinary case where a man is to be sent to gaol for six weeks, it takes two justices and a clerk and a hearing, before he is sent away. I am putting it perhaps rather strongly, but a man may be sent away to confinement for life without any of the formalities which are thought necessary in the case where a man has committed a crime.

19,499. Then you do favour the reversion to the idea of having justices appointed *ad hoc* for the purpose of administering this jurisdiction?—I am afraid there might be some inconveniences about it.

19,500. That is what I am going to follow up with you, but let us hear your view generally?—My view generally is that there should be a more stable jurisdiction in this matter. Here is the justice and he can do these things. That, of course, was the old state of things under the general law before the Summary Jurisdiction Acts. A justice sitting in his own room, as we have read in many works, simply exercised jurisdiction without any formality and without any publicity, without anything of that kind. At the present time all that is altered, and my Association suggests that the time has come when this jurisdiction, which has a very important effect upon the future of an individual, should be exercised under something like the safeguards which appertain in the case of other jurisdiction.

19,501. Of course it is a different jurisdiction, Sir Lewis, from the ordinary jurisdiction in criminal or petty civil matters, because it is a case in which the justice must to a very large extent depend upon expert evidence in the shape of a medical certificate. I mean he can weigh, no doubt, the value of the certificate, but he is not a competent judge in the same way as he is when he hears a case before him with general evidence, the value of which he is really in a position as a citizen to assess?—I appreciate that, if I may say so; but I would call attention to

the fact that the question which the justice has to determine is whether the lunatic is a proper person to be detained. He has not got to decide whether he is a lunatic or not.

19,502. No; the medical question of his suffering from the disease of insanity is determined by the expert, namely, the doctor?—That is so.

19,503. But then the question of the suitability of the case for detention depends again upon the medical diagnosis, because a layman may see a patient in a state of mind when he thinks he is a fairly safe person, and there is no reason why he should be detained, but the medical man knows that such a person at other moments may be very dangerous to himself and to others. How is he to judge?—Of course he has got to judge to a large extent upon the medical evidence; but what I want to put forward is that the medical evidence is material on which the justice has to determine. The medical evidence as to whether he is insane or not has to be accepted, the conclusion has to be accepted. In the one case the medical man has to conclude as well as examine; in the other case he has to submit to the justice certain matters upon which he is to come to a conclusion. What I suggest is that this is such an important point, as to whether a man is to be detained or not, that there should be a more, what shall I say—a more formal method of dealing with it than there is now; that it should not be simply a question of a man in his own house, or in his own office, signing a certificate. I do not know how often it is resorted to, but it is perfectly open under the present law; a man may sign a certificate anywhere, and he need not even see the patient in many cases; but I suggest in all cases the patient should be seen, and that the matter should be dealt with formally, and the clerk to the justices should be present, not only in order that he may advise the justice as to what his jurisdiction is, but also that he may keep a record.

Mr. Micklem: He must be seen if it is one certificate.

19,504. Chairman: The pauper case must be seen; the private patient need not be, there being two certificates there?—That is so.

19,505. But you concur with a large body of evidence we have had, that in all cases the order of certification should be preceded by the justice actually seeing the patient?—Oh clearly, yes.

19,506. One always thinks of these things in practical terms, Sir Lewis; and if one were dealing with a case of that sort, however formally, with the clerk and so on in attendance, in the end of the day it would still be very difficult to get away from the medical evidence of the case. I am thinking of myself, as a layman with a patient brought to me with medical certificates of unsoundness of mind; it would be very difficult to judge on my responsibility whether that person needed to be detained or not; I could be very easily hoodwinked, if I may so put it, as a layman on a subject of that sort?—Possibly.

19,507. I think it is a very difficult jurisdiction for a justice, is it not?—It is a very difficult jurisdiction; that is why I desire to fence it round with safeguards.

Sir David Drummond: Do I understand that Sir Lewis suggests that the justice's clerk should be present in every case?

Chairman: Yes, he does.

19,508. Sir David Drummond: Do you think that is feasible?—Yes; I except in my evidence and my proof, cases of great urgency.

19,509. Chairman: The emergency certificate?—The emergency certificate. Then I suggest that the emergency certificate should not last for more than a certain time, it should be quite a short date certificate, and before that expires, then there should be the formal procedure.

19,510. Of course we all recognise there must be some means of dealing instantly with urgency cases, and you are not so concerned with them. You are

11 July, 1925.]

Sir LEWIS BEARD.

[Continued.]

thinking of what may be called the permanent sentence of detention?—And the emergency case at the present time ceases to be an emergency case as soon as the certificate is signed.

19,511. How far would you carry this, Sir Lewis? It is manifest that you cannot convert the matter into an ordinary judicial investigation—I mean, to require that would be obviously undesirable, but how far would you wish additional formalities? You say the presence of a clerk is desirable who would be there to advise the justice?—Yes.

19,512. Secondly, he would be able to keep a record of the proceedings?—Yes.

19,513. Have you carried the matter further in your mind—have you considered the question of the proceedings being in public?—No, I do not think they should be in public.

19,514. But you do consider that the patient should always be there?—Yes.

19,515. Have you considered further whether relatives of the patient should be present?—I have not.

19,516. Or a representative of the patient? You may recall that in the case of the private patient provision is made for the attendance, if desired, of someone who represents the patient?—I think there might be (I have not any instructions on this point) power in the justice, if he thought fit, to adjourn the case and send for the relatives, but what I rather had in mind was this: at the present time the whole thing is too apt to become a mere formality. Now I think the attention of the justice should be drawn to the fact that he is exercising a jurisdiction, and that the points are so-and-so, and so-and-so. Then on the question which is the real question for him to decide, whether the case is one for permanent detention or not, there I think it would be well to have a trained mind like that of the clerk, perusing the certificate “On this certificate had you not better ask the doctor whether this case could not be dealt with without permanent detention?”

19,517. On that do you propose the doctor should be present?—If the justice requires him, if he is not satisfied with the certificate.

19,518. That he should be at liberty to call for the doctor's attendance?—Yes.

19,519. Then you further suggest that he should be entitled to call for the attendance of the relatives or guardian, if there be any available, to inform his mind further on the circumstances of the case?—I think if he is not fully satisfied, he must either call for further evidence or discharge the certificate.

19,520. *Mr. Micklem*: In the ordinary case of a magistrate making an order does not he, in fact, see the doctor as well as the relieving officer?—I am afraid I cannot answer that question.

19,521. I mean, I have a very small experience, but I should have thought, speaking generally, the justice of the peace would never have made an order without consulting the doctor?—That may very well be so, and I am not disputing it for a moment. What I am venturing to suggest is I am looking at the Act of Parliament and the possibilities of the Act of Parliament, and it seems to me that the possibilities are rather serious. The procedure is unnecessarily loose, and I want it tightened up. Possibly what you have suggested is the normal procedure, and what one rather wants is to make it the normal procedure, but while at the present time it may be the normal procedure it is not the universal procedure, and it is not necessarily the procedure under the Act.

Mr. Micklem: But I should have thought the justices found this a very difficult jurisdiction to exercise, and that almost always, if not quite always, they saw the doctor and made every possible enquiry before making an order.

Chairman: I am afraid not, *Mr. Micklem*. We have had evidence of cases being certified, simply on being brought in a taxicab to the justice's house.

Mr. Micklem: They were raving cases.

19,522. *Sir Ernest Hiley*: Do you suggest that the patient should be present at every stage of this enquiry?—Not necessarily. I think the justice certainly ought to see him, but it would be for the justice to decide whether he wanted to see him all the time.

19,523. *Chairman*: Now, just to carry this a little further, are you in favour of any justice being entitled to exercise this jurisdiction, or should it be delegated to specially selected justices?—If the jurisdiction is fenced by the safeguards I have suggested, I do not think it is necessary to restrict it to any particular body of justices.

Chairman: We have had evidence of this sort; Sir John Barnsley, for example, gave us evidence at Question 1805: “Is the medical practitioner present when you are interviewing the patient?—Not as a rule.” Of course, in other cases *Mr. Micklem* has had other experience, but it is not required, I understand.

Mr. Micklem: Yes, he was speaking there of violent emergency cases.

19,524. *Chairman*: No, I think there is a good deal of evidence of that sort. The difficult point is that we are dealing with sick people, and therefore one has to see that we do not import formalities which are unnecessary?—Quite.

19,525. And which may be distressing?—Quite.

19,526. At the same time we want the safeguards to be adequate. It is the accommodation of these two considerations which is the real problem?—Yes.

19,527. In Scotland, as you probably know, the certificates are all granted by what one would call the county court judge, the sheriff, who is a professional man of standing?—Yes.

19,528. And in England provision is made for a county court judge performing this work, but I understand he has never done it?—I understand not.

Mr. Jowitt: He has not got time.

Chairman: He has not got time, and the statute contemplates that he need not undertake it?—As a matter of fact I understand that the reason urged for making this the duty of all justices, is that it is desirable to have someone, especially in country areas, who is within reach. I quite appreciate the force of that.

19,529. *Mr. Jowitt*: That is why I ventured to hesitate as to your idea about the clerk to the justices. If that is a part of the necessary formality, it may sometimes be very difficult to get hold of him?—I agree, but they appoint so many justices nowadays that I should have thought it would not have always been difficult.

19,530. *Chairman*: Take *Mr. Jowitt*'s point: suppose you have a case occurring in a more or less remote country village; you have a justice of the peace there, but the clerk of the justices is probably resident in the county town, possibly 30 or 40 miles away; it might be very difficult and expensive too to bring him along for the purpose of participating in this ceremony?—I should make two comments upon that, if I may.

19,531. If you please?—The first is, that it would be possible in those cases for the justice to make an emergency order, just to detain the patient pending further investigation. After all any system will have difficulties, and this difficulty would have to give way to the greater good of the greater number. It is for the Commission to weigh the advantages and disadvantages, I think.

19,532. Now you suggest also, I observe, that this jurisdiction should be exercised by two justices with the clerk?—Yes.

19,533. You are making it even more difficult?—Quite.

19,534. Because one justice has first to be sought, then you need to get another, and then you need to get the clerk. That could only be for the formal certification, not for emergency orders?—Not for the emergency orders. Perhaps I was thinking in terms of my own district where there are plenty of justices

11 July, 1925.]

Sir LEWIS BEARD.

[Continued.]

who sit every day. One naturally thinks in terms of one's own surroundings, and one has to be corrected.

19,535. We have had a lot of evidence from the London area where facilities exist on a larger scale still, and similarly from large areas like your own; but when one is considering the case of the rural districts, it is not so easy to have machinery that will function as you suggest?—I quite appreciate that, and perhaps, speaking on behalf of the Association of urban authorities, I have not dealt with that case particularly. One has rather to think in terms of the conditions one knows, but one had in mind that the Commission would have evidence from other people who are more experienced in those things, and one did not want to tread upon ground one was not familiar with.

Sir David Drummond: Has Sir Lewis had any experience of abuses under this system which has led him to insist upon more strict formalities?

19,536. Chairman: Are your suggestions, Sir Lewis, for reform of the procedure based on any abuses which have occurred in your experience, or are they based rather upon the desirability of appeasing public anxiety—on which do you lay emphasis?—I would point out, in the first instance, that this is not only my evidence, but the evidence of the Association of Municipal Corporations. This proof was submitted to, and was amended by, the Committee of that Association, and there was amongst the members of that Committee, a very experienced justice's clerk, and he stiffened it very much on this point. He had experience which he gave me (it is secondhand); I have no personal experience because I am not in contact with this thing at all personally, but it has been told me by people who have been in contact, and whom I can trust, and they have cited instances which were rather serious.

19,537. You have drawn attention to what your Association regards as the casual nature of the procedure?—Yes.

19,538. And what one rather wanted to know was whether the casualness of the procedure had led to irregularity in the instances under your own notice?—Not under my own notice; they would not come under my notice.

19,539. I follow. Sometimes you know a casual system works in practice all right, but nevertheless it may be undesirable to continue it because of the risks?—Yes.

19,540. Then all this which your Association recommends is apart from the emergency case with regard to which you give your approval to certification by a single medical practitioner, as at present, with one justice?—Yes.

19,541. But any such order should not be valid beyond a short period, and thereafter formal certification?—Yes.

19,542. Of course if the suggestions that have been made for an intermediate stage of observation were adopted, the temporary order might be extended in order to allow of that period of observation intervening before formal certification?—Precisely.

19,543. I take it your recommendations for stiffening the procedure apply to formal certification, at whatever stage it takes place?—Yes.

19,544. Whether it is postponed for some period of observation or otherwise?—Precisely.

19,545. Then even in the emergency case where the justice would be functioning without his clerk, you recommend that the clerk should be notified at once in order that a record may be kept of the emergency order having been pronounced, and of the circumstances under which it was made?—Yes.

19,546. Then there is one other topic which is not referred to in your *précis*, upon which I want to ask your views. It has been suggested that the powers of the Board of Control in the matter of the regulation of mental hospitals might be strengthened. At present, as you know, the Board of Control visit the institutions and enter recommendations in the book

for the purpose, which come before the visiting committee and are considered, and no doubt, where thought proper, given effect to. It has been suggested in some quarters that with a view to attaining a standard, a more or less regular standard throughout the mental hospitals of the country, some sanction should be attached to the Board of Control's recommendations; that they should be empowered to set a standard, and to enforce a standard in such matters as diet and clothing, and so on, of general application, or to make rules which would be obligatory in particular districts, because one can conceive that in certain districts you might have to modify your rules. What is the view of your Association, if they have considered it, of the relations of the visiting committee's *vis-à-vis* of the Board of Control on this point?—My Association have not had that point before them.

19,547. The real reason why I am asking you this question is this, that you represent and voice the feelings of the Municipal Corporations who are charged with these important duties, and what one rather wanted to know was whether your Association would resent in any way further power being vested in the Board of Control in the matter of directing, as distinguished from merely recommending standards?—The general view that my Association take with respect to such questions is that as far as possible local authorities should have freedom of action in matters of detail; and that is all to the good because it leads to experiment, and from experiment to experiment we gradually improve. There are many things (if I may digress for a moment) which have been introduced into public legislation simply by that method. Notification of births, of course, was an experiment at Huddersfield. The late Mr. Broadbent, who died the other day, was the originator of that. Notification of infectious disease was also an experiment; it was optional at first, and ultimately made obligatory. The regular course of legislation in local government has been of that kind. One authority promotes a Bill in Parliament to get certain powers; those powers are looked upon by Parliament askance, the first time they come up—I have had that fate myself.

19,548. I have promoted many of them personally.—No doubt you have, Sir. After a time the thing does not look as formidable as it looked at first, and the Ministry of Health, or the Local Government Board, are persuaded that there is something in it, and then it is tried and it works. Then it is put in an optional Bill like the Public Health Acts Amendment Act, 1890, or the Public Health Act of 1907, and it becomes within the power of the local authority to adopt that by order of the Ministry of Health, or by simple regulation subject to certain formalities; and at the end of a certain period it is put in a general Bill. At the present moment my Association is engaged, in conjunction with the Ministry of Health and other bodies, in consolidating the Public Health Acts, the Act of 1875, which was itself a consolidation, the Act of 1890, the Act of 1907, and a number of provisions which have been enacted in local Acts of Parliament since that date. These are all being now consolidated. We shall have a fresh Public Health Act which consolidates everything, and then we shall start making experiments beyond that.

19,549. I am very familiar with the process by which local legislation ultimately crystallises; but do you think it is better to leave to the local authorities in this matter of lunacy administration as much autonomy as possible, just because of the value of experiments in such work?—Yes. Even in such a matter as diet I think the practice and experience of medical superintendents is exceedingly valuable in seeing the effect of diet on various patients, what is the best standard diet, and what you can get economically.

19,550. You in no way resent the powers which reside in the Board of Control to make recommenda-

11 July, 1925.]

Sir LEWIS BEARD.

[Continued.]

tions. In your own experience have you found that the recommendations of the Board of Control were worth considering?—Yes.

19,551. And have you given effect to them from time to time?—I could not say to all of them, but to many of them undoubtedly. They very often represent the experience of other mental hospitals, and so on, but they are always backed with the weight of the Board of Control and *primâ facie* one would adopt them. One has to go into the question of cost and advisability, and get the report of the medical superintendent upon them. He is the man to whom we ultimately look for our advice on recommendations.

19,552. I take it your Association would prefer that the existing system of advice and recommendation by the Board of Control be continued, rather than that the Board of Control's views should be enforceable by them?—I am sure they would.

19,553. Has your Association considered the advisability of fostering research in connection with this branch of medical science?—No.

19,554. One of the provisions of the Mental Treatment Bill was a clause to enable local authorities to contribute to research?—Yes.

19,555. Is that one of the clauses that has the approval of the Association you represent?—All I can say is that they approved the principle of the Bill. They had not gone into clauses.

19,556. A possible charge on local funds is suggested there to aid research. It would at present be *ultra vires* to make grants for that purpose, and an enabling clause was inserted, but your Association has not considered the desirability of that?—No. We do carry on research work at the asylum of which I am Vice-Chairman, but I do not know how we pay for it.

19,557. You have a pathological laboratory I have no doubt there?—Yes.

19,558. Then, I think, Sir Lewis, as far as I am concerned we have covered the ground in your *précis*, but perhaps some of my colleagues would like to put some questions to you.

19,559. Mr. Micklem: I should like to ask you this question on certification. Do you think in every case, except the urgency cases, there should be a petition presented?—No, I do not think it necessary.

19,560. You would not put the private and pauper patients upon exactly the same footing in that respect?—No, I should not.

19,561. Do you think if you had the provision that the justices should sit in a quasi-court with their clerk that the further formality of a petition might be disregarded?—Yes.

19,562. Miss Symons: Sir Lewis, does your Association approve the principle embodied in the Mental Treatment Bill, providing for a certain number of women on visiting committees?—That is a clause point again, if I may say so. I do not see why they should object to it.

19,563. Chairman: Have you any ladies on your visiting committee?—No, there is no woman on it, not the visiting committee I am a member of. We have some ladies on the mental deficiency committee of the Asylums Board.

19,564. Miss Symons: Do not you think, in view of the very large proportion of women in mental hospitals, it is advisable to make some fresh provision?—I do not see any objection to it. I think it is probably desirable if only for the purpose of appeasing public opinion. I have not had very much experience of committees of mixed ladies and gentlemen; I do not know much about it.

19,565. Mrs. Mathew: I only just want to ask, Sir Lewis, would not the short date certificates cover that difficulty of collecting the clerk and the justices, because presumably even in the most rural districts that would give sufficient time to collect the justices and clerk and to bring the mental patient before them?—That was the idea which lay behind it, that you could carry over cases, where you could not get a full court at the time.

Chairman: Then, Sir Lewis, it only remains for me to thank you for your attendance here this morning, and for your valuable contribution to our deliberations.

(The Witness withdrew.)

(Adjourned.)

5, OLD PALACE YARD,
WESTMINSTER, S.W.1.

THIRTY-EIGHTH DAY.

Tuesday, 20th October, 1925.

MEMBERS PRESENT :

THE RIGHT HON. H. P. MACMILLAN, K.C. (*Chairman.*)

THE EARL RUSSELL.

SIR HUMPHRY ROLLESTON, BART., K.C.B., M.D.

SIR ERNEST HILEY, K.B.E.

SIR DAVID DRUMMOND, C.B.E., M.D.

MR. W. A. JOWITT, K.C.

MR. N. MICKLEM, K.C.

MR. H. SNELL, M.P.

MRS. C. J. MATHEW.

MISS MADELEINE SYMONS.

MR. P. BARTER, *Secretary.*

MR. W. FAIRLEY, *Assistant Secretary.*

EVIDENCE TAKEN IN PRIVATE.

Miss H. called and examined.

19,566. *Chairman:* I understand you are here this morning to give us some account of your experiences while you were a mental nurse at C. Mental Hospital?—Yes.

19,567. What we should like to have from you, Miss H., is as short an account as you can give us of your actual experiences when you were there. I understand that you had in view the idea of becoming a professional mental nurse?—Yes; I thought perhaps I could get along and take private cases on my own afterwards; that was my intention.

19,568. And with that object you thought it would be a good plan to go to one of the public institutions for training?—Yes.

19,569. Was that in 1921?—It was that very hot summer. I cannot tell you whether it was 1921 or 1922.

19,570. I understand that you went to C. on the 3rd August, 1921—is that right?—Yes, that is right.

19,571. And you naturally, of course, started as a probationer?—Yes.

19,572. Had you had any previous training at all?—Not in mental nursing. I had done quite a lot of nursing at other times, home nursing and in schools.

19,573. Had you had any training in any institution before?—None whatever. I was told none was necessary, for one thing.

19,574. Perhaps, if you do not mind, you might tell us how old you were when you started on this work?—I was getting on for my 28th year—28 in the following March.

19,575. How did you make your application?—I got a list of the whole thing; they are advertised in the papers, and I chose C. because I had friends out that way at B. They send you a form that you have to fill in. They want to know whether your voice is contralto or soprano, and those kind of things. That is on the form. I mention that because I wish to mention afterwards the different things they did not think it necessary to find out about you. They did not think it necessary to find out whether your references were correct or not, but they sent up your birth certificate for confirmation.

19,576. Did they ask for references?—They asked for references. I sent them two. I got two ladies

to give me references and they did not take them up; but they kept back the birth certificate for quite a long time. When I asked what had happened to it, they said they had sent it up for confirmation. It seems to me much more necessary to find out where a person has grown up rather than when she was born.

19,577. I gather that in your view more searching inquiries should be made?—Most decidedly. If you only saw the class of nurses on their own there—what type of people are there to look after them! The block I was put in to sleep was called White-chapel, because the language was so bad. That scarcely was bad enough to describe it. The first night I was there a lot of them came in considerably the worse for drink. It had been their pay day, and they had all been down in the town and they came back using obscene and blasphemous language.

19,578. You made your application, and it was accepted I understand, and you entered on your duties?—Yes. You have to be examined by the doctor before you enter. They put you to bed in a little side room off one of the wards. You see the matron first of all. She gave me a belt and scissors and keys. She did not tell me anything about my duties; nobody ever told me what my duties would be. She told me that I should have to work under girls who were not so well educated as myself.

19,579. Were you furnished with any book of rules, or were there any books of rules?—No; that I must explain. It was about three days after I was there I had to go to the office—that is when I demanded my birth certificate. They gave me a paper to sign in three or four different places. I naturally insisted on reading the paper before signing. One of the things I had to sign was that I had read and would do my best to keep this book of rules. I had not had a book of rules, so I was not going to sign it. In two or three days the matron brought me a book of rules. Some of the nurses had been there since March and had never seen the book of rules, but they had all signed a paper to say that they would keep them.

19,580. If you had no instructions as to your duties, how did you start to do your work?—That is just

20 October, 1925.]

Miss H.

[Continued.]

it, you are left. You are told to report on such and such a duty in such and such a ward; when you get there you are told off to do this and do the other—take this patient that, and; this patient something else, but you are not explained anything at all.

19,581. Of course you must be given a bedroom or something of that kind?—You are given a cubicle.

19,582. And I suppose you took your things there and settled in?—Yes. Two patients were told off to carry my trunk up to the place where this cubicle was, in South Block B, I believe it is called. As I say, it was known as Whitechapel.

19,583. Do you get a cubicle to yourself?—You get a cubicle to yourself, but every nurse's key fits the door, and also the charge nurse has a key that fits every door. But one drawer you are allowed a private key for.

19,584. You got your cubicle assigned to you and took in your possessions, and you say you were assigned a certain ward to go to?—Yes. I can tell you the ward I went to first of all—4th August. First of all, I would just like to mention that the nurses were talking (I know you will say this is only gossip) the first evening I was there, about a woman having a miscarriage in the courtyard; no one knew she was pregnant. I saw her the next day; she was just a little bit abnormal, like people get at the pregnant time, and she told me she had come there in March; she became pregnant in February, and no one knew she was pregnant even.

19,585. Have you got her name?—I cannot give you her name; I did not hear it because I was moved about from ward to ward.

19,586. What was the date?—It was 4th August.

19,587. It was the first day you started your work?—Yes; so I suppose it happened the day before. It must have happened either on 3rd August, or 4th August.

19,588. *Earl Russell*: Had the woman herself not mentioned that she was pregnant?—I suppose not; I do not know. She told me she always became funny at times when she was pregnant, and that her husband knew it. I should know the woman again if I saw her but I am sorry I cannot give you her name.

19,589. *Chairman*: You say she had been admitted in March?—Yes. She became pregnant in February she told me, and this you will see is August when she had this miscarriage.

19,590. That is what you heard from some of the other nurses?—I had heard she had had a miscarriage. I saw the woman next day, and she told me she always became abnormal when she was pregnant. She was in the infirmary ward, you see; that is where I went on the 4th.

19,591. Did she describe this incident to you?—No. She was really rather amused because the nurses would not believe it was her. When they found this in the yard they naturally started looking round to find who it was from; and when she said it was from her, they would not believe her at first until they got her in and got the doctor to her, and then she was put in the infirmary ward.

19,592. We will now turn to your own actual experiences. First of all I think you wished to tell us about the type of nurses whom you found in this ward. I would like to know your impression of them?—My impression of them is that they are of the very lowest factory girl type; they are certainly not the kind of girl you would trust to do anything out of your sight.

19,593. How did you get on with them?—One does not get on with them. One does not talk to them any more than one can help. I was moved about from ward to ward. You are not properly warded until you have been there three months.

19,594. *Sir David Drummond*: What is the charge in connection with the case of the woman becoming pregnant and having a miscarriage?—Insufficient examination by the doctor when the patients go in.

19,595. You mean the doctor had not discovered she was pregnant?—Decidedly.

19,596. I am afraid that is a very frequent event in ordinary practice.—From March until August the woman was under their care and they did not discover she was pregnant.

19,597. *Chairman*: Then you were not in any particular ward?—No, I was moved about; I was sometimes in three or four wards during the day.

19,598. Your duties were what you might call general duties?—General factotum I should call it, moved about from one ward to another. When they wanted an extra one in a ward for the dinner hour, I went there. When I was in the T.B. ward, they were mostly bed patients; I was sent next to another ward for the meal hour, and I was not allowed disinfectant to wash my hands before going from the enteric and tubercular ward to help with their food.

19,599. *Earl Russell*: Did you ask for it?—I asked for it, decidedly; cleanliness demands that much, anyway.

19,600. *Chairman*: Then your first comment is that the class of nurses whom you found engaged in C. were in many instances unsuitable persons?—Decidedly. They might have been all right if they had been under proper control, but they certainly should not have authority and opportunity to behave as they did. For instance—this is not on one occasion, but I have frequently seen them tease helpless bed patients in an obscene manner for their own amusement. There was one unfortunate woman who was paralysed, and her bed was just inside the door of one ward, and there were several nurses that made it a practice to pull up her bed clothes and tease her in an obscene manner when they went by her, on purpose to hear her squeak. Is that the kind of woman you would expect to be a nurse?

19,601. Did you see that yourself?—I saw that myself on very many occasions. Another practice with the same nurses there—one's name was Nurse H.—I cannot tell you the names of the others—was to tell patients she had mixed cats' filth in their soup that she was feeding them with, and that kind of thing, and using the vilest words you could imagine to describe these things she was mixing with the stuff. That I heard myself.

19,602. I see you say that bad language was commonly used—is that so?—Decidedly, not only bad, but the lowest vile words.

19,603. By the women?—By the nurses; I never spoke to a male attendant while I was there; I never saw them except outside cuddling the nurses when I came in at night.

19,604. Was bad language common among all the nurses?—No, not amongst all of them; amongst a great many. I was not put into the very worst wards, because I was rather small.

19,605. What was the occasion of using bad language?—It was their common talk.

19,606. Do you mean among themselves?—Among themselves. It was worse, if anything, up in the cubicles than it was down in the wards; the vilest obscenities. I could not possibly bring myself to describe them to you any more than that, that they are the lowest words I have ever heard anywhere.

19,607. Did they use that language in addressing the patients?—Always when no charge nurse was about. There was a Nurse H. in one ward; she did not mind what her nurses said to their patients because she screamed at them all day herself; she was well on the way to becoming mental herself.

19,608. Did the charge nurse in the wards you were in control the nurses at all?—The best ones of them contented themselves with not doing the thing themselves; it is no small proposition to be up against a bunch of girls like that. Some of the charge nurses did their duty in the best way they could—in the easiest way they could. I know there are two or three very able charge nurses. There is a Nurse C. in Villa 2—that is the receiving ward; the only thing I have against her is that with patients who were

20 October, 1925.]

Miss H.

[Continued.]

useful in doing the work she had her own means of retarding discharge; their discharge would be kept back a week or two because they were useful to her. In that ward they did their own cooking. But otherwise she was kind and fair to every one there; she would always give you advice if you asked her about things.

19,609. Do you say the use of bad language was universal among the nurses?—Among all the nurses I came into contact with.

19,610. Universal?—I cannot tell you that every one used bad language, but it was the general practice.

19,611. *Earl Russell*: Did you ever hear anyone protest about the language?—No. If I mentioned anything at all I was told not to be a "soft," and then a nice kind of word, and to mind my own business, so I gave up protesting.

19,612. *Sir Humphry Rolleston*: I suppose you cannot suggest any means by which that can be detected or controlled?—One could suggest a means by which those kinds of things could be stopped, and that is by having a properly trained nurse to watch over these people all the time; and that these people should be merely servants to the patients, not be in charge of them, and not be in authority over them as if they were some great Eastern potentate. As it is, they have absolute control over them. They should not be allowed to. They should be told they were there as servants and attendants, and there was someone in control to look after them. Half of those nurses there, even the charge nurses, have no hospital training in the T.B. ward and the enteric ward.

19,613. *Chairman*: Apart from the language which you have described, I would like to know further from you what was the conduct of the nurses generally to the patients whom you saw?—Extremely brutal. For instance, a lot of the patients had very bad bed sores; some of them you could put your thumb into; and the general method of treating those was with a lighted candle. They light a candle and drop the hot grease into the sores; they do not explain or do anything to the patients; if they dare to wriggle or protest at all, they are just banged about. That was both in the infirmary ward and in the T.B. and enteric ward.

19,614. How many patients did you see treated in that fashion?—I cannot tell you how many. One was a dying one; she had the worst bed sores I saw on any of them.

19,615. *Sir Humphry Rolleston*: I think I ought to say that this "amberine" treatment was recognised during the war as a treatment for burns—I mean dropping hot wax on the wound at first sight sounds a brutal proceeding?—It is brutal.

19,616. But it was recognised as a form of treatment for burns, which is very much the same thing?—Yes, but treating the men during the war is different from treating those helpless patients; and when it comes to treating a foreign dying patient, you cannot understand one word of the language, anyway; she is pulled round by her hair and that kind of thing, and there is the dabbing at these sores and dropping this hot grease on. This was the enteric patient who died while I was in the ward; she was put down as an enteric patient. Then they went to the next patient; I do not know what was the matter with her; they would take a little drop of water and wash the body of M.B.; they go to the next patient and they attempt to wash her face with the same water and the same filthy bit of rag; she naturally protests and there is a free fight. That is a usual occurrence amongst them; they wash anything from 12 patients upwards in the same drop of water.

19,617. *Sir David Drummond*: Did the nurses drag this patient about, knowing she was suffering from enteric fever?—I suppose so, Sir; it was the enteric ward.

19,618. *Sir Humphry Rolleston*: You have got to draw a distinction between treatment and the way

it is carried out?—Yes. If the rules were kept it would be all right, but no one takes the trouble to keep them. Fancy a decent girl being told that she is not to use strong and intemperate language to the patients. There is another one about not putting a patient's head under water to punish them. Those things are insults to decent girls.

19,619. *Chairman*: Have you got a copy of the rules?—I have copied out some of them; you are not allowed to bring the rules out of the hospital.

19,620. We can get a copy of that?—It is rule 22—"the attendant shall on no account use coarse, violent or intemperate language."

19,621. That seems a necessary rule?—Yes, but why necessary? If you got in a nurse for your child or wife who was ill would you tell her she was not to use coarse or intemperate language to her? About putting the head under water, "under no pretence whatever is a patient's head to be under water"—that is rule 79, under the bathing of patients.

19,622. I cannot see anything wrong with a rule of that sort?—No, but my point is that that shows what class of girl they expect to get in, that would torture a helpless patient by putting her head under water to punish her.

19,623. *Mr. Snell*: Is your point that there may have been cases of this kind reported, and the rule is made in order to prevent its repetition?—My case is that it must have happened so frequently there that they made the rule.

19,624. *Sir David Drummond*: Would you tell us a little more in detail about pulling this typhoid patient about? What did they do actually?—The best way I can explain is by just telling you I was told off to help first of all, but I was not rough enough. They come along, pull down the bed clothes and catch hold of her shoulders or hair, and turn her over on her face, and pull these rags off her that are on her back.

19,625. There was washing going on, I suppose?—I should not call it washing, myself. This water had already been used on other patients. They just pull the rags off and jab them like this with a rough towel.

19,626. My point is they did not pull her about for the fun of it?—No, they went there on that occasion to wash her, not to pull her about.

19,627. And they turned her over?—It is not turning, they simply pulled and hauled.

19,628. *Chairman*: Your point is that in performing their duties they did it too roughly?—They did it brutally. They would not treat an animal like it because the animal would bite.

19,629. *Mr. Snell*: Do you suggest that this was habitual—it was not done in a moment of excitement?—I do; it was habitual.

19,630. *Chairman*: And you say this was the kind of conduct on the part of all the nurses—all except the head nurse?—No, not all the nurses, but a great many of them, the majority whom I came in contact with.

19,631. Did you ever protest yourself?—To the charge nurses, and I was always told not to be a soft —, or to mind my own something, something business.

19,632. *Earl Russell*: Did you ever protest to any of the doctors?—I never saw a doctor but three times there, and then he was wandering round talking to someone. I once saw a doctor come on the verandah, when a patient's arm had been badly bruised; she showed her arm to the doctor.

19,633. You might have drawn his attention to that too?—I was inside with a few others; this was on the verandah. If I had drawn attention to it, the result would not have been what I wanted anyway.

19,634. *Mrs. Mathew*: How long were you there?—Six weeks.

Earl Russell: Only a month according to your *présis*.

19,635. *Chairman*: It is four weeks you see, Miss H.?—No, I left on the 7th or 9th; I am not quite

20 October, 1925.]

Miss H.

[Continued.]

sure which it is. But I want to tell you this. The last week I was there I had given my notice, and everyone was much more careful; they knew I was going, and they were much more careful.

19,636. You tell us you left on the 3rd September, 1921—is that accurate?—In my diary I have the 7th.

19,637. Did you keep a diary all the time you were there?—No, not all the time. I generally keep a diary when I go to a new job. The medical superintendent suggested to me the first time I saw him that, if I cared to stay on after the three months, I might get a post as interpreter there on the female side. I rather liked the idea; and then when I saw how things were, I thought I would keep a detailed account, and I might be able to do something about things if I got a post like that. I could do nothing but protest, and that did nothing at all.

19,638. *Mr. Snell*: Did you go to the hospital with any other motive in your mind than to make yourself a competent nurse?—No; I wanted to take up mental nursing.

19,639. You have not any charges against the institution?—No, I have no charges against it.

19,640. And your prejudice grew from what you saw?—Yes, it did. I have heard many thing about private institutions that were pretty dreadful, but I did not believe them.

19,641. *Chairman*: From whom have you heard them?—From various people. There were some people of mine—not precisely people of mine—but distant relatives of my mother; the lady had been in and she had had her thumb bitten off in an asylum, and there were dreadful stories. I remember hearing about that, but that was a private place. Then also one of the other witnesses, the one whose lawyer I am going to, told me, but I did not think it was true, it sounded too dreadful; and that is one reason why I chose a County Council place in preference to a private place.

19,642. *Sir Humphry Rolleston*: The thumb was bitten off by another patient, I suppose?—That I do not remember distinctly, except that her ribs were broken and that her thumb was bitten off. I could get details of that from my mother, if necessary.

19,643. *Chairman*: You heard all these stories before you went to this institution?—I heard that ages ago.

19,644. I should have thought it would have rendered the profession rather repugnant to you?—I could not believe them.

19,645. Did you go to see if they were true?—No, I did not. I wanted to take up nursing seriously, and I had known a nurse who was a private mental nurse; she had a very good time, and she went about all over the world with a patient, and I did not see any reason why I should not get a similar place.

19,646. I can quite understand there may be some undesirable persons in the ordinary class of nurses that are employed, but the picture which you draw of this institution is much more serious than that. You suggest that practically all the nurses except those in charge were given to using bad language, to treating patients brutally, and generally to showing complete want of consideration. It is a very strong accusation against an entire institution, remember?—I did not say nearly all of them; I said the majority with whom I came into contact. There are 400 nurses.

19,647. How many did you come into contact with?—I could count up and tell you.

19,648. *Earl Russell*: Would it be 60, or that kind of thing?—Yes, I suppose about that.

19,649. *Mrs. Mathew*: You met the nurses in the mess room?—Very seldom; even at mess time their language was so revolting as to put you off your food very often. You are not going to carry on a conversation with those kind of people.

19,650. *Chairman*: Suppose you did come into contact with about 60, as you suggest, how many of those behaved in this fashion?—It is difficult to say, because being in a ward for about a couple of hours you would see three or four nurses behaving brutally.

Then you are sent to another ward and see the same kind of thing.

19,651. *Earl Russell*: Were you ever in any ward where they did not behave brutally?—Yes; for instance, in Villa 2, where Nurse C. was, that is the receiving ward; there was no brutality there; it was the one ward in the place where they did their own cooking, everything was spotlessly clean, everything was hygienic and splendidly carried out. Then there was another villa, Villa 6 I believe it is, the convalescent place, I suppose you would call it. There were 30 patients there who stayed all day; there were about another 30 who came in to sleep. There was nothing wrong there at all. The nurses and the charge nurse there were all very nice.

19,652. *Mr. Snell*: Were you in this particular ward?—I was over there for a while.

19,653. So you had opportunities of seeing that things were properly carried on?—Yes, they were properly carried on. The heads of the institution, I believe, did all they possibly could under the existing circumstances to keep things proper. The matron, I believe, came in March—I never knew her name, because she was always called “the old —” or “the old cat”; she was disliked because she turned up unexpectedly at places. They have a system whenever a nurse or doctor moves to telephone from ward to ward, and so on; but the matron would start off for one ward and change when she got behind the shrubs. She evidently knew what to expect.

19,654. *Chairman*: What do you mean by changing behind the shrubs?—Changing her direction. I have been several times in a ward when they have said the matron is coming, and the matron has not arrived; she went to so-and-so and caught them on the hop. She was not liked, naturally.

19,655. *Sir David Drummond*: Is it your contention that the conduct you are explaining to us now was carried out in the spirit of cruelty rather than just a rough method of carrying out their duties? Do you mean they would actually shake a patient and irritate and cruelly treat a patient independently altogether of any nursing duties?—Yes. There are some patients that the nurses are afraid of; the nurse dare not vent her spite on that patient.

19,656. You have not answered my question.—This is my way of answering it, please—so they go to other patients who are helpless and vent their spite on them deliberately.

19,657. *Sir Humphry Rolleston*: I gather really that a good deal of it is due to callousness and poor education?—And a lack of understanding. A lot of those girls go there quite young, I suppose about 18; they are given no directions; they are not told what a mad person is; they are given the idea that any patient may become homicidal at any moment, therefore it is their duty to keep them cowed. They go into a ward, nothing is told them; they see the nurses treating the patients in that way, and they do the same kind of thing, and it very quickly becomes a habit.

19,658. Are there not lectures given?—There are, but you are not forced to go to them unless you are going to start for your preliminary examination. They do not expect you to go until you have been there three months. I do not think you are allowed to go until you have been warded.

19,659. *Earl Russell*: For a different reason the method you have been describing is not unlike the way in which parents treat their own children?—If only you saw them!

19,660. We have heard of children being caught by the hair or arms and pulled along to be washed?—That is gentle compared with the way the nurses treated these patients.

19,661. *Chairman*: You say it was not merely callousness, but it was done from spite?—It very often was, not always. That nurse who told the patient she mixed the cat's filth in her food, that same one, I have seen deliberately tease patients and get them in a temper.

20 October, 1925.]

Miss H.

[Continued.]

19,662. What was the object of that?—Because there was a girl called J. in that ward that every one was afraid of, she always annoyed the nurses; she was supposed to have attacked the medical superintendent at one time; she was a drug fiend; she was in that ward simply because she was a "carrier" of some description, enteric, I believe; otherwise she would have been put in the refractory ward. She used to help the nurses give out the drugs in the evening to patients, until they found she drank most of them herself.

19,663. *Mr. Snell*: I am very anxious to get from you your careful judgment on this point. Is this charge that you are making one against the institution as an institution, or against the staff employed?—It is against the staff employed, and it is against the institution in this way, that they do not look to see that their rules are carried out; their rules are excellent. It is a case of *laissez faire*.

19,664. *Sir Humphry Rolleston*: The matron on the other hand, did take steps?—The matron was trained, and she was fairly new. Poor soul, she was up against 400 nurses of that class.

19,665. *Earl Russell*: Is not the other step they can take to have a charge nurse always present in a ward?—The charge nurse is usually there, but she turns her back when things are going on that she does not want to see. They ought also to have a hospital nurse.

19,666. *Mr. Micklem*: Why do you lay stress on that?—Because a lot of them are ill in other ways besides mentally ill. For instance, there is no need for all those patients to have got bed sores, if they had been properly nursed. For instance, there was not one patient who had not bed sores in the infirmary. Of course a lot of them were only in there for a little while, like that woman who had a miscarriage; but those who stayed in, those who were habitual bed patients were mostly people that went in either through mishaps, or because they got battered about by the nurses; but in the T.B. and the enteric ward—that is where I had my biggest experience of bed patients—they had all got these bed sores. It was quite unnecessary.

19,667. *Earl Russell*: Did the doctor never look at them on his rounds?—I never saw a doctor coming his rounds there, so I could not tell you.

19,668. What time did he come in the day?—I could not tell you.

19,669. *Sir Ernest Hiley*: How long were you in either the enteric or the T.B. ward?—Sometimes I was there the whole of my half day, a p.m. duty or a.m. duty. Sometimes I was sent away to another ward to help, and then back again.

19,670. But you were in this asylum for four or five weeks; how long were you nursing in the enteric ward out of that period?—I have not added it up; I should have to go right through my diary.

19,671. About a fortnight?—No, not a fortnight right off. I suppose I was there possibly on six occasions for my half-day duty. I could not tell you for sure without adding it up.

19,672. *Chairman*: A half-day on each occasion?—Yes, what they call an a.m. or p.m. duty.

19,673. *Earl Russell*: What I want to get at is this: between them did you cover the whole day, so that if the doctors had come at any time you ought to have seen them?—No. If you are on a.m. duty you are off duty p.m. and *vice versa*.

19,674. But still you were there both mornings and evenings?—Not on the same days.

19,675. No, on different days; and you never saw a doctor either morning or evening?—No, because I was moved about so frequently; I may just have been sent from one ward to another when the doctor arrived there. I cannot say anything about that except when I noticed that girl with her arms all bruised. Dr. A. was back from his holidays, and all the nurses said, "We shall have to take care now because he keeps his eyes open." Another thing I know about Dr. M. who left the week I went there—he condemned the

meat they had been given to eat, and he was always doing those kind of things, according to the nurses, so he was sure not to stop.

Mr. Snell: I should like, Sir, to ask about the visiting committee.

19,676. *Chairman*: You have told us about the matron and the doctor. While you were there were there any visits by the visiting committee?—I could not tell you; I never say anything.

19,677. *Earl Russell*: Did you never see any outside stranger at all in the wards?—Yes, because they have their visiting days, and patients that were very ill were allowed to have visitors at other times, but the nurses were not allowed to speak to visitors; they were not allowed to answer any question that visitors put to them.

19,678. *Chairman*: I would like to follow that up. You say that relatives and friends of the patients came on certain days, did they?—Yes; I am not sure whether it was every Sunday now—Sundays and some Mondays.

19,679. And the nurses were told not to speak to the visitors?—I was told; so I suppose the others were.

19,680. So these people saw their relatives or friends who were in the institution, and who therefore would have an opportunity of saying if they were ill-treated in any way?—Yes. The thing is that they very often did, but the people would not believe it.

19,681. How do you know they very often did?—Because I have heard them sometimes.

19,682. The visitors?—No; I have heard the patients complaining. For instance I have heard a visitor go up to the charge nurse and say, "My daughter, or sister, has complained that so-and-so has happened." She is told it is a delusion. Or, "She has complained that she has not had those eggs I brought her." The nurse says she has given them in her milk. I know it is true the nurses take most of the stuff that is brought in for the patients.

19,683. You are drawing a very serious picture. They are not only brutal and spiteful, but they are also thieves.—They are thieves. They attempted to break open my box, after the first pay day there. All the nurses were complaining that there were a lot of petty thefts when they bought their face creams and powders.

19,684. Now you might tell us about the arrangements for bathing and washing, which is one of the matters on which you have certain observations to make?—It is dreadful. They have those shower baths, and they will put one, two or three under the same shower bath when there is not room for one, and they will turn on the hot water before the cold. The patients are afraid to come out; the nurses go for them. Some of those patients are all covered with sores. It is very awful for a nude patient to be pushed up against a patient all covered with sores.

19,685. Did you see that?—Yes, I saw that, and it is very dreadful. They would put two or three in the same lot of water, one in after the other, and some of those patients are in a dreadful state. I conclude it is venereal disease—I do not know, but it looks like it.

19,686. Without changing the water?—Without changing the water. They say, "Oh, you old so-and-so, you cause me a lot of trouble," and under they go. There are not enough towels to dry them. It is almost too revolting to describe the whole arrangement down there.

19,687. Was that so in all the wards you had to do with?—I was only in the bath once.

19,688. *Sir David Drummond*: Was a charge nurse ever present?—Head attendant; a charge nurse was always present, and I believe a head attendant was supposed to be present also; I am not sure, but sometimes there was one. Although I was not the bath nurse very often, I frequently met the parties coming out, and I sometimes saw a head attendant with them.

20 October, 1925.]

Miss H.

[Continued.]

19,689. *Chairman*: Now will you tell us about the clothing that you saw?—It was very often in a very dreadful state. For instance, there was a dreadful thing; it is rather awkward to speak about. In most of the wards they were not allowed to use sanitary towels; the result was very revolting; neither was there any lavatory paper; so when they were wearing these filthy things it was revolting. The clothes did not fit them at all, and sometimes a patient was given two boots for the same foot, with brads sticking up, and all that kind of thing.

19,690. *Earl Russell*: Did they ever ask for sanitary towels?—I suppose they did; I do not know.

19,691. Did you see any in the wards at all?—No. On one occasion, in Villa 2, a patient came in from another hospital. She was wearing a sanitary towel at the time, and it was taken away from her.

19,692. *Miss Madeleine Symons*: You are quite sure they were not provided and available?—Quite sure. I went to a charge nurse in one place and told her that someone was needing one, and she said she was not allowed to have them.

19,693. *Chairman*: Supposing patients were going to the lavatory, could not they get any paper?—No, there was none to be found anywhere.

19,694. Was there none supplied?—I cannot say. It is like brushes and combs; they are supplied, but they are not used. Every night you will find on a radiator a whole row of clean brushes and combs, but they are never used; they are put away. It is too much trouble to the nurses to use them. They will take two or three little scraps of broken comb and haul it through a patient's hair. I never saw a hair brush used the whole time I was there, but every night I was on p.m. duty I found all these brushes put out for the head attendant to inspect. It is possibly the same with the lavatory paper; I cannot say.

19,695. You have described the clothing of the patients. I suppose if we visit the institution we will see the clothing such as you have described?—You will in the wards where you are pleased to be taken. If you visit the institution and ask to see such a ward you will most probably see it. If you were to go and demand to go into the courts of the old building at airing time, you will find in these tiny places three or four wards exercising at the same time, and all these patients with their filthy stained clothes on, rolling about on the ground, or sitting in corners like so many poor caged animals.

19,696. *Sir David Drummond*: Do you suppose that what you are describing is going on at present, as far as you know?—I do not know; I know nothing whatsoever of what they are doing at present. This change probably has been made. While I was there you only got hot water twice in the week; of course, that makes a vast difference to cleanliness. I have been told since that that was only a war-time arrangement, because of the coal scarcity or something like that. They probably have the water every day now, and that makes a vast difference in washing out odds and ends of clothing, and so on.

19,697. *Chairman*: You tell us that you have been told that since. Have you been in communication with anybody from the asylum?—I went to a newspaper and got them to publish a little statement made some time since, and they told me that there was a Mrs. S., I believe the name was, who said when she was there they had hot water every day; so I concluded that what happened while I was there was merely the effect of the war-time shortage of coal, and that it is probably over by now; I do not know.

19,698. *Earl Russell*: Are you the nurse whose experiences were published in those two numbers of the paper?—Yes.

19,699. *Chairman*: How did you come into contact with them?—Mrs. G. knew him, and I said I felt so strongly about it, could not I do something? She said probably if I wrote it up, Mr. B. might take it, and he did.

19,700. Were you paid for the article?—Yes.

19,701. Now another matter that we are interested in is the food. Will you tell us about the food; first of all, the nurses' food, and then the patients' food?—The nurses' food was very bad. Did you want to have the detailed dieting?

19,702. I should like you to tell us what you thought of the food.—It was dreadfully bad. The nurses' food was bad, and the patients' food was worse. The bread was always very stale, and frequently sour.

19,703. Was it made on the premises?—That I could not tell you. I believe it was, but I am not sure about it.

19,704. Was the food sufficient?—For the nurses there was sufficient at that time, but there was this awkward arrangement about the nurses' meals. You had to book your meals two days in advance, but if you were in the institution at meal times, and had not booked them, you could not get them, but you would be charged for them.

19,705. What do you mean by having to book your meals two days beforehand?—There is a paper put up two days in advance. On Monday you would find Wednesday's paper put up, and you have to sign your name. If you do not sign your name there, in two days' time, that is, on the Wednesday, you could not get that meal, but if you were in the institution at that meal time you would be charged for it, because you had not clocked off.

19,706. Does that enable the cooking department to know how many meals to provide?—I suppose it does.

19,707. Was there anything very wrong about it?—Only this: One day I was too unwell to go out; I was in for both the dinner and the tea time, but I could not get any meals, not even a drop of milk, yet I had to pay for both that dinner and tea, which I could not get.

19,708. Did you see the doctor?—No. I had just got a very bad attack of diarrhoea. It was not necessary to see the doctor, but I could not go out, you see.

19,709. Did you speak to the charge nurse?—I spoke to one of the nurses.

19,710. Did she not get you some hot milk?—No; she did not get me anything at all.

19,711. *Mr. Mickle*: How did you get charged for these meals which you did not take? I do not follow it?—It is all put down and deducted out of your monthly wage.

19,712. But your name was not on the rota for the food?—No, but I had not clocked off. All those who have not clocked off are considered to be in the institution; therefore they are considered to be having a meal. There was no notice put up to that effect for some time. The notice about being charged for meals if you were not in was put up on the 12th. On one occasion I was out about five minutes after the dinner hour; I was in about ten minutes before the tea hour. Therefore I was charged for those two meals, although I did not have them there, and though I had not booked for them. I mean, those kinds of things frequently happen when they are trying to arrange things beautifully.

19,713. *Miss Madeleine Symons*: Do you mean that if you were actually in your sleeping quarters you would be counted as not having clocked off?—Yes, because you would only be clocked off when you went out of the building.

19,714. *Chairman*: And if you had not booked for one of these meals, was it charged to you if you were in the building?—Yes, that is so. The nurses explained that to me at first, and I laughed at it. However, after a bit the notice went up to that effect, so I found it was perfectly correct.

19,715. It is rather an odd way of arranging things?—I do not know. Once you get to know of it, you can look out for that kind of thing. There is another point about the nurses' food. You sometimes do a 9-10 duty. You have four wards to look after entirely on your own. The patients are in bed. You have to go round with each nurse of that

20 October, 1925.]

Miss H.

[Continued.]

ward and look at each patient, and the nurse signs a paper to say that she has handed over those patients to you, and you sign a paper to say that you have received them. Then you have to go round once or twice in between, alone, and clock on in each ward to show that you have been round. Then at 10 the night nurses come for each of the wards, and you go through the same formula of signing papers. That nurse is supposed to go with you to the same patients and see that you are not handing one over dead to her, and so on. Then you go down to the visiting room and say you have handed over these wards, and it is too late to go out and get anything; you really need something. There ought to be a canteen or something like that, where you could buy stuff.

19,716. *Sir David Drummond*: Do I gather that you were yourself in charge of four wards?—Yes, for the 9-10 duty.

19,717. You had just gone to the place; you had no experience; and you were in sole charge of four wards?—Yes, for just over the hour.

19,718. Was a charge nurse or some other experienced person within your call?—No, I did not see another nurse at all, until the night nurses turned up.

19,719. *Chairman*: Were the four wards all together?—No. You went from one to the other, and to get to the other one you had to go along a corridor and up some stairs.

19,720. Were they all in bed?—Yes, they were all in bed. There were side rooms, padded rooms and half-pads and that kind of thing.

19,721. And you were in charge of the whole four were you?—Yes, just for the hour.

19,722. Did anything happen?—No. It is very eerie, and it is very worrying. You have to go through twice during that hour, with the lights down very low, and the patients were all jabbering; some of them were shrieking, and some were bumping at the side doors to come out. You are supposed to look at every one to see that they are all right. They take their bed clothes off.

19,723. Had any of them done that?—Yes.

19,724. What did you do, if you were single-handed, with patients with their clothes off?—If you coax them, most of them will do what you want them to. There was one I did not go in to see; she was bumping about so furiously at her door that I was afraid to open it on my own, because I could not have done anything if she had attacked me, so I did not open her door.

19,725. I should like to follow this a little further. For just over an hour's interval between the day and night turns you say you were in charge of four wards?—I can give you the numbers of the wards, if you wish them.

19,726. It might be as well?—I do not quite know where to put my hand on them, but I know I did put them down here somewhere.

19,727. You say that these four wards contained a number of patients who were shrieking, shouting and getting out of bed and so on. How did you possibly manage to control that large number of people in that state?—A lot of them did not need controlling.

19,728. But even supposing there were only two or three, how did you deal with them simultaneously?—By treating them like children. If you say: "Come along, dear; get into bed; you will get so cold," most of them submit to that kind of treatment.

19,729. *Earl Russell*: You alone, with your entire absence of training, had to prevent these people from committing suicide or fighting?—I do not think they were liable to commit suicide, but they might have fought.

19,730. *Miss Madeleine Symons*: Could you have got help quickly?—I do not know, because I did not see another nurse the whole time.

19,731. *Earl Russell*: Were you told there was any bell you could ring if you wanted any assistance?—No. I did not know that I had got the 9-10 duty until about five minutes beforehand.

19,732. *Chairman*: Who gave you this task?—One of the head attendants; I cannot tell you which. I had not the remotest idea what the duty was.

19,733. Did you ask?—She went off and left me to the charge nurse, and I asked the charge nurse what it was, and she told me, but that did not quite explain what it was.

19,734. Did she go away?—Not immediately; she just went round with me. There are a lot of patients one knows it is unnecessary to look to in that way. There are a lot marked down as "wet" patients, or suicidal. You are supposed to look at all those kinds of cases, but she did not give me very much time. Then of course I got to the next ward, and the charge nurse came along and said, "H., you are late."

19,735. How often were you on this special duty?—I only did that 9-10 duty once. I think you are supposed to do it once a month.

19,736. I see you have got a book there. Is that your diary?—Yes.

19,737. When did you write it?—When I was there.

19,738. Day by day?—Yes, or night by night.

19,739. Do you mind my looking at it?—No, you can have it with pleasure. I cannot find which day it was I did the 9-10 duty; it was the sports day. I would like you to look at that; when I was left entirely alone in the ward. (*Handing diary to the Chairman.*)

19,740. *Earl Russell*: Did other nurses with as little experience as you get put on to this 9-10 duty?—I could not tell you, Sir.

19,741. *Sir Ernest Hiley*: I understand you were only on that duty once?—I was only on once, but I was only there just over a month. Each nurse once a month is picked out for the 9-10 duty.

19,742. *Sir David Drummond*: Were they epileptic patients and bed-ridden patients?—I do not know about that. I cannot tell you what they all were there. There were no epileptics when I was doing 9-10 duty.

19,743. I suppose bed pans would be required occasionally?—I never saw one in the whole place. There are commodes at the sides of the beds; and I have frequently seen a patient stark naked pulled out of bed, and sat there for about an hour, after she has fouled her nightdress.

19,744. *Earl Russell*: Are the patients not able to get back into bed by themselves?—They dare not; they would be knocked about if they did.

19,745. *Chairman*: How could you see them sitting there for an hour, if your duty was only for one hour?—I do not mean the 9-10 duty; I mean at any time. This is it: "I did my first 9-10 to-night, 22 sections, that comprises wards 24, 26, 27 and E.2."

19,746. *Sir Humphry Rolleston*: Were those chronic wards; could you say what kind of patients those were?—No, I could not, because I had not been into those wards before, except 24 once to help with meals.

19,747. For one nurse to look after four wards, if they contain at all acute or dangerous cases, is rather different from being in charge if they are chronic imbeciles?—I cannot tell you that, but you could easily find out the patients they have in wards 24, 26, 27 and E.2.

19,748. *Chairman*: But you told us these were wards with padded rooms and half-padded rooms, and that violent conduct was going on?—Yes. There are padded or half-padded rooms to every ward; the refractory wards are nearly all padded, I believe. I was not allowed to go into the padded wards, because I was under-size. The date is 20th August.

19,749. *Sir David Drummond*: Did it never occur to you to pull a blanket off and put it over this patient who was sitting naked for an hour?—Some of the wards are "T" shaped, like that (*describing*). I have been in *here* and saw it happening in *there*.

20 October, 1925.]

Miss H.

[Continued.]

I am not allowed to go in there when anything happens, nor may I put something round a patient. If it were my own patient who got out of bed, I would attend to her properly and get her back as soon as possible.

19,750. *Mrs. Mathew*: What was the other ward you were in?—I have only got 26, 27 and E.2. What was the fourth?—The Chairman has got my diary. I cannot tell offhand. I do not mind admitting that I was rather frightened. In fact I was too frightened to open the side door of the one that was bumping about so. I could not have done anything, had she attacked me.

19,751. *Mr. Snell*: Had you had any previous nursing training before you went to this place?—No, no training. I had been at S.'s School at W.

19,752. So you were quite untrained, to all intents and purposes?—I was quite untrained.

19,753. Have you any reason to believe that the conditions which you have described were the same on the male side as on the female side?—No. I know nothing about the male side, whatsoever. I did not speak to an attendant the whole time. The only thing I saw on the male side was a cricket match once, where the patients were waiting on the attendants.

19,754. *Sir David Drummond*: You have described the dirty state in which these patients were, their filthy clothes, and so on. The matron would see that, I suppose, when she came round?—One supposed she would, but the thing she seemed to notice most was whether some of the nurses had their hair bobbed. I heard her frequently making remarks such as, "You are wearing dark blue stockings, nurse. You should wear black."

19,755. *Chairman*: Miss H., why did you keep this diary?—In the first place, I usually keep a diary, and after the medical superintendent suggested that I might get this post as interpreter I thought it would be very useful to keep the data.

19,756. *Earl Russell*: That was another question I was going to ask you. When you spoke about the diary, you said, "I generally keep a diary when I go to a new job"?—Yes, I do. I have been a nursery governess, and I have been a nurse, and I have been an assistant matron, and that kind of thing. I have earned my living since I was 14.

19,757. *Chairman*: I am bound to say that from a glance at this diary it looks as if you had from the very start decided to keep a record of everything you saw, as if you thought it proper to do so?—I thought it proper. You cannot learn if you do not keep a diary of things.

19,758. But the type of thing you record is not what your duties are so much as things which you saw, of which you are telling us to-day?—Things which terrified me.

19,759. *Sir Ernest Hiley*: What sort of diary did you keep when you were a governess?—The usual kind of thing—my various duties, and how the children got on.

19,760. *Chairman*: This is a special diary which begins at this time?—No, I had not kept a diary for quite a bit.

19,761. What was written on the first page that is torn off?—The same thing as is there now. I cut it out because my pen inked all over the place.

19,762. I do not think you could have copied here exactly what was on the first page?—Not absolutely. I wrote it on the same day. I cut that out.

19,763. Something different has been written out?—I do not suppose it was word for word the same for a moment.

19,764. Why did you cut out the passage you wrote first?—There was this manuscript also; I was writing up this because I was getting out leaflets for the Lunacy Reform people.

19,765. Had you been in contact with the Lunacy Reform Society before you went into the institution?—No. It was possibly a year after I came out that I knew anything of them; it was some considerable time after I had seen the newspaper people, anyway.

19,766. May we keep these documents for a little, and return them to you afterwards?—Certainly.

19,767. *Earl Russell*: You were not in communication with the newspaper before you went there?—No. I had seen Mr. B. once before I went there.

19,768. Had there been any discussion about keeping observation or anything?—No. That was the only time I had seen Mr. B. before.

19,769. *Chairman*: Had Mrs. G. talked to you about abuses in these institutions?—She had before, but I thought she had exaggerated. I did not think they could possibly happen, and I asked her if it were a thing anyone could take up properly. She said any lady could take it up; it would be better if they did. So I picked out the County Council places, because I thought: "Well, if there is any truth in those statements at all, it could not happen in a place with proper rules."

19,770. Was your object in going there to train yourself for nursing work, or was your object to find out whether the stories you had heard were true?—My object was to train myself for nursing work.

19,771. Because your diary suggests that you were more interested in finding out whether those abuses actually occurred, than in learning your profession?—If you have time to read it properly, you will see that it is not so. Things are so horrid that no one would willingly believe them; I would not willingly believe them; one would much rather not believe them; I would much rather believe they were not true.

19,772. I quite agree that the story you have told us is a most revolting story.—And yet I considered going back, and then I could not.

19,773. Just tell us the circumstances under which you left?—My mother was ill, and my sister came home from India, ill.

19,774. As a probationer, had you not to stay for a certain length of time?—No. If you stay over the three months, you have to; I think that is at the root of a great deal of the trouble. A lot of these girls go there, they do three months, and after a time they have to say whether they are likely to stop. Then I believe they are given more instruction, and they have to attend lectures.

19,775. When you left, did you go to the matron and say that for family reasons you had to leave?—I gave her the letter my sister wrote me.

19,776. What did the matron say?—She was very vexed; she had had excellent reports of me. The medical superintendent had said before that they wanted more people of my class. Then I asked him if I could come back again when things were settled up.

19,777. You contemplated going back?—I did contemplate going back, because I wanted to try for that interpreting job; I thought it would be rather a nice job.

19,778. *Earl Russell*: From whom did they get the excellent reports—not from your fellow nurses, I suppose?—From the charge nurses, I suppose. I suppose they keep a certain watch over you.

19,779. *Mr. Snell*: There is one very important point which emerges from what you have said. Were most of these nurses, about whose conduct you complain, probationers of under three months?—No; some of them were; but there was one nurse, a nurse named S.—I believe you will find she was in Villa 4 there—she was a fiend. I never had a row with that nurse, because I had not really much to do with her; she had been there for ages.

19,780. Could you give me your general view? How many of them do you think were people who had passed their three months' probation, and then had chosen this as a vocation?—I think it was mostly on their own part. The other was a different kind of ill-treatment—furtive jabs, and a slap in the face. It was different, somehow, to the way the other nurses went about it.

19,781. *Chairman*: Why did you contemplate going back? Because it seems to me that after what you have described as the condition of affairs there, you

20 October, 1925.]

Miss H.

[Continued.]

would have been very reluctant to go back to the institution?—I thought the interpreting job would be quite a good job. I have to earn my living, you see. Evidently the medical superintendent wanted people who would try to do their duty.

19,782. How soon after you left the institution did you communicate with the newspaper?—Some months afterwards; it was when my sister started getting better, and I left home again. I cannot tell you the date.

19,783. *Sir Humphry Rolleston*: Have you done any journalistic work, besides that for this paper?—No, except the small effort which the Chairman has there, which I was going to try and get out in leaflets.

19,784. *Earl Russell*: Did you communicate with the paper in writing, or verbally?—In writing.

19,785. There were letters?—Yes.

19,786. You would not mind our having them, if the newspaper would let us have them?—Please do. Then you will find the dates.

19,787. *Chairman*: In point of fact you did not go back?—No, I just could not bring myself to it when it came to doing so.

19,788. Would it be discourteous to ask you what you are doing now?—At the moment I am trying to get a job as a stewardess.

19,789. How have you been employed since 1921?—In various ways; odd jobs; domestic work and that kind of thing. At the present moment I am helping some people do some printing.

19,790. When did you come into contact with the National Society for Lunacy Reform?—I cannot tell you what the date was, and I cannot tell you who put me on to them; I believe they wrote to me after the articles came out in the newspaper.

19,791. Had you many communications with the Society or with their officials?—I went up a good many times; I did not like them very much; I do not think they are very useful.

19,792. Who took a statement from you?—I believe it was a Mrs. A. G.; I am not sure. They wrote to me to know could they publish the articles which were in the newspaper as leaflets, and I said: "It is nothing to do with me, because I got paid for them as articles, and you must apply to Mr. B."

19,793. You gave a statement to someone to send in to us?—Yes, I suppose I did. Was it from the Lunacy Reform people? I do not know. I was going to come in with those people at first.

19,794. It came to us, I am told, from a firm of solicitors in town?—Yes, that is so. I was going to go in through the Lunacy Reform Society, and I came to the conclusion they were rather futile, so Mrs. G. offered me the services of her lawyers.

19,795. Did you give them the statement which has been written down and sent in to us?—Yes, I saw a barrister—Mr. P., I believe he was.

19,796. Well, Miss H., we will give every consideration to what you have said. We will keep these books for a short period, and send them back to you, if we may?—Would you like this, also? It is a copy of some of the rules (*handing in the document*). Will you also get the book of rules?

Chairman: If you please.

19,797. *Earl Russell*: In paragraph 10 of your *précis* you say that you reported these matters often to the charge nurses. What did the charge nurses do when you reported them?—I would just go up to them and tell them, and they would say, "Oh, well"; "Oh, perhaps"; "Oh, you go and do so-and-so"—that kind of thing.

19,798. *Mrs. Mathew*: What languages do you speak?—Only French, you know.

(*The Witness withdrew.*)

Mr. M., called and examined.

19,812. *Chairman*: You are Mr. M.?—Yes.

19,813. You have come this morning to give us some evidence about your experiences as an attendant at N.?—Quite so.

19,799. Of course, there are a lot of aliens at C. are there not?—Yes. I do not know who it was told me. I had spoken French to some of the patients who could not speak English. Their interpreter was away at the moment. The superintendent said there was no such appointment as female interpreter, but he did not see why there should not be one, and as soon as I could tell him whether I was going to stay on he would put it to the Committee that they should make the post of female interpreter, and offer it to me, and then this other interpreter would teach me other languages. It was rather an opening for anyone who had to earn their living, and that was the only thing that made me consider going back again.

19,800. The probationers begin there at about the age of 18, do they not?—Yes, about that.

19,801. Are they left in charge of the wards, as you were?—On the 9-10 duty?

19,802. Yes?—I suppose so. I never spoke to one about it, but I suppose they were.

19,803. You think that does happen?—I never troubled to think about it one way or the other. It happened to me.

19,804. Of course, you had had a little experience, had you not; you were not absolutely without experience?—I cannot tell you what they chose me for, but I had had no experience of mental nursing other than during the time I was there, and I really was frightened when I found what it really did comprise, though I only knew of it two or three minutes before.

19,805. Were you ever on night duty?—No. I usually finished at eight, when I was doing p.m. duty; and somewhere about two, when doing a.m. duty.

19,806. Are those the usual hours of the people under three months there, do you suppose?—Yes. I do not know about the 9-10 duty, but they were the recognised hours for the a.m. duty and the p.m. duty. As regards the 9-10 duty, I do not know, except that I did it that once, and was not keen on doing it again.

19,807. *Sir Ernest Hiley*: Miss H., when you left C., you had a little conversation with the matron before you went, did you not?—Yes. I do not know if it was on the last day, or when I gave in my notice.

19,808. Did you say anything to her about your experiences in the asylum?—No, I did not. She was very annoyed with me because I was going. At the same time I made the complaint about someone attempting to force my box after pay day. She said she would have it looked into, but I think it rather upset her. Someone came along almost immediately, and she sent me off. I was very worried about my mother. My sister had written me a very worrying letter, and I was anxious to get home as soon as I could to her; and then, with my sister coming home from India, I did not know where I was—on my head or my heels.

19,809. You did not tell her you had been keeping a diary, and offer her the diary to look at?—No, it did not occur to me; she could have had it if she wanted it.

19,810. I suppose she did not know you had been keeping it?—She did not ask me. If she had asked me I would have told her, but she did not have any conversation with me. In any case, it was up in my room, and since any of the head nurses or nurses had a key that fitted all the drawers except one, and it was not in that, they could easily have seen it; frequently I left it on the chest of drawers.

19,811. *Chairman*: Thank you, Miss H. We are obliged to you for coming to us this morning.—I wish I could do something to help matters, because I think they are dreadful.

19,814. We have been favoured with a statement of what you are going to tell us this morning. Does that represent your evidence?—Yes. I should like you to refresh my memory as to the statement I gave

20 October, 1925.]

Mr. M.

[Continued.]

to Mr. C., who is secretary of the Lunacy Reform Society, 12 months ago; because since that time I have not been notified, and I thought the thing was falling through. There are several points I deal with in that paper, when he visited me at N., particularly with regard to ill-treatment.

19,815. Did you give a statement to the Lunacy Reform Society?—Yes, I did, to Mr. C.

19,816. Did you see the statement after it was prepared?—I gave him the fullest particulars, and he put them down in my statement.

19,817. I mean since it was written out, have you not seen it?—No, I have not seen it.

19,818. However, you told him what you were going to say?—Yes, I did.

19,819. That is how it has come to us, I suppose?—That is quite true.

19,820. Was it in 1908 that you joined the staff of N.?—Quite so.

19,821. And did you intend to adopt mental nursing as a profession?—I did.

19,822. I suppose you went in as a probationer?—Yes.

19,823. And passed through various stages until, in 1914, you reached the grade of third charge attendant?—Yes.

19,824. Then in 1914 you served in the War, and were away from N. until 1919?—Yes.

19,825. Then you returned, and remained till 1921, when you resigned?—Yes.

19,826. So that you were, in all, just over seven years. I take it, at N.?—Somewhere thereabouts, yes.

19,827. Now you can, I think, best assist us by telling us what are the matters, which came under your personal observation while you were an attendant at N., which you think call for remedy; matters which you thought were undesirable or improper, and which came under your own notice?—I think when people put their patients in those sort of places, they should have their pay, that is to say, when they pay fees for a special attendant, which I have been to the deceased Mr. T., brother-in-law of Mr. Justice C. I think first of all, if I may state it, that I was an eligible person to get that pay, which those people paid for an attendant to look after the patient. Furthermore, the food is very inferior. I, for one, during my service there made complaints, which it was my duty to do when I was special attendant, and I was absolutely put down as a marked man for a length of time.

19,828. Will you tell us this, Mr. M. Is N. a licensed house?—It is a mental institution—very large.

19,829. Is it a licensed house, or a registered hospital?—If I may say so, I should say from what I have seen, from my experience there, it is a money-making place.

19,830. Yes, but you know there are various types of institutions. There are public asylums, licensed houses, registered hospitals?—I think it is a private asylum.

19,831. That is what is called a licensed house or a registered hospital; do you not know which it is?—I do not know that.

19,832. Were all the patients there private patients?—Yes, private patients.

19,833. That is to say, they were all paying patients?—Yes. If there have been patients, while I was there, who have got no money, they have been in there for some time, and they have transferred them as pauper patients.

19,834. *Mr. Micklem*: To some other institution, of course?—Yes. I remember two, during my time, who were removed from that place because they had no money.

19,835. *Chairman*: Now the first point that you have made to us this morning is that patients, on whose behalf special attendance was being paid for, did not get the attendance. Is that it?—They got the attendance.

19,836. But the attendant did not get the pay?—The attendant did not get the pay. That is what I told their relatives when they interviewed me. I was surprised at their paying the fee to the accountant, and the attendant not getting it, though giving them the best of his attention.

19,837. If you were told off to be a special attendant upon a patient, you did not get any special pay?—No, none whatsoever.

19,838. Is that your point?—That is the point.

19,839. That is a grievance about yourself rather than about the patients?—Very good. When you go to that place, you dare not say anything, and I thought I should like to bring the matter before you now for the benefit of the others in the institution.

19,840. But the point is that when you were told off to be a special attendant upon a patient, you did not get any special pay?—That is so.

19,841. What was your contract when you went there?—I went there, so far as the contract was concerned, on a certain wage, as a probationer. Then as you go up the scale, I was under the impression that I should get more money as I went along.

19,842. Why should you be specially paid if you are a special attendant?—You are in special and sole charge of a patient, and the patient's people pay two, three or four guineas extra fee for the special attendant to have the money, which he does not get.

19,843. But the patient got the benefit of your attendance?—Quite so; I gave him the best attention while I was there.

19,844. But, of course, as long as you were in special attendance upon that particular patient, you would not be available for general duties in the hospital?—There were things that want remedying. When you are paid to look after a special gentleman, you should give that special gentleman the best of your care from the time he rises in the morning till you hand him over to the man on night duty. At times you are taken away from that, and are doing all sorts of work. The patient wants you, and you have to push the patient aside and go away, which is not a proper thing in the institution. You should give the patient every minute of your care.

19,845. That is one matter. Will you tell us next anything else which you would like to bring to our notice?—I should like to bring this matter before you, as regards people paying specially for a patient. There was a man of the name of S., a highly educated man from Oxford. I used to pay attention to that man, and at times he used to tell me things, when his mind came back. He wanted to know when he was going out for drives. As he got along, that patient's drives used to fade away. His relations used to pay those people for that patient on specified days to go out for those drives, which he did not get, for the simple reason that the man did not know whether it was Monday or Tuesday. When some visitors came to N. they asked to see Mr. S.'s special room. I think it was a sort of a guardian, if I remember rightly. Now Mr. S. did not sleep in that very room that this gentleman was shown. The gentleman was taken into the hospital ward and shown this special room, but it was not the room that Mr. S. slept in. I had to take that very man to bed, and he had to go into an observation ward. He wanted to know why he was not going into the room that was prepared for him.

19,846. Was he never in that room?—I never knew him go into that room.

19,847. Who occupied the room?—Some other patient.

19,848. Do you say that, although he was paying for a special room, and although that special room was shown to his relatives as being his room, he did not occupy it?—He did not occupy that room.

19,849. He never occupied it?—I took him up to the observation ward upstairs.

19,850. Were you his special attendant?—No, I do not think he had a special attendant.

20 October, 1925.]

Mr. M.

[Continued.]

19,851. When you were acting as special attendant to any patient, did that patient have a separate room?—Certainly; I saw that he had it.

19,852. How was it that Mr. S.'s special attendant, if he had one, did not see that he had his room, too?—Of course, that is a matter for the officials.

19,853. That is the next point. Is there anything else you would like to bring before our notice?—Yes. Again, I do not think it is right that patients should sit down to Sunday dinner and have poultry come through, and not issued out to the patients; it is absolutely taken right away. The patients did not have it. I was one who wanted to strike against that. Those things were taken away from those patients, and that is a sort of thing I do not think ought to be allowed. There ought to be a strict rule that patients under all circumstances who are insane, or whatever they may be, should have the food that comes through. I should expect it if I was at home.

19,854. What do you mean by "the food that comes through"?—That is to say, the food is put through a sort of open space. It is put on the table, and the charge of the ward is supposed to cut that poultry up and issue it out to those patients who can use knives and forks; the others have it cut up in a sort of mince. But it is not issued out to them; it is all taken away.

19,855. Do you suggest that the things are brought on to the sideboard and then that somebody goes through the motions of carving up portions, and the portions, having been carved up, are removed and not given to the patients?—They are not given to the patients; or perhaps they have not carved the chicken up at all.

19,856. It is just exhibited?—I do not think they show the patients. It is a thing that wants remedying. When the patients sit there and are expecting their ordinary course which is put through, that is a thing which wants absolutely remedying.

19,857. *Earl Russell*: Where did he get the mince that he substituted for the chicken?—There is so much mince comes in in a tureen, and they make that mince do for the patients.

19,858. *Mr. Micklem*: What happens to the chickens, do you say?—They are taken out of the building.

19,859. *Chairman*: By the attendants?—By the attendants.

19,860. By your fellow attendants?—My so-called fellow attendants. I reported that. That was one of the things I mentioned to Mr. C.

19,861. If you reported that, was it stopped?—Again, Sir, there I was under an obligation.

19,862. You were there for quite a number of years. You saw things going on, and you should have reported them?—When I reported it to the charge and the chief attendant, it would get so far, and would not get any farther. If I did say anything about that, I knew very well I should be checked in very many ways there.

19,863. Was the attendant in charge, that is to say, the head attendant, sharing in the plunder?—The head attendant of the ward was sharing in the plunder and taking those special things out.

19,864. Did he live out?—He lived out.

19,865. Did he take these things home?—I know he took them out of the place; that is all I can say.

19,866. *Earl Russell*: I understand you to say in your proof that he shared the plunder. Did he take it all?—He might have shared it outside. I could not say that.

19,867. *Chairman*: You never got any?—No.

19,868. Did you live out?—I was a single man inside.

19,869. Was this the food of the patients?—That was the food of the patients.

19,870. Did none of the patients themselves complain?—Well, you see, one particular patient named Mr. S. knew right from wrong, and he was put back towards that table. He was given one leg of that chicken. When I was asked who the other was to

be issued out to, it was all rushed out and taken through a side door, and the other patients got a sort of a mince.

19,871. Was this known to the doctors?—I think, as far as my experience is concerned, birds of a feather flock together.

19,872. Do you mean by that that the doctors did know?—I should say so. I think, if I remember rightly, when I interviewed Dr. L. I told him that particular thing, and he said, "That is a recognised thing in places of that description," so I let the matter drop.

19,873. Now this point may be summarised in this way: You say that the food which was purchased, cooked and intended for the patients, did not reach the patients?—Everything was prepared, and it did not reach the patients. It was put on to the table. I saw it myself on various occasions; it happened many times, until I was removed from the ward.

19,874. I would rather like to understand the ceremony. The chickens are cooked and brought in and put on the sideboard?—Yes.

19,875. Then did somebody carve them up?—Yes, the charge of the ward.

19,876. In the sight of the patients, who were expecting to get a share?—Those who knew enough.

19,877. Then the chickens, having been carved up, I understand, were removed, and some other dish was brought in?—That is quite right, Sir.

19,878. What was the use of going through this idle ceremony of carving the chickens in the presence of the patients, if something else was brought in?—I should say it was to suit their purpose—if anyone should come in.

19,879. But if they were all "birds of a feather," as you described, what would it have mattered if the chief charge had come in, or if even the doctor (according to you) had come in?—I think as far as I could see it was a sort of line worked in with them. It has been done, and if the chief charge or the doctor comes through, which is once in a dozen times, it is cut up; and as soon as ever they know that the man has gone through, they go and do that sort of thing; or they do it before he comes, and he will come and say, "Is everything all right?" and they say, "Yes."

19,880. It only happens when chickens are on the menu?—They do not have a menu.

19,881. I mean to say, when chickens were the meal of the day. Did it only happen when there were chickens?—It happened with meat as well.

19,882. *Earl Russell*: And what was substituted for the meat; the mince in the tureen?—Yes, a sort of mince in the tureen.

19,883. *Chairman*: Were you the only one who did not share?—I do not know about the only one. There was a friend of mine who worked there, and who left about twelve months ago, and he and I used to be the two who were marked men.

19,884. Although you were marked men, you stayed there no less than seven or eight years?—This happened since the war. Before the war I did not take any steps in that direction, as the third charge there. I did what you may term the manual work.

19,885. What other things happened at this institution which you think we ought to know about?—A patient of the name of Mr. T. was knocked about by an attendant named S., who was discharged from there.

19,886. The attendant was?—Yes.

19,887. How did he come to be discharged?—Because he liked his drink, and he was not a fit man for the work in a place of that description. I think complaints did get to the medical superintendent, if I remember rightly, and he got discharged.

19,888. He was not a suitable person?—That is it.

19,889. With regard to this assault that took place on Mr. T., did it take place in your presence?—Yes, in my presence, in the bathroom of the hospital ward.

20 October, 1925.]

Mr. M.

[Continued.]

19,890. Will you please describe what you saw?—All that I saw of the incident with S. was this: the patient did not know whether he was to get into the bath or not, but S. got so impatient that he hit the patient, and the patient swerved from the bath; and there was a sort of gas fixture on the bath, and a kettle, and the patient's head caught the spout of the kettle.

19,891. Did he give him a shove, in other words?—A shove or a push. There was not much in it, because he went with such a force, and he lost himself.

19,892. *Earl Russell*: Was it a shove or a push or a blow?—I should say it was a blow, because just as I was going in he hit the patient like that—(describing). The patient was knocked right off the bath, and he caught his head against the spout of the kettle. I remember that we had to call Dr. P.'s attention to that case.

19,893. *Chairman*: What was told to the doctor, and what did the doctor do?—This attendant sent me round to fetch Dr. P.

19,894. The same attendant who had given him the blow asked you to fetch the doctor?—Yes, because of the blood. The charge attendant was nowhere about. I went to fetch the doctor, and when I came back the charge attendant was there and the door was closed. You are not allowed, unless the charge attendant authorises you, to speak to the doctor. He took my arm and said: "You are to keep there and you are to say nothing."

19,895. You got the doctor. First of all, was S. the man's name?—Yes.

19,896. Did you hear S. giving an account of what had happened?—The only thing that S. said was that the patient had slipped when he got into the bath. I heard S. say that.

19,897. Are you quite sure he did not slip?—I know that patient never slipped from that bath.

19,898. Was he a difficult patient to manage?—He was and he was not. He was rather difficult to get into the bath, admitted.

19,899. How could you get a man into a bath if he would not go into it?—With their stupidity, they put one foot in, and you have to lift the other up. But I do not remember this patient ever doing that sort of thing, because he would go straight into the bath.

19,900. Had he refused to go into the bath that morning?—I do not think he refused at all.

19,901. Then what was the object of S.'s behaviour?—I expect he lost himself.

19,902. Why?—I should say he was under the influence of drink.

19,903. You think he was drunk that morning?—I should say he was, because that is the particular point I think those men got their discharge for.

19,904. If he was drunk, it was rather odd of him to ask you to send for the doctor?—To put that into a nutshell, as regards "drunk," I think he would drink a vat of beer.

19,905. He did ask you to get the doctor, and, of course, the doctor would see that he was drunk?—I should say that he ought to have done so, but whether he did or not I do not know. I did not ask Dr. P. that.

19,906. Was it soon after that that the attendant was dismissed?—No; he ran on for some considerable time.

19,907. For how long?—This happened before the war; he served through the war, and came back after the war, and that is when he got discharged.

19,908. *Mr. Jowitt*: Did this happen in the morning?—No; evening time.

19,909. *Chairman*: Do you think that Mr. T. had refused to go into his bath on this occasion?—As I said before, I do not think Mr. T. did refuse to get into the bath, from the way in which he behaved when I bathed the patient myself.

19,910. How near were you when the incident happened?—I should say about as far as I am from you.

19,911. Two or three yards, shall we say?—Yes, somewhere thereabouts.

19,912. That was an incident that happened before the war?—Yes.

19,913. Did you make any comment or report upon it?—As I said before, being a probationer I had to see things and close my eyes for the simple reason of my berth.

19,914. Suppose there had not been this kettle there on the bath, would the patient have been hurt at all?—No, I do not think he would; he would perhaps have fallen against the wall. If the kettle had not been there, there was a probability of his striking the gas fixture.

19,915. That is what caused the cut, I suppose?—It was the kettle; he bled very, very much.

19,916. That is an incident which happened before 1914. Are there any other things which you wish to put on record?—Yes, there is another case of ill-treatment, to a patient named N. They tell me in the institution—where rumours will go round—that he is a very, very wealthy man; he is in the refractory ward, and to see that patient you would never think he was a wealthy man. Again they say that this patient is so wealthy that he should have a special attendant, or they would pay for a special attendant. He is rather an awkward patient, admitted; very awkward; but let him have his way. When he goes to bed, he would walk a certain distance and back again; I do not think he would do any harm. He is at times mischievous, but I have seen attendants hit him on the back of the neck, and hit him very much indeed.

19,917. Why did they do that?—I suppose the attendant found that the patient was obstinate, as you might term it; he had the most irritating way of going to the door and back again, and I expect the attendant wanted to get him to bed. That has sometimes happened in the daytime, and I have seen the attendant hit the patient on the back of the neck.

19,918. Why did they strike him, do you think?—I do not know; I should say again that they lost themselves; I do not think it is a right thing.

19,919. You mean the patient's conduct was irritating?—He did not irritate the patients; he irritated the attendant, and that is what made him strike him.

19,920. Did that happen often?—Once in the bedroom, or twice in the bedroom, if I remember rightly, and I might say a third time in the bedroom; and at other times I have seen him downstairs, but it was done when there was no one about.

19,921. Did you interfere?—No, not at all.

19,922. Did you ever strike him?—No, no.

19,923. Who was it that struck him in the way that you have indicated—do you remember the name of the person?—I think the two persons are there now: one is attendant T. and the other attendant R.

19,924. What sort of men were they?—If I had my way as a medical superintendent, I should check them in all sorts of ways, and tell them to do all sorts of things myself; but they told me they were not engaged there as attendants, but that they were engaged as athletes, and that just suits the medical superintendent.

19,925. I am afraid we do not quite understand that answer. My question was, what sort of men were they? I gather from you that you think they ought not to be there any longer?—I should not think so, Sir.

19,926. What was wrong with them? Were they cruel, or were they negligent?—I do not think they should do that sort of thing. They are not engaged there to knock a man about; they are engaged to do their work, the same as other men. If they were all alike in N. it would be a jolly good place.

19,927. Did they strike any other patients?—No, I have never seen them do so.

19,928. *Mr. Mickle*: What was it that irritated them in this case, Mr. M.?—I should say that the man lost himself on the spur of the moment.

20 October, 1925.]

Mr. M.

[Continued.]

19,929. I mean what was irritating them?—As I said before, he would walk to the bed and then walk back again. As you took the patients upstairs to bed, you took them up there like a flock of sheep.

19,930. And he would come back?—He would come back; he would walk up four or five stairs, and then come back again, but if you let the man alone he would be all right. He so irritated these attendants, because he did not go straight to his bed, that they struck the patient.

19,931. *Earl Russell*: What do you mean by your last remark, "engaged as athletes"? That is quite beyond me.—It may be that after the war these things have changed altogether, but during my time there these attendants, R. and T., were in a ward where I was, and I was taking then a post as second charge. When the charge was off duty I took the post of assistant charge, and these men talk to you in various parts of the institution; they do not care. Dr. R. knew that these men were very good at hockey; I could be the same myself, if I had the practice. These men say: "We are not attendants; we are here as athletes."

19,932. *Chairman*: A sort of games master?—That is quite so, and the patients are neglected. I have been in a ward when the bell has rung. I cannot go and answer that bell, because it is not my place to leave 30 patients there. If anything happens to those patients, what am I to do?

19,933. But when you became deputy charge, you then had direct access to the doctor, had you not?—Quite so.

19,934. If you saw anything going wrong, did you not tell the doctor?—I did.

19,935. And what happened?—He said he would see the chief attendant about it. Whether he did so or not, of course, I do not know.

19,936. *Mr. Jowitt*: What did you tell the doctor?—I told the doctor that I was here alone, and it was not a proper thing to leave a nurse in an institution like that alone. Those men who should have been in the ward, perhaps three or four of them, would be up on the cricket ground, if it was the cricket season.

19,937. Did you make any complaint to the doctor about these men?—I did not say that. You see, you are under rather a funny restriction—very, very funny.

19,938. *Chairman*: Do you mean to say that when they ought to have been in attendance in the wards they were away in the playing fields?—To put that more clearly, they were detailed off for it; they did not go on their own orders.

19,939. *Mr. Snell*: That is to say, they were playing with patients?—I do not think there would be many patients playing there.

19,940. *Chairman*: Still, that was their duty, to be on the playing fields?—Yes.

19,941. Your complaint is that under the arrangements of this place you were left alone while the attendants were away on the playing fields?—That is so.

19,942. How many people had you under your charge when you were left alone?—Sometimes 20 or 30, and sometimes, in the hospital, 20.

19,943. One ward?—One ward. The hospital ward is a ward where there are dormitories.

19,944. How long would you be in sole charge?—From half-past two to five o'clock or half-past five, or when they thought fit to come in.

19,945. Had you any assistants under you?—No. They were my assistants, supposed to be under me.

19,946. But they had been detailed off to the playing fields?—Quite so.

19,947. If you had wanted assistance could you have got it?—There were no bells to ring for anyone else. You would have to open a door, and, as you saw them pass by, tell them.

19,948. Now, in the whole period you were there, about seven or eight years, are the incidents you

have told us about—Mr. T. and the bathroom, and Mr. N. when he would not go to bed—the only cases of ill-usage you can recall, or can you remember any others that we should know about?—No, I do not think I can; only one minor one, in self-defence.

19,949. Is it worth going into?—Well, I do not think I need go into it, because it was a sort of protection on the charge's part.

19,950. You mean he was assaulted, was he?—When the patient was well he was very nice, but when he had these attacks he did go for attendant T., and attendant T. retaliated; that is the only other one.

19,951. Of course, you will agree that it is not proper for an attendant to retaliate at all, but he must protect himself?—That is so.

19,952. Do you say he did more than was necessary to protect himself?—Yes, I think he did.

19,953. Now, apart from these three matters, because we will call that a third, what would you say was the character and conduct of the attendants in this institution, those that you saw yourself and that you associated with?—As regards their conduct, the only misconduct is what I have seen them do, knock the patients about. As regards anything else, I have never seen them do it.

19,954. Then, when you talk of knocking the patients about, are you still referring to the incidents in regard to Mr. T. and Mr. N.?—Quite so.

19,955. At other times, apart from those occasions, were they kind to the patients?—Yes. As regards S., I do not think he had a kind act in him at all, but the others did kindnesses to the patients at times.

19,956. Now, may we pass to something else. Have you any other matters to refer to—for instance, what about the food?—The food is very inferior.

19,957. Of course, that may mean a good deal. Some people talk about food in hotels being inferior, which is very much better than we get at home?—I might say, Mr. Chairman, that if I paid the money as a patient in an institution like N., I should expect different food from what the patients got there. I looked after a Mr. W., a man who made a massive sum of money over photography, and that particular man would not have anyone else but me to look after him. I was always going up to the steward and complaining about his food, because it was not proper food to put before him. I was his special attendant, and I used to go out of the hospital, by his permission, and fetch bread in, because the bread was very, very bad bread. I told him myself when in his private room that he must pull himself together and tell the doctor himself. He did so, and afterwards they took notice of it. I used to go every day at half-past two round to the bakery and get a little loaf, and that satisfied Mr. W.; I worked out his menu in a book myself, and by doing that he got jolly good food, but before that he did not. Other patients who paid as much money as Mr. W. did not get such good food as I used to fetch from the lift on the tray.

19,958. Had you to pay for that food which you got, or was it included in his weekly charge?—It came into his weekly charge.

19,959. *Sir David Drummond*: Do you know what this particular gentleman paid?—Roughly I should say somewhere about—I think his brother who lives in Ireland told me when he came to see him—eight to nine or ten guineas a week. That would be including the special attendant. I do not think that I ever asked about it, really. My big friend, Mr. B., of N., had 19 years' experience in the hospital. He was a devoted servant of those people, and he himself has told me more, since he got pushed out of the hospital within half an hour's time, than I ever did know while I was there. He was the chief charge there for many, many years.

19,960. *Sir Humphry Rolleston*: Why was he turned out? What was the reason of his being ejected?—That was the time when there was a

20 October, 1925.]

Mr. M.

[Continued.]

dispute with the hospital. The matron is a most beautiful woman, and Mr. B. is a most beautiful man for the patients; and they both got pushed out; they were jolly good at their work. It is the same in these institutions as it is when you are in a home: if you have got a man you like, it helps to build the patients up. It was just the same with the matron there, and Mr. B., the chief attendant. There was some sort of mysterious thing going on with the medical superintendent, and Mr. B. was discharged in a very short time.

19,961. *Mr. Jowitt*: Did you ever hear why these two beautiful people were pushed out in half an hour's time?—Because they linked in Dr. M., who was the assistant superintendent. Dr. R. was the superintendent, and while he was away Dr. M., if I remember rightly what Mr. B. said, was putting forward the rights of the patients as regards money; and I expect, owing to their own affairs, they fell out; and Dr. M. got up a paper, which was a round robin, and I ran round the ward with it, and it was carried, and those men were instantly dismissed. It was a big thing that Dr. L. wanted to get hold of, if I remember rightly. It was somewhere about four years ago.

19,962. *Chairman*: Now in the case of those patients whom you saw not getting sufficient food, did their relatives or friends come and see them at any time?—The only case I know of was that of Mr. W. I mentioned it to his son, and he said to me: "Will you see to it for me? I cannot go into it," so I carried it out. As regards Mr. T., Mr. Justice C. came when I was his special attendant, and Mr. Justice C. said that Mr. T. had told him that he had been knocked about. I asked Mr. T. in the presence of Mr. Justice C. whether I was the man who had knocked him about, and he said "No." He would not tell them who had knocked him about. If it had been done, it must have been done during the night, when he was in an observation ward. Mr. Justice C. asked me if there were any other things that I wanted to complain about, and I said, "Yes; Mr. T. keeps complaining about the food," and he said, "I am going shooting, and I will send him a brace of pheasants." Of course, Mr. T. at that time did say things which Mr. Justice C. listened to, but there was no truth in them. He himself at times did have good food, but it was immaterial to him whether it was good or bad.

19,963. Do you mean to say that this patient in your hearing made complaints which were quite unfounded?—Yes, at times.

19,964. And you knew the things he was saying were not true?—Yes. His food was quite all right, in the condition in which the patient was.

19,965. *Mr. Jowitt*: Did he ever complain about you?—No. They are rather complicated gentlemen in those places. I was with him for 16 or 18 months, or longer than that—two years. Of course, he passed away.

19,966. *Chairman*: Were there any visits by visiting justices, or the house committee or the Commissioners while you were at N.?—Yes, the Commissioners came.

19,967. Will you tell us about the visits?—When B.W. notified N., everything was all prepared, and the patients were put in their best clothes, and washed, and everything was all kept calm. That is the time that I remarked to the charge attendant: "Oh! The food has come through all right now the Commissioners are here."

19,968. How did you know the Commissioners were coming?—Because the chief charge attendant's duty is to come round and put the wards on guard.

19,969. *Mr. Snell*: His duty? Is he ordered to do it?—Yes, by the medical superintendent.

19,970. *Chairman*: What sort of order is given?—The order is that if things go on in the usual way, and they did not notify them, patients would be out in the yards, and things would be neglected, but when

they knew the Commissioners were coming, no parole patient was allowed to go out, and everybody was kept in the ward; everything worked in a nice, smooth manner until the Commissioners had gone.

19,971. I thought one of the objects of the Commissioners coming was to see all the patients; and therefore it would be quite proper to arrange that they were not away?—They do see all the patients, but they allow them so much time. They have about three or four doctors at the side of the chief attendant, and the patients want to say a lot to the Commissioners. What happens is they do not get near enough to listen; but when they have gone the patients say: "I wish they had let me say that, and I wish they had let me say this." They allow them a certain time, and there have been occasions when they have given them five or ten minutes' interview, but not many.

19,972. *Sir Humphry Rolleston*: What warning did you get of the approach of the Commissioners—was it the evening before?—I think they did know about some of the visits the evening before, but we should know somewhere about ten o'clock. They may know before us, but the wards are never notified much before half-past ten or eleven. I have known the patients to be out in the courts and gardens, and to be all fetched in.

19,973. *Chairman*: What was the nature of the order? Was the order this: "The Commissioners are coming, and you must have all the patients ready and in proper order to show the Commissioners," or was it a sinister order that you were to get things arranged in a way they were never in at any other time, in order to deceive the Commissioners?—That is it.

19,974. Who gave the orders to deceive the Commissioners?—That comes through the fountain head—through the medical superintendent.

19,975. You understand what I am putting to you? It is one thing to issue an order saying that the Commissioners are coming round, and the patients are to be produced. It is another thing to try and give an impression of matters that does not exist at ordinary times. Do you suggest that the instructions you got were to try and deceive the Commissioners as to the true state of your wards?—I should say that would be so.

19,976. Why do you say that?—Because at other times things do not go on that way. I have put a man at a certain place, and that man would be there the whole of the time till the Commissioners came through. At other times you would be away from that ward, and the patients would be wanting to know why you cannot keep them amused; you have got to keep on with some domestic duty. That is the way I look at it, as regards the Commissioners coming.

19,977. But when the Commissioners came were the patients dressed differently from what they were when the Commissioners were not there?—Yes, a good many of them in the various wards; refractory ward patients and hospital ward patients. No. 1 patients, of course, are what they call the gentlemen patients. They dress themselves and put on their own clothes; but the refractory ward and the hospital ward patients do not.

19,978. *Mr. Snell*: Were they specially washed?—Again with a routine like that a No. 1 ward patient would have a bath every day. A refractory ward or hospital ward patient would have a bath only once a week.

19,979. *Chairman*: Apparently as regards most of the patients it made no difference whether the Commissioners were coming or not, but you say that some of the patients got a bath and were specially dressed because the Commissioners were coming?—Yes.

19,980. *Mr. Jowitt*: They must have had a bath in the middle of the day, then?—No. If they knew the Commissioners were coming in the morning, and there was a patient who had been neglected during

20 October, 1925.]

Mr. M.

[Continued.]

other times, they would give that patient a special bath.

19,981. At what time, though?—They would do it while the Commissioners came through the ward.

19,982. At what time of day did you know it done?—Sometimes they used to visit the ladies in the morning—

19,983. What time of day did you know a patient given a special bath?—Three o'clock and eleven o'clock.

19,984. *Chairman*: It must have been rather difficult to have got a lot of them bathed at the same time?—They would not bath them all; they would bath two or three; the others would have to get a sponge and sponge round their faces, and brush their hair.

19,985. There was not anything very wrong about that, was there?—No, but if they do it one day, they should do it every day.

19,986. Then you suggest that patients were being neglected in this institution?—Yes.

19,987. What was the nature of the neglect?—I think it is more hygienic to give the patients a bath every morning. There are three baths in the hospital ward. A patient asks for a bath, and if I asked the charge attendant about it, he tells me to mind my own business and get on with my own work; and the patient is given a sort of dab with a sponge, and they have not perhaps been accustomed to it.

19,988. Have you any observations to make about the detention of persons in N. who, in your opinion, should not have been there?—Well, I should like to bring one man's name forward, a Mr. B.

19,989. Is that the only name you want to bring forward?—I do not think I can think of any other.

19,990. When did you last see Mr. B.?—I have left there now this last 3½ years.

19,991. Did you think he was quite sane?—I should think so, from what I had seen of him.

19,992. Were you able to judge?—Well, I am not a medical superintendent, but I do not think Mr. B. ought to have been in there.

19,993. *Sir Ernest Hiley*: Is he in there now?—Yes, he has been in there for years. He is a man with a memory, and can talk to you about matters, and can tell you all the news.

19,994. *Chairman*: What was he said to be suffering from?—I did not notice the diagnosis of the man, but when Dr. R. came in he got very, very excited.

19,995. Why?—Because he has been there so long—he gets that way. When he is by himself with the attendant he is all right, but whenever he sees the medical superintendent or the Commissioners come in he gets rather highly excited.

19,996. Was he under your charge?—I have had him under my charge down in Wales.

19,997. Was that on leave?—No, that is their summer place.

19,998. Did you bring his case before the medical superintendent?—Well, you see, again Sir, the medical superintendent never asked me; they never ask you those things.

19,999. But if you think that a patient is quite sane, and he is under your charge, do you not say to somebody in authority: "This man has recovered now; he ought to get out"?—But that is a thing they do not allow you to say. They never asked me, all the time I was at N. or down in Wales, about the patient at all.

20,000. How do the patients ever come to be released, then?—That is when the relatives interview the patients, and in discussion with the doctor.

20,001. Had Mr. B. no relatives?—I do not think he has now. He did have when he was put in. He was put in at P. Asylum, and then he was transferred from there to N.

20,002. Is that the only case you came across in your experience of a man who you thought should not be there?—I do not know of any others.

20,003. *Sir David Drummond*: I suppose you cannot tell us what was the nature of his mental trouble?—No.

20,004. He was not classified?—I think they gave him a classification, but I do not know what he was.

20,005. Was he depressed?—No; he was a very bright man.

20,006. In what state was he when he became excited, when the superintendent came in?—He said: "Why was he put there? Why could not he go and work for his living?" and all this, that and the other. I used to hear him say that to the medical superintendent.

20,007. *Chairman*: Did you ever see his case book?—He never had a case book while I was there.

20,008. Are there any other matters that you would like to bring before our notice in regard to neglect of patients that you observed yourself?—No, I do not think there is. I think I might say that there was a suicidal case, and that was negligence. The reason I bring that up is because I say it was negligence on their part. This man had a razor, and if the man had done his work as he ought to have done (what has become of him I do not know; he went abroad), that patient would have been alive now, I should say, but it was absolutely negligence on the attendant's part—letting things lie about; but since that time they have remedied that. All the attendants have to go down and shave in a special place, and keep their razors locked up. What made me bring that case up before you is this. I was attending upon Mr. T., and I had to go before the medical superintendent. He knew I was a special attendant, and could not be in two places at once, so I was washed out of that case; but if the attendants were to do their work a little better, and the medical superintendent were more strict, I do not think that would have happened, but they have remedied things like this.

20,009. Now, Mr. M., you have come here this morning as an attendant who has had considerable experience. We are anxious to have from you all you wish to tell us. Is there anything else you would like to tell us, beyond what you have already told us this morning, which you think we ought to know?—No, I do not think there is.

20,010. *Earl Russell*: I want to ask you, Mr. M., a little more about Mr. B. I understand that you do not know anything about what his illness was?—No, I do not.

20,011. You have not seen his case book or heard anything about it?—No.

20,012. But what you say is that in your opinion he is kept there because he knows too much about the place—not because he is insane?—Well, I have talked to the man in the garden and I have found him a man in whom I could not see any difference at all. He has asked me "Why am I kept here?" and I have said: "I do not know why you are kept here." He is a man whom they do not allow to see things, because he would expose them.

20,013. You are a responsible man, Mr. M., are you not?—Since I have left there. As regards notification of a case, I think all nurses should be notified of the conditions of a case.

20,014. Do not you think it is a very serious thing to take it upon yourself to say, when you really know nothing about his mental condition, that he is kept there simply because, if he were let out, he would say too much about the place? You are taking upon yourself a great responsibility in saying that, are you not?—I might be, as far as that is concerned, but he is a well-behaved man, keeps himself clean and everything.

20,015. You go on in the same paragraph of your *précis* to say: "He always behaves in a thoroughly sane and rational manner." Did you ever say this, that he was kept there simply because he would know too much, and not because he was insane—did you say that?—I would not say that he was not insane. He knows a lot about the place.

20 October, 1925.]

Mr. M.

[Continued.]

20,016. *Chairman*: Did you ever say to any person outside this institution that that man was there because he knew too much, and was not allowed to be out?—I did say that.

20,017. To whom?—I do not know whether I told Mr. C. that.

20,018. *Earl Russell*: Anyhow, you say in your *précis* that he behaves in a thoroughly sane and rational manner; and do you remember that a short time ago you told us whenever he saw the doctor he got excited?—That is the only point about him.

Earl Russell: That is unfortunate, is it not?

20,019. *Mrs. Mathew*: I just want to ask you this, Mr. M. You say in paragraph 56: "Amongst others who were there when I left I would name Messrs. B., M., McE., C., B., W., H., and several others," and in the paragraph before that you say: "In my opinion there are a number of patients detained at N. who should long since have been given their discharge." Are these others dead, or why do you not say that they are now wrongfully detained?—Would you mention those names again, please?

20,020. Perhaps you would like to read them, would you (*handing précis to witness*)?—Thank you. Mr. M. has gone out, Mr. C. has gone out, Mr. B. has gone out, Mr. W. has gone out, Mr. McE. is still there. If I have put Mr. McE. in, that man is quite all right; he is a nice old gentleman; I see no difference in the man. I myself think that he ought to be given a chance in a home, to see if he could be trusted there to go back to his people. That is why I state that case. The same with Mr. M.; I saw Mr. M. some months ago; he is out of N. Mr. H.—that is Captain H.—is also out. That only leaves Mr. B.

20,021. Where are they?—They are all discharged from the hospital.

20,022. How did you happen to see them all?—I have not seen them all. The two men I have seen are Mr. M. and Mr. C.

20,023. Is Mr. M. leading an ordinary life now?—Yes.

20,024. And Mr. C.?—And Mr. C. He was the Mayor of B., and he has gone back to B.

20,025. *Chairman*: These people have all left since you were an attendant there?—Since I made this statement.

20,026. How do you know what befalls them, after you have ceased to be an attendant?—The reason I

know that is because a companion of mine goes to my friend at E. B. and tells him all the news. I was over there a week ago, and he told me that these men were discharged from N.

20,027. Did you ask about these men?—Mr. B. told me all about them. He said to me: "Do you know that Mr. M. has been discharged?"

20,028. How does Mr. B., whose services were dispensed with, continue his interest in the institution?—Of course, as regards taking an interest in it, this companion goes over there and tells him.

20,029. *Sir Humphry Rolleston*: You resigned, did you not?—I resigned.

20,030. Did you get a testimonial when you left?—Yes, I did. I do not know whether I have got it here. If I had not given in my resignation, I should perhaps have got served the same as the others. I wanted a character. That is what Dr. R. gave me (*handing document to Sir Humphry Rolleston*).

20,031. *Mr. Jowitt*: What have you done since you left?—Most unfortunately, I cannot get any stationary berth at all.

20,032. Have you had any temporary work?—Only at times. Mr. B. has got a nursing home, and I am relieving him for this week with a case.

20,033. Is that all you have done?—I have had several private cases.

20,034. You look after cases?—Yes.

20,035. *Chairman*: Why did you resign, Mr. M.?—When I came back from my holidays, all this disturbance happened, rather unawares to me; and several of the attendants said in my presence that I was a marked man, and I wanted to know why I was a marked man; and since Mr. B. left and I have left, Mr. B. has said that Dr. R. said he had no use for little men in there; I was too popular with the patients.

20,036. But Dr. R. gives you a very good certificate there?—Yes, that is the most extraordinary part about it.

20,037. Mr. B. told you this after he had been discharged?—Yes.

20,038. *Mr. Jowitt*: May I just ask about these certificates? Are these copies of the certificates?—Yes, that is a copy.

Chairman: Thank you, Mr. M. I do not think we need detain you any further.

(*The Witness withdrew.*) •

(*After a short adjournment.*)

Mr. O., called and examined.

20,039. *Chairman*: Are you Mr. O.?—Yes.

20,040. I understand that you are here this afternoon to give us some of your experience while you were a mental patient?—Yes.

20,041. First of all, I should like a little account of yourself. Were you storeman for a builder's merchant at B.?—That is right.

20,042. And was it in July, 1920, that you had a nervous breakdown?—Yes, that is right.

20,043. Did you see your doctor?—Yes.

20,044. Was he your panel doctor?—Yes.

20,045. And what were you advised?—When I saw the panel doctor?

20,046. Yes?—He informed my wife that it would be advisable for me to go away for a rest and change.

20,047. Were you able to do that?—I went to C. Infirmary.

20,048. That is near B., is it?—Yes, that is the B. guardians' infirmary.

20,049. Did you go there of your own free will, Mr. O.?—Yes.

20,050. For treatment?—To the infirmary?

20,051. Yes?—Well, there was nothing much to complain about the treatment there.

20,052. Did you go there for treatment?—I went there for rest. I do know exactly what I went there for. I did not stay long enough to have any treatment.

20,053. What did you think was wrong with you at the time?—A nervous breakdown—low-spirited. I had no strength and was very low.

20,054. Then it was on your application that you went to the infirmary?—Yes.

20,055. Now will you tell us about the infirmary? What ward were you put in there?—I was put in an isolated ward alone when I was first put there. I was restless and kept getting out of bed, and they had some difficulty in keeping me in bed. They put the porter of the infirmary to watch me and look after me; and after I had been there some little time, and I would not stay in bed, he tied me in bed one night, and he sat down by the fire, put his cloak round him and almost went to sleep, and told me, "You will find yourself somewhere else in a very short time," and I then went to F.

20,056. How long were you at C. Infirmary?—From the Wednesday to the Tuesday.

20,057. Just inside a week?—Yes.

20 October, 1925.]

Mr. O.

[Continued.]

20,058. *Earl Russell*: Did he tie you unkindly at all, or just simply enough to hold you down?—Not particularly unkindly; of course, he was very rough; he tied my hand each side of the bed to stop me from getting out of bed.

20,059. *Chairman*: Would you say you had any cause to complain of the treatment you got at C.?—No.

20,060. Now from C. where did you go?—To F.

20,061. And that is at S.?—Yes.

20,062. That is a mental hospital?—Yes.

20,063. How did you come to go there?—Somebody certified me as insane; I do not know who it was.

20,064. Did you not see a doctor?—As far as I know, there was a doctor came in to see me. Three gentlemen came in; I could not say whether they were doctors or not; they came in to see me and asked me a few questions. I could not remember exactly the questions now. That is all that I can tell you.

20,065. As you know, Mr. O., you cannot be taken away to a mental hospital unless you have been seen by a doctor who gives a certificate?—Yes.

20,066. Now some doctor must have seen you, surely. Do not you remember any interview with a doctor?—No, I do not remember any interview with a doctor at all, no more than on the Sunday three gentlemen came in together, while I was lying in the bed in the infirmary.

20,067. Were you able to talk intelligently to them, do you think?—Yes; I was never in a state but what I could talk intelligently and knew everything that was going on.

20,068. Did these gentlemen speak to you?—Yes, they spoke as they came through, but I cannot remember the conversation now.

20,069. Do you remember seeing a doctor called Dr. D.?—No, not to my knowledge, not to know his name.

20,070. Do you remember what you said to the doctor?—No, I do not.

20,071. You see we have got the medical certificate before us, and the medical certificate says that you stated that you had committed a sin against God. Do you remember saying that?—Not in the infirmary, Sir.

20,072. And that you imagined that milk which was offered to you was poisoned?—Yes, that is right.

20,073. Did you say that?—That was my idea. By the taste of it I thought there was something wrong with it any way.

20,074. Do you know who those three gentlemen were?—No, I do not know; I could not say.

20,075. Do you know that one of them was a doctor?—No, I do not know. I do not remember seeing them afterwards.

20,076. Looking back on it, Mr. O., do you think you were fit to be at large at this time?—Yes, Sir.

20,077. How were you taken to F.?—In a taxicab with the porter of the workhouse with me, and I understood the other gentleman who went with me was a magistrate, a magistrate of C.

20,078. Did they tell you where you were going?—No, they did not.

20,079. Then where did you think you were going?—I guessed where I was going by what the porter said to me; and I might say that my wife, after she knew I was going (she was not acquainted that they were going to take me with them), made enquiries as to who certified me insane, but they would never inform her who it was. The chairman of the guardians told her he dare not divulge the name of the person who certified me insane.

20,080. If you knew where you were going, and you thought the gentleman who was with you was a magistrate, did you make any complaint to him about your being taken to this place?—No, Sir; in fact, I was so low at that time that I was not very particular what they did with me.

20,081. You did not care, I suppose?—No.

20,082. When you arrived at F. how were you received, and what was done with you?—I was taken to F., and they took away my clothes and put me in a cot bed.

20,083. That seems quite a sensible thing?—Yes, that is right.

20,084. Where did they put you to bed; in what ward?—In the infirmary ward.

20,085. Now we would like very much to know what sort of people you found yourself amongst there—can you remember?—Well, there were some very epileptic cases there who had fits at almost all times of the day and night; and there were about 32 or 34 beds, I suppose, in the ward.

20,086. Did you find that disturbing?—No, it did not disturb me particularly, because my complaint was that I could not sleep at all. I might say I was put in bed there, and, of course, I was restless, and I got out of bed there the same as I did at C.

20,087. But if you were suffering from sleeplessness did you not find it trying to be in a ward where there were epileptics?—Well, I did not find it very helpful.

20,088. Were there any noisy patients in the ward?—Rather, Sir; there was one especially who used to come from another ward. It was supposed to be an observation ward, and there were several patients put in there from another ward; and one in particular used to swear and was shouting and swearing almost up to nine or sometimes ten o'clock at night, a man they called by the name of R.

20,089. Did you not find it rather trying?—Yes, I found it rather trying.

20,090. Because if you were suffering from sleeplessness, I should have thought you wanted some quiet?—Of course, I did. I should never have been put in a place like that; in fact, the superintendent at F. told my wife that he did not know why I was sent there. A man by the name of H. told my wife, and had a conversation with my wife several times, and the superintendent there told her at different times that if I could only pull myself together I could go home, but he said he could not let me go home without the guardians' permission.

20,091. For the moment I want to find out a little more about your time in the infirmary ward. You say there were epileptic patients and noisy patients there. Did you complain about being placed with them?—No.

20,092. Why not?—Well, I do not know why not. There was no other place to put us; there was only one place there.

20,093. Do you think you would have recovered sooner if you had been put in a quieter place?—I could not say.

20,094. Is it the case that at this time you were really so ill that you did not care what was happening to you?—Yes, that was to a large extent my feeling.

20,095. Then you did not really resent being put in this ward?—No.

20,096. However, it was a noisy ward?—It was a noisy ward. There was one man particularly, in the next bed to me, who used to have fits of laughing, and who would keep on laughing almost the whole night.

20,097. Have you any complaint to make about the treatment you yourself got in the infirmary ward?—No, I have no particular complaint; the attendants there were very good to me. As far as I was concerned, they allowed me practically to do as I liked.

20,098. What about the food you got?—The food was very very thin—very bad.

20,099. What was wrong with it? Just tell us. We really want to know, Mr. O., how you fared when you were there?—In the first place, when I was in the bed, they fed me with an apology for milk sop, which was nothing more or less than a little margarine with some water put to it—an apology for milk. That did not taste very agreeable; and they threatened me

20 October, 1925.]

Mr. O.

[Continued.]

that if I did not take it they would forcibly feed me with it, and, of course, I managed to get through part of it sometimes, but not very much.

20,100. Did you think it was poison?—No. I had no idea about it being poison.

20,101. What else did you get to eat?—A thick slice of bread and margarine. Mine at the time was cut in two slices—margarine for breakfast. For dinner—well, I do not know how to explain what the dinner was. Two days a week the dinner was what they called potato pie, some potato stuff, rind and all mixed together, and a bit of crust put along the top. S. pie they called it there; that was the dinner for two days a week. Another day, on Friday, it was as a rule fish, supposed to be fish, which generally amounted to one fresh herring. On another day a kind of thick soup with bacon rind, and various other comestibles in it which I hardly ever used to eat, just a mouthful of bread sometimes. I used to dip the bread in it and manage to get it down that way.

20,102. What was wrong with it; was it bad food?—It was not very tasty at any rate. There were perhaps three potatoes, and two of them were bad. I do not know whether you remember, but, of course, that year potatoes were very scarce. I hardly ever ate what they brought me at that time; but a Jap that was there used to wait at the side of my bed, and as soon as I finished, what I had put back, he would come and “scoff” the lot and eat it up.

20,103. How long were you in the infirmary ward at F.?—I was there all the time, except for just a little while when they put me upstairs to sleep, but I was in there practically the whole time.

20,104. Were you in bed all the time you were there?—No, I was not in bed all the time. As far as I remember, I was somewhere about six weeks or two months in bed before they gave me clothes, so that I could get up.

20,105. I think you were altogether at F. just over a year, from the 2nd November, 1920, to 17th November, 1921?—Yes, I went there on 2nd November and stayed there till 17th November.

20,106. Now, you were in the infirmary ward which you have described to us at first; and were you in the general wards of the institution later on, or were you in the infirmary ward the whole time?—I suppose to a certain extent I was privileged; they allowed me to stay in the infirmary ward practically all the time.

20,107. Now, Mr. O., you are a person who has had experience of this establishment, and we are anxious to know exactly what you have to report to us. What is your impression of the treatment which you got while you were there. What do you think of it?—Apart from the fact that the food was of very inferior quality, I do not know that I have got very much to complain of. As I say I was in such a state that I was not very particular what happened to me.

20,108. That is with regard to yourself. So far as you yourself were concerned, you really cannot say, apart from the food, that there was anything that you could complain of?—No.

20,109. But was there anything in the conduct of the establishment which you saw which you think we should hear about from you—anything which you think was wrong?—There was one thing which I think was wrong. The place was never inspected properly. The second night I was there, as I told you, I was restless, and I got out of bed and walked down the ward to the place where the night watchman was on duty, and he hustled me back to bed; and when the night watchman who walked round from ward to ward came in, they brought me a sleeping draught to drink, and because I would not swallow the sleeping draught, the attendant who was on duty struck me in the breast and I had a pain in the chest for several weeks afterwards.

20,110. If you were restless and wanted to wander about, was it not a good idea to give you a sleeping draught?—I suppose it was.

20,111. Why did you spit it out?—Because it was nasty, it scented the whole place.

20,112. When you spat it out, do you say the attendant struck you?—Yes.

20,113. How did he strike you?—He struck me with his fist in the chest.

20,114. Were you sitting up in bed at the time?—Yes.

20,115. Why do you think he struck you?—His temper, I suppose, Sir.

20,116. Because you would not take the sleeping draught?—That is right.

20,117. Did he strike you hard?—Fairly hard; I felt the pain there for several days afterwards.

20,118. Did you report it to the doctor?—No.

20,119. Why not?—I do not know. I did not see much use in it.

20,120. When did you next see the doctor after that?—The next day.

20,121. And did you not tell the doctor you had had a blow from one of the attendants?—No.

Earl Russell: How did you know it was not much use, if you never tried?

20,122. Chairman: What makes you say that?—I do not know at all, Sir.

20,123. Was the doctor sympathetic?—He was a very good doctor; he tried to buck me up, told me to look on the bright side, and all that sort of thing.

20,124. If he was talking to you in that encouraging way why did you not say “One of the men there struck me last night”?—I do not know why I did not.

20,125. Was there any mark on you?—No, I do not think there was any mark.

20,126. Was it with his open hand, or with his fist that he struck you?—With his fist.

20,127. Did he clench his fist and strike you?—Yes, a very severe blow.

20,128. Earl Russell: Do you mean to say it did not bruise at all?—I did not see any bruise at all.

Earl Russell: I should have thought a hard blow such as you have described would have bruised you.

20,129. Chairman: Were you in a nightshirt at the time?—Yes.

20,130. If he struck you at all you would expect some kind of bruise to show, would you not?—Yes, I suppose there would have been if it was actually hard.

20,131. Was there any other occasion while you were at F. that anybody struck you, or tried to strike you?—No.

20,132. That is the only incident?—That is the only one.

20,133. And it took place when you were spitting out this sleeping draught?—That is right.

20,134. Did you see anything else at F.—anything done to any of the other patients?—I saw several patients struck there. I might say that this particular attendant was not there so very long afterwards. There was an old doctor that was put in bed there, and there was a complaint made against the attendant; the patient was put in bed at night and the next morning he died. The doctor came and asked me a question as to whether I heard anything because they knew I was awake all night, and I said: “Well, I heard some smacking going on.” It was some distance from me down the room, in fact, eight or ten beds from where I was. There was an inquiry held, and he had notice.

20,135. Was it the same attendant?—The same attendant.

20,136. And that attendant was dismissed, was he?—Yes, that is right.

20,137. How long after he had struck you was it?—I could not say how long it was after he had struck me; some little time.

20,138. Apart from that attendant who was subsequently dismissed, did you see anything wrong on the part of any of the other attendants?—No, I did not. There was a night attendant who took his place, who came on duty; I saw him strike a patient.

20,139. Under what circumstances?—Because he struck another patient. This patient R. was sitting in the bed and kept shouting and swearing

20 October, 1925.]

Mr. O.

[Continued.]

and using obscene language, and the patient in the next bed to him got out of bed and struck him, and then the night attendant deliberately came and struck this patient. His name was M. C. I saw him distinctly, because I was only about two beds from him; he struck him in the face, struck him in the eye. I might say that this man was restless and he used to wake up about four or five in the morning and continually keep talking. He was a Roman Catholic and used to say: "In the name of the Father, in the name of the Son, and in the name of the Holy Ghost," and keep on interrupting the other patients; and the attendant used to take him out of bed and put him out of the ward in the dark for the remainder of the night. Then I saw this same attendant very much ill-use a man by the name of G. He had a controversy with him when he came in; he was not in that ward really, he came there to sleep from another ward; he had some altercation with him as he came into the ward and threatened the man what he would do, and this same patient G. got out of bed and picked up the pot.

20,140. Were these incidents you have spoken of in connection with an attendant other than the one that was dismissed?—Yes, this was the other one.

20,141. A different man?—Yes, the one that took his place.

20,142. Was he no better than the previous one?—He was no better in that case, if anybody upset him in that way. He did not interfere with me at all; in fact, nobody, with the exception of that one time, ever interfered with me in any way.

20,143. How far were you able at that time to take notice of what was going on around you?—I was conscious all the time, I knew everything that was going on, I was never unconscious the whole time. When I was at the guardians' infirmary I was rather delirious, but after I went to F. I knew everything that was going on; I was not unconscious in the least.

20,144. Now tell us about the visits of the doctor; how often did the doctor come round?—The doctor came round every day.

20,145. Did you see him every day?—Yes.

20,146. Did he speak to you every day?—Not every day, he usually just came and said a word or two and had a look at me.

20,147. Had you a chance of speaking to him if you wanted to tell him anything?—Yes, I had the chance of speaking to him.

20,148. Have you any complaint to make about the doctor?—No, I have no complaint.

20,149. When he did speak to you, was he kind?—All right.

20,150. Now about your ordinary daily life at F.; were there any things that struck you as unsatisfactory?—Not particularly, except one thing which I thought was very unsatisfactory, that oftentimes there were only about two attendants on duty for somewhere about 60 patients.

20,151. You thought there was not enough staff?—Understaffed.

20,152. Did anything ever happen because there was not enough staff—was there any trouble or any row?—There would have been one night, the same night as G. picked up the pot; there were two attendants who were off duty, but they did not go out, and when this man got obstreperous in this way, this night watchman gave his keys to the patient in the next bed, and asked him to call the other two attendants, and the two came in and the four together put this man in a single room.

20,153. Now what about the lavatory arrangements?—They were very unsatisfactory indeed.

20,154. What was wrong with them?—There was only one place, and very often it was overflowing with water; and if you wanted to go in there, there

was only one lavatory for the whole of these patients that were in there. Sometimes it was stopped up, it would not flush at all; and you had to go in there in your naked feet on cold tiles, just up two steps just outside the infirmary ward where we were, that is No. 5A ward.

20,155. You are speaking of the water closet just now. What arrangements were there for washing?—There were about three basins in the bathroom; and I might say here that if there was a dirty case, as a rule the attendants used to take a dirty case in there and put him in the bath, and oftentimes the water was scarcely lukewarm; sometimes it was a cold bath.

20,156. How often had you a bath, Mr. O.?—I do not think I had a bath; they did not enforce it in my case, but the rule was to have a bath once in three weeks, but I cannot remember how many weeks I went without a bath.

20,157. Did you not want one?—I did not want one particularly.

20,158. Did they give you a wash in bed—sponge you over?—They did not do it, I did it myself. They brought me a basin. I did not have a bath while I was in bed at all.

20,159. When you were up, how did you do?—When I was up I used to go in the bathroom and wash myself; there were three little wash basins in this bathroom where the bath was.

20,160. How many patients were there to use these three basins?—I could not say exactly the number, because these were infirmary patients and most of them belonged out in No. 5 ward, and they were supposed to go and wash in the other places outside.

20,161. This is the best way to test it: could you always get to the basin when you wanted it, or were there others waiting for it?—I could get to it by waiting. One patient used to do some of the work in the ward, and it was very difficult sometimes; I had to wait sometimes to get a wash there.

20,162. How did you know what happened in the bathroom, if you never had a bath yourself, Mr. O.?—I knew because there were chairs just outside the bathroom, and we were allowed to sit in these chairs when we got up, and occasionally of course I used to do a little dusting. I used to dust round the beds and occasionally try and polish the floor, but I had no strength for the work. The attendant used to tell me, "You want to get hold of the scrubbing brush and scrub some of the rooms out," but I was unable to do the work. I could see that these men were dirty cases, and I saw them taken in there, and I saw them brought out; in fact they were sometimes brought in there while I was in there washing; I used to go in there and wipe up the pots at night.

20,163. Were there any side rooms in the ward you were in?—I forget now whether there were four or five side rooms.

20,163A. What about them?—One of them where the Jap slept was simply like a case; it was called a room and they used to put a hair bed on the floor and what they call a canvas rug. There were two little bedsteads in one or two of the others.

20,164. Were they used much?—Yes, they were always occupied; if there was an obstreperous case they used to take the patient out of those rooms and put the other case in. I have seen this Jap brought out. A man by the name of B. came there one night, and there was no other room to put him in, and they brought this Jap out of his room; it was no better than a pigsty; there were no urinal arrangements at all; whatever was done was done about on the floor, and this man B. was put in the same room as that Jap was that night. In fact he stayed there; the Jap was put in the same bed. I never heard him speak at all. The patients used to say he could speak English, but I never heard him

20 October, 1925.]

Mr. O.

[Continued.]

I saw him strike one of the patients one day, the Japanese patient.

20,165. Was he violent?—Not particularly. I saw him strike the attendant once when he wanted to undress him; apart from that there was nothing very serious the matter with him.

20,166. Do you remember any official people visiting F. when you were there?—The only people I ever remember visiting there were the Commissioners, who used to come round. I am not sure, but as far as I can remember I believe they came round twice while I was there. The whole time I was there I never saw a person from the B. Guardians; in fact, the Chairman of the B. Guardians promised my wife he would visit me while I was there, but I never saw a guardian at all.

20,167. You might tell us about the Commissioners' visits?—I might say they always knew when the Commissioners were coming, and everybody was touched up a bit; put on a fresh suit of clothes. There were several private patients there; in fact, they were so dressed up when the Commissioners came round, especially one man, I did not know who he was; everybody was lined up in the yard, and the doctor and the attendants used to walk up along the line just like a regiment of soldiers, and if you had any complaint to make they would allow you to speak to them.

20,168. Did you ever speak to any of them?—No, I never spoke.

20,169. Did you want to?—No, I did not want to.

20,170. Did you not want to get out?—I cannot say that I did, in the state I was in at that time. The fact of the matter was that I had lost hope, I had lost strength; the result was that everything and everybody was against me, and I simply had no desire for anything different.

20,171. Now you were transferred, were you, on 17th November, 1921, to P.?—Yes.

20,172. How did you come to be transferred? Were you complaining about F. and wanting a change?—No. All B. pauper patients were transferred; they decided to transfer all B. pauper patients from F. to P.

20,173. Were there a number of others who went at the same time?—Yes. The B. patients went at two different times; there were about three weeks between.

20,174. How did P. compare with F.?—It was like going out of a dungeon into a palace.

20,175. Was it a much better place?—Much better.

20,176. Was it a newer place?—Yes, it was practically brand new when we were put into it; I think we were about the second or third lot that went there.

20,177. Was it better fitted up?—Much better fitted up.

20,178. More modern?—And more modern with every convenience, equipped for cleanliness.

20,179. You must have been among one of the first people to go into it?—Yes.

20,180. And you think it showed a great improvement in its arrangements as compared with F.?—Yes.

20,181. *Mrs. Mathew*: Were there more attendants at P.?—Yes, a great deal more attendants there.

20,182. *Chairman*: And were you satisfied with the treatment you had at P.?—Yes, I was satisfied with the treatment; it was all right; the only complaint I had against P. was that they kept me there nine months after I was well.

20,183. When I speak of treatment, I mean were they kind to you?—Yes. I was in three different wards. I might say when I went there I was taken ill just about Christmas time with influenza, and I had a boil on my arm, and I was put in the infirmary ward; at that time the food was not very special; at any rate, I did not eat any Christmas dinner there. I do not know what it was, it appeared to me to be

like artichokes, it was something black, anyway, and I did not eat a mouthful. But after that, especially after I was transferred to No. 8 ward, that is the convalescent ward, I had nothing much to complain about. I went from No. 1 to No. 2 for some while, and I worked in the scullery, and when I went out to work on the grounds I was transferred to No. 8.

20,184. Did the Commissioners come round there also?—Well, Sir, I cannot say about the Commissioners; I do not remember seeing any Commissioners. The committee used to come round the ward.

20,185. You remember the committee coming round?—Yes, not many of the committee—Mrs. M. and the Duke of X.—I was informed that was his name—used to come through the ward occasionally; in fact, every month, I think, when the committee meeting was held, he used to come through.

20,186. Now your chief complaint is that you were kept too long in F.?—That is right. Of course, I could not see that the place was thoroughly inspected any more than the other place; because whoever was coming they always knew when they were coming. Even the doctors themselves did not know what was going on there. I defy anybody except they have been through the particular experience themselves, and been in the place, to have any idea what was being done there.

20,187. Did you complain to the visiting committee that you were being detained, although you were quite well?—Yes, I did; I asked twice to go before the committee. I might say, in the first place, my son was informed by the relieving officer (my wife had been trying to get me out for a long time then) that if he was willing to be responsible for me he could claim me; so my son came for me and we went before the committee, and they asked me a few questions, whether I had got a job to go to. I said "No." The chairman said, "Did I not think I would be all the better for staying another month?" I said, "No, I did not, but if that was their idea I was prepared to abide by it." I stayed that month, and when my son came back for me the superintendent wired back to say, "No, I must stop till I was better."

20,188. *Earl Russell*: You were not very strong and well at this time?—There was not much the matter; I had been going out to work in the fields and on the ground.

20,189. Were you not getting better every day with the rest and the food?—I was no better after that eight months was up. I had been improving then for three months. This was the Thursday before Easter when my son came for me. Then I asked the next time to go before the committee, and when I got before the committee there was no committee there except the chairman and the doctor. I had quite a long conversation with the chairman, and he was sorry he could not go against the superintendent's instructions.

20,190. *Chairman*: Why do you think they would want to keep you on after you were better?—I do not know, Sir; I have no idea at all.

20,191. You were costing a good deal of money, you know?—That is what I told the chairman when he came through, when I began to know there were men in that ward that had been in from 12 and up to 25 years. As far as I saw while I was there, there was nothing more wrong with them than with me. I began to get anxious; and each time I was expecting to go home, I told them they could not do anything worse to give me a set-back.

20,192. You were not engaged in any work in the place?—Yes; after Easter I was going out to work with the stokers; we used to unload trucks of coal, and we used to empty the cesspools in the attendants' gardens, from half past eight in the morning till half past twelve, and from half past one to half past five from Easter to November, when I got my discharge.

20 October, 1925.]

Mr. O.

[Continued.]

20,193. Were you fit for that kind of work?—Yes. Of course we were not pressed, we worked our own pace; in fact the attendant told me one day I could please myself. I said I was there working for them. He said, "You can please yourself; you need not work unless you choose to." I said, "I know all about that."

20,194. The medical superintendent would have no motive, would he, for keeping you there any longer than was necessary?—I do not know, unless he was playing for safety—I do not know why.

20,195. Perhaps he was playing for safety.

20,196. *Sir David Drummond*: You had several nervous illnesses before that; since 1893 you have had several nervous illnesses?—Yes, I had one before.

20,197. So it is quite reasonable to suppose that the superintendent was playing for safety?—Yes, that is right.

20,198. *Earl Russell*: And you had had two pretty bad accidents?—Yes.

20,199. *Mr. Jowitt*: Looking back at it now, do not you think he was quite wise to play for safety. Here you are as well as ever?—No, I do not; I consider he ought to have let me come home at Easter. I think I was quite fit and well to come home considering I had had no set back, especially when I was willing to stay a month and had had no set back in any degree. In fact I asked the superintendent; he came through the ward on one of the committee days, and he said "Hullo, O., are you settling down," and I said I supposed I was.

20,200. *Earl Russell*: But what possible motive could he have in keeping you, except your own health?—That I could not say.

20,201. *Chairman*: And did he not examine you so late as October 1922?—No.

20,202. You left, you remember, on the 9th November, 1922, and was not there a special report upon you on the 21st October? Do you remember being seen by Dr. B. then?—By a special visit do you mean?

20,203. By the medical superintendent?—On what date?

20,204. On the 21st October, that is about three weeks before you left. Do you remember being examined?—He did not examine me, he had a conversation with me. When my son came for me Dr. D. thoroughly examined me and told me I was all right—that was when my son was there waiting to take me home. Of course when I got up into the room fully expecting to put my own clothes on, they put me back.

20,205. It is only fair to tell you, Mr. O. that on the 21st October, which is two or three weeks before you left, the medical officer of the institution certified that he saw you, and that you were suffering from melancholia, that you were unstable and lacking in self control, and had no insight into your own condition; that you resented being questioned and were evasive in your answers, and were inclined to be abusive when pressed for an answer; and that you told the doctor that it was no business of his to question you on religious matters, that you were in constant communication with God, and that it was the will of God that you should be kept in the asylum. Do you remember anything of that sort?—Yes, I remember about that, but I told him at that particular time that I did not think it was the will of God that I should be kept there indefinitely.

Earl Russell: Neither were you.

20,206. *Chairman*: You were not?—I consider I was; I was kept there for eight months longer than I ought to have been. What I would like to know is how did Dr. B. know that I talked to God. I can truthfully say that nobody ever heard me in any way.

20,207. What the doctor says is that you yourself told him that you were in constant communication with God?—Yes, that is right. It does not follow, does it, because a man has religious convictions, if he talks with God, that his mind is necessarily unstable?

20,208. Of course not, but there are ways and ways of doing things you know, Mr. O. There are some ways that are normal and some that are abnormal?—Yes.

20,209. Did you tell the doctor that it was the will of God that you should remain on in the asylum?—Indeed I did not, not that I should remain there indefinitely.

20,210. Do not you think it was a wise precaution to take?—No, I do not, Sir; unless, as I say, I had any definite set back, any reason that they should keep me there, which I could understand; but I had no set back whatever. I began to pick up from the Boxing Day.

20,211. Can you suggest any reason why they should have kept you all these months at the public expense unless they thought it was for your good?—That did not affect the asylum, did it? That was a case for the B. Corporation; they had to pay for me—not the asylum authorities.

20,212. What I have a little difficulty in understanding is this: Suppose that you were, as you say, quite recovered, can you suggest any motive that the medical superintendent could have for keeping you on there?—No, I cannot suggest any motive.

20,213. *Earl Russell*: Any wrong reason?—A good many of the patients there had the idea they were there because they were useful and helping in doing the work. That was squashed, because from what the attendant said to me it was immaterial to them whether I worked or not; they would want somebody to do the work; if I had refused to have done it, that would have been another set back against me.

20,214. Do you think that you were being kept there because of the work you were doing?—No, I should not like definitely to state that.

20,215. Do you think it at all—have you got that idea at the back of your mind?—That they kept me there for it?

20,216. Yes.—No, not exactly. I should not truthfully say that they did so, but that was the impression of a good many of the patients there, whether it was right or not.

20,217. But I would like to go a little further than "not exactly," and I would like to know whether you have got that impression in your mind at all, that that was the reason they kept you?—No, I have not.

20,218. *Sir David Drummond*: The sum and substance of your charge is that the doctor's opinion was wrong, that is all. His opinion was that you should stay there, and you say his opinion is wrong. Some of us may give opinions that are wrong, but we do the best we can. We do not claim to be always right. Apparently this doctor was right, judging from your history, but your opinion is that he was wrong—that is the sum and substance of your charge?—Yes; but do not you think, Sir, that with the particular complaint that I was suffering from, it would set me back to be told the same thing continuously almost every month? It was the usual thing, when a patient was going to get his discharge, the doctor came and spoke to him on the Sunday morning previous to his discharge; and several times he did that to me. Do not you think that the fact that he treated me in that way could have been anything but to aggravate my case? In fact, I told him so. If he wished to put me back where I was, I did not think he could have done anything worse.

20,219. As a matter of fact, it has not?—No, it has not, but you can take it from me I was very much upset at the time, especially when my son came for me. If I had given way to my feelings I should have been as bad, if not worse.

20,220. *Chairman*: You told us that P. was a much nicer place to be in, in every way. Were the attendants kinder and more attentive there than they had been at F.?—They were not kinder to me,

20 October, 1925.]

Mr. O.

[Continued.]

because, apart from that incident that I gave you when this attendant struck me, I had nothing to complain about the attendants at F.

20,221. Were they a better class of attendants, or more attentive?—Certainly.

20,222. Were there more of them?—Very many more of them; there were four on duty in the ward where I was. As far as I could gather, the attendants at F. had no qualifications at all. There was a particular patient there who was practically covered with sores, and he had no convenience at all. When they used to dress these wounds, we could smell the wounds five or six beds away from him. As far as I could gather they had no definite experience for their position. I was given to understand that all the attendants at P. were Royal Medical Corps men, they had to pass the test before they could be attendants.

20,223. *Miss Madeleine Symons*: You saw no case of ill-treatment at P., did you?—Not definite ill-treatment. There were certain patients there in the bathroom sometimes, and they were inclined to be stubborn; and they would give the patients a dig in the ribs while they were having a shower bath.

20,224. *Mr. Micklem*: Is P. a private asylum, or is it one of the county asylums?—It is a county asylum. I understand that B. have 200 beds.

20,225. *Chairman*: Now when you came out in November?—I might say when I went out the doctor told me it would be best that I should be on probation for a month, but I understood when a man was put out on probation he would have pay for that month; but I have heard nothing from them from that time to this.

20,226. When you came out did you make any complaint to anybody about your having been detained for these months?—Not definitely; I was very glad to get home, and I did not want to bother any more about it.

20,227. How did you come to write for details of your certificate?—I forget now; I cannot remember exactly.

20,228. You wrote to the Secretary of the Board of Control two years after you came out, in November, 1924?—Yes.

20,229. How did you come to write for your certificate then?—I think that was something when I had to give evidence. I came up to London to give evidence before somebody to do with the Royal Commission on Lunacy.

20,230. Who asked you?—I could not say who it was. I have not got any name or address now.

20,231. Was it the Lunacy Reform Society who asked you?—Yes, I believe that was it.

20,232. How did they get your name?—I expect they got my name through W., as far as I can tell.

20,233. That is the witness who is coming this afternoon?—Yes. He came to me and asked me if I was prepared to verify his statements, and I said, "Yes, I was."

20,234. Had you not thought of making any complaint yourself until Mr. W. came to you?—No, I had not.

20,235. And when you came to London, then did you see a gentleman at the offices of this society?—Yes; he took down my experiences at P.

20,236. He wrote them down, did he?—Yes.

Chairman: Well, Mr. O., we are obliged to you for having come this afternoon; we do not need to detain you any longer.

20,237. *Earl Russell*: And we hope you will go on keeping quite well.—I hope so. I might say that nobody, not having been in this place, can have the faintest idea of what it was like. I told the doctor one day that I defy any man, if he had not been through the experience I had been through, to have the faintest idea of what it was like.

Chairman: It must be a very painful experience, I am sure.

(The Witness withdrew).

Mr. W. called and examined.

20,238. *Chairman*: Mr. W., are you a fishmonger and poulterer at B.?—Yes.

20,239. Are you engaged in that business at present?—I have been laid up, Sir, for over five years. I have not recovered; my health is good, but physical weakness, largely resulting from my treatment in the first place I was in, is what I wish to give evidence about.

20,240. That is F., I think?—That is so.

20,241. So you are not in business just now?—I am still laid up; still in the doctor's hands.

20,242. Now, in 1920 had you a breakdown?—Yes, in May, 1920.

20,243. And did you get worse?—Yes. At first it was a physical crash, largely resulting from the stress of the business. I had been managing a shop, on the premises of which I am still living, in C. Road, and the firm had sold out in a hurry and left me stranded, but I had had five years practically without a break at all, 365 days a year. There was a good bit of worry and responsibility as well as work, and at first it was a physical crash, a sheer collapse, but in October, 1920, acute neurasthenia set in.

20,244. What was the form that it took?—At first sheer physical weakness, and then when acute neurasthenia set in there was a good deal of pain in the head, hissing in the ears, and a distorted view of my own character.

20,245. Would it be fair to say that at that time you were not in your proper mind?—I claim, Sir, that I have never been insane during my life. I have had two nervous breakdowns, but I was not insane, Sir.

20,246. Did you continue at home during this period?—Yes; I came out of business. The firm gave up on the 23rd March, 1920, and in the May I

collapsed, and I stayed at home until the July of 1921.

20,247. You were not able to work during that time?—No.

20,248. Were you very morbid?—Depressed; but the chief mental symptom was the same when I had my other crash (I was about 35 then), a distorted view I had of my own character, the idea being that I was the most despicable skunk that had ever been allowed to live; and because of that I avoided everybody, including my own wife, but other than that I could converse on everything when anybody came to see me. That I put down generally to a very narrow form of orthodox Christianity that I was crammed with as a youngster.

20,249. Did you feel that you had committed sins?—The feeling was that everything I had done was wrong, and because of that I was ashamed to meet people. I used to go about with my head down.

20,250. Of course, there was no foundation for that, Mr. W.?—Not at all. I do not wish to be egotistical, but I can say that I have walked as clean a line as most, and better than a good many.

20,251. But at this time you believed, did you, that you had done wrong?—The opinion then, and when I had my first crash, was that I was the most despicable humbug that ever had walked this earth.

20,252. That feeling must have upset you very much?—Yes; it was really worse than physical pain, a feeling of utter shame, because I have always prided myself I could look anybody in the face. There was no cause for it other than the weak state of nerves in which I was.

20,253. Now, in that state of matters, do you remember the relieving officer coming to your house?—Yes.

20 October, 1925.]

Mr. W.

[Continued.]

20,254. Why did he come?—Well, in a nutshell, the situation is this, Sir: I think I had been home, roughly, about 13 months, gradually getting worse, and my doctor said that it was imperative for me to go away for a change of air. When a working man, who has never taken a decent wage, has been laid up for 13 months, there is no spare cash for change of air. The doctor impressed on my wife that if I did not go I should not get better; it was my only chance. I do not know whether you know C. Road, B., but it is a very busy thoroughfare, and a very narrow thoroughfare; trams are continually coming up the road; there is a lot of heavy traffic, and the conditions were just about as unfavourable for nerve trouble as they could be; and he said it was imperative for me to go away for a change of air. On that the wife consented to my going. I did not know.

20,255. Did you see the relieving officer yourself?—No, Sir, not till the morning they took me away. This is what happened. The doctor wrote to the guardians. The next thing that I knew was that the relieving officer called, but I did not see him, the wife had an interview with him, and she requested that I be not sent away. The next morning a Mr. D., a man who I know, a J.P., called; I did not know what for—I do now, and have known for some time; but he was not in that house 45 seconds. He just came up the stairs behind my wife, came into the room, and asked me how I was. I replied, "I cannot see you." I went past him into the next room and burst into tears. In the state I was, that was nothing to be wondered at, but on that he certified me as insane.

20,256. Who was your doctor?—Dr. R.

20,257. Was he a panel doctor?—No; I have never taken up a panel doctor; I have paid for my doctor.

20,258. You had been a tradesman in your shop?—A manager of a shop, yes; but I never took up the panel doctor, although I was entitled to it.

20,259. Your own doctor had been attending you, had he?—That is so.

20,260. Had you any reason to distrust your own doctor?—No, not at all. In fact, I believe the only reason he did what he did was to get me the necessary change. You see a hospital will not take you with a nervous breakdown; it is too long a job, and it is not interesting. If they are going to cut off an arm or a leg, they are only too eager.

20,261. *Earl Russell*: You mean you were certified for the purpose of getting a change of air?—Roughly. The doctor may have taken the acute depression, and what I did say—I said at one time I was cursed by God and blinded by the devil, but that was only some stuff that had been pumped into my head when I was a child and re-affirmed later on at a revivalist meeting in my teens.

20,262. *Chairman*: You see Dr. R. on the 5th July, 1921, gave a certificate, Mr. W., that you were then?—A fit and proper person to be—

20,263. —detained?—That is so.

20,264. And he gives the circumstances?—Yes.

20,265. You do not suggest that he had any improper motive?—Not at all, I would not suggest that for a moment. Dr. R. has always behaved as a gentleman to me.

20,266. It is so difficult for people to judge of their own condition?—Agreed. May I tell you a few facts which should have a little bearing on the matter, to prove my own sanity?

20,267. If you please?—I did not know where they were taking me till the morning of my departure, and then I knew that I had been certified insane, and I did not resist because I knew it would be taken as a proof of my insanity if I did; I went quietly. The second item which does not look quite on a par with a madman's action was this: a Mr. H., a relieving officer, and a friend of mine who was then one of the guardians, and my wife went

with me. A taxi, practically like an open victoria, came, and there were two seats and two peculiar swing-down seats which fold up in rather a tricky manner. Mr. N. and the relieving officer both had a terrible struggle to let those seats down and could not do it; I said "Let me have a go," and I did it. That does not altogether look as if I was particularly over the border. One other point. On my arrival at F., when I had not been in that building very many days, because of what I saw, I registered a vow to myself if ever again I got my liberty, I would devote the remainder of my life to bringing that place and its proprietor to book.

20,268. *Earl Russell*: So you have very strong feelings of animosity towards that asylum?—Animosity is hardly the word.

20,269. Well, what shall I say?—I do not like that word. There is a feeling of this kind, that if I did not do my level best to bring that place and its owner to book, I should be neglecting to do my duty. I look upon it as a religious duty.

20,270. *Chairman*: Now about the certification. The doctor had given a medical certificate, and then Mr. D., who was a justice of the peace, came to your house, did he?—Yes.

20,271. And I suppose he had seen the medical certificate?—I assume so, I do not know.

20,272. Did he try to speak to you?—What happened was this, Sir. He came into the house, followed my wife up the stairs into a front bedroom where I was, and she said "Mr. D. has come to see you." I had met Mr. D. before, and I did not place any significance on his visit. I thought perhaps he had called out of friendship at the time; but as I tell you at the time I was avoiding everybody, and on his entry to the room he said "Good morning, how are you?" I walked past him into another bedroom at the back—there were two bedrooms on the top floor. I walked into the back bedroom past him and burst into tears.

20,273. It was very odd conduct, was it not?—Yes, odd, but not odd for a nervous breakdown if you have any experience of them. There is nothing unusual in a man exhibiting emotion in a nervous breakdown. As I say the feeling is that you want to get away from everybody and everything; the slightest noise was an agony; there was nothing to be wondered at. But this is the point. On my going into the other room the wife followed me, and she tried to quieten me; I was quite quiet then, but Mr. D. did not stop and have another word with my wife, not even to wish her good morning; he walked down those stairs and out of the house, and in less than 45 seconds of his entry into the house I was certified as a pauper lunatic. I was neither a pauper nor a lunatic. There were two mistakes, Sir. A pauper is a man without visible means of support.

20,274. You need not worry about that side of it, Mr. W.?—I do not worry about it, Sir, but it was a mistake.

20,275. *Mr. Snell*: What is your opinion as to what should have been done with you at that time. You were ill—you will admit that?—I should say I was ill. If you have seen a nervous breakdown, you will know that a person with a nervous breakdown is obviously ill.

20,276. You admit your own home was not very suitable at that time?—Yes, because of the noise in the place; but my point is this: I happened to know a case which happened a little bit prior to my own, but it was a wealthy lady who was over the border, and was certified; but in this case another justice of the peace had to verify the doctor's certificate, and he spent over an hour with that lady before he would sign the paper. So I suggest that if Mr. D. can sign up an insane man in 45 seconds, he should be in one of these asylums to send them out.

20,277. *Sir David Drummond*: You were not over the border yourself?—I was not over the border myself. I suggest this, Sir, that when ill-health

20 October, 1925.]

Mr. W.

[Continued.]

comes about, if it is only a case of influenza, a person is not normal. The border line between sanity and insanity, we all know, is a very very thin one; but my claim is this that a man or woman who knows what they are doing, who is not violent, who takes what is given him for his own good, who can even, because of what he sees, register a vow that he will devote the remainder of his life—if you want any more proof of sanity than that, Sir, well I was not normal—a person is not normal even with a bad cold.

20,278. *Chairman*: Now, Mr. W., you must remember that we are very near the end of a long inquiry, and we have heard a great deal from other witnesses regarding the general considerations. The value of your contribution is your personal experience; and what we all want to hear from you is an account of any occurrences which took place at F. under your own eye which you think we ought to know about, and for which it may be proper for us to suggest some remedy. That is a practical question. Would you kindly tell us what were the things you think we ought to know about, which occurred during your period at F. where you were for some months?—I was there from July to November, 1921.

20,279. During that period did anything occur which you think we should know about?—Well, Sir, first and foremost, on my arrival at the institution I was examined to see if I was clean, and I was put to bed in the infirmary ward. We arrived there about midday, a bell was chiming twelve as we arrived there. I had left home fairly early in the morning; but nothing in the way of food, or a suggestion whether I would like even as much as a glass of water, came my way until four o'clock, when we had our tea. I may mention that I was also photographed, a very distressing performance in the condition I was. I was put to bed in the infirmary ward, and in that ward I remained until I left the institution. Let me tell you something about this infirmary ward. There was, to the best of my knowledge, 30 or 32 beds in it; they were so close together that you could not get a chair in between them, and there was a general mixture of poor beggars in various stages of dementia and other complaints; there were tubercular cases; there were epileptics, general paralysis, one poor old chap rotting with venereal trouble; some were singing; some were cursing and some were creating ructions; there was not a moment's peace during the 24 hours, and it was about the last place, and about the vilest conditions in which to incarcerate anybody with a nervous breakdown. Let me tell you something about the food.

20,280. Just one moment. How long were you in this noisy place?—I was attached to the infirmary ward from the time I went there to the time I went to P.

20,281. All the time?—All the time, and my argument is this. I am given to understand (I have had no experience of prisons yet—but I may have later!) that in workhouses and in gaols the infirmary ward is better than the others. I should assume that in a mental hospital so called, the infirmary ward should have been as good or better than the others. If what I am going to tell you is better than the others, God help the others. With regard to food. I may say that my diet during the four months I was there was practically nothing but bread and margarine, two smallish slices, and a basin of tea morning and night. The other food was so repulsive that a hungry dog would not eat it. We had bully beef three times a week. Bully beef is not a good thing for neurasthenia. I do not know whether you will accept that, but on Saturdays we had about two small slices of it, and either two small potatoes, or one sizable potato cut in half, and a half slice of bread—that was our dinner. The other twice we had bully beef, it was pounded up into shreds like blood worms; it was mixed up with filthy vegetables, often pig potatoes, not only not skinned but the dirt and

all adhering to them, rotten carrots and onions, and put under a crust which was as hard as the top of this table, and that was potato pie. That is three days. One day we had boiled meat, one day roast meat, one day fish and one day soup. I would like you to see the soup, the least we say about it the better; it was utterly repulsive, Sir. During that four months I never saw an egg or a drop of milk; and with regard to the medical attention, after my first two days they came round and ran a rule over me fairly well, took all my marks in case I ran away, and generally added to my distressed condition by what I was living amongst, plus this very rigid examination. Well, as I tell you, there was not a minute in the 24 hours that we were quiet, and the medical attention was this: the doctor came round and walked through; sometimes he would look at you and give you a good morning, sometimes he would not. The latter part of the time I was there, I cannot tell you how long this was, we had a new doctor, I believe he is still there, a Dr. M. He came, and to the best of my recollection I should say it would be a week or ten days before I went to P., before I was transferred. During that time he never as much as spoke to me, let alone ask how I was.

20,282. How many patients were there in this ward?—30 or 32, if I remember rightly. The beds on one side were more congested than on the other, but on the other side at the bottom end of the room they were fairly close, and then there was a gap. There was an old patient, this venereal case, and there was a bedpan by the side of the bed so they had to give him a bit more space. Let me tell you something about that poor old chap. They used occasionally to give him a bath. I may tell you there was skin off his body as big as that (*describing*), and on the arms where they caught hold of him the skin was coming away in their hands; they used to give him a bath in the bathroom, there was one bath in there. We were bathed in the same bath later on if we had one, and when they put him back into bed, do you know how they put him back, Sir? I will tell you: the two attendants would get hold of that chap on each side arm and leg, and they would stand at the foot of the bed: "One, two, three, this time," and he would be thrown into the middle of that bed there to make three or four violent bounces until those springs came to rest—that is one item.

20,283. *Mr. Micklem*: Were you in this place the whole time you were there in bed?—Not in bed, Sir; I was in bed seven or eight weeks, and then I was still attached to that ward, and slept in it, and in fact lived in it all the while I was there, with this exception, that the last—

20,284. But this was crowded up with beds in every part?—With the exception of a little bit of open space in front of the fireplace, where there was a table and two or three chairs alongside.

20,285. *Chairman*: Do you think it hurt this man to be treated in the way you have described?—Would you not think that dropping down on a sore place like that would be rather a painful proposition, and even assuming that that skin had not already broken, do not you think that was likely to produce bed sores with a poor old chap lying in bed?

20,286. Much would depend, of course, upon how it was done?—But could you swing a man from the foot of the bed and drop him in the middle in a gentle manner?

20,287. How often did you see this happen?—Several times; I cannot tell you how many; it was the rule.

20,288. Did the man himself complain?—No, because he was in such a state he could hardly speak, and he was stone deaf; but what he felt I cannot tell you.

20,289. *Sir Ernest Hilcy*: What do you mean by the rule—did they always do this?—They put him

20 October, 1925.]

Mr. W.

[Continued.]

back after the bath. The bed clothes and our under-clothes were never aired, they were rough dried and often not dried. I have seen a sheet put on the bed, a patch from there to there on the corner of the sheet with the wet standing in it, and because of that I knew dirt was going to do me less harm than wet clothes, so I did not ask for a bath. I had three baths, and three clean shirts in four months. Let me tell you some more about what I saw in that ward. There was an old doctor—I was given to understand that he was a London doctor who somehow or other had got in there; I assume he was a paying patient; anyway he was attached to other wards which I do not know, but eventually he was taken ill; it was his last illness, and he was brought into this infirmary ward to be tenderly cared for. Within about two days of his death his brother came, I believe from London, to see him, but they dare not bring him down in this infirmary ward to see his brother in the awful conditions under which the poor old chap was living; so they wrapped him in a blanket, put him in a carrying chair, took him out of that ward and across an open green into another ward; and I assume he was put in a nice comfy bed in a private ward and everything was lovely. As soon as the brother had gone he was brought back into this place, where he died two days later.

20,290. *Sir David Drummond*: Were the patients in this infirmary ward physically ill?—Yes.

20,291. What were you suffering from, physically?—Weakness at first, but there was this. To be perfectly frank, when I got there and found myself surrounded with what I was, there was a certain amount of personal fear of getting out of bed and rubbing shoulders with some of the chaps; and it was largely, I suppose, my own responsibility that I stopped in bed as long as I did; no pressure was brought to bear upon me.

20,292. It was not reserved for people who were physically ill?—Yes, it was; it was the infirmary ward, but it was also something else. I forgot to mention this, and I am glad you reminded me. It was the observation and the refractory ward; it is a decent mixture; it was a general utility hack—that is what it was in a few words. Let me tell you something else. In the next bed to me—my friend who has just been in here was in No. 6 bed, I was in No. 5, and in No. 4 bed next to me was a boy. I was given to understand he was a son of a Mr. B., who has an ironmonger's shop in B. at the present moment, but what I do know is this: the boy was an epileptic and he had a tremendous number of fits; as these fits were always accompanied by a violent shriek and sometimes a terrific spasm, when all the muscles were rigid, and the body which was naked was red from head to toe. It was a distressing sight to myself; and in one of these fits I got a kick on the side of my face by his foot as it shot out rigid, because the beds were so close together. Now that lad, I will admit, in between his fits was troublesome. On this particular night he had 11 fits in that night. I have seen that lad knocked flying with an open-handed smack from one of the attendants in the middle of the back, and I have seen the mark of the open hand in red in between that lad's shoulders an hour after it happened.

20,293. *Mr. Micklem*: Were these all what might be called pauper patients, or were they paying patients?—No; that lad I was just referring to was a paying patient, and when his parents or friends came to see him, you could take it from me they never saw where he lived and had his being; he was taken to another part of the building.

20,294. *Sir David Drummond*: How many patients were in F. altogether?—I really do not know, but I am given to understand somewhere about 700; there may have been more or less.

20,295. This is the only infirmary ward?—For the male side; what there was on the female side I cannot tell you.

20,296. How many deaths were there in the four months—the old gentleman died?—Yes, and there was another death while I was there; there were two deaths in that ward while I was there.

20,297. Only two deaths in four months?—That is so.

20,298. That was the male infirmary ward?—Yes.

20,299. *Chairman*: We have heard from Mr. O. about the lavatory arrangements, and so on; we do not want to have it twice down on the note?—No, I should not think you would.

20,300. But I would like to know this: when you left this institution on the 3rd November, 1921, and went to P., that was a new institution, was it not?—Yes, opened in the September as I went in in the November.

20,301. You were one of the first residents there?—Yes.

20,302. Was it better?—The difference between the two places, Sir, I describe in two words—one was hell, and the other was heaven relatively; although there is room for improvement even at P. But there is something else I would like to mention that I saw in that infirmary ward. A man by the name of G. was an epileptic; again I am prepared to admit he was troublesome at times, but his troublesomeness did not warrant what I saw, and I am given to understand it happened more often than I saw it, but I know it happened once for I saw it.

20,303. What did you see?—He had cut up a bit rough, how rough I cannot altogether say, but what I saw with my own eyes was this: four attendants got hold of him, an arm and a leg each, and they carried him, frog-marched him back downwards; in a corner of the infirmary ward there were three stairs which led up to a passage off which six side rooms opened; and as they took him up those stairs I saw those chaps—there was a nod given—and I saw them raise him and drop him on the edge of those stairs twice to quieten him. That sort of treatment is not warranted, but again I do not blame the attendants. Let me tell you how they fared. As far as I know their food was very little better than we got ourselves. They did a 14-hours day; they were on at six in the morning till eight at night; they were then off duty for about a couple of hours; they went out in the town and, I assume, had several drinks, and they had to come back and sleep in the ward with other lunatics, from 13 to 30; they did not even have a bedroom to themselves. You can quite understand what that meant—that is going to get on those men's nerves, they are going to be irritable, and it is going to react on the care of the patients. That sort of thing did not go on at P.

20,304. At P. do I understand that you had no complaint to make?—No complaint at all. The only thing that I would say as regards P. is this, and that is more to do, I suppose, with the County Council: there should be a more generous scale of diet, particularly for convalescent patients. Another thing, I do think this, that, arguing from myself and other cases that I know, I do think they hang on to you a little bit too long. Once you are certified as a lunatic, and you are a lunatic, it does not matter what anybody else may say.

20,305. Of course, your point of view is that you were never insane at all, and should never have been certified, I understand?—That is my point of view.

20,306. But assuming that the doctor was right, and that you were for the time being not yourself, do you say that you were kept too long?—Yes. I will tell you something—

20,307. Just let me follow that out, because I am interested in this part of it. Did you complain to anybody that you were being kept there against your will?—No, I did not, for this reason: if you protest,

20 October, 1925.]

Mr. W.

[Continued.]

it is taken as a sign of lunacy—the more you protest the bigger the lunatic; that is the idea always. Even at F. this is rather amusing—I spoke about the medical attention. Between you and me, the only things they were generous with there were Epsom salts and sleeping draughts; you could have a bath in them if you wanted it. I had a considerable amount of pain in my head; it was acute brain fag accentuated by the nervous state I was in; the doctor said it was delusions—it is a useful word in those places. Sir.

20,308. It is also a common fact in those places?—Possibly, but it is a very useful word to cover a lot of matters which should see daylight. Even when the guardians and the visiting committees come round they only see what is wanted to be seen; there is window dressing going on.

20,309. How does it come about that anyone ever gets out at all, Mr. W?—I take it that the medical officers have got to discharge a few, or they would see about getting another medical officer; but you may take it from me, Sir, because of this fact, when a person has had a nervous breakdown there is always a likelihood of his having another one. On the other hand, when you have had any other illness, you may have another—still it may happen, and because of that fact the medical officer hangs on to you. In my opinion—this is only an opinion, but it can be pretty well substantiated, I will try and do it presently—he hangs on to you for this reason that by his inaction he is playing for safety all the while; but if he discharges you to-day, and you get another relapse in two or three days time, it is a black mark.

20,310. Then you think his motive in keeping you longer than you ought to have been there, was for safety?—It is purely a reflex on the system. There is too much responsibility in my opinion put upon the medical officer.

20,311. I cannot see what object the doctor could have in wishing to keep a person any longer than necessary, because every patient who is there means more people under his charge. Most of us are glad to get rid of anxieties?—Agreed.

20,312. Why do you think the doctor kept you there longer than was necessary?—Because of the fact—this is only an opinion—.

20,313. Let us have your opinion.—Because of the fact that with nervous breakdown cases there is

always a fear (we have only got to pick up our papers to prove this) of suicide, and assuming that he discharged me—as a matter of fact it was only physical weakness for a long while—if he had discharged me and in another two or three weeks a recurrence had come about, and assuming I had taken another turn, and I had gone over the border and had cut the knot, it would have been a black mark against that man. But there again it is based upon the fact that you are certified insane, and they are always looking for insanity in those places.

20,314. Did he not detain you longer than you thought he should have done, because it was in your interest to do so?—I will tell you something which may help you, Sir. The last summer that I was in business, our trade is very dangerous and I may tell you for why—whenever you get a cut or a prick with a fish bone or game bone or oystershell, or whatever it is, there is always a lot of slime knocking about, and you inoculate yourself. In the badly rundown condition of my health I had a number of cuts, and every one turned septic, and blood-poisoning was my trouble.

20,315. I am afraid we do not want to go into all this.—Just a moment. I am going to jump from that to P. When I went to P. in November of 1921, in the May of 1922 I was put to bed with a badly swollen neck; my neck started swelling from here and went right down to the shoulders, and it was nothing more or less than that blood-poisoning settled at one place. They opened the neck on both sides; but here comes the point—while I was in bed in that state the Lunacy Commissioners came round and one overhauled me pretty considerably, and I answered his questions in a perfectly logical manner, and he complimented me, and said he would like to talk to me about it. But the trouble was physical weakness, and because of the fact that the diet was not calculated to build up my strength, I never got strong—I doubt if I ever shall.

Chairman: Well, Mr. W., it is after four o'clock, and I am afraid we must rise. We are obliged to you for your account of your experiences. We have also heard Mr. O.'s evidence regarding both these institutions; so that we have had to-day an account which we shall, of course, consider carefully. We are obliged to you for coming here this afternoon.

(The Witness withdrew.)

(Adjourned to to-morrow at 10.30.)

5, OLD PALACE YARD,
WESTMINSTER, S.W.1.

THIRTY-NINTH DAY.

Wednesday, 21st October, 1925.

MEMBERS PRESENT :

THE RIGHT HON. H. P. MACMILLAN, K.C. (*Chairman*).

THE EARL RUSSELL.

SIR ERNEST HILEY, K.B.E.

SIR DAVID DRUMMOND, C.B.E., M.D.

MR. N. MICKLEM, K.C.

MR. H. SNELL, M.P.

MRS. C. J. MATHEW.

MISS MADELEINE SYMONS.

MR. P. BARTER (*Secretary*).

MR. W. FAIRLEY (*Assistant Secretary*).

EVIDENCE TAKEN IN PRIVATE.

Mr. L., called and examined.

20,316. *Chairman*: You are Mr. L.?—Yes.

20,317. We have of course had the advantage of reading through the *précis* with which you have furnished us; and, if I may say so, what we should specially like to hear from you is the account of your experiences after B., because, as you appreciate, it does not fall within our province to consider the arrangements at B. But we should very much like to hear from you an account of your experiences in several institutions which you went to after you had left B., you remember, H., V. and W.; you have been in them all?—That is so.

20,318. And we are specially concerned to have evidence upon any matters that would help us to suggest reforms in the conduct of institutions of that nature, relating to the questions of certification, treatment and detention. So perhaps, as we have only a comparatively short time this morning, you would do us the best service if you confined yourself to these matters?—Certainly. There is just one point as to the hearing of the case before Mr. Justice D. He made a statement in sentencing me to six months in the First Division to the effect that if there was any question as to the state of my mentality, he sentenced me to six months with the view that an enquiry should be held by the Home Office as to my mental state. I must just ask one question—of course with regard to any statement I make here, I understand that I receive the protection of the Commission.

20,319. Yes. You realise, on the other hand, that we have to publish any statements that you make here—the evidence you give here has to be printed.—Published in the form of a Blue Book?

20,320. Yes; but we propose in the case of all witnesses examined in private to omit names. We think it is undesirable, of course, for people who come here and volunteer to give evidence, that their names should be made public?—As far as I am concerned, I have the protection of the Commission as to any after-effect of it, in regard to police administration?

20,321. Yes, but you will keep in your mind that what you say will be taken down and will be made available to the public also?—I have no objection to that at all; only I should like to be assured that no

false accusation or false evidence should in any way be manufactured against me, with a view of bringing any further proceedings outside this Commission.

20,322. What you say here, Mr. L., is entirely protected.—There is an enormous amount of intimidation which we barristers know, which probably this Commission is not aware of. The only point I want to raise, as far as Mr. Justice D. and the High Court are concerned, is that he gave me that sentence, which of course, is a very severe sentence for the actual *contretemps* which occurred; and as a rule it is simply punished by a fine—it was simply done in a more sarcastic manner, though it was alleged that I was waving the revolver about and threatening people; that was not so at all; it was done in a sarcastic way to a man who was provoking me. Mr. Justice D. stated that he gave me that sentence with the view that the Home Office could hold an enquiry as to my mental state. When I applied for this enquiry the Home Office refused to give it to me, and I submit that in any future law which may be passed, which I trust confidently will be the effect of the sitting of this Royal Commission—the Home Office should not have the power of overruling a High Court Judge. That is the only point I wanted to raise on any proceedings which caused me to be sent down to B.

20,323. Now will you pass to your experiences after you left B.?—When my six months expired in the ordinary course of events, the prison doctor, Dr. G. of B., who certified me, stated—(although I had only five minutes' interview with him, and I was never better either physically or mentally in my life)—he stated on false information given him by the police that I was dangerously insane, which, of course, was wholly untrue.

20,324. At the end of the six months in the ordinary course you would have been a free man. Now instead of that you were certified?—I was certified originally by the prison doctor before I was sent there; they could not have sent me there unless I had been, and only on an interview probably of five minutes by a man who knew nothing whatever of me and accepted the police story without hearing me.

21 October, 1925.]

Mr. L.

[Continued.]

20,325. Was there any further certification of you at the expiration of the six months?—No; after the six months at B. naturally I was entitled to release, because the doctor who certified me stated before the Criminal Court that I was perfectly capable of pleading; and therefore, personally, I do not see if a man is perfectly capable of pleading that he can be called insane. His statement was that I was dangerously insane, but perfectly capable of pleading. After my six months passed, naturally I ought to have been released: instead of which two days before my time was up, which would be about 4th September, 1919 (the *contretemps* which caused all this trouble in my life occurred in February, 1919, so it was about 4th September, 1919), I was called by the P.M.O. at B., who was Dr. B. at that time, and before one of the visiting committee who was a justice of the peace; and after five minutes' conversation with him, he, personally, listening more to what had already been stated before I came in to him at all, of which I knew nothing, made an extending order by which I was sent to H. County Asylum.

20,326. Who was that doctor—Dr. B. was it?—He is the Superintendent at B.; yes; and the magistrate was, I think, Arthur W. He was one of the visiting committee, and I think it is rather unfair when a justice of the peace is called in. I should also like to point out that I had already lost something like £30,000 owing to this prosecution, and although my means were not very great I was then a householder, and had at some time been a landowner with landed property. I was put under that order under the Criminal Lunatics Act, and certified as a criminal lunatic. I was neither a lunatic nor a criminal.

20,327. Mr. Micklethorp: But were you not re-certified, Mr. L.?—I went into H. under the Criminal Lunatics Act.

20,328. Were you re-certified, do you think?—No; they had a further extending order; it is not requisite that you should have another certification.

20,329. Was not that a simple order transferring you from B. to the new asylum?—It was more than that; it was under the Criminal Lunatics Act, and under that Act I was sent to H. as a criminal lunatic and a pauper lunatic. I was not a pauper lunatic; therefore when I got there they had no right to put me as a pauper lunatic on the rates; and I naturally became a private inmate of the asylum, where I remained for a fortnight. There are a certain few privileges extended to private patients, of course.

20,330. Chairman: There does seem to be some procedure under the Criminal Lunatics Act, 1884, applicable to such cases, under Section 7 of the Act?—Yes. I was entitled to release at the end of the six months, and because of certain vindictiveness on the part of Dr. B. of B. I was sent on to H.; and as I was not a pauper, but a householder, I do not see that they had any right to send me on to H. as a pauper lunatic. I had to go through all the sufferings that a pauper has to do.

20,331. Just to take the matter in order, I want to see how it runs. On the 1st September, 1919, this Mr. W., this justice of the peace, made an order purporting to be under the Criminal Lunatics Act, 1884, in which he authorised the Superintendent of B. to cause you to be removed to H.?—That is so. That was the Act I quoted.

20,332. Yes, you are quite right; there is provision made for that.—But I was not a pauper, as I was a householder.

Earl Russell: That was not re-certification, of course, only a removal order.

20,333. Chairman: Yes, and then when you went to H. you were admitted there as a pauper patient—that is quite true?—That is so, for two days, and then I became a private patient, but I was sent there as a pauper patient. That is a point I wish to raise, which is grossly unfair to a man in any position.

20,334. You may take it we have had a great deal of evidence about this pauperisation of every person who passes through these forms of procedure, and upon

that I think most of us have already formed a pretty strong view?—Yes. Of course I am only now to a certain extent giving a sort of *resumé* of my case; but I should like later on to go into the details and the facts and the cruelties that I saw in the various places, and the way in which paupers are treated in county asylums, and also in the various asylums, and the question of diet, and of exercise, and fresh air, and other things.

20,335. We understand from you now how you reached H.?—Quite. I just want to give a *resumé* so that you may understand my case more easily than if an opening statement of any sort had been made. After two or three days at H. I got in communication with my friends, they came down and saw me, and I got a transfer order into V.

20,336. Earl Russell: As a private patient?—Yes.

20,337. Chairman: You went to H. on the 3rd September, 1919, and on the 19th September you entered V.?—Yes, and is so, owing to the intervention of my friends; otherwise if I had not been able to pay that amount weekly which I had to at V., I should probably have had to remain where I was. Of course the conditions there are awful.

20,338. Perhaps you had better tell us what you mean by the conditions being awful at H.?—If you will allow me to take my own case in my own way, I only want to give a sort of *resumé* first, and I will go into the details of it after.

20,339. Our time is limited. I am very anxious to get the vital matters from you, and I think you might give us your experiences for the 16 days at H., and then we will pass to V.?—Very well. The first point, as far as H. is concerned, is that naturally when I first went there, I saw the principal medical officer, and protested against a sane man being still kept under detention, and the only result I got was rudeness. He was not only rude to me, but to my family. He said I was only a pauper lunatic; and my sister who had been down there, who was the widow of a Field Officer, a Colonel, was as rudely treated as I was. I consider that that sort of statement from the principal medical officer is quite uncalled for and unnecessary. That is only a view that I put forward to show the way in which patients are treated even by the highest authorities in these asylums; they are treated with contempt and are insulted. Then, as far as H. was concerned, one of my principal objections is that we were simply herded together, two or three thousand in a courtyard with no opportunity of any sort of exercise, of games, or cricket, or anything of that kind, which usually takes place in other places. At B. of course, all those things are arranged for.

20,340. Lord Russell: Mr. L., I know H. very well—you do not mean 2,000 or 3,000 in one courtyard?—We had 2,000 in one courtyard.

20,341. In one courtyard?—Yes, in one courtyard.

20,342. Male and female?—Only male; they are not altogether of course.

20,343. Chairman: I think your figures are exaggerated?—Anyway at the time I was there I should say there were quite 2,000 turned out for exercise in that yard. After all, it is immaterial whether it is 1,500 or 2,000—the point is that better opportunity should be given for people who are unfortunate enough, whether it is through intrigue or whether it is through a terrible affliction, to be put into these asylums, for some sort of treatment which will make them regain their health; and it is certainly not conducive to their regaining their health if they go idling about, playing cards on stumps of trees and allowed to associate (of course there is another point there of classification) with all sorts of raving lunatics, who go about round this yard singing and interfering with other patients; when there might be opportunities given for the saner part of that conglomeration of human beings to take part in cricket matches, as they do at B.; and also there might be tennis courts for the better men, and some opportunity, which they have only on a special permit, of

21 October, 1925.]

Mr. L.

[Continued.]

going into the libraries where they can read and naturally use their brains.

20,344. Do you say the conditions at B. were better than at H.?—Far better; no comparison whatever. B. as a whole is a very well run institution indeed; the arrangements they have at B. are exceptionally good. One of the principal things that they have at B. is that each man is allowed to cultivate his own plot of land, and he can grow his own vegetables and his own flowers, and many of the men make quite a large income from the cultivation of flowers, and add to their diet by a very good supply of vegetables. I would like to put forward to this Royal Commission that something of that sort should be done in all the county asylums; instead of allowing these men to play cards and go swearing about the place and mixing very bad cases with cases which are virtually sane men. Greater classification should take place and greater opportunities should be given for exercise, and plots should be given them in which to dig and to cultivate flowers and vegetables.

20,345. *Earl Russell*: But you know at H. a very considerable number are employed in agriculture?—Yes, outside on the farm; I am not speaking of that at all.

20,346. I mean they are not playing cards on stumps of trees?—Those are only a very few cases. There may be one or two at H. who are sufficiently mentally efficient to be permitted to go outside the asylum itself and work on a farm. That is not my point; that only applies to a few. My point is that nearly all these people (as they can do in the better divisions or wards at B.) nearly all of them can be permitted to cultivate flowers and potatoes, and to have some sort of form of exercise in the way of cricket matches, and so forth.

20,347. *Chairman*: May we take your two points as regards H. to be these? First, insufficient classification; and, secondly, absence of sufficient interesting recreation?—Quite so; both physical and mental.

20,348. And you particularly recommend some gardening work, the cultivation of flowers and vegetables, as being a desirable form of recreation for the patients?—Quite so; that is my point. There is a further question that I should like to put forward, and that is that the patients should be permitted out on parole in many cases. At the present moment my experience is that there is no curative treatment of any sort or kind. The whole time that I was there, outside of B., I was mixing in society all round, everywhere travelling by train, going to Ascot, and everything else. I was virtually a free man. I was on parole from the first week I was there for over two years, and yet they would not let me out. I went all over the place.

20,349. *Mr. Micklem*: That was at V., was it?—At all of them: at V. and at W., the whole time. I was bicycling and going to point-to-point steeplechases, and all sorts of things, mixing in the ordinary community; and not only that, but I attended University lectures. I am a Master of Arts at Cambridge myself, and I attended lectures the whole of that time with the undergraduates on modern languages.

20,350. *Chairman*: Then you got ample parole, Mr. L.?—Yes, and I advocated that more of it should be given. There was only one other man besides myself to whom it was permitted.

20,351. Of course, it must depend upon the nature of the case to a large extent?—Absolutely; but I say there are many cases where there is a chance of recovery, if parole be given in order to get away from all these raving lunatics. The man who has a chance of recovery, or the woman, especially in the case of women; in a large number of cases they are simply temporarily afflicted by all sorts of causes. There is a much greater opportunity if they can only break and get away from their environment than if they are kept within prison walls and railings and have to mix with the very bad cases all day and all the night, too.

20,352. The law already provides, as you know, for parole. Your criticism, evidently, is that the law is not sufficiently taken advantage of, in the matter of parole?—No, that is so. Of course, the whole way through, as far as the Lunacy Act is concerned, very great opportunities are given, but none of the Lunacy Commissioners and the visiting committees and other authorities will function; they all rest simply and solely on the opinion of the principal medical officer; and unless they get the recommendation of the principal medical officer to let the patients out, then there is no hope for them. If I gave you the statistics of the number of Lunacy Commissioners that I appealed to for my discharge, it would show you that it is absolutely useless to make any application to the Lunacy Commissioners with a view of getting that discharge, unless it is recommended by the principal medical officer.

20,353. After all, you know, a mental patient is an ill patient?—Sometimes, but sometimes he is perfectly sane, as in my case.

20,354. But assume he is a person who is properly there, and the great bulk of them no doubt are properly there, suffering from varying degrees of mental illness?—But there are a bigger majority, probably, than you suppose who are sane.

20,355. Let me put my point: in the matter of pathology we must rely to a large extent upon the medical adviser in charge of the case, just as we lawyers naturally are relied upon in matters of technical legal affairs?—Quite so.

20,356. And I have a difficulty in seeing how you can invite any visiting committee to overrule the considered opinion of what, after all, is an expert?—My suggestion is that there should be a judicial authority appointed, that in all doubtful cases the patient should be heard, that the patient should have the right of having the protection of counsel, and also be entitled to instruct a solicitor.

20,357. *Earl Russell*: At the public expense?—And they should be heard before a judicial authority just in the same way as an ordinary case is heard in any Court of the United Kingdom; and the case for the doctor should be presented before the Court, and also the case for the patient.

20,358. *Chairman*: Are you contemplating this in ordinary pauper cases?—I do not say for the ordinary pauper cases; I say for any person who chooses to ask for it; that under any new Act which may be the result of this Royal Commission, a judicial authority should be appointed whom the patient could apply to for a hearing of his case where his discharge is systematically refused. And I go further. I say that in a case of paupers a subsidy should be allowed by the State to enable them to pay any costs, in order to free those who are not in a position to remit.

20,359. *Earl Russell*: And how often do you contemplate they should be allowed to make this application—once only, or at intervals?—I say at periods of either three months or six months; certainly, three months for choice, from the point of view of the patient.

20,360. That might mean a good many inquiries, might it not?—So there ought to be. If a man is a sane man, what right has anybody to keep him detained and shut up? No right whatever, and therefore it is far better that an opportunity should be given for a reconsideration of the case. You have only got to consider a man at the present time, an exactly similar case to mine, Mr. S. I had 25 years of it. S. had six, but he has been absolutely driven insane, and is now in B., but he was put in at His Majesty's pleasure, which is a totally different thing. I was fortunate enough to get a sentence of six months; after that six months they could not detain me; but in the case of S. he is more or less there for life.

20,361. I am putting to you the case of a man who has had a judicial inquiry, and has been found to be properly detained; I am asking you whether you think that every three months he is to have a fresh

21 October, 1925.]

Mr. L.

[Continued.]

inquiry?—No, not at all. My proposal is that a man should have a right of asking for an inquiry every three months; but if an inquiry is held, naturally that ought to hold good for a distinctive period, probably, I should think, for 12 months. But I say that in 12 months many cases have a chance of recovery and do recover, and therefore they should not be detained when they have recovered for a considerable time afterwards.

20,362. *Chairman*: We naturally have received many suggestions of all sorts. There is one suggestion which we are considering which may go far to alleviate the position you are putting, i.e., that if certification is postponed and a period of observation and examination of the case interposed, it is very probable that many cases will not be certified at all that are at present being certified?—Quite so; they should not be.

20,363. I do not think you need elaborate that aspect of it, because we have heard a great deal about it, and that is one of the matters we are considering very fully?—Quite so; I only wish to support that view.

20,364. What I should like so much is the personal experiences of witnesses like yourself; because you can imagine that general questions of reform we can pretty well appreciate—I mean we have heard a great deal of the general aspects of the matter?—Perhaps some of the submissions which I could bring before you have not been considered by you.

20,365. Those you have mentioned have already been very fully considered.—That was in answer to your question.

20,366. I am anxious to get from you matters which in your own experience seem to call for reform. You say it is undesirable to have patients herded together without classification. You said you noticed that many seemed to be idle and unemployed and you recommend further facilities for recreation and employment. Now what else did you notice in those institutions while you were there, which seemed to you to call for reform?—Especially diet. One of the principal remedial measures is the question of diet which is undoubtedly recognised by all the medical profession. That is the principal remedial measure, for any hope of recovery. Now the diet, as a matter of fact, is absolutely poor; in the county asylums it is disgraceful, and even in places like V. and W. There is not sufficient supervision; and I should like to put this point forward, that it is impossible for the doctor to look after his patients from the medical point of view, and be an administrator at the same time. There is required a very large increase both in the medical staff and in the nursing staff, because it is an impossible task for a man; for instance in the case of W. there were two doctors there, and I should think there were about 700 patients, and therefore any curative treatment was absolutely impossible. He does not even know the men; he goes through them, but he does not know them personally, and therefore it is impossible. I say that the two functions should be separated. There should be an administrator, or a visiting committee or a sub-committee of the visiting committee should be appointed, to be the administrator to the asylum; and the medical officer should be occupied in attempting to improve the mental state of the patients. At present he has not got the time to do it, because his time is so fully occupied in an administrative capacity.

20,367. What is wrong with the food now?—For instance—I do not say that this takes place systematically, but even in a place like V., which is I should say one of the best places in England, the food is insufficient, unless you pay extra for late dinner. In the case of extra payment you do get sufficient food, but a sufficiency of food is certainly necessary in order to regain your mental health.

20,368. *Mr. Micklem*: What about the food at H.?—At H. it was extremely bad; there is too much of it; it is cooked in a disgraceful way, and it is

simply piled up on your plate, every sort of thing, potatoes and greens, and they simply sicken you with the amount they give you. It is extremely badly cooked, and very badly served, and is in no way the sort of food that anyway a private patient in ordinary life would be accustomed to. I cannot answer for the pauper patient, but the cooking when I was there was extremely bad. I submit that whoever does the cooking, a better class of cook should be engaged.

20,369. *Chairman*: Of course, you know probably that the whole question of the dietary in the L. County institutions has been recently overhauled very closely?—Yes.

20,370. And an improved dietary has been introduced? You are speaking of 1919, which was indeed a year after the conclusion of the war, and it is satisfactory for you to know that the matter has been gone into?—Quite so. Of course, naturally, I can have no remedy for my past troubles. I come here to-day only with a view of alleviating the sufferings of those poor people that may be there now, or who may be there in the future, and the point which I wish to make is that it is impossible for the principal medical officer to see to everything which he does at the present moment. The visiting committee virtually do little or nothing except to come in at certain stated times, have about five minutes' conversation with the various patients, who are all more or less applying for discharge or parole, or something of that sort; and outside the question of finance have very little to do with the arrangement of the institution, and it all falls on the doctor. I submit that all these questions of diet, of exercise, and of food—I formed personally a sports committee at W., and we gave sports very successfully; I formed it with one of the junior doctors and several of the attendants there, and we improved the condition of things very greatly indeed. The point I wish to make is that a sub-committee should be appointed by the visiting committee, with a view of paying attention to these questions of diet, of exercise and of entertainments; that it is impossible for a doctor to do everything that he is required to do at the present day.

20,371. At V. was the food better?—The food as a rule was very good. I only have one point to make as regards V., and that is that the porridge which we had for about three weeks was in a sour state, and I personally found in my bowl of porridge a sort of meal maggot about 1½ inches long—of course, that was an accident, probably, as far as I was concerned.

20,372. They do not always make the best porridge in England, you know?—No, but if you had a sub-committee who could examine these things and go into them, this committee might listen to the complaints, and you might get improvements. At the present time the doctor has not got time to listen to you, and will not listen to you.

20,373. Tell me about your interviews with the visiting committee. Did you have any talks with the members of the visiting committee yourself?—Nearly every single visiting committee, and nearly all the Lunacy Commissioners.

20,374. Had you any difficulty in having that talk with them when you wanted?—None whatever, but it was absolutely useless. They pay no attention whatever to it. They hear your case, and they then go to the doctor and ask the doctor whether this man is fit to be discharged; if the doctor says no, there is an end of it, but if the doctor says, "Well, I think it is a case where he might be let out on trial," then the committee will consider the question and probably decide that he may be let out.

20,375. *Earl Russell*: But suppose that I am a member of a visiting committee without any medical knowledge. Would you expect me to set my opinion above that of the doctor if he says a patient is definitely insane?—No, certainly not; but I should like you to hear more evidence of the individual case. The mere statement of the doctor is not sufficient for you to form a judgment upon at all.

21 October, 1925.]

Mr. L.

[Continued.]

20,376. Are you quite sure that that is all the evidence the visiting committee have?—No. Of course, there are papers given, and a certain account of the patient, we all know that; but very often those statements made in those reports and papers are wholly incorrect and erroneous—they were in my case from the start; and therefore every person who read the particulars of my case obtained an erroneous view, because it was formulated on false information, made by the police originally, when I was first placed under the mental observation order.

20,377. I was going to say the visitor does begin, does he not, by hearing the patient's own statement of what he has to say?—Quite so; but as a rule he pays no attention to it at all, and you can do so as often as you like without any result whatever. During the time I was there I never heard of any man getting out by any assistance given by the visiting committee. Every man who did get out got out simply and solely by the medical officer. I submit that the visiting committee should not be bound so much by the autocratic system which is now in force, which gives such terrible power to one single man, the principal medical officer; but that in doubtful cases, where a patient's discharge is systematically refused, he should be able to apply to a judicial authority to have his case heard, as he can under the Act at the present moment, if he can get outside and get a solicitor to act for him. At present the judicial authority reports to the Lunacy Commissioners.

20,378. *Chairman*: You saw some of the Commissioners, did you, from the Board of Control?—Nearly all of them. I know some of them personally. Mr. Trevor was agent for my uncle, who was Member of Parliament for K. for 19 years and a great nephew of R. G., K.C., M.P. Mr. Trevor was his election agent. He was one of the worst.

20,379. Why was it—because he knew you best, or what?—I do not know whether he had a vindictiveness against my uncle or not, but he vented it on me, or perhaps he thought my uncle had not treated him sufficiently well.

20,380. However, we understand your point. Now I want to ask you this: you had opportunities of observation in these institutions. What do you say about the treatment of the patients?—I say that, virtually, there is no curative treatment at all. As regards treatment from the point of view of cruelty, of course I personally did not see very much, though we heard all sorts of tales and yarns from various people, but I do not wish to put hearsay evidence before this Commission.

20,381. Were tales of all sorts going round the institution?—Yes, all sorts of yarns, but then I mean you take them *cum grano salis*, and one does not pay attention to a large number of them because it depends upon from whom they come.

20,382. Was this among the patients?—Among the patients, what had been done to them and so forth. But from my personal observation, of course, the cases were not very many, but I saw one or two.

20,383. What incidents did you see?—For instance at V. there was a man called B. who was a brutal bully. We were going to have a cricket match, and one of these men was anxious to be wicket keeper; I do not say that he was the best wicket keeper in the place, but he evidently thought he was better than most people did, so he got hold of a pair of wicket keeper's gloves and he put them on, and would not take them off, and when B. went up to him he ran away. B. ought to have run after him and taken these gloves off him and put them on the man who was usually the wicket keeper; instead of which, he barged or threw himself on this man as hard as he could in the way that a professional footballer would and knocked him flying right up against a tree, which might have given him concussion of the brain: as a matter of fact it did not, because his head just missed the tree, but it was a brutal sort of thing to do; and it was quite unnecessary, and the end of it was that the wicket keeper's gloves were

taken away from this man and the match commenced. But my point is that they used brutality when it was unnecessary, and if you make a complaint of what you have seen to the principal medical officer when he comes his round the following morning, he always upholds his staff and does not pay the slightest attention to what any of the patients say; he treats them as if they were *non compos mentis*, and they are not.

20,384. Tell me any other incident besides this wicket keeper?—Another case was at H.; there was a small boy of about 16; he was virtually more or less a mere skeleton; he was undoubtedly incurably insane, but he was put in the padded cell, he was stark naked, and the attendants brought him out in the state he was. He was kept in the padded cell stark naked all day long because as soon as any clothes were put on him he took them off. He had not got the strength to do any damage; but simply, from the point of view of indecency, he was therefore put into the padded cell; the attendants put a towel round his loins, brought him out and began spanking him and making him sing. This was the case of a boy; I should think he was probably not more than a seven months' child, and he was deficient in every sort of way with no hope of cure.

20,385. But were they cruel to him?—Certainly I call that cruelty, if they smack a boy all over, two or three of them, and when his own power of speech was so slight that he could hardly articulate at all, they were trying to make him sing.

20,386. Was that teasing him, or what was the object of it?—Yes, teasing him and laughing at him and mocking him. That sort of thing never comes to the notice of the visiting committee and never comes to the notice of the principal medical officer; because if you make any complaint as regards food then you will get less of it. For instance, at W. the whole of the potatoes for nearly nine months I was there were full of wireworms—of course the wireworms were dead, but you could see the tracks of them naturally; but if I make a complaint to the doctor about anything in the food, or insufficiency, I get less of it as a punishment by the attendants. The same thing obtains at B., in order to intimidate patients so as to prevent them from making any complaint at all. The only chance, if you want to get out, is to say that everything is perfect, and that can only be known by the people who have gone through this sort of treatment, and is not known by the doctor or the visiting committee at all.

20,387. What about the relatives of the patients. Did your sister go and see you or did you see any of your relatives while you were at any of these institutions?—No, not as far as W. was concerned. The only place I saw them was down at H., when I got two of them to come and remove me to V.

20,388. I was thinking of the relatives who are paying, as they often are, for the maintenance of patients.—Many people will pay in order to keep him there.

20,389. Be it so. If a patient complains to a relative that he is not being properly fed, one would imagine the relatives would go to the medical superintendent and say, "This will not do; I am paying for this patient, and he ought to be properly fed."—No, with all due deference to you, I submit in the first place the complaints are not passed on at all; and your letters—that is another suggestion which you may not have had which I wish to make, that all letters which are censored by the principal medical officer should be returned to the sender; he does not know whether the letters go or not.

20,390. *Mr. Micklem*: Before you go to the letters let me ask you this. Why should the attendants object to your complaining of the food?—Because they hate to be complained about, it reflects on them and their management, and they naturally attain a higher position according to the view which is held by the doctor of their capacity.

20,391. *Earl Russell*: But the attendants in a ward have nothing to do either with the preparation

21 October, 1925.]

Mr. L.

[Continued.]

or the choosing of the food?—I am not talking about the choosing of the food; my statement is that if you complain about it, you get punished for it.

Earl Russell: But Mr. Micklem asks you why.

20,392. *Mr. Micklem:* Why should the attendants object to your complaining? They are not responsible?—Because they hate any sort of complaint at all being made to the doctor when he comes round. If you make any complaint against the ward or anything, you always either get punished for it or you get a statement made, which is harmful to yourself in the opinion of the doctor, by the attendants. I mean absolutely false accusations. For instance, I will give you an example of one or two cases—one at H. When we were in the infirmary at H. there was a light burning at night, and it was just above my bed. I asked the attendant in the night infirmary ward there if he would lower the gas; I could not sleep while the gas was alight. He had a night book, and he would not put the light down. I went round and looked in the night book. He had put a note for the benefit of the doctor when he read the reports of the night, that I was dictatorial and interfering.

20,393. *Earl Russell:* You say this was at H.—do you not mean B.?—B., yes; I stand corrected there. He put that down, because I asked to have the gas turned down in order to sleep, that I was dictatorial and interfering. That was put in for the benefit of the doctor. I happened to suspect this man, and I went round to see what he had written down because I saw him commence writing, and I knew he made a report every night. Then I complained to the doctor that false reports had been sent in to the doctor, but he said, “I do not pay any attention to them and it does not matter,” but still he probably does; because if you have complaints from a man which are made from the point of view of vindictiveness, it does to a certain extent affect the mind of the doctor and prejudices the doctor's mind against the patient.

20,394. *Chairman:* You were dealing with letters?—Yes. Now the question of letters and having communication with the outside world is a point which I should like to press—that greater opportunities should be given for the sending of letters, and there should be a letter box somewhere in the grounds which should be able to be cleared by the postal authorities outside of the asylum authorities altogether; that the postman should collect those letters without any interference of the asylum authorities; that the letters could be posted when the men are out for their exercise in the yard; that one side of the letter box should be inside the yard and the other part of it (for clearing) should be on the outside, and the letters collected by the postal authorities. In that case the patients would have greater opportunities of communicating with their friends and relatives. At present they have no chance whatever in most cases, because the letters in, I suppose 95 cases out of 100, are censored and not posted.

20,395. *Sir David Drummond:* Are you aware of the contents of these letters, sometimes filth and nastiness?—Of course I admit that some of the letters are absolute nonsense from start to finish, but if they are and they are not sent, I submit that the sender of them should have the letters returned and the doctor should say why he is not sending them. The patient does not know whether the letter has gone or not. I daresay in 75 per cent. of the cases that the letters are absolute nonsense from start to finish; my remarks do not apply to those.

20,396. They do contain filth and nastiness?—I know nothing about that.

20,397. That is so.—Certainly, if there is anything of that sort, and if it is not commonsense in the letter, and the statements are not justified, naturally I would say that they are rightly censored; but what I do say is that the doctor should return the letters to the sender so as to let him know that he is not going to let him send them.

20,398. *Earl Russell:* But the suggestion you made just now would give the doctor no chance of censoring them?—That is a greater improvement still, except in the cases which have just been suggested. I did not know they were as bad as that; but if they are, those cases could be so classified that they would not have an opportunity of posting their letters in that box at all.

20,399. But you admit that 75 per cent. of the letters are insane?—I do not admit it. I say it is possible that a large number of those letters that are written are not ordinary commonsense.

20,400. *Mr. Micklem:* Your suggestion would be that there is no harm in them?—If they are mere nonsense, well let them go; it does not matter.

20,401. *Chairman:* There are grave difficulties in that proposal. Suppose some patients, as many do, spend their whole time in writing letters, are these letters to be put into the post office box? First of all, how are they to be stamped? His Majesty's Postmaster-General requires that letters should be stamped before they are posted. It would not be a very pleasant thing for a relative to receive a dozen letters a day on each of which he has to pay 3d. because the medical officer was allowing this patient to send all these letters?—No, but I submit this, that if there is better classification, those very bad cases would not go out into that yard—that that yard would only be for those doubtful cases where men are perfectly capable of writing sensible letters.

20,401a. Very few of these letters, you may take it, are stopped?—I have had letters stopped, and I was out on parole all the time, and I was told by Dr. M., who was the principal medical officer at V., that if I wrote to my petitioner and sent it under cover—the letter I wished to send to my petitioner—he could not interfere with it. That I know, of course, under the Lunacy Acts.

20,402. *Mr. Micklem:* When you were on parole you could post them where you liked?—You give your word of honour that you will not do so; otherwise they probably will not give you parole. What I submit is that greater opportunity should be given in the future to the inmates of these asylums to communicate with their families and the outside world.

20,403. *Earl Russell:* But this is news to me. Does your parole include an undertaking not to post letters?—Certainly, and not only that; but Field-Marshal Sir A. B. was my stepmother's uncle, and I wrote a letter asking him, who was personally known to the King, to bring forward my case to the notice of His Majesty. He declined to do so. My stepmother is the daughter of a Baronet, and also the niece of a Field Marshal. I requested that letter to be sent; he sent all the others, but he would not send that one.

20,404. *Chairman:* After all, that is a matter for his discretion, you know?—There was nothing in the letter; it was a perfectly sensible letter simply stating my case and asking for an inquiry, and that the statement of Mr. Justice D. had been overruled by the Home Office, and that no inquiry had been made in my case as to whether I was sane, or whether I was not.

Earl Russell: Mr. Chairman, before we part from this patient could you clear up the position as to whether he had a petitioner ultimately when he was in a private asylum, and at what stage that happened?

20,405. *Chairman (to the Witness):* Had you a petitioner, Mr. L., ultimately?—No, I was under the Home Secretary's warrant. The two usual ways are by petitioner, and also by the Home Secretary's warrant. I had no petitioner, and I did not require one.

20,406. But you referred to your petitioner?—Yes, because the doctor was under a wrong impression, and he was more or less stating to me what he should have stated to an ordinary patient. I was under the Home Office warrant, therefore his statement to me that I could get my letters sent by sending them to my petitioner was virtually erroneous; though, as a

21 October, 1925.]

Mr. L.

[Continued.]

matter of fact, my sister petitioned to remove me from H. to V.

20,407. The person who is paying on your behalf is treated as equivalent to your petitioner?—She was not paying.

20,408. Who was paying?—I was paying most of it.

20,409. Somebody must have been doing it for you. Was it your solicitor originally—I mean you were not drawing cheques yourself?—I had the Official Solicitor, who arranged the whole of my estate and property; he ran the whole thing.

20,410. *Mr. Micklem*: Did the Official Solicitor pay you a personal visit, or his clerk?—Never, but a Mr. T., who is a man with a great experience of something like 40 years at the Official Solicitor's office, came down and saw me and had a conversation with me at V.; and he told me he would recommend me for release, as, in his opinion, I was a perfectly sane man. Mr. Trevor (that is one of the points I have against Mr. Trevor) came down shortly after. I can give you the actual dates; it is hardly necessary because I am trying to make this evidence as short as possible; and I said to Mr. Trevor: "Mr. T. came down here, and, in his opinion, he says I am perfectly sane, and that he would recommend my release." Mr. Trevor turned round and said: "Oh, T., why T. is only a clerk." Well, in my view, Mr. T. had a much greater knowledge and experience than Mr. Trevor. He had been 40 years in the Official Solicitor's office, and did more or less nothing else. Mr. Trevor was originally an election agent, and got this appointment, and had been for only a few years a Lunacy Commissioner.

20,411. *Chairman*: Now, Mr. L., our next witness is waiting for us. Is there anything else you can tell us before you leave?—Yes, there are several points as to the actual clauses of the Act.

20,412. May we take it that they are those which you have set out for us. If I run through them with you will that be the best plan do you think?—So far as I have stated them at the present moment.

20,413. Just to see how far we have covered the ground?—Yes. I should be much obliged.

20,414. Then, first of all, you have a recommendation with regard to the right of patients to see the judicial authority. You have practically told us your views with regard to that matter. Then you say, "Power for a relation or friend to take charge of a lunatic should be made easier." That is related to your views on parole?—Quite so, and that there should be an increase of parole.

20,415. "Powers to appoint substitute for the person who applied for reception order extended especially to those patients under Home Secretary's warrant." You think there should be the equivalent of a petitioner in the case of such persons?—Certainly, and who would be empowered to demand his release in the ordinary way that a petitioner does.

20,416. We have your view. Then you recommend that "absence on trial should be made more easy to obtain and more frequently given." On that I notice that on the 26th October, 1921, after you had been just a little less than a year in W., you were sent out on trial and were discharged?—That is so, under the view of the chairman of the visiting committee, Dr. S., of New College, who is now dead, I think, and the principal medical officer.

20,417. Then you recommend that Section 72, subsection 2, should be made more definite especially in the case of those patients who are under Home Office warrant. You suggest that the powers under Section 75 should be enlarged, and then you suggest that the copies of reception orders, and all particulars of the case affecting the patient, should be given to him. We have heard a good deal of evidence upon that; I do not think you need enlarge upon that aspect. Then you suggest that penalties should be increased for the defaults of the medical officers' administrative staffs, and that greater facilities should be given to patients to communicate with

the local police or solicitors in the case of unwarrantable assaults by attendants on patients; and you propose that the Ministry of Health should be made a court of appeal from the Board of Control. You further suggest that the transfers to private medical men and hostels should be more easily obtainable?—Yes.

20,418. Then you have given your views about correspondence; and you further propose that part of Section 49 of the Lunacy Act should be eliminated?—The words "who satisfies."

20,419. The words "who satisfies the Commissioners that it is proper for them to grant such order" should be eliminated?—Yes.

20,420. And that all complaints made by patients either to the visiting committee, or the Visitors in Lunacy, should be entered in a book kept for the purpose, and the same should be open to the inspection of all relatives and friends of patients, and copies of the complaints sent to them. Then you express your views as to the legal position of doctors who have certified wrongly. Well, we need not go into that. Then you make some comments on the system of police procedure. Again that is not quite within our province. I think we really have covered most of the points upon which you can assist us?—There is one other matter from the legal point of view, and that is that opportunity should be given for a patient who has been wrongly certified, to bring an action in the High Court. As you no doubt are well aware, a large amount of money has been spent by a considerable number of men who have been wrongly incarcerated, such as the E. case and the B. case, and the various other cases; and in one case something like £30,000 was spent in various actions in the High Court lately with a view of getting damages from the doctors who have wrongly certified sane men. Now I think that there should be some clause in the new Lunacy Act, if it ever reaches the statute book, that if a doctor wrongly certifies a patient he should be liable in damages to the patient.

20,421. Even although he does it *bonâ fide*?—Ah, well, of course that is a tremendous question for argument as to what *bonâ fide* is.

Mr. Micklem: That would not alter the law, would it?

20,422. *Chairman*: He is liable at the present moment if he does it without proper care?—"Reasonable care," I think; but the point is, what is "reasonable care"? The law in the future should eliminate that word "reasonable."

20,423. *Earl Russell*: It is a question for a jury, is it not?—And some other word should be inserted which would give the patient a better right, or a better chance, of gaining his case.

20,424. *Chairman*: Well, Mr. L., I do not think we will enter upon that topic just now. We are fully alive to it, and it is too long a matter to take up at the end of your evidence?—Yes, but virtually a man has no remedy after he has come out, of bringing an action with any chance of success.

20,425. We appreciate that. I should like to correct some of the figures you have given us. The actual number of patients at V. was 331, on the 1st of January, 1924, and at W. 87, so the figures you have given us are rather inaccurate. 87 is the number of patients at W?—But that is not including the women—not the whole establishment.

20,426. The total number of lunatics at the 1st of January, 1924, in W.?—There were many more than that. There were, I should think, that number of women. I think statistics are not always proof.

Chairman: Well, Mr. L., we must now take our next witness. We are obliged to you for coming here this morning, and we hope you are also satisfied with the audience we have given you?

Witness: Absolutely. I only hope that the sufferings of those in asylums at the present time and of those who eventually get out will have more considerate treatment than they have to-day.

21 October, 1925.]

Mr. L.

[Continued.]

20,427. That is one of the matters you may be assured we are giving every attention to.—The principal point I would like to put before the Royal Commission is, that there is too much autocratic power in the doctor, and the visiting committee do not in any way act without his assistance or sanction, and

that power should be given for application to be made to some judicial authority.

Chairman: We will take that as your parting recommendation, Mr. L.

Witness: Thank you.

(*The Witness withdrew.*)

Miss G., called and examined.

20,428. *Chairman:* You are Miss G., I understand?—Yes.

20,429. May I just say, before we go into your evidence in some detail, that the aspect of it which interests us specially is this, that you were a voluntary patient?—So called.

20,430. So called, I know. We have not had the advantage hitherto, as far as I know, of seeing any person who has entered an institution voluntarily. Your special point, I take it, is that, having entered an institution as a voluntary patient, you found yourself converted into an involuntary patient?—Immediately.

20,431. We are very anxious to know (I am sure I speak for my colleagues also) your experiences in that respect, how you came to enter the institution, and how you came to be dealt with compulsorily; because, you see, we are considering the extension of the voluntary system, and we are very anxious to know of any points in the voluntary system that are unsatisfactory.—Do you mean, Mr. Chairman, compulsory under an order, or compulsory under false imprisonment?

20,432. This is rather the aspect of it that is in my mind. There is a considerable movement for an extension of the voluntary system—that is to say, for patients being treated without the stigma of certification. On the other hand, there is a risk attached to that system; and I understand you are one of those who can tell us of the risks which you encountered, and of what befel you. Having consented to be a voluntary patient, you found yourself converted into an involuntary patient. That is one of the risks we shall have to guard against if we propose any extension of the voluntary system. Your experience may be helpful to us in making recommendations in regard to the treatment of voluntary patients. It is that aspect of it which is special to your case, and we should like to hear your views?—I think I ought to mention first, Mr. Chairman, the fact which I now know, that the Commission are only prepared to give a very short time to the hearing of my case.

20,433. We will give you a full hour.—I call that a very short time for a case of a criminal conspiracy; because what I think you mean by my treatment—that is possibly involving allegations of cruelty as it does to a voluntary boarder—I have put that all before you in the article I sent you; and that is not what my proof and my original application state as being the important matters upon which I can prove my charge of criminal conspiracy. I mean it seems to me that allegations of cruelty which are all open to immediate disproof by the mere word of some eminent doctor, as taken against the word of a person afterwards certified, would be very painful matters for me to give and very useless matters for me to give, as compared with the evidence of criminal procedure, including forgery, by the persons under whose allegations I was confined.

20,434. The trouble about that is this: that we are not a judicial body and we cannot enter into topics which have been the subject of litigation. I should have thought myself that the contribution you could have made to the cause which you have at heart, would be most useful if you were to discuss with us the question of the voluntary patient; because I have read, of course, the paper you sent me, and the experiences which you relate are very painful; and one would like to be able, in making any recommendations as to the extension of the voluntary

system, to ensure that such things did not occur in other cases as seem to have occurred in your case. It is your experiences as a voluntary patient which struck me as being one of those matters on which you could particularly assist us. Perhaps I may help you to see what is in our mind?—I have taken legal advice on the meaning of your original letter, Mr. Chairman, in which you say the Commission would be unable to investigate matters which have been the subject of judicial proceedings. All these criminal matters have never been before any Court of any kind, with the sole exception of a short hearing before the late Mr. Justice B. in Chambers when he said I need not give the details of the alleged irregularities; but the only matters that have been the subject of judicial proceedings (and this my legal advisers were puzzled by in your letter) are the matters which constituted I should say my voluntary boarder treatment. If you ask me for evidence upon that, the best evidence I can give you is the concentrated evidence in my statement of particulars. There was a judicial finding of sorts upon that, that there had been no breach of contract. My contract was held only to cover the voluntary boarder period, and that was the only matter which was the subject of judicial proceedings.

20,435. Of course we are not really greatly interested in legal technicalities here; we are looking at the problem in its broad aspect. I would like to put this question to you: Are you in favour of the voluntary system of entering institutions, provided it is adequately safeguarded; do you think it is a good system?—I am very much in favour of the Maudsley system, but that is the one and only system in which a doctor has been found to hold out at great odds, I understand, against the possibility of certification in that institution.

20,436. Now there we are just touching upon what I think is a very important question. You would be in favour of institutions where patients who desired treatment could obtain it voluntarily; but I understand you think that in such institutions there should never be certification of those cases?—I think that not only should there never be certification, but there should be a very clear definition beforehand, Mr. Chairman, that the patient either is lawfully subject to the allegation that he is of unsound mind, or else, as is at present the law, that he is not lawfully subject to that. It is laid down in the early reports, to which I have called your attention in a letter, that at every visit even to licensed houses and registered hospitals it should be ascertained beyond all doubt that the boarder—(of course the word "patient" is always avoided; so far you have used it and I have protested, but I cannot continue to protest)—I mean it is illegal to receive a voluntary boarder as a patient technically, as you know, at the present day.

20,437. Now in the case of the Maudsley system of course the patients enter Maudsley voluntarily?—They do.

20,438. And they are never certified in Maudsley; but, on the other hand, unhappily some of the cases that go into Maudsley become much worse, and it becomes necessary to have them certified. What is done then, of course, is that they are removed from Maudsley and certified elsewhere.—Yes. I have unfortunately myself been obliged to remove a case of the kind that I was very very happy to get into Maudsley; but in the Maudsley Hospital there are, of course, mixed cases; there are cases that I think

21 October, 1925.]

Miss G.

[Continued.]

no doctor would want to call certifiable on admission, and there are distinct cases that are certifiable on admission, although not certified. I mean I could not deny it myself; I would not want to deny it. Now if that is to be the case, that the boarder is to be a person of tainted evidence from the moment they go in—as, of course, I understood myself not to be, and as in law I am not—I mean I understand from legal advisers that it is libel under the present law to use defamatory expressions of a voluntary boarder; but if you ask me, am I in favour of these cases being mixed I scarcely know; I think I am; but I think it should be very clearly defined. I think the Maudsley institution is doing such a very noble work that I should be the last to wish to put any sort of difficulty in their way, or even to suggest it. I do not think I could suggest an improvement on what I know of the Maudsley, much as I am impressed against this system.

20,439. Let me ask you this, Miss G. When you unfortunately became ill?—Will you say when I took laudanum, please?

20,440. I thought I was using the most neutral term I could. What would you rather I said?—I was not in the least ill.

20,441. Well, I will put it in another way. When you entered N. on the 26th April, 1917, I understand that you wanted to go there yourself as a voluntary boarder?—I cannot agree that, though I will not quibble about it. My family wanted me to go, and I consented under great pressure. There was this scandal, as it has been called, about my having attempted suicide. I was no more ill than Dr. H. when he attempted suicide, whom the Recorder of L. discharged with high eulogy and without imprisonment. What I craved was that I should be lawfully dealt with. I was exceedingly ignorant of the law at that time; and if it was a crime, I hope I was woman enough to receive the sentence for my crime, but I had not the ghost of a notion at that time that if I was accepted as a voluntary patient, that is as a sane patient which I was in law, I could afterwards on the mere allegation of this crime be made out to be insane.

20,442. But let us take matters in order. You consented as you say under pressure from your relatives to go in as a voluntary boarder to N.?—Yes.

20,443. Now I suppose you understood there that going in as a voluntary boarder you were at liberty to leave whenever you wanted to?—Absolutely.

20,444. You told us you signed a contract: I suppose that was the usual contract that you would obey the rules of the institution and would not leave without 24 hours' notice?—No, there was no 24 hours' notice.

Mr. Micklem: Have you got a copy of the contract?

20,445. Chairman: It would be interesting to see the terms on which you entered N.?—There was no mention of notice, and that at least has been decided in Parliament and in the Courts, that the registered hospitals have no right to impose such a notice.

20,446. Can you give Mr. Micklem and us a copy of the contract you made with N. when you went in?—I must ask you to excuse the fact that it is a copy which has some pencil notes on it because I thought this would not be taken as a subject of the ordinary strict laws. (*Handing in the document.*)

20,447. May we just get this down on the note? It is interesting to us to see what is asked of a voluntary boarder. Miss G.'s copy of her application to the hospital reads: "I, the undersigned, hereby request to be allowed to be received into the above-named hospital as a voluntary boarder for treatment. I promise to conform to the rules and regulations of the hospital so long as I am residing there." That is dated 26th April, 1917, and is addressed to the medical superintendent of the hospital?—May I point out that in every other place it is called "Hospital for Mental Diseases." It

is a printed document, and in this particular document that was omitted.

20,448. Has that got the rules and regulations that are referred to here?—The printed document?

20,449. Yes?—That is a typescript facsimile of the printed contract that the voluntary boarders sign.

20,450. Had you seen the rules and regulations before you signed them?—No; that is admitted, that they were not brought to my notice.

20,451. Did you see them afterwards?—I asked for them, but I was refused them. There are no printed rules and regulations for boarders, only for certified lunatics.

20,452. Mr. Micklem: In your statement you say there was a printed contract document supplied by Dr. R. on 30th April which contains exhaustive provisions for an extended stay, including funeral arrangements?—That was a contract statement signed by a third party behind my back.

20,453. That is what I want to see. Have you got that?—This is what I very particularly object to. (*Handing in the document.*)

Chairman: This is the document under which a relative becomes responsible for the keep of the voluntary boarder, and a similar document is taken at Maudsley also from the relatives of any boarder.

Earl Russell: How is she described in the document?

Chairman: "In consideration that the Governors of — Hospital for Mental Diseases situate at N. will provide lodging maintenance, care and medical treatment for Miss G. a boarder in the said hospital."

Witness: It is there called a hospital for mental diseases. I should not have signed in the first place without asking the question, "Am I supposed to be treated here for any mental disease?" Of course, I should immediately have been put under an urgency order; that I know now, but at any rate I should not have had the horror of having signed my own doom in that way.

20,454. Earl Russell: A boarder, of course, means a voluntary boarder?—Oh, yes. May I say that, in my submission, the important point of my contract—which was found in the Courts by the jury and Mr. Justice D. to be a contract with myself, and that the document which the defendants put in was no contract—may I say that the important point is that the words "as such" are left out. In the contract put forward by the defendants in this case they said, "so long as she remains as such." Of course, I should not have signed it. No one believing themselves to be sane would, I think, be quite so insane as to sign a document which says, "so long as I remain as such," meaning, if I cannot help going insane—

20,455. Is not the issue a much larger one than a mere verbal matter of that sort? The real question in the public interest that we are considering is how the voluntary system may be best safeguarded. You are a person who is able to tell us that in your case it was inadequately safeguarded; we want to see that it is properly safeguarded in the future. It is not a matter of words, it is a matter of substance?—Mr. Chairman, if this Commission does not regard that as a misrepresentation, do you think people like myself will believe that so long as I am residing there I am a person not residing "as such"—and so long as I reside there I am a person who is under a promise and an obligation, which I could not undertake if there was any suggestion that during a part of my residence there I should be a person from whom it would be immoral to ask a promise.

20,456. But you appreciate the practical bearing of it. Do you suggest that the documents which are signed by a voluntary boarder on entering an institution are at present unfortunately worded and ought to be worded differently?—I suggest they are criminal misrepresentations.

20,457. How do you think they should be worded? What is the form which you suggest a voluntary boarder should be asked to sign on entering an

21 October, 1925.]

Miss G.

[Continued.]

institution?—I did not think you would do me the honour to ask me to suggest it. I have one suggestion, and the very first is that if the voluntary boarder document mentions the word "treatment," then the nature of the treatment should be plainly indicated by calling the hospital a hospital for mental diseases. I did not know that the hospital at N. was a hospital for mental diseases alone. I think many people might go into these beautiful houses and suspect nothing of the kind. When they ask for treatment they ask for rest and cure, as I did, as was admitted on oath. They should at least be allowed to know if they are signing their own names to a request for mental treatment. I do not think you would get any sane person to do that, and I should be sorry if any sane person would do it.

20,458. You see, in Maudsley you consent to become a voluntary boarder there, and the treatment that is given at Maudsley is treatment for mental ailments?—Yes, and Mr. Chairman, the conditions which apply to them on entrance do, in fact, as well as in law, apply to them so long as they reside there; they cannot be anything else but voluntary boarders.

20,459. Then would you suggest that the model is the form that is adopted at Maudsley?—I am not very well acquainted with it, but no suggestion has occurred to me for improving that.

20,460. You see a voluntary boarder entering Maudsley has to sign a consent to enter, and then there also has to be a document signed by a relative undertaking responsibility for the monetary side of the transaction, and agreeing to remove the boarder if called upon to do so. There must be somebody, you know, outside who will undertake the responsibility?—I fully admit that, and it is a very painful responsibility and, as I say, I have had to undertake it in one case. But now that you ask me that question I do remember one thing, and that is of course that the question of the 24 hours' notice to leave seems to me to require very very careful explanation. Does it mean to leave, or does it mean to leave the hospital, that is to say, for a walk, or does it mean to quit, as the reports of the Board of Control always put it? I mean if the boarder has got to give 24 hours' notice to leave the hospital in the ordinary sense, then every walk that a voluntary boarder takes has got to be taken on the following day, so to speak, and they are in a very much worse position.

20,461. I am afraid we are getting into mere verbal niceties; everybody knows what 24 hours' notice means.—Then do I understand that you think that the voluntary boarder has the right to go out of doors, to leave the hospital in ordinary circumstances?

20,462. No, because they have undertaken to reside in the place, and not to leave it except at 24 hours' notice. The question of going out from time to time is a question for the doctor's discretion?—It is not really so at N. at present.

20,463. Is it not?—Oh no, Mr. Chairman. There was a genuine voluntary boarder there who, for special reasons, could not be certified; while I was there, she took a railway journey to Birmingham entirely without permission.

20,464. Surely by arrangement with the medical officer?—No; she would not have been allowed to. Immediately I was a genuine voluntary boarder I consulted a lawyer and protected my position. I did become a voluntary boarder again for special reasons. That was another form of trap which I should like to put before you. I signed the voluntary boarder document a second time, but that time there was no pretence of keeping me in bed. I received visits from my brother, and I immediately consulted a lawyer, but, of course, without telling the authorities.

20,465. Now you consented to go into this institution at N. as a voluntary boarder. I understand that you have reason to complain of what happened to you there; would you just tell us as simply as you

can what did happen to you, and what you complain of, so that we may see that these things do not befall anybody else in the future?—May I read you (because I shall be shorter in doing so) the particulars that I was bidden to give in the case.

20,466. We would very much rather have it in the form that we are having it just now, because we can get the points we want. When you arrived at the institution, how were you received? We are practical people here, Miss G.; we are really not much concerned with the legal technicalities. We want to get a practical view of the question?—I have put it in a concentrated form which I thought would take up very much less of your time.

20,467. Would you like to hand it in, and we can read it for ourselves, if you would rather do it that way?—Yes, I think I have a second copy.

20,468. But I think you should take advantage of my offer, Miss G. I think you could assist us?—I will, with very great pleasure, if you think it will take you a shorter time. After signing the voluntary boarder document I was asked to follow an attendant to a room. I did so, and then I immediately found myself in a very horrible ward—I think I have mentioned this in my proof.

20,469. Yes?—Of course, I am liable to forget little incidents. I said that I had arranged with the brother-in-law doctor who came with me, and I understood he had arranged with the authorities, that I was to spend the afternoon out-of-doors. I was not suffering from lumbago at the time though it was said that I was. I was advised very strongly, by my own doctor, to be a "daughter of the soil," and it was arranged that I should spend the afternoon out-of-doors. It suddenly turned to very fine weather. The attendant replied to me very stonily, "The doctor's orders are that you are to have a bath"—so I objected to that; I asked if I could see the superintendent. I was getting very frightened by this time by the look of the ward—terrified.

20,470. What was alarming about the ward?—There were such obvious lunatics about the ward and of very horrible appearance, one of them in particular—it struck horror into me.

20,471. That is very important?—I was getting very alarmed, so I asked if I could see the superintendent. The attendant, practically turning her back on me, said, "Oh, he sometimes comes round in the evening," so I said, "Well, I do not wish to undress until I have seen him." She said, "If you cannot undress yourself I can get assistance and have you undressed." I then thought it would be less undignified to undress. She then said I was to take my hair down; I said, "I object to taking my hair down." She repeated the remark, "I can get someone to take it down for you."

20,472. What was the object of all this?—It is the rule with troublesome certified lunatics, and no doubt it is necessary in some cases, and I have the admission on oath that the orders received for me were the same in every respect as for certified lunatics.

20,473. Of course you were, in law, a perfectly free agent at this time; you could have walked out again if you had wanted?—An absolutely free agent. I wanted to ask questions of the doctor; I ultimately did, but he stopped me after three days; I was too terrified to ask any more of him.

20,474. On the other hand, if this is a rule of the institution, that persons coming in were to take a bath in the first instance, there was not necessarily anything wrong about that, was there? It may have been distasteful, but many of the rules of an institution to which one goes are distasteful?—That is why I take such exception to that terrible voluntary boarder document, that it made me understand I always had the option as in a hotel.

20,475. Not quite the same as in a hotel, because when one puts oneself under the régime of the doctor one is expected to carry it out. When one sits in a dentist's chair one is able to get up and walk out, but we are more or less under a certain measure

21 October, 1925.]

Miss G.

[Continued.]

of restraint?—Surely not. If you find that the dentist is going to extract sound teeth, surely you can get out of the chair and walk out.

20,476. I quite agree, but when one accepts a course of treatment one often has to subject oneself to a number of things which are not very pleasant?—I did subject myself to this institution for a few moments, until I found it was a place that was impossible.

20,477. That aspect of it, to my mind, is by far the gravest aspect of the system: that a boarder entering a place of that sort voluntarily in the hope of finding rest and comfort in it, should find himself or herself mixed up with people, many of whom are alarming and terrifying in their behaviour. It seems to me a most serious thing, because that is very much calculated just to increase the disturbance?—I am very glad to hear you say that, Mr. Chairman.

20,478. I have a very strong view about that, and I think most of my colleagues have the same view, that persons who for the time being are distressed and disturbed and seek a place of retreat, should find themselves amongst people who, instead of comforting them, alarm and terrify them. It is obviously undesirable. What is your experience—did you find yourself among people who were quite unsuitable, and were you not dealt with individually?—No; I was subjected, as I have said, and, as it has been admitted on oath, to all the conditions of a certified lunatic, from the first moment, all of them without exception.

20,479. *Sir David Drummond*: Did you gather that that was the practice in that institution as regards other voluntary boarders?—Entirely, I had great difficulty in extracting it from the attendant, but under cross-examination the charge attendant admitted that her orders were the same as for certified lunatics.

20,480. *Chairman*: And was no difference made in your case, although you were a voluntary boarder, from what was done in the case of the patients who were certified?—I will not go so far as to say that no difference was made. I noticed, for instance, a very little thing that I hugged in the hope it meant something: I was allowed a special pot of tea, for instance. I rather protested against the tea because it was out of a tin can, and it was very, very disagreeable, and I was immediately allowed a special pot of tea. I had very great kindness now and then shown to me while I was still in that infirmary ward; I was only there for eight days, and I had very great kindness shown to me. That I took as meaning, on the part of the attendants, a recognition that I was really not a fit person to be there; it was very comforting, indeed, and very reassuring.

20,481. The only thing is this, that when a person undertakes voluntarily to enter one of those institutions, it might be said that you undertake voluntarily to go through the ordinary routine of the establishment, but as a voluntary person, instead of doing it compulsorily?—But always with the alternative of leaving. I mean I have had relatives who have walked out of an ordinary nursing home; but my clothes were taken away. Now, man is an animal who wears clothes, and I can give this Commission no idea of the terror of having one's clothes surreptitiously removed, being forced into a bath and being examined for bruises and all sorts of indignities. What they called bruises were found on me in number; though I pointed out that they had the square outline of mustard plasters, they were taken as bruises. The woman standing about me with a perfectly stony face took down "bruises here and there." I pointed it out then in abject terror, nothing more nor less, but it made no difference at all, she put them down as bruises. I had promised to obey the rules and regulations, and I had obeyed many arduous rules and regulations before. Anyone who has been to Girton College knows about arduous rules and regulations, but I could have walked out of Girton College at any time if they were unendurable, and I supposed I could have walked out of this place.

20,482. *Mr. Micklem*: You were paying four guineas a week for it?—I was paying four guineas a week, and that was during the time when prices really had not gone up very much. I mean, I could have got accommodation at a hydro, or S.'s Hotel, for that.

20,483. *Chairman*: Now, first of all, it seems to me that your ground of criticism is that having entered this place as a voluntary boarder, entitled to leave as and when you pleased, you were subjected to association with alarming and terrifying people, and were compelled to take a bath contrary to your wishes, and generally you did not seem to get the consideration to which you were entitled as a voluntary boarder?—I got the most dangerous kind of torture for eight days and nights.

20,484. What sort of accommodation had you at night?—My bed was filthy in some respects, but I did get that changed under repeated protests. I have to say that about the bed, it was absolutely filthy. The habits of the maids, the utterly untrained maids who attended to the room, were very disgusting. I think perhaps the Commission might like, while I am speaking, to look at these particulars which I have mentioned; I know I have a copy. Should I hand them in while I am speaking, or should I hand them in afterwards?

20,485. We do not want too many documents. It always seems to me more impressive if we hear from you yourself what you experienced.

20,486. *Sir David Drummond*: Could we hear in detail what your objection to the bed and the maids was? Will you please tell us in detail?—It is very disgusting.

20,487. *Chairman*: Never mind; we are all practical people here?—The bed had evidently last been slept in by a patient who had not passed a certain period. Not the sheets but the blankets bore very distinct marks of that and of other horrors.

20,488. You did not get clean sheets?—Yes, I think I had clean sheets.

20,489. The sheets were clean, but you say the blankets were not clean?—The blankets were not clean. And as regards the disgusting actions, well, a typical one was that the face towel was taken to wipe out the commode.

20,490. Did you see that done by the maid?—Yes.

20,491. Was that the only face towel that you had to use?—No, it was taken away then. I am sorry. It was taken away without my asking.

20,492. Do you mean that the maid who was taking away the slops, putting it quite frankly, used the towel to wipe the vessel?—Yes. I think I did inadvertently give a very exaggerated impression of that.

20,493. It was not the towel you were expected to use after that?—No, it was certainly washed after that.

20,494. That, of course, is not a nice thing to do. An untrained maid might do a thing of that sort?—They were all very untrained.

20,495. These were not the attendants; were they not the domestic staff?—There was no distinction. They were all servants. There were no nurses except the head nurse. I mean there was no one who had any pretence to any nursing degree. The attendants were very largely taken from very rough homes in Ireland, brought straight to the institution; and Dr. R. admitted to Mr. Justice D. that weight was a great consideration; his expression was "They fill a gap better if they are very huge girls."

20,496. *Miss Madeleine Symons*: Will you tell us what the bathing and washing arrangements were like; were they clean?—Yes, they were quite proper. The lavatory arrangements, closet arrangements, were very careless and rather disgusting; but I have no complaint to find about the bath except, of course, the very, very serious complaint that the bath is originally used as a means of depriving you surreptitiously of your clothes. I should have absolutely refused to undress, if I found that I had to leave my clothes behind in a little room—my

21 October, 1925.]

Miss G.

[Continued.]

clothes, my hat, my bag, and all sorts of things; I was obliged to leave those behind in a little curtained department, and when I got out of the bath everything was gone.

20,497. *Chairman*: Where were they put?—They were taken away, and they were not restored to me until afterwards.

20,498. Could you not have got them if you had asked for them?—I demanded them at first.

20,499. Did they refuse to give them to you?—Absolutely. I was supposed to be under a delusion. The defence is that I never asked to get up. I sent in written notices. I came to the conclusion that perhaps something in writing might be better. I sent in three written notices; they were all denied. What is to prevent that?

20,500. Had you a bedroom to yourself?—I had a very, very small room off the main ward.

20,501. Could you hear what was going on in the ward?—The door is open the whole of the day.

20,502. I am thinking of your comfort. How did you spend your day? Take the first day that you arrived there. Were you put into bed after your experience with regard to the bath?—I was kept in bed the whole of the first day.

20,503. In a small bedroom with an open door, opening off the ward?—Yes.

20,504. Could you hear what was going on in the ward?—Yes, I could hear forcible feeding and everything, and shrieks, of course; I could hear all sorts of painful things besides that; and also the smell was very dreadful at times.

20,505. Did you find all that very disturbing and alarming?—I found it more than anything else terrifying. I mean I knew then that I was trapped; I knew in the first few hours that I was trapped; and the sense of trapping quite obscures any other misery, anything that can be called misery. I am quite sure it is impossible to conceive the meaning of stark terror.

20,506. Speaking from your own experience, what do you suggest as a proper safeguard for a voluntary boarder, who enters an institution, against the possibility of such things happening? I can see myself practical difficulties?—There are.

20,507. Suppose a voluntary boarder agrees to go in, and let us assume everything has been done, and that bed is the proper place; a patient is put to bed. Well, I can see the desirability of having a quiet place certainly, but it might be a very ill-advised thing for the patient to get up at once, put on her clothes, and go away just after she has come in?—That had been arranged by two doctors as my programme for that day, my own doctor, and my brother-in-law doctor who came with me, because of this idea that what I wanted was fresh air and plenty of exercise, and I desired that so myself. Mr. Chairman, I have thought out a little safeguard which perhaps you will allow me to put before you.

20,508. If you please?—That is, instead of what I must call the sham safeguard of giving notice which can be put into the wastepaper basket, there should be a rule that the patient or boarder on his side signs or initials every day a statement that he is willing to remain, and that the absence of that initial on any occasion, if the facts be in dispute, should be evidence that he is not willing to remain.

20,509. *Earl Russell*: That is a very good idea, but suppose there comes a time when he is ill for three days and is too ill to do it?—You mean that he is mad—that he is insane?

20,510. Physically or mentally ill just for three days—upset in some way?—That is an insuperable difficulty, but I think that there can be no case in which there is not some evidence of insanity which probably the person in question will be very loth to cause to be brought up. I had not thought of that, but you see my suggestions have really been confined only to the case in which the voluntary boarder is sane in law. It does come under the definition in the early report of the Board of Control:

without any doubt, "of sound mind and capable of managing his own affairs," I think it is, and having full knowledge of his ability to leave at any moment—to quit at any moment.

20,511. *Chairman*: Now I can see in your case, Miss G., that one of your grounds of complaint is that, having entered this place intending to be a voluntary boarder, you were certified in that place?—Yes.

20,512. That is a very definite point?—I was a certified lunatic.

20,513. You were a voluntary boarder, who went in as a voluntary boarder on the 26th April, if I remember aright, and you were certified as a person of unsound mind early on the 8th May?—My certificates, if you mean "certified" in the medical term, are dated May 1st and May 3rd. I was a voluntary boarder and a certified lunatic for many days at the same time, which is an anomaly in itself, and, in my submission, ought not to be contemplated for a moment. I mean I was not under two certificates of lunacy, as you say, "a person of unsound mind," but, in fact, the term "lunatic" was chosen by the last doctor; but I was under a cautionary notice to all nurses as a dangerous lunatic, suicidal and dangerous to myself, and all the time I was a voluntary boarder in law, and according to the doctor's sworn answers I had free ingress and egress at all times.

20,514. Of course, cases must arise where a person who enters as a voluntary boarder unfortunately gets worse and becomes a certifiable case, and may have to be certified. It is a question whether that certification should take place in the same institution. In your case you were certified in the same institution as you had entered voluntarily. The actual admission on the 8th May is as a private patient, after two certificates, one of the 1st and the other of the 3rd May?—I was certified on the 1st May, and again certified on the 3rd.

20,515. Now, you think that you should have left the place, and, if it were necessary that you should have been certified, that you should have been certified outside the institution altogether?—Yes. As you have asked me to make a suggestion, I have only to say that Section 13 of the Act gives the necessary and, in my opinion, sufficient conditions for certifying all such cases. I have had this question raised in Parliament, and the answer was that the steps are laid down in the rules of the Act, but they did not say which section. I can find no section, and I know of no one else who has found any section which admits of lawfully certifying.

20,516. Will you tell us the circumstances under which you came to be certified. Having started, as you told us, as a voluntary boarder, how did the certification come about. Do you remember being seen by a doctor?—Oh, yes, a gentleman in khaki was introduced to me on the fifth morning (I have put it in my proof, I think), by Dr. M., who was the doctor on the women's side, whom alone I saw; except on the Sunday evening, when Dr. R. came in answer to my written requests to go—after three of them—but he denies, of course, having received them—he discussed them with me at the time, but he now denies having received them. On the fifth morning this gentleman in khaki was brought into my room. Dr. M. said, "Now, Miss G., you have asked to see somebody from the outside world. I have brought you Captain W."

20,517. How long did he remain with you?—About a quarter of an hour, I think.

20,518. Did you know he was a doctor?—I did afterwards know he was a doctor; I did not at first; I thought he was a very, very kind visitor, and I asked him how long he could stay. I remember, because I was glad to have an opportunity of speaking freely. Then I began to explain to him why I was there, and I said, "It is an act I am not ashamed of; I thought at first to take my life," and so on. He rather prompted me to that subject, I remember. Then, of course, he entered on the

21 October, 1925.]

Miss G.

[Continued.]

certificate. "Harps perpetually on the subject of suicide." I asked him if he knew whether Jonathan had not committed suicide. Neither he nor I could remember, or whether he was the man who had asked the young man to run him through with his sword. He entered, "Quotes the Bible." That is another symptom of insanity. I asked him what he thought about Captain Oates, and so on. That is the sort of conversation I had with him.

20,519. Do you think he had an opportunity such as a doctor would require to diagnose your case?—No. It did not enter my mind that a perfect stranger would certify me. I did not know doctors did certify one; I thought it would be somebody who knew something about me.

20,520. Then on the 3rd May do you remember seeing Dr. P.?—Oh, yes.

20,521. How was he introduced to you?—He was introduced to me by Dr. M. in something of the same way. I had had a fall the night before; I had been taken up and treated very kindly by the attendant; I was very, very dizzy—I do not think it was exactly fainting; I thought he had come for that, and so I proceeded to tell him how absolutely terrible my suffering in this place was, and could not be doing something for me as a doctor; so he did—he certified me, and his certificate is also rather remarkable. He says that I stated that I lived for the war, though I had no relatives there, and remarks of that sort.

20,522. Then I understand you represent that both these doctors were wrong in diagnosing your case as one of unsound mind?—I do, Mr. Chairman. I think they were much more than wrong. They were unlawfully called in as agents of the medical superintendent who informed my brother, and who, in my submission, showed his complete *mala fides*.

20,523. What motives would these two doctors have to certify you insane unless they believed it, Miss G.?—I feel that that motive is very very plain if a few details can be gone into: and, particularly, Mr. Chairman, that Dr. R., of the institution, and Dr. M., who is a barrister at law (he was the women's doctor and he has left the hospital now), were perfectly aware that it is in fact unlawful and that they had quite unlawfully received me as a voluntary boarder, after I had made an attempt on my life, which was morally justified in my own mind; because their admissions all show that they intended, as Dr. R. told me, to keep me under observation, to keep me in bed; to give all the nurses a caution that I was suicidal, that I was to be very closely watched; and their intention, which I take to be a moral intention, was to prevent any repetition of the act.

20,524. Was not that quite right?—That was quite right and quite moral, but it happens to be lawful in one place only, and that is an institution for lunatics where you are allowed to be kept under restraint because it is quite right to do so.

20,525. It seems to me that you had voluntarily gone into an institution, and it was an institution where care is taken of people and people are observed; it is just in order that they may be prevented from doing themselves any harm?—Mr. Chairman, if it is your opinion that a voluntary boarder may be what I can only call trapped into a mental institution which has its own rules, it is I think immoral to trap a person whom they have received as a voluntary person able to quit at any time, on false representations, that is.

20,526. It seems to me that the whole essence of the thing is that it is a mental institution and that you voluntarily are willing to go into this place as a mental institution?—Then what is the use of the certificates and an order, if an attempted suicide may have her liberty restrained without any order?

20,527. But was your liberty restrained?—Certainly. I have said that I protested frequently and demanded my clothes and my liberty.

20,528. That, of course, is quite correct, but I do not quite see your objection to the institution?—I

have absolutely not another word to say to this Commission if that is considered to be what the Commission is going to recommend. I honestly would rather not, Mr. Chairman, say anything else. That was Mr. Justice D.'s view, in fact; he put before the jury the plea of justification. It was never raised by the defence for a moment.

20,529. We are not prejudging anything at all. We are merely endeavouring to get light upon a difficult problem, Miss G.?—Mr. Chairman, when you say to me, "I do not quite see your objection—"

20,530. I do not quite see your objection to its being a mental institution; but I do see very grave objection to a person who has gone voluntarily into a mental institution being deprived of her liberty there?—I was explaining the reason for all this chicanery, as I have called it, for the superintendent telling my brother-in-law, "I can get the certification locally." That is to say, "I can avoid the usual medical attendant, and then invent a reason myself afterwards."

20,531. Were all these people, the doctors and your brother, not, in your opinion, interested in your welfare, but really desirous of doing you some injury?—My brother was certainly interested in my welfare. His idea was: "She has committed this act; I want to prevent it coming into the Police Court," and he was assured by Dr. S. that it would jeopardise his position if it went into the Police Court. He is master at M., and he wanted to prevent it. He only knew of one way. He was told by Dr. S. that the doctors at N. would be willing to take me as a voluntary boarder, but, in fact, to restrain me. He absolutely (I have to exonerate him) thought I had been informed I should be restrained. He was taking this information from doctors who presumably knew something about it. I think he was quite genuine in his wish to do his best for me, but, incidentally, the best for himself, which involves much more important considerations, namely, to keep the matter out of the Police Court, which I would have prayed for if it was the only alternative. I have seen many doctors since who say it was very improper. As regards the institution, I do not suggest that in my case the acquiring of three months' fees, although considerable and very, very much added to, doubted, almost, after the original contract—I do not suggest that that was any very vital consideration in their minds in securing me for the three months for which they insisted on prepayment; but what I do know is this, that they were in full knowledge of the fact that it was unlawful to receive me, and that the Commissioners would never for an instant have allowed the reception of a suicide.

20,532. Where should you have gone, then?

20,533. *Sir David Drummond*: Do you mean they should have certified you before you entered as a voluntary boarder?—If any doctor thinks that is the right thing to do, to certify an attempted suicide alone, I mean following the ordinary coroner's verdict—

20,534. *Chairman*: But where should you have gone, Miss G.?—I have heard from Dr. F., whom I asked to advise, so to speak, in this matter, what ought to have been done (I was his patient afterwards): he thought it was a very, very abominable proceeding that had taken place in my case, and he said, "Had you been in my hands instead of Dr. S.'s I should have asked your family to put in a nurse for a day or two, got your word of honour that you would submit to a certain amount of restriction of your liberty, because you had given your family a great shock, and because they could send you before the Police Court if they liked, and then, just as soon as I felt satisfied about you" (not about my health, he did not pretend to have anything to do with health), "and I could trust your word of honour, take the nurse away."

20,535. That is treatment at home with a nurse?—He did not call it treatment, he did not suggest a mental nurse, or anything of that sort, but he

21 October, 1925.]

Miss G.

[Continued.]

thought I ought to submit to being under some sort of restriction which would give my family confidence.

20,536. But do not you think it would be extremely useful that people who have passed through such an experience as you have, should be able to enter, if they wish, an institution where there are people who are familiar with such cases, and who will observe and safeguard these cases?—I do not think it has anything to do with mentality or mental disorder, neither does my very good friend, Dr. W., the mental expert: he knows all about my case. He lent me a book, Mr. Chairman, which I would very greatly desire that this Commission should know of, written by a lawyer on this very subject of the connection between suicide and insanity.

20,537. You see, Miss G., it would be much more helpful if you would apply your mind to the real case we are considering, namely, whether the voluntary system of admission to mental institutions is a good thing or a bad thing. It may be a good thing or a bad thing, according as it is administered. Your case seems to me to be a case, if I may say so, in which the system has not been well administered, because of the undue restraint which was put upon you. You, having entered as a voluntary patient, were subjected to those unpleasant things which you have told us of, and were ultimately certified and compulsorily detained in the institution?—Mr. Chairman, I object very strongly to that—that I became a person to be compulsorily detained.

20,538. You were in law a person who became subject to that?—Unlawfully.

20,539. I should have thought the value of your experience would be to assist us in seeing how this system could be freed of such possibilities of abuse as you say occurred in your case, and it was in that direction that I was hoping we would get assistance from you?—My first suggestion after that, Mr. Chairman, is that I think the idea of admitting a person who has attempted suicide as a voluntary boarder in a mental institution, should be scouted.

20,540. Why?—In the first place, when these cases come before the Courts—

20,541. Let me put to you a very simple case. Suppose you have got a young girl who, for the time being, has got a little hysterical and has attempted suicide, but there is nothing very much wrong with her really, and all she requires is a little care and a chance of being removed from her own relations, who are perhaps distasteful to her. Why should it not be possible for her to say, "I am quite willing to go to Maudsley, where for a month or two I shall be removed from my present circumstances, and be able to regain control of myself"? It is very unfortunate if that is not to be done?—You are postulating, Mr. Chairman, that a person who has attempted suicide has lost control of herself.

20,542. Yes, I am?—The statistics of attempted suicide which were pointed out to me by Dr. W., who is, I think, an acknowledged authority, show that when these cases are brought before the Courts the proportion of insane to sane is 4 out of 1,227—about .3 per cent. in whom there is any trace of insanity.

Chairman: It is not a question of sanity or insanity, it is a case of abnormality and danger. It is a social offence, of course, to commit suicide, and persons who have tried to do so must be prevented from doing so again, whether they are sane or insane.

20,543. *Sir David Drummond*: There is a considerable proportion of people who enter these institutions voluntarily, because they tell the doctor they have a feeling they may do themselves an injury?—Well, I think they are very suitable cases to be certified.

20,544. *Chairman*: But surely you would not wish the stigma of certification put upon a case of that sort, a case merely of temporary disturbance?—Not if there is to be a new regulation by which restraint without certification is to be lawful.

20,545. Your criticism of the present system may be well founded, but we are in the position of being able to make recommendations for the improvement of the present system?—It seems to me that many of the dangers of the present system will not only not be removed, but very much intensified.

20,546. How do you know what we are going to recommend, Miss G.?—Because I have attended all your sittings, and it has been very plain to me in which way your sympathies have lain, just as you have made plain to me that you consider any person who attempts her life lacking in control. I have never changed my views at all. Under the same circumstances, it is my intention to end my life myself just the same as it was then, and I told that to Dr. R.; but Sir David puts the case of a young girl—

20,547. *Sir David Drummond*: It was the Chairman who put that particular case?—Yes, who feared that she might attempt her life.

20,548. *Chairman*: We are not going to enter upon the large topic of what is the causation of the suicidal instinct now; but I can only say that I am interested that you should be able to know in advance what our recommendations are, because I do not know them myself yet?—I do not think I said your recommendations, Mr. Chairman. I have said something about the views you take. You have just announced a view to me, and I cannot help knowing it.

20,549. I have announced the view that attempted suicide indicates a certain abnormality of the mind. If we do not agree about that, I am afraid we must leave it, but that is not the question we are discussing to-day. We are discussing the question of what is the best form of regulations for the voluntary boarder, so as to prevent a recurrence of such abuses as you have unfortunately suffered from. Do not think that we do not sympathise with what you have undergone. We want to prevent that in future, but we want at the same time to have a voluntary system by which people can get the protection and care which an institution can give?—What I particularly want to prevent is legislation so called, safeguarding legislation in which, as Lord Chief Justice Coleridge has pointed out, "The safeguards are in my judgment," he says, "far worse than no safeguards at all"—far worse. It does seem to me that all that I have heard in this Commission points to their views upon safeguards, including certain remarks that I have heard to-day, being all, or very very many of them, precisely of that kind which Lord Chief Justice Coleridge referred to.

20,550. You think they will be futile?—Absolutely futile, and worse than futile.

20,551. I have asked you to tell us one that will not be futile, and I cannot say that you have told us any?—I have suggested one that Lord Russell thought was a good idea to a certain extent, I think I understood so, but that it might fail in cases where a person did really become insane.

20,552. I can assure you that we do not want to recommend futilities, but we want to get help from witnesses as to practical safeguards.

20,553. *Mr. Micklem*: Do you not suggest that the medical superintendent should never be allowed to be a petitioner in certain cases?—Certainly.

20,554. *Chairman*: That is a very good point; would you not like us to recommend that?—Yes, I should, indeed.

20,555. Would you say that was a futility?—No, I should not, but I should like to be able to point out to the Commission a few reasons why that is so undesirable.

Earl Russell: But you need not do that, need you?

Chairman: I think it is pretty obvious.

20,556. *Mr. Micklem*: He was the petitioner in your case?—He was not the nominal petitioner; the nominal petitioner in my case was a brother of mine; but then he did absolutely nothing except sign the perfectly formal parts of the petition, the other parts of which were entered afterwards. Mr. Chairman,

21 October, 1925.]

Miss G.

[Continued.]

I hope you will allow me to say, as you have said that I have not suggested anything valuable, that I think the most valuable thing is for this Commission to be able to realise by a specific case the way in which the voluntary system in a multitude of ways works, especially in registered hospitals.

20,557. Please do not misunderstand us, Miss G.: that has impressed us immensely. The account of what happened to you when you entered that institution as a voluntary boarder has left its impression upon my mind. Also there is the question as to whether it is proper that a person, having entered as a voluntary boarder, should subsequently be certified in the same institution at the instance, apparently in this case, of the medical superintendent. These are really important points which have certainly impressed us?—But it does not seem to have impressed itself upon your minds at all. When I speak of the workings of the system I do not mean what you have just said, though I am obliged to you for what you have said, Mr. Chairman; but when I speak of the workings of the system I mean such serious things as forging documents, making falsified copies of a document, and obtaining orders by every kind of illegality—matters which never, by any conceivable possibility, come before the Commission unless they are put before them by such a person as myself, or unless (to which you reduce me absolutely) I get these matters known about; I consider that my duty to the public—unless I bring them before the Criminal Courts, as Mr. Justice D. suggested as my remedy. He does not deny that there was forgery and criminal contrivances to get the order made; and that, in my opinion, is vastly more important than that you should go into the question of what can always be discounted, namely, the treatment. These things cannot be discounted. I mean either the petition

was forged, or it was not, either there was a criminal conspiracy, or there was not; and if it is a fact, what is the comparative value of the details of my so-called treatment as a voluntary boarder.

20,558. I think the question of how you were treated as a voluntary boarder is infinitely more important than some irregularities in the forms of your certification, if I may say so?—But there is a widespread system which I alleged of obtaining orders for sane people through the voluntary system; that the voluntary system can be easily adapted to obtaining the certificates and orders by numerous forms of illegalities, including forgery.

20,559. *Earl Russell*: But you know, Miss G., conspiracies and forgery are already criminal offences; we do not need to recommend that they should be made criminal offences?—But you cannot believe that these conspiracies exist unless you have evidence. You cannot report differently. I am not expecting you will recommend, without having heard any evidence, that there should be preventive measures against obtaining orders and certificates by conspiracy. You could not recommend that in your report unless you found it yourself on the evidence I can give you, or else it can be found in the Criminal Court.

Chairman: I am afraid we must refer you to your remedy in other Courts, Miss G. We are obliged to you for telling us your experience of the voluntary system. I am sorry you should think our attitude is not sympathetic; I think you are quite mistaken in that respect, if I may say so.

Witness: I think your whole position, Mr. Chairman, is summed up in your public announcements, against which I have already protested.

Chairman: I am sorry if that is your view, Miss G. However, we are obliged to you for coming here this morning, and we shall now adjourn.

(The Witness withdrew.)

(After a short adjournment.)

Mrs. G., called and examined.

20,560. *Chairman*: Mrs. G., I understand that you were yourself a patient a considerable number of years ago from August, 1900, to June, 1912?—Yes, in an asylum.

20,561. What I understand that you desire to do is to assist our deliberations by some suggestions you have to make for reform?—Yes.

20,562. We should be very glad to have from you any points to which you think our attention should be directed?—You will understand that I must give instances of what I think should be altered. I cannot say I want such and such a law made, and give you no reason for it; I must give you a reason why it should be made.

20,563. Certainly?—I must say something about what happens in asylums.

20,564. If you please?—Thank you. I am a very bad hand at remembering names, but I have got some written down here. My lawyer said that you might like to see the certificates I got immediately I came out from an asylum; I could not send them at the time, because I had them over in France, but I have brought them to-day. One thing is that I think that it should not be legal to certify a person, as I was, without telling that person anything about it, and never letting them know. Of course, when I went in I was very upset at my husband's death, but they could have seen that, and I never had the slightest idea I was certified until I was at W. No one ever told me. I had no opportunity to speak to anybody about it before. When the nurses spoke to me about it, I said, "I suppose the Commissioners do not like me speaking about the things that have happened, so they determined I should be kept." That I consider a very wrong thing.

20,565. Do you remember being visited by two doctors?—I do, afterwards, when I saw the certi-

ficates. When I was out I applied for them, and I tried to remember; and I remember two gentlemen coming and speaking to me out in the garden at C. One of them said he knew me, but I had never known him, and I said I did not wish to talk to him. I was not accustomed to a gentleman coming and speaking to me, and I did not wish him to talk to me. He talked with me, and he asked me about other things, "Have you ever felt you would like to end your life?" and I said, "I have," but I did not do it. I had every means of doing it, but I thought of my mother, and of my people, and I did not do it, so I said "Yes." That was one. Another came, and he talked much in the same strain, and he said, "You seem melancholy." I said, "I have lost my husband under very sad circumstances." I do not know that I am more sensitive than other people, but I felt it very much. He was my husband, and I thought I ought to have taken more care of him, and perhaps he would not have died; I was very unhappy about it. I did not know that those men were going to certify me; they should have told me. You cannot alter it, I cannot alter it, but I think it should not be allowed to occur.

20,566. *Sir David Drummond*: Might we hear what advantage it would have been, supposing they had told you that you were going to be certified?—I should have said, "I do not know that I want to be certified as insane." I went to C. voluntarily. My brother asked me if I would mind going; I knew two of the doctors there; they were friends of my husband; and he said, "There you can have drives; there is a nice park, and you will get quiet and rest," and he said, "We would like it." "Well," I said, "I do not care what I do; I am very unhappy; I do not care where I go or what I do." I had not agreed to be certified as insane.

21 October, 1925.]

MRS. G.

[Continued.]

20,567. But what advantage would it have been if they had told you that they had come there with the object of examining you for that purpose?—Because I should have said, “I wish to go out.” I went in voluntarily; I could have gone home; I could have written to my people.

20,568. *Sir Ernest Hiley*: Had you signed any agreement, or anything of that sort?—I signed it without reading it through. My brother said, “Do not trouble; it is quite all right; you are going to be taken care of here; you are all right.” and I put my name at the bottom of a paper, so I imagined that it was to say that I went there voluntarily.

20,569. *Chairman*: How long was it afterwards when you were certified?—You do not take much notice of time when you are unhappy and surrounded by lunatics and that sort of thing. I have been given the date, but I forget; it might be a fortnight or three weeks. I cannot say definitely. I have got the dates of when I went in, but I could not say from memory.

20,570. Were you always treated as a certified patient?—First of all, do you mean?

20,571. No. You went in as a voluntary boarder, first of all?—Yes.

20,572. Then a fortnight afterwards you were certified?—Yes.

20,573. Then, for the remainder of these 12 years when you were living in institutions, were you always certified?—Always. I was treated just the same before; there was no difference made when you got in. I thought it was a dear little room, and if they would leave me alone I should begin to feel better, and in the evening when I went to go to bed I walked to that room, and they said, “You will not go to that room; we will find you another.” The lady took me round, and the nurse said, “Do not bring her here.” and another one, “No, not here.” I think I went to five different rooms, and then there was a room full of lunatics. The whole night long a woman in the next room shouted and screamed and stamped her feet. The next morning they said, “Oh, there is that awful Miss B. who kept the people awake.” I am not a good sleeper, and that was where I went. There was no difference made after I was certified in that way, except that one day, when I had been there two or three weeks, I was taken into a different part of the asylum; and that may have been some special ward for people who first arrived.

20,574. *Mr. Micklen*: Did you have a quiet sitting room from the beginning?—No, no sitting room.

20,575. I thought you said at first that you had?—There is a little room they always take you in to be examined by the doctor, but I was not examined by the doctor at that asylum. You are always taken into that room when you arrive.

20,576. *Chairman*: Now, as you say, you wish to emphasise matters calling for reform. Your suggestion is, that when a person is being examined by two doctors, in order that her mental state may be ascertained, she should be told?—I do. It cannot hurt a person who is out of her mind. I have been with them; it could not have hurt them. I do not say so in the case of puerperal mania, but that is another point; they should never be certified for that; they should be put in a separate place, because they come to themselves. Now Dr. M., where I was last, talked to me about that, and he got me to go and sit with a lady so that she never knew she was in an asylum. Of course, I would not say anything about it, but I think that is an exception. Otherwise how could it hurt an insane person? And the harm that it does to people who are not insane is much outbalanced. That is my idea.

20,577. May I just follow up a suggestion you made a moment ago. You spoke of the surroundings in which you found yourself when you went into this institution, and apparently you can also testify to this, that on entering such an institution you found yourself mixed up with undesirable people?—Yes; they were a nicer class, but they were insane; they

were a better class at C. I did not come into contact with the very low people who swore and cursed and used foul language, but there were some very much insane. I was puzzled. There was one who used to get little bits of fat and hold them in front of the fire and say some sort of incantation, and the nurses would go and join in, and she was always telling the nurses their fortunes. I thought it was a dreadful thing; but these people, I suppose, are extraordinary people.

20,578. We have had some evidence to-day from a lady who said she found it very terrifying to be placed among people who were obviously and acutely insane when she started to live in the place she went to. Have you had any experience like that—did you find yourself among people who frightened you?—I thought they were not insane, really. They spoke quite sensibly, but I thought to myself, “I do not know why they are locked up.” There was one, a great big tall person: she was always spitting on the floor; she was very beautifully dressed; she was a very rich person. Those sort of things disgust one, but I cannot say I was frightened because of them.

20,579. Do you think you found it disturbing to be among these people?—You think to yourself, “What do they think of me?” They must have imagined there was something terribly wrong with me. I did not know; I thought they had made a mistake. I have not a very unkind mind, and I thought, “Well, they are trying to get me better, and what they are giving me is making me worse.” It is no good; you have no one to speak to. I thought the treatment in some way made me worse. I felt very bad because they began giving me drugs, and I cannot stand drugs; I thought it was something that was no harm, but I was quite dazed; I wondered what it was. I used to look round and wonder what was happening, and every night they forced me to take drugs. I struggled against it, because my husband told me never to take drugs. They were quite good to me there; they were not meaning to be unkind at C.

20,580. What sort of drugs were they; were they sedatives?—To make me sleep, I think.

20,581. Were you sleepless at times?—Yes, I was. My husband's death was a great shock to me, and I did not sleep well; I could not get out of the way of thinking about it; I would sleep a few hours and wake up with a start, even at home.

20,582. Do you not think that a sedative drug was quite a good thing to take in such a case?—My husband told me I ought never to touch drugs; they have a very violent effect on me. I used to have bad headaches, and one day he gave me a drug, and I did not feel any different. A little while after he came and said, “You had better come out for a drive with me,” and on the way I could not think what I was talking about; I said, “What has happened to me; I am going out of my mind?” He said, “Oh, nonsense; you keep quiet.” He told me it was the smallest quantity of hashish he had given me; he said he could not have made a more infinitesimal dose.

20,583. Was your husband a medical man?—He was. Opium nearly kills me; I do not think I was given opium much.

20,584. But did the doctors in the institution not see then that the medicine they were giving you was having bad results? Did it have the same results when you were taking it in the institution as you had previously experienced outside?—I do not know; it might have had. No, I never had that loss of memory.

20,585. I mean, the doctor or the nurses would have seen if it had been doing you harm?—The nurses do not see anything; the nurses are no good, they are absolutely no good. No nurse ever notices a thing; I assure you they do not. All they do is to try and save themselves trouble. For instance, take the case of one nurse: I was standing a little way away from the patients; of course, they were

21 October, 1925.]

MRS. G.

[Continued.]

all filthily dirty, and they were wet and other things, and there were trails from them, and the smell was awful; I stood a little bit away. She was a woman who drank a lot. She gave me a shove like this, and two or three poor things stumbled down. When I was up in the bedroom she came and said, "Here, take this," so I said, "What is it for?" She said, "Well, you have got to take it for your behaviour in the vestibule," or whatever they call it. I said, "I have done nothing; what do you mean?" and she said, "If you do not take it you will have two nurses hold you down and have it forced down your throat." That was about three-quarters of a cup full of cascara. After that you can imagine the effect, when the doors are not opened, and that sort of thing. I can assure you that you are looked upon as something awful. The nurses are no use. At C. I saw the nurses kind to the people, and I should say their reports might be taken; but they are no class you know—they do not take up their characters—they told me so themselves. Some are very nice, but as a rule those go away after a time.

20,586. Now are there any other matters you would like to bring before us?—Yes; I think this should not be allowed. When I went to L. at the last I applied to see the committee when they came—the magistrates. A gentleman said to me, "Come and speak to me in this room." It was a very nice place. I went into the little drawing room, and when I got in he said, "Oh, well, you have been so long in asylums, and of course you are much better." I said, "I do not know; I was bad from my husband's death," but I said, "I was not insane when I got into the asylum." He said, "Just tell me about it." So I told him about it, and how I went into that bedroom, as I told you. He said, "You slept?" and I said, "No, I could not." He said, "Why could you not? My good lady—voices!" I said, "Excuse me, it was not voices." "Oh, yes, it was." Now that, I think, should not be allowed. I said, "I can give you the name of the person, and then you can go and ask." Nobody should be allowed to come, and, as they call it, damn you. Why should he say it was voices? It was not voices. That, I think, should be made a punishable thing against a person who keeps people locked up. They are so accustomed to people out of their minds that it does not matter; but there comes a time when it does matter.

20,587. *Mr. Micklem*: Was this a magistrate?—It was the magistrate's doctor. He came with them afterwards. Of course, you are helpless—you have no one to appeal to. Another thing—I think the violent and noisy patients should not be put in the room with other people as it was when I first arrived, and as it continues to be.

20,588. *Chairman*: That is a question of classification.—I do not know if you call it classification. I do know that the nurse gets a rest in the day, but I know the patients do not, and if you are kept awake all night there is nothing curative about it; I think it should not be allowed. That was the same in every asylum I went to. At W. it was the same. There was one patient who danced about and screamed the whole night on her bed. The nurses, of course, were very angry with her, but that does not help the people who are trying to go to sleep. There are plenty of side rooms of course, only it means an extra nurse, and they have not many nurses; they cannot put them separately. A woman like that taken straight in would want a nurse. Well, they have not got them; it does not matter what happens to the patients. Also a person likely to die should not be put in a ward with other people, I think. I do not think it is very nice to be with people dying, when you think you may be kept until you die yourself.

20,589. Were you in the general ward?—In the sick room as they call it, and several died.

20,590. You were there, of course, as a private patient?—Yes.

20,591. Do you mind telling us what you were paying?—I do not know—I was never told. I have got the account, but no details were given me of what was spent while I was away. It was very cheap.

20,592. Was not there a weekly charge?—It was under £100 a year, I think. My brother told me it was very cheap.

20,593. *Mrs. Mathew*: Which one was very cheap?—S., it is a County Council place, I think.

20,594. *Chairman*: You seem to have been in quite a number of institutions. Why were you transferred from one to the other like this?—I do not know. I can only imagine that when I got hold of anyone in those asylums to listen to me a little I was sent off to another—that happened on several occasions. I managed to find out who to get hold of, and then I was told immediately after I was going on somewhere else. I cannot say, I do not know, but I only thought that.

20,595. I see your first transfer which was from C. to N., was apparently made at the request of a relative of yours?—That may have been because of the expense.

20,596. *Colonel B.*?—That is my brother. I do not know what he found about it that he did not like. He was a very great dear.

20,597. Apparently the transfer was made at his special request?—Well, my brother, *Dr. B.*, said, "What was it you did always to upset them?" Well, I cannot tell what I did to upset them; I am not a disagreeable person. I do not know except that I may have said I did not like things, but I do not remember ever complaining at C. I know in that few days after I was there they broke my ivory brush by hitting a girl. I rather treasured my things. It is not nice to have your brush broken.

20,598. *Mr. Snell*: You were not removed, were you, because of any obvious quarrels with the authorities?—No, not that I know of. I never had one.

20,599. *Sir Ernest Hiley*: Is this one of the instances that you referred to in paragraph 16 regarding ill-treatment by nurses, when your brush was broken?—There were much worse things than that, that is nothing.

20,600. How was it your brush was broken?—I do not know; she held the handle and whacked this girl. There was the tiniest crack in the ivory, but I had used it for years after that. They take your things. I had another one with me, and that was stolen from me at the next place. I could not get one for a long time. That is another thing, you have things sent, and they are taken, you do not get them.

20,601. *Chairman*: Were you in touch with your brother all the time you were in these institutions?—Yes, he used to come and see me.

20,602. And I suppose you had opportunities of telling him how you were getting on?—Yes. I was very unhappy; it was the drugs, I think. I was not like that when I was at my mother's before I went away, and I think it depressed me frightfully, and I used to say I was miserably unhappy.

20,603. You do not suggest that your brother was keeping you there for anything but the best motives?—No. They are deceived, just like you all are. They do not believe these things; they did not, I mean. Just lately things have altered, but I would not believe before I went in that these things happened. My husband told me that nurses of asylums were rather of a bad class, because I wanted to take one as a servant, and she had not a very good character, and he said, "No, you had better not." Otherwise I had no idea that such things could happen.

20,604. What are the things that you specially refer to?—That was at S. At N. the only thing I think that was exceedingly wrong was to feed me forcibly. I was frightened of the food often because there is not enough care taken. I had the idea that these people were diseased, because my husband did tell me that; he said, "Asylums are filled with two things, that is, drinking and a very bad disease; they

21 October, 1925.]

MRS. G.

[Continued.]

fill asylums." When I got there I thought I was surrounded with these things, and I believe I was; I think so still; and it made me very nervous about the people. They have filthy habits, and they used to catch hold of your things, and I did not like to eat them, if I did not think they were clean, and I often went without. A nurse came to me one day after I had been there a little time, and said, "Come on, if you see me mix the egg and milk, will you take it?" I said, "Yes, I will." I was really awfully hungry. I went in, she mixed some good milk and two eggs. I took it and drank the whole of it. That should be sufficient. They should feed me and let me see a little of the food. If I gained confidence, I would have gone on, instead of which the same thing happened; I did not complain, and I simply went without. I was taken one day up into a bathroom, and the doctor—D., I think, was the name of the head doctor—it was his son; he was a man who could not get any practice outside, he had a bad reputation—he was the man; he came in; and they took me before I knew; they caught hold of me and put me in a great chair with wooden arms like that, bound my hands down, and I saw my veins starting out, and I was kept in the chair like that. He came in, took a tube, put it into some bath water that had been left by somebody; I had a horror of these people; it was dropped in, and then he tried to wrench my mouth open. I had exceptionally good teeth; he broke my teeth and he could not get my mouth open. Then he took a smaller tube and fed me through my nostril. That was not only once, it was twice.

20,605. If you had said, "I am quite willing to take the food," would not that have been an end of the trouble?—The second time I knew what they were going to do. I saw the nurse put the drugs in the food. I went on my knees, and I said, "Give it to me." They said, "You are too late, you cannot have it," then I tried to knock it over; of course, that is "violence," you see. I did my best to knock over this food they had prepared, and I would have done it if I could. Those things should not happen. I read about Mrs. P. They put the most tempting things before her, and when she had knocked it over she had another lot given her, and then they went on a long time before they forcibly fed her, because it is so very dangerous to forcibly feed a person. Three times would be enough to kill them, I saw in one article. I thought to myself, "I have never done any wrong; I am sure I do not know why I am having all these things." I cannot, of course, forget it. I could not have lived if I had always thought about it, but you do not forget those things, you know. Now, another thing. At W. Dr. S. was a nice gentleman, but when I got there I learned a great deal about asylums, and I said so at once when they were examining me. First of all, they strip you there, and all sorts of things, and I had some bruises on me through helping a nurse that a patient had attacked. I told them that it was not any ill-treatment; but I said to him, "I should like some work to do." I had always asked for it; I said, "Give me some work; I cannot live doing nothing; let me do something." "What sort of work?" they said. Dr. G. was quite a good friend, but he turned round and said, "What work?" I said, "There is a lot of snow outside. Can I go and clear it up?" So later on, to my astonishment, I was told the matron had said I might; a nurse was to come with me, and we had two little coal shovels, and it was really quite deep, a very deep fall, it was in Yorkshire, and I said, "It is playing the fool; I cannot get the snow up with that." However, I said, "I will have a try," and I went out. I had not worked for so long that my heart seemed to beat a lot, and I thought I was out to kill myself, but it was better to die outside in the open than to die inside. We went on, and we cleared quite a nice place. She said to me, "You be ganger to-night, and I will do what you order." She made it as nice as she could. That

girl left because she could not put up with things. She began by ill-treating the people, and I told her she must not do it, and she said, "Why not; they have no feelings?" I said, "What do you mean? They feel more than we do; they are all nerves; they forget it the moment after." She said, "They tell me they have no feelings." I saw her afterwards again, and I said, "Just think if your mother came into an asylum; you love your mother," and she said, "I will never ill-treat a person again." That girl got into trouble for not kicking a patient. She came to me and said, "You have got me into a good row." I said, "I have not seen you for days," and she said, "I was told I must kick the patients, and I will not," and she said, "Somebody has broken the door because I did not kick her." I can give you the name of that nurse; she is out of the asylum now. They were quite fond of me. The doctors do not know; they have no idea what goes on.

20,606. Have you any other suggestions to make to us?—Another thing I want to say is, that I think that if the doctors do promise to do a thing, they should do it. When I went to W. I asked if I might have an interview, and the doctor said, Yes. He never came, and I asked him the next time he came round; it went on for three months, so I thought, "I will not give him any more chances. When the committee come the next time I will speak to them." So I had the courage, when they came round, to speak to them. They came right in, and I said, "May I speak to you?" The chairman said, "Certainly." I said, "I should like an interview with someone; I have asked the doctor, and I have never got one." I forgot the man's name, but he said, Yes, he would come one day; he could not see me then. Dr. S. then stepped forward and said, "Oh, Mrs. G., would you not like an interview with me better?" so I said, "Yes, Dr. S., I have asked you for it, if you will let me speak to you," and he said he would, so he said, "The next day," but he never came. I should think it was quite three weeks afterwards before I caught him again. Then he opened the door, and he stood in a passage against the window, and he said, "What is it?" There was a cup in the window, and he said, "Is this the place where they keep cups?" and I said, "I have something very serious to talk to you about." I said, "Why am I in an asylum?" He said, "It is very nice; you have a piano and other amusements." I said, "Will you listen to what I have to say?" He said, "You would have things outside that were not so pleasant." I got no more out of him than that. Those are the things, I think, that should be altered. You should have some means of getting at someone. At S. I tried to speak to the committee. I found that they came on a certain day, and people went to see them, and I asked the matron if I could see them, and the matron said, "Certainly, Mrs. G." I never saw them; they came and they went. The next day I said to the matron, "I did not see the committee, although you promised." She said, "Oh, no, they said they preferred not to see you." These are the only chances you are given that you can possibly get out by.

20,607. *Chairman:* Well, we are obliged to you for what you have told us. Is there any other specific instance beyond these general charges?—I do think there is one nurse to speak about, that was a Nurse M. Other people wore my nightdress and made it dirty, or someone had gone with her dirty, filthy hands and wiped them on my sheets, and I felt I could not get into the bed. One night I had seen this going on, and I could not put my nightdress on. The nurse said I was to put it on. I said, "Let me get into bed without a nightdress." "Oh, no, you cannot," she said, so I sat up without a nightdress, and the matron came in at that time and she said, "Oh, give her a blanket," but when I struggled, they took it away. Another thing is this—it is rather horrible, but they only allow you to go to the lavatory in a crowd; and it is filthy

21 October, 1925.]

Mrs. G.

[Continued.]

dirty, and they do not allow you to pull the plug. These people used to pass all sorts of horribleness out of them. I always used to try to avoid using it then; sometimes I could sneak in by some chance, but there was a commode in this place in the bedroom, and I used to try to use that. It is not a great crime, but, of course, that required emptying; I have often been sent to empty it myself, the patients do it, but I used to try. One night I tried to get out of bed, and this girl tried to keep me in bed. She said she would keep me in bed, and, in order to keep me in bed, she got the underclothing of one of the filthiest patients in that place, and she put the filthiest part of those combinations, which were as filthy as a woman's combinations can be, and tied it round my mouth. You can imagine after that the horror of the thing. Also, I did not know if this woman was diseased or not. Then she took the chamber and put it on my head, and it trickled down into my mouth, and she held my hands so that I could not wipe the trickles that came down my face. I told my lawyer when I came out, and he said, "Get hold of the woman; get evidence of this." I said, "Surely I can bring her up for assault." He said, "Try and get hold of her." I got that girl, and I got her up to London. Now, when she was asked, (she has no shame at all), "Why did you do those things?" she said, "There was no other way of managing you."

20,608. When was this, and at which institution? --At S. You were put into dirty beds.

20,609. That must have been at least 16 or 17 years ago?—Yes. I daresay it is; it does not alter it having happened though.

20,610. But the same sort of thing may not be going on now?—That I cannot say; the same managing people are there, the same matron and the same doctor.

20,611. Did you complain to anybody of this incident?—No, not at the time; you have no chance of complaining. I did complain once to the doctor. I had been put on to that very commode I talk of which was absolutely full, and I knew one or two of those people were diseased people. I would not sit down on it, and I was shoved into it, and I thought "Here of course I must get disease," and when I saw the doctor, I said, "Will you tell me what to do? Such a horrible thing has happened. I have been pushed into that commode, which is full of filthiness." He said, "I will tell you what to do; it is easy enough. Take one little cup of tea," so I thought it a curious thing. He said, "That is all you require to do, drink a little cup of tea." This is said because you are supposed to be a lunatic when you talk about these things. I went to the nurses, and asked, "Did you ever hear of such a thing?" I told the nurses about it. It was a thing I never told my brothers; I could not have mentioned it to them. Now there is one big suggestion which seems to me might alter some of these things. Of course, your letters are not delivered to the doctors. You cannot speak to them without writing letters, and they do not get the letters. Dr. G. has told me he never got the letters. I think that, without seeing what anyone is like or how they are, everyone should be supplied with a book they could write in. It could not hurt anyone if they wrote the most utter nonsense, but they might be told, "The nurses cannot see that book; that book is yours; they may not take it from you, and you may put it in a postbox once a week or something." That I think would be a great help to the doctors. They would see how patients were improving. If you had this book you could make these statements to them. If the majority of people who had some sense in the ward all reported the same thing, they would know what was going on. For instance, there was a person who died afterwards. She was so brutally knocked about that I had to get out and help the nurse. I have written about these things, but you get nothing back.

20,612. *Sir David Drummond*: With regard to the five institutions you were in. Mrs. G., was there any one of them better conducted than the others?—At C. I did not see people cruelly treated, neither at N.; the nurses were kind to the people. I had that forcible feeding, which was horrible for me, but I think they were quite good to the patients. At C. they were much better than at S., but certainly there they were knocked about very badly; but Dr. M.'s institution is as good as anything could be; it is quite all right.

20,613. *Chairman*: I am afraid, Mrs. G., our next witness is waiting for us now, and we require to finish his evidence this afternoon?—I have a great many more things I could say, because I feel you will listen to this. You take no names of anybody. I am being heard as a lunatic because I have been in an asylum, and you are not going to take any evidence except possibly ask the doctors. They will say it never happened; of course they will. If I could give you the names of people who are out, you could go to them, and you would find that what I have said is all true, but evidence given with no proof is as good as evidence not given at all; it is no good. No Court of Justice would take evidence of a person being killed and not take any other evidence to show it was true. I have seen people who have died from the treatment they have had. Evidence given like this, well, it is just the best I am allowed to do. Later on, when I saw a patient being brutally knocked about, I thought, "Now I can do it; I have my diary with me in bed." As she called out, I wrote down the things that happened, and I sent it away at once. I said, "You will believe me now, because you can find her in the sick room brutally knocked about; therefore you will no longer tell me these things do not happen." I heard nothing. About three weeks after, I was called out from dinner, I was told somebody wanted to speak to me. It was Dr. B., and he said, "I have come. You complain of the food." I said, "Yes, I do." I said, "I have come out from dinner; go in yourself and see what stuff it is." He said he had seen a delicious leg of mutton. I do not know who ate the leg of mutton—the nurses, possibly. Then I said, "Will you allow me to fetch my diary, because I have the date, and that will be better for you," and he said, "Certainly." I said, "May I speak to you about it?", and I said, "I should like Dr. G. to be in the room; I would prefer a witness, because I find if you speak to one person it is no evidence at all." So he said, "Certainly," and Dr. G. was there, and Dr. T. I went away, and when I came back he said, "Oh, I am very sorry, I hear the train is just going, goodbye. I cannot say any more." Now that man was sent down by the Lord Chancellor to enquire into this complaint I had made. Those things should be altered.

20,614. We had a witness yesterday, called Miss H.?—Yes.

20,615. When did you first meet her?—She was a baby when I first saw her, her mother was my servant, and her father was my servant; and, of course, I did not see her for a good many years because I was locked up.

20,616. Did you suggest to her that she might take up mental nursing?—In a way I did; I thought it would be a good thing; I had often spoken to her and said it would be a good thing. In fact, I wrote to my brother and suggested that my niece should come and be a nurse.

20,617. But if you had these distressing experiences in these institutions and found the nurses there were so undesirable, why did you recommend this young woman to go in for it?—Because I think the people who are good should go. I would offer myself.

20,618. Were you disappointed when you found she only stayed a month?—I do not really know how long it was. She could not stay.

20,619. Did you see her after she came out?—Yes; I saw her while she was there.

21 October, 1925.]

Mrs. G.

[Continued.]

20,620. *Earl Russell*: Why do you say she could not stay?—Because the nurses were so horrible she said; they were cruel to the patients, and their language was the most terrible. The patients, of course, you have to listen to. I did say to Dr. S. once, "I think it must be worse on the female side; they must be worse than the men." He said, "That is quite right, they are much worse."

20,621. That is not the reason she gave us for not stopping?—She left because her mother was ill.

Chairman: We must now take our next witness, Mrs. G.

Witness: There are many more things I could say. As I say it is worthless evidence if no proof is taken of it, and I have spent much of my life in helping many nurses who would be willing to come and speak. One has written to me and said, "I hope good will result," and Dr. M. has said the same thing to me. You are doing quite rightly to try and get these things known, but they are not known if there is no evidence taken. It is no evidence to go and ask the doctors; they never see it, and they always say

it does not happen. My brothers were the same, they could not believe it, so I was supposed to be insane; so will anyone be who dares to speak about it. You would not want to see my certificates, I suppose? Directly I came out I went to the Red Cross people, and after that I took up massage and midwifery. I passed examinations and got honours. Dr. M. came to me and said, "Take my advice, do not go to see anyone; your having an outside opinion will harm you irretrievably." "Well," I said, "I have to think for myself; I will have to go." This thing was called trial by inquisition; I simply went and consulted Sir G. S., who believed me. He said, "I think I should write a book." I did not get much chance of doing that, but I believe you have seen the book I wrote; everything in it is absolutely true. I have kept my conscience clear all the time, and have tried not to be spoilt. My brother said, "Do not do it; you have the whole world against you." I said, "If I have, I have truth as my friend." I could tell you much more only it is, perhaps, no good.

Chairman: Thank you. We are much obliged.

(The Witness withdrew.)

Mr. Y., called and examined.

20,622. *Chairman*: You are Mr. Y.?—Yes.

20,623. I think you had the misfortune at one time to be a patient from August, 1899, to March, 1901, but that is a long time ago?—Yes.

20,624. And you have been engaged in your ordinary work, I suppose, since then?—Yes.

20,625. You have taken an interest, I understand, in the question of the reform of the Lunacy laws?—Yes.

20,626. And there is a league, I see, called the Ex-Patients' Asylum Reform League—is that associated with you?—Yes, at P.—really P. only. We formed it amongst ourselves.

20,627. How many members have you?—We have about 30 interested in it.

20,628. You have furnished us with a long statement, which I have seen; and I think this afternoon, in the time available, the most convenient course would be if you would emphasise any special reforms which you have in mind?—I think I have emphasised that at the end of that declaration that we made, that was signed by five of us. I think you have received that, have you not?

20,629. We offered you the opportunity this afternoon of supplementing orally the *précis* which you have furnished in writing. I understood you wanted to give evidence before us, and we are giving you the opportunity this afternoon of telling us anything you wish to say in addition to what you have written. Have you anything to tell us?—I should like to emphasise that I think there ought to be a supervision over asylums outside of the Lunacy authorities, and I think that is one of the most important things. I mean to say from my own experience, the medical superintendent who is responsible for perhaps a large area and a big number of patients, we will say up to 1,500, is guarantor to the British public and ratepayers that everyone under him is treated properly. He cannot possibly see over a square mile of area and know what is going on; he cannot see through a brick wall. The only man he has under him to refer any matter to is the chief attendant. The chief attendant as a rule is drawn from the ranks of the attendants.

20,630. But that is a point we have heard a good deal about, namely, that some of the institutions just now are too large to be capably administered?—Quite so.

20,631. Then another point that has been put to us, and a good deal emphasised, is that it is undesirable that the medical superintendent should also have administrative matters to look to. These are matters we have had, of course, put very fully before us?—I know, but I wanted to point out that

he has only one man to depend upon, and that is the chief attendant, and the chief attendant as a rule is drawn from the ranks, from the attendants.

20,632. A promoted attendant, I suppose?—Yes, he is a promoted attendant. I have known many instances of certain attendants who have been promoted that I should be very sorry to be under, and consequently he is merely a buffer. Nothing gets to the medical superintendent unless he allows it to.

20,633. What is your suggestion—that somebody from outside should be brought in as a chief attendant?—Yes, or that the medical superintendent should have his own "scuds" in the building. It is a railway word; they travel in railway carriages to see what is going on.

20,634. Now you have compiled a list, Mr. Y. which has reached my hands, called "The Red List of Cruelties Witnessed."—Quite so.

20,635. I have read it through. Do you say that you saw all these things yourself?—Certainly, and I am prepared to make an affidavit on it, and another man also.

20,636. *Earl Russell*: You say you have endured every one of them yourself, except No. 3?—Except No. 3.

20,637. *Chairman*: As I say, it is a matter of 24 years ago since you returned to ordinary life?—Yes.

20,638. Do you suggest that these things are still occurring?—Yes, I do, and I have had proof, very strong proof, only lately; I understand that matters are absolutely unchanged. We have got pretty good knowledge of what is going on.

20,639. Where do you get your knowledge from?—I get it from certain sources. I do not want to disclose them, but I will tell you what they are. I get a lot of knowledge from attendants (I have talked to a great number of attendants), and from patients, too. I was only talking to a recovering patient (he was out a fortnight after I visited him) two months ago, and I was in the ward with him, and he said, "You see that attendant walking down there." I said, "Yes, you do not want to tell me anything about it, I can see it in your face." He said, "He is the most brutal man. He knocks the patients about unmercifully." He said, "You know nothing," and I said, "No, I say nothing"; and the man was absolutely sane. He came out a fortnight after, recovered; he was in a recovering state when I spoke to him.

20,640. But why not say anything about it?—Why not? You would not make a report a second time. That is just it—that is the way the knowledge does not come through. You make a report to the doctor, and directly the doctor has gone you get four or

21 October, 1925.]

MR. Y.

[Continued.]

five on the top of you, and they make some excuse, and into a single room you go, and they start knocking a man about, and you do not make a second report.

20,641. How does it come about that quite a lot of attendants are dismissed in consequence of reports made about them?—I do not know; there were not many where I was.

20,642. *Mr. Snell*: Why should the attendants tell you some of these things. They are not attendants who themselves practice cruelties, I assume?—No, they are in the minority, they are not strong enough to rebel.

20,643. So that there are good and kind attendants?—Yes; you will see that in my report.

20,644. *Earl Russell*: But the attendants are able to report without being jumped on or put in single rooms, are they not?—Yes, but you very seldom find one attendant give away another one.

20,645. *Chairman*: The majority of the attendants, I suppose, are decent fellows?—No, not the majority, that is not my experience not at the present moment, because, as a rule, an attendant's job is a kind of last dole to a good many when they cannot get work elsewhere. That is a recognised fact.

20,646. Of course, it is not a very attractive job, I am afraid; it is a rather difficult job?—Yes; but still, I say this: I know a man who has been 33 years in the service; he talks to me quite openly. He knows I know everything behind the scenes, and he said, "I can truly say that I have never put my hand on a patient wrongfully." I know that is a fact from his fellow workers, but he said the majority of cases of violence are aggravated. He said, "I could go and take a patient from five who were handling him roughly and he would be perfectly quiet with me." I believe that, because I knew him in the P. asylum.

20,647. Now take the case of an attendant of that sort. He would not, I take it, allow anything wrong to be done in his ward, would he?—Well, sometimes he cannot help it; he cannot have his eyes everywhere. I have seen cruelties going on that nobody else in the ward saw, and perhaps some of the attendants and some of the patients did not see, because they take the patient away up in the side rooms and pay him there, or in the lavatory or the bathroom.

20,648. Are you referring to things you saw yourself in these three institutions, L., E., and P.?—Yes. There was a sharp supervision at P.; P. was not so bad as E.; it is something awful there, there is no supervision there at all. The doctor never came near the ward for three months, Dr. R.

20,649. *Mr. Snell*: Which institution is that?—E. I have seen patients come out every day and keep on asking for him week after week and could not see him, and Dr. L., who was the second in charge, had no power whatever.

20,650. *Chairman*: During the time that you were in these institutions, were you pretty ill?—Well, I do not know what you mean by ill.

20,651. Were you in a disturbed state?—No, I do not think I was.

20,652. Not at all?—No. I had got the same mind as I have got on me now.

20,653. I want to know if you were one of those cases where, in your own view, you should never have been in an asylum at all?—It was the view of a good many who knew me, Sir. I was violent because I was aggravated into violence continually. I would not give in to their violence.

20,654. *Sir David Drummond*: You were wrongfully certified, you maintain?—Yes, I do.

20,655. *Chairman*: Have you seen the certificates on which you were detained?—No, I have never seen the certificates.

20,656. You have a right to see them if you like?—I never have seen them. I had an interview with the Commissioners in Lunacy directly after I was released.

20,657. After you come out you know you are entitled to have copies of the certificate. We have them before us here, and they represent you at the very least as having a very seriously disturbed mentality?—I know; perhaps they were responsible for that apparent state.

20,658. I am really putting that not in order to say anything unpleasant?—I understand.

20,659. But it is rather from the point of view of the reliability of your recollection of what you saw at that time, and distinguishing that from what you have heard since. Of course, you are now entirely re-established, but during the time you were in those institutions I just wonder whether you were really able to appreciate what was going on around you?—I can only throw some light upon that in this way: There is a man within a mile and a half from here, he is an Inspector of Police; he was an attendant at the time I was at E. I went and called on him the other day just after one of the meetings of the Commission, before you went on holiday. I had a chat with him, and we got on to the "Red List," and in fact he told me everything in the "Red List" was true; that he had seen men there strangled out of their life, and I gave him facts alongside these cruelties. We talked about the patients, of their names and that, and he said, "You must have been perfectly sane," because he knew all the patients, and I named their actions. We had a famous patient in this place, a great grandson of W.; he reckoned he ought never to have been there. So do I; he was a very clever man.

20,660. The sort of thing one would like to explore is this: You state that victims are strangled often into a state of unconsciousness?—Yes.

20,661. If a patient is rendered unconscious, it must be obvious to a doctor?—When he has recovered?

20,662. No; while he is unconscious?—I do not see that; they may strangle you unconscious, but they let you go immediately. I have been strangled twice.

20,663. What is the object of doing that?—That is the way they have there of paying out a patient who resists them. That is a common thing; that is nothing; it is done with a stocking.

20,664. Is that only done to a patient who is resisting?—Yes, or one they knocked, out of temper.

20,665. *Sir David Drummond*: What about this "Grand Circle"?—I have seen that done, I saw that done to a poor man.

20,666. With what object?—That is a matter of sport. That occurred during lunch time, when the other attendants were gone to lunch.

20,667. *Chairman*: How often?—I have seen it done twice, and apparently they did not think anything of it at all. I saw it done, and I went in to two men, and I got the best hiding because I drew them on the top of me; they went for me and left the patient because I went for them, and I knew who the attendants were, too. I met one of them not long ago.

20,668. This "Red List" of yours is published now, and you tell us that you saw this occurring twice, over 24 years ago?—Yes.

20,669. I must say that any person reading this would assume that this was something that was happening every day, or commonly happening in asylums. Have you any evidence that that has happened in any asylum recently?—No, not that particular thing, but I have another. I have one here, a very grave case, which only occurred in 1922, and came out in open Court, where a man was killed.

20,670. What is the reference to the case? If it came out in open Court we can get the record?—There is the full case, and there are the two statements made to the police, copies of which I got from the Chief Constable of P.

20,671. You understand we can get all these documents if you will just give me the name of the case?

21 October, 1925.]

MR. Y.

[Continued.]

and the date. (*The document was handed in.*) It is a P. case, in the Coroner's Court, P., February 22nd, 1922, and the death being investigated was that of F.B.; we can get that?—What about the statements made afterwards by men who never came forward in the case?

20,672. That is rather different. Why did they not come forward and give their evidence?—Because they were afraid to. This man was under observation. He made that statement before the police, and there is another one made by the attendant.

20,673. We can look at those along with the report?—I will lend you these if you like.

20,674. Thank you. All I suggest is that, if that particular form of cruelty to which you refer, the third in that list, occurred twice in your experience, over 24 years ago, I think you should be careful about suggesting that that is happening at the present day, unless you know?—Well, I did not say it was.

20,675. When I read this, I got the impression from it that this is one of the things that is happening?—It would not surprise me if it is. I know of no cure.

20,676. *Earl Russell*: You know one of the statements about you says that you did not speak for weeks in the asylum—is that true?—Longer than that, because it is no good speaking at all there. Their only language was force, that is all. They never told you anything.

Chairman: On the other hand, the certificate says he repeated the same things over and over again.

Earl Russell: Yes, but that is a different date, I think?

20,677. *Chairman*: Yes. Now, Mr. Y., is there anything else you would like to bring before us in supplement of what you have written to us? Now is your chance, if I may say so?—It all depends; it is such a huge subject to take up.

20,678. It is. We have had a great deal of evidence on all sides and all aspects of the question, and we really acceded to your request in order that you might have an opportunity of telling us anything that you wanted to?—We have not thrashed this point out. I used to talk to the doctor. I was a personal friend, and I used to talk on psychology with him. He knew I was out for reform, and that was the one thing I used to put before him, and that is, the lack of supervision. He said, "I try to make surprise visits." Directly he goes out of his office, there is a tap on the window, and it is known he has gone on his round; and the same with the chief attendant; and therefore the patients are absolutely under the jailers, the attendants. Personally, I never got any help at all. If I had not been able to fight, I should have been in the grave long ago. I had no help from anybody.

20,679. I think we quite understand that point; you made that point quite clear. Is there any other

matter which you wish to emphasise?—Do you mean with the administration of the asylum inside?

20,680. As I say, it is anything you wish to put before us?—I think in the matter of drugs and detention in cells, that is sometimes done merely out of punishment. I do not think that a patient, although he may misbehave himself, ought to be punished for that, but they are; shoved away in a cell and kept there. I will give you an instance. I was standing in the airing court at E., and Dr. R. drove past (there were only wire railings round the court) in his carriage, and there was a patient near me, and as he came past, he started to curse and swear at the doctor because he kept him there. Now this man was sane; he was an actor named D., and that doctor stopped the carriage, and he pulled down the window, he called two attendants and he said, "Take that man in." They put the arm-lock on, and took him into the ward, put him in a single room, pulled the shutter down and locked the door. They kept him there for over three weeks, which I can swear to, and I believe I could bring a witness to that act.

20,681. Was that also when you were there yourself?—Yes. Now I believe I could bring a witness to that. He was put there for swearing, and every time they opened the door, of course the man swore more, so they locked him up more and more.

20,682. How did he get out at the end of the three weeks?—They let him out after a time, and he was told if he did not keep quiet they would put him on short rations.

20,683. *Earl Russell*: Is this the kind of seclusion which would be booked as "seclusion"?—I do not know, Sir. All I know was that it occurred.

20,684. Was the key turned in the door?—Yes; he was locked in there.

20,685. Then it would be booked as "seclusion"?—Yes.

Chairman: I do not know whether that rule was in operation then.

Earl Russell: It is true it is a long time ago.

20,686. *Mr. Micklem*: You do not complain of the medical superintendents themselves in any sense, do you?—Yes, I do, especially in that instance. Of course, Dr. R. was a very callous man, and he was known by the attendants as such. He died mad.

20,687. *Chairman*: Well, I think, Mr. Y., if you are content to leave the matter in our hands with the written *précis* you have given us, and what you have told us this afternoon, it only remains for us to thank you for coming, if there is nothing else you wish to add specially?—No, I only hope that something will be done.

20,688. I can assure you we are paying special attention to all the points?—Yes, I will leave this with your Secretary.

Chairman: If you please.

(*The Witness withdrew.*)

(*Adjourned.*)

1, WHITEHALL GARDENS,
LONDON, S.W.1.

FORTIETH DAY.

Tuesday, 10th November, 1925,

MEMBERS PRESENT:

THE RIGHT HON. H. P. MACMILLAN, K.C. (*Chairman.*)

THE EARL RUSSELL.

SIR HUMPHRY ROLLESTON, BART., K.C.B., M.D

SIR ERNEST HILEY, K.B.E.

MR. W. A. JOWITT, K.C.

MR. N. MICKLEM, K.C.

MR. H. SNELL, M.P.

MRS. C. J. MATHEW.

MISS MADELEINE SYMONS.

MR. P. BARTER (*Secretary*).

MR. W. FAIRLEY (*Assistant Secretary*).

Sir MAURICE CRAIG, C.B.E., M.D., F.R.C.P., called and examined.

20,689. *Chairman*: This morning our first witness is Sir Maurice Craig. (*To the Witness*): You are a Doctor of Medicine, Cambridge, and a Fellow of the Royal College of Physicians, London?—Yes.

20,690. And you are at present Physician for and Lecturer in Psychological Medicine at Guy's Hospital?—Yes.

20,691. You are also Honorary Consulting Neurologist to the Ministry of Pensions?—Yes.

20,692. You have been Advisor in Psychological Medicine to the Ministry of Health, Examiner in Psychological Medicine to the University of Cambridge, and Examiner in Mental Diseases at the London University?—Yes.

20,693. And I think you have had practical asylum experience as Assistant Physician for 15 years in the Bethlem Royal Hospital?—Yes.

20,694. And for one year you were Assistant Medical Officer at the West Riding Mental Hospital, Wakefield?—Yes.

20,695. And since you left actual asylum practice you have been a consultant for 18 years, I understand?—Yes.

20,696. And you are Chairman of the Medical Committee of the Cassel Hospital for Functional Nervous Disorders at Penshurst, Kent, and as we all know, you have written extensively upon the subject upon which you are to give evidence here this morning?—Yes.

20,697. We have had the advantage of reading the *précis* of the evidence with which you propose to favour us, and it has occurred to me on a perusal of it that you have very carefully expressed your considered opinions on the matters in question in this *précis*. I think it would be a convenient course on this occasion if we were to start this morning by your reading your *précis* through to us. It is not long, and it is manifestly so carefully considered a document that we should like to have the actual words of it upon our note, so perhaps you would be good enough

to read it to us?—The Lunacy Acts of 1890-91 were intended, *inter alia*, to protect the liberty of the subject, but in practice they have interfered with the liberty of many mentally sick persons who were capable of properly using their liberty. Throughout the Acts emphasis is laid upon the legal aspect and the medical treatment of the patient takes a secondary place instead of being the primary object. No branch of medicine has been so trammelled by legal enactments as psychological medicine and as a result its progress has been slow and many medical men are shy of taking it up.

In the certification of persons of unsound mind an obligation has been placed upon medical men by the legislature which in fact has nothing to do with medicine, indeed certification is an embarrassment to medical science, for it embarrasses the relationship of physician to patient, and in my opinion, is responsible for much recoverable mental disorder being permitted to become chronic before suitable treatment is started. Mental disorder in many instances is of slow development, and the patient is fully conscious that his mental faculties are failing and, as a result, he fears that he may become insane or be regarded as insane, and in consequence he fears being certified as insane, whereas, if he can be reassured on this point, he is usually willing to be treated. The definition of insanity in the present Lunacy Acts is a deterrent to treatment, and it frightens a large number of conscientious persons from undertaking the care of early cases. Although I am fully aware of the importance of proper supervision by a central authority being accorded to insane persons, it must not be forgotten that certification, in addition to acting as a deterrent to treatment, brings into the life of those who have been subjected to it the burden of a feeling that they are in some way different from their fellowmen, and from this feeling they may never be able to free themselves even when restored to health. With some it leaves a dominant belief that an injustice has

10 November, 1925.]

Sir MAURICE CRAIG, C.B.E., M.D., F.R.C.P.

[Continued.]

been done and that it is their duty to challenge, and if possible, correct this wrong. It is a matter for note that all actions by patients, who have been regarded as mentally unsound, against medical men and others have been taken by those who have been certified and placed under legal protection and, so far as I am aware, it is unknown for a patient to take action against a medical man for *mala praxis* or improper treatment when no such certificate has been signed; and yet in these circumstances the medical man is entirely without the protection against his patient that he would have had if he had treated him under the Lunacy Acts. In this country it is common experience to have in hospitals or infirmaries persons whose minds are unsound either from old age or disease, delirious or comatose individuals, and yet they would not appear to be improperly treated nor to suffer any harm, and those who recover do so without any sense of resentment.

To turn to the consideration of the position of the medical man. Certification is a legal matter, and yet a medical man is directed to carry it out and thus become responsible in law for a medical statement, which by statute becomes a legal instrument and which can subsequently be challenged by the person against whom it is made and by whom it can be taken before a legal tribunal, attached to which there are no medical assessors. It is not a matter for surprise that medical men in increasing numbers are refusing to sign certificates for recent cases of insanity on the ground that they do not understand what legal insanity means.

Experience has taught me that the harm done by certifying patients in the early stages of insanity far outweighs any advantages. Do away with such certification and the whole outlook of psychological medicine will be changed, for it will then for the first time come into line with the treatment of physical disease. Patients whose treatment must be considered may for convenience be divided into three groups:

- (1) The willing or co-operative patients;
- (2) The passive or non-volitional patients who cannot or do not express their wishes;
- (3) The unwilling patients who demand their freedom.

If certification is abolished,* I am of opinion that the first, which is already by no means a small group, will steadily increase as patients find that to seek treatment does not endanger their liberty. Provision for the treatment of these persons should be made in general hospitals or in special hospitals or clinics which are separate from and not in the grounds of mental hospitals where certified patients are taken. The study of mental disorder has proved how important it is for the patients who are suffering from it to be within reach of all those departments which are of such value in the treatment of physical disease. Much mental disorder is due to mental re-actions to the toxins or bacteria or other poisons, or to disturbances of the various systems of the body. Indeed the closer treatment of mental disorder keeps to that of physical disease, the more favourable will be the results. The greater difficulty will be met when the patient's behaviour makes it impossible for him to reside in an ordinary hospital, and for this reason special hospitals of the type of the Maudsley Hospital will be necessary. The non-volitional patient should be granted the same freedom from certification at any rate for such reasonable time as to permit of his recovery. Neither group 1 nor 2 calls for enforced detention against the patient's wishes.

As regards supervision or notification, it would seem quite unnecessary to have any routine personal supervision by a central authority for groups 1 and 2 if treatment were carried out in a public institution with a recognised committee. On the other hand,

if public funds were used (and I am of opinion that the local authorities should be instructed to devote money to this purpose), the right of general supervision would go with it.

With regard to the "unwilling" group, although from the medical standpoint it is unfortunate that these persons should be penalised as the result of their hostile attitude, nevertheless I appreciate the difficulty of enforced detention without some form of notification or certification. As it is so important both for the treatment of the patients belonging to groups 1 and 2 and for the education of the public into a proper understanding of mental disorders and their treatment that these groups should be treated in hospitals where enforced detention does not exist, therefore it will be necessary to exclude the third group from this class of hospital. Consequently the "unwilling" patient will have to continue to be treated in mental hospitals under some form of provisional notification or certification.

I am in agreement that all borough or county mental hospitals should be permitted to take voluntary patients; and further I am of opinion that, until such time as fresh accommodation is found, the non-volitional group should be admissible to these institutions without certification.

In licensed houses the "willing" group should be able to go for treatment on their own written request without having to apply to the central authority for permission; and legislation should be enacted to permit of the treatment of non-volitional cases on notification only and the "unwilling" group by some form of provisional certification.

With regard to the treatment of patients who can pay, it is appreciated that public funds will not be available for this class, and as the majority of patients and their friends will object to the registered mental hospitals and licensed houses on the grounds that the patient will have to associate with the chronically insane and those who are forcibly detained, and as the beds available in these hospitals are far too few in number for those who will seek for treatment, it will be necessary to permit patients belonging to groups 1 and 2 to go to nursing homes or the houses of medical men. I know that there is a body of opinion that private persons should not be permitted to take and treat patients suffering from mental disorder for gain, but here I am in complete disagreement, as experience has proved to me the great value of small well-run homes or institutions or placing a patient in single care. Many patients when given a choice prefer to be treated in this way rather than in a larger hospital. That the persons who administer these homes are as a class untrustworthy is untrue in fact. In every walk of life unreliable persons will be found and, if it is sought to suggest unworthy motives, this imputation could be made about almost every profession or calling in life. I will even go so far as to forecast that, if the legislature were to prohibit private persons from taking and treating mental patients, the public would endeavour to evade the law in every possible way, for I have learnt from over thirty years' experience how much they trust and rely upon this form of treatment. I am of opinion that even in private homes routine personal supervision of patients is highly undesirable in the patients' interests and should be reduced to a minimum. I appreciate that for the non-volitional cases some form of notification will be necessary, but the most satisfactory method would be the registering of all nursing homes and the inspecting of such homes, as opposed to a routine inspection of the patients.

I am aware that there is a diversity of opinion as to who should be the central authority responsible for supervising patients in the early stages of mental disorder. For many years I felt with others that the Board of Control were too much steeped in the traditional treatment of mental disorder and that it might be difficult for them to free themselves from

* See Q. 20886.

10 November, 1925.]

Sir MAURICE CRAIG, C.B.E., M.D., F.R.C.P.

[Continued.]

this outlook, and in consequence I feared that it might in practice be difficult to have this body visiting patients who were not insane. But it has been impossible to watch the work of the Board of Control during recent years without appreciating how much they have taken up the more modern views of psychological medicine, indeed they have shown such power of adapting their functions to the medical outlook that I am now of opinion that this body is fitted to undertake the supervision of all mental patients including those in the early stages of illness. Like physicians and others whose work has been in this department of medicine, they have learnt much by experience and this must be of value when methods are being remodelled. I am, however, of opinion that the medical side of the Board should be strengthened, as any ordinary visitation of patients of the "willing" and non-volitional types should be entirely medical.

Out-patient clinics for patients suffering from mental disorders should be available at all hospitals and I am of opinion that the system that exists at Guy's Hospital is the best, for here there is one Neurological Department and all patients, whatever their nervous complaint, attend there. Where no hospital is available, a special clinic for these patients should be established.

20,698. We are much obliged to you, Sir Maurice, for that very careful survey of the whole position in its larger aspects. I think we might usefully employ a little time with you this morning in following out some of your ideas in a little more detail. As you will appreciate, we are desirous of investigating first of all the defects, if any, in the existing system, and secondly the remedies which should be proposed to Parliament for those defects. Manifestly your conception of the future of this branch of medicine would involve, would it not, a very considerable alteration of the existing system?—Yes, so far as releasing the medical people to do the work is concerned. The great difficulty at the present time is that so many of the better type of medical men are a little shy of entering this field, because of the legal difficulties in the work itself.

20,699. You appreciate, of course, that this particular branch of medicine is one which is necessarily brought in contact with the sister profession of the law?—Yes, and quite properly so, I think.

20,700. And that the problem, again stating it in its larger aspect, is the accommodation of the medical man's desire to cure his patient with the legal man's desire to protect the liberty of the subject. One cannot put it more broadly than that?—Quite.

20,701. I suppose from a medical point of view one may say that there is really no distinction in principle between what is commonly called mental disease and physical disease?—None at all; that is a fundamental point at the present time, and it is getting forced upon one more and more.

20,702. Again, however, has one not to recognise that while from the medical point of view there is no distinction, from the social or legal point of view the particular kind of ailment which we call mental disease entails, necessarily, measures which are not entailed in the treatment of ordinary disease—I mean measures of restraint?—That is so; where you have got a delirium or a confused state of mind you require certain protection of the individual during that period of time.

20,703. You have referred in your evidence to the class of case where a delirium is a symptom or concomitant of some quite well-recognised physical disease, such as pneumonia or uræmia and other instances?—If I might, I would put it even more strongly, that some persons react on the physical side to any stress or poison; another highly sensitive type of person will react on the mental side; so that with the same stress or condition you will find one becoming mentally disturbed and the other physically disturbed.

20,704. Now as regards the type of case where delirium is a symptom or concomitant of some well-known or recognised ailment, that must happen, I suppose, quite frequently in hospital practice?—Very frequently.

20,705. *Sir Humphry Rolleston*: Is it not very largely a question of the period of restraint? If we have an acute case of pneumonia, and a person wishes to throw himself out of the window, we restrain him; but when you are dealing with a chronic condition like that, then one does not take the power into one's own hands. It is very difficult to restrain a person for months or years. Is not that where the difficulty comes in?—Not in the case of a physical illness; but because of some acute phase in that illness, the law is against us. For instance, I have seen a case where a man has dined on mushrooms the night before, and for some weeks it has been necessary to restrain him from going out of the window or injuring himself or other people, but in law there are difficulties, because the person is of unsound mind; whereas in hospital, if he has got pneumonia he is regarded as suffering from pneumonia and the mental side is a secondary thing; and really the mental side is secondary in the other toxic condition, but it is not so recognised in law.

20,706. *Chairman*: We were rather surprised to hear that in practice, in workhouse infirmaries, it is apparently not infrequent for a patient who has developed these transient symptoms of insanity to be sent to the mental side and possibly certified; whereas I gather from you that if the patient had been in an ordinary general hospital the mental disturbance would be treated simply as an element in his disease, and a certain measure of restraint would be imposed without certification?—A greater measure of restraint than in a mental hospital, there might be, in some cases.

20,707. Of course there is a difficulty there, as Sir Humphry is pointing out, that some restraint upon the activities of the patient is imposed against the apparent, though probably pathological, desires of the patient for the time being?—Yes.

20,708. I suppose you will agree it is highly undesirable that in cases of that sort certification should be resorted to?—Most harmful. It may be very, very serious to the person in later life, apart from any sentimental consideration, which is a very important one, too. It is a pure accident that has happened to the person, and the patient is nearly always only too grateful that you have treated him in that way; when the patient recovers his reasoning judgment, he is only too grateful for what you have done for him.

20,709. Do you think, with your experience and practice, that it would be desirable to accord any special protection to medical men in that measure of restraint which they impose upon what I will call ordinary patients, who are showing for the time being mental symptoms, or would you prefer to leave it as it is?—I am speaking for myself when I say that I should never seek protection. After all, if a patient charges you with anything he is only charging you with being human and regarding him in a human light. I am not afraid of that in law. Therefore I do not see that protection is required.

20,710. It occurs to me that while a transitory state of mental disturbance may be associated with certain well-known and defined ailments, such as pneumonia or uræmia, where it is a recognised symptom of the ailment, many of the other transient maniacal states may also be associated with physical disturbance, which you are not able to attribute to some well-known ailment, although it may nevertheless be associated possibly with some unascertained and obscure physical ailment?—Quite. Of course the

10 November, 1925.]

Sir MAURICE CRAIG, C.B.E., M.D., F.R.C.P.

[Continued.]

best example really is delirium tremens, which may last for two or three weeks, and yet, I say, in law, a person would not be expected to certify a man suffering from delirium tremens, because it is too well understood in law. They would say, "This is a transitory condition." It would be improper to place him in an asylum and treat him as insane, though he may be dangerously insane during his illness.

20,711. And it may be, I suppose, that as medical science advances, certain forms of insanity may be found associated as definitely with new diagnosed diseases just as at present certain mental states are associated with pneumonia and uræmia?—That is what we look forward to.

Sir Humphry Rolleston: It is the time factor that seems the difficulty.

20,712. *Chairman*: It does, Sir Humphry. A limited measure of restraint may be one of those things of which the law will not take cognisance?—I quite agree there.

20,713. On the other hand, when the state becomes declared and has some permanency, it is at that stage that difficulty will arise?—That is how I have always worked myself. It has been my attitude towards the law, because the law would not be hostile to my attitude, provided I was doing it reasonably; but if it was for a length of time, then I would be outstepping my right.

21,714. I think the duration of the state would be a most important element, because whenever a person is laid aside with mental ailment for more than a very short time, of course questions of property administration emerge at once. That is one aspect of it?—Quite.

20,715. And further, the question of the continued personal restraint also arises?—Yes.

20,716. Now, following out your conception, I take it that those cases where the temporary insanity is merely a symptom of physical disease would in your view be properly treated in ordinary hospitals?—Yes.

20,717. Where, I suppose, at present they are really treated, for the most part?—Yes, but not in the way they might be, because the hospitals have not got accommodation for them; but one looks forward to the day when there will be a ward in each hospital for them.

20,718. That is the next question I am coming to. Is there any difficulty, in the ward of a general hospital, in dealing with such cases? I can imagine that such cases are often noisy and liable to disturb others?—They generally have them in special rooms.

20,719. In practice there are wards in general hospitals to which such cases can be taken for the time being?—There are one or two such hospitals. At the Middlesex Hospital they have got one; at Guy's they have about three beds where they could take them.

20,720. In a ward where other patients are?—No; a separate ward.

20,721. So that when one of your cases at Guy's develops symptoms of that kind, and consequently the other patients may be disturbed, the particular sufferer is removed?—He is moved into that part of the hospital, yes.

20,722. Do you ever find that such cases become so established in their mental disturbance that you have to resort to certification?—If they are likely to remain so for long, then they would be moved into the infirmary for further observation, where they are allowed another ten days or a fortnight. That is the next step that is generally taken.

20,723. Then the patient who has gone to a general hospital, such as Guy's, has the advantage at present of a period of observation before certification, if certification is necessary?—Yes; quite limited, unfortunately, at the present time.

20,724. *Sir Humphry Rolleston*: That is provided they have got some gross organic cause. I mean, if you cannot detect a gross organic cause they would probably be sent off straight away?—As soon as possible, yes.

20,725. *Chairman*: Now you desire to encourage the view, do you not, Sir Maurice, that mental ailments are, after all, just a branch of general illness?—Yes.

20,726. And you appear to favour the idea of treating such cases as can be treated in general hospitals, either in clinics or wards there?—Yes.

20,727. Would it involve any very large re-organisation of the existing hospital system?—For the in-patients it might, to a certain extent, but for the out-patients, of course, many of them now have their special out-patients clinics. At Guy's I always objected to having a special one for so-called mental cases, and, as I think I noted in the report, the Guy's clinic was instituted as a general neurological clinic to which all patients suffering from gross nervous disease, as well as functional nervous disease, came.

20,728. Now taking a concrete example: Would a person who was feeling mentally unstable and unhappy be entitled to resort to your clinic at Guy's and ask for advice?—Certainly.

20,729. And do you find in practice that many people go there?—Yes, they do. They are not afraid of a general hospital in the same way that they might be of a special hospital.

20,730. Do they recognise that it is a place to which they can go for such advice? I mean, is it recognised that Guy's is a place where people can go who have not got a broken leg or anything of that sort, but just want general advice on their mental condition?—Quite. I think they have three special sessions for these patients. They began with one, and there are now three.

20,731. *Mr. Snell*: Each week, Sir Maurice?—Each week; so it is obviously sought after.

20,732. *Chairman*: Then it apparently is possible to associate clinics, and indeed in-patient treatment of mental disease, in some of its aspects at any rate, with a general hospital?—With great advantage, because you would get them coming for treatment earlier.

20,733. *Mr. Micklem*: Would some of these out-patients be brought into the hospital?—They could be; that is again very limited now, owing to the beds available for that type of case.

20,734. *Chairman*: You would not take in a case of pronounced insanity, which obviously would require prolonged treatment, would you?—No—or personal supervision; the hospital cannot do it, where you require supervision, at the moment.

20,735. It would really be the curable case that you would take in?—The Cassel Hospital is a very good instance of that. In 1918 Sir Frederick Treves asked me to place a scheme before this benefactor of pioneer work, and I said I would give him the dream of my life, which I did, and he told me that I had got the money. Now that hospital has 57 or 58 beds for functional cases, and to-day we always have a waiting list of 40 to 50 patients waiting to come in.

20,736. These are non-certified cases?—Yes.

20,737. Is it a charity?—It is, partially. Most pay five guineas, and there are two wards at three guineas, but that includes everything—all nursing and medical attendance.

20,738. *Mr. Micklem*: Where is that?—At Penshurst in Kent; but that shows how it is sought after, and we follow up the medical cases; that is to say, we publish every year what has happened to patients who were there one, two and three years before, so as to see whether they really did benefit by the treatment, or whether they did not.

20,739. *Chairman*: Where the present system seems to fall short is in the provision for early treatment and in the provision for those cases which are short

10 November, 1925.]

Sir MAURICE CRAIG, C.B.E., M.D., F.R.C.P.

[Continued.]

of certifiable insanity but which nevertheless require care and treatment?—That is so.

20,740. That seems to be where the gap is in the system?—That is so; and the great difficulty is in saying when a person is certifiable and when he is not. I have put this to many legal persons, and they have never given me an answer yet: if a person is sane for so many hours, and insane for so many hours, is he sane or insane in the eyes of the law? It is perfectly open for the medical man to be charged with not having done something, if something happens during the hours that the man is insane, and yet it is most difficult for the medical man to say is he sane or insane in the eyes of the law. I have never got an answer from any legal person as to how a medical man should treat such a patient.

20,741. *Mr. Micklem*: Would not such a person be clearly a person of unsound mind?—Well, the legal people do not say so.

20,742. That seems to be the definition in the Act?—It is, during the insane moments for some hours of the day; but if he was perfectly capable of discussing his position and discussing his profession and his work for the greater part of the day, and if at such a time he was interviewed by a solicitor or by a member of the Board of Control, they would say that person was sane. I have had plenty of instances of it.

20,743. *Chairman*: It is an extraordinarily interesting topic to embark upon, but is not the legal test propounded in the statute rather what one might call an objective test than a subjective test? Is it not certifiable insanity looked at from the point of view of the person's conduct and behaviour, as to whether it is a menace to himself and others or not? You know the terms of the certificate?—I do, but there again the legal answer is, when you are speaking of a person who is very sane during the greater part of the day, if he does abnormal things he is responsible for his acts. I have seen such a case, I have talked to him, he is fully cognisant of everything that is going on in the world, and he must be regarded as responsible.

20,744. Of course we lawyers are familiar with what is known as lucid intervals, but if you have an alternation of lucidity with darkness I can quite see the difficulty of medical diagnosis?—Some of those cases have a mental side, but we should prefer not to treat them as insane, because we should say we hoped to get the clear times lasting longer, and we will try to keep them as pure medical cases. Indeed, one can do it. If you say, "I am not going to treat you as a person of unsound mind. If you will trust me and listen to me I will do my best for you," many of these persons will do so.

20,745. *Sir Humphry Rolleston*: Is any answer of the legal profession to be gathered from the treatment of criminal lunatics in Broadmoor, because they recognise they are not insane all the time?—The epileptic case?

20,746. Yes?—Yes, certainly. It is really a question of fact, I take it, in law; it would be a question of what the condition was.

20,747. *Chairman*: Of course, insanity is not a thing that is susceptible of precise mathematical ascertainment. The border line, as we know, is always difficult to define?—Yes, but it is extraordinarily precise when a medical man makes a certificate, and he is brought up before a tribunal to answer for that certificate, and there is a large amount of evidence brought against him to show how sane the person was on the day the certificate was given.

20,748. *Mr. Snell*: Are there occasions when the alternation between lucidity and darkness occurs during the day, Sir Maurice?—Yes; in the day you may get it.

20,749. And on successive days?—On successive days. I remember one case some years ago which was stated to me—this was one of these difficult cases.

An examination had been held under the Board of Control as to whether the person was properly to remain uncertified. Now from the history I felt that that person was a proper person to remain. When I held my examination I had four other lay persons present during the interview. Now with that patient the Board were good enough to allow him to remain in a nursing home, and that patient did perfectly well. But there was a case very near where the legal side was leaning one way and the medical side was leaning heavily the other; and there are plenty of those cases.

20,750. *Chairman*: Of course the line of demarcation is not possible of exact ascertainment, and I suppose even in your own profession, Sir Maurice, taking a given case, it is quite possible that two experts might quite honestly arrive at different conclusions as to the state of the patient?—Yes, but there are not the same contingencies following and liabilities attached.

20,751. I was thinking rather of the possible definition of insanity?—Quite, but it is the other relationship that comes in and makes the difficulty.

20,752. But if you are looking at it entirely from the medical point of view, there must be many cases with regard to which two medical men of equal competence, having examined a case, would arrive at different conclusions?—Quite.

20,753. These are honest conclusions?—Quite honest conclusions.

20,754. And if there be no improper motive in arriving at the conclusion—which of course I assume when I say an honest opinion—that class of case is very difficult; because, as you say, the person, if certified, might feel aggrieved and might be able to adduce very imposing evidence to the fact that he was quite sane, and yet the doctor must discharge his duty according to the best of his knowledge and belief?—Quite.

20,755. Is that class of case adequately protected now? Is the medical man adequately protected?—I do not think he is, altogether. There is one case in which he is very unprotected, and that is the one in which I myself got into difficulties; that is to say, if you certify a criminal in prison you are unprotected in law. I had an action taken against me which lasted for two and a half days; it was the case of G., a very well known case, in which he was threatening the lives of certain Cabinet Ministers. In that case the medical man is unprotected, but I think a medical man ought to be absolutely protected if he gives an honest opinion, because he is always in this difficulty, that the patient may not absolutely recover; therefore he is left with a person whose judgment is not quite normal, even at the finish.

20,756. *Mr. Micklem*: Does not the Act apply in that case just as much as in any other?—No, not for the criminal. The Law Officers of the Crown decided that I was unprotected; it was not able to be quashed; that is a flaw in the Act, clearly.

20,757. *Chairman*: Of course, it is very undesirable, Sir Maurice, that a doctor concerned with the welfare of his patients should feel himself embarrassed in expressing his candid opinion of the case, by what one may call legal menaces lurking in the background. He ought not to be embarrassed in forming his opinion by the possible legal consequences.—Of course, he is very seriously embarrassed at the moment.

20,758. Properly speaking, as a medical man, he should approach a case without any consideration of the consequences whatever. He should give his opinion to the best of his knowledge and belief, without fear or favour?—Absolutely.

20,759. And if he does that, he ought to be protected, of course?—I think he ought to be protected—provided that he has got nothing else against him.

20,760. I am assuming it is in good faith, and we must rely upon the good faith of the medical man

10 November, 1925.]

Sir MAURICE CRAIG, C.B.E., M.D., F.R.C.P.

[Continued.]

in many walks of life. There is a measure of protection afforded under the statute in such cases, that you can have the proceedings stopped if you can satisfy a Judge that the case is frivolous or that there is no substance in the case. Do not you regard that as sufficient?—Here, of course, I am coming on to a legal question. The question is whether there is not a way out of it now by bringing in the word "conspiracy"—whatever that covers; that is to say, that persons agree together that this ought to be done. Therefore there is a question whether that would be covered by the Lunacy Act as it stands.

20,761. One does want to eliminate from a doctor's mind, when he is addressing himself to his own task, those collateral ideas of the fear of legal consequences?—A very large number will not touch it now. I am constantly being rung up by people who ask what they are to do. I have to say, "I am so sorry I cannot help you." Indeed it is a term in the partnership deeds of some medical men that they shall not certify patients.

20,762. *Mr. Micklem*: I suppose in the case you were referring to, where you gave the certificate, you were not certifying for the purpose of detention in an asylum, but you were certifying for the purpose of protecting this man as a criminal?—No. I was certifying at the time his sentence was ceasing, and he was becoming a civilian. He was still finishing his sentence, but he was passing from the criminal order to the civil order. I should be certifying him as a civilian; he was still under the Home Secretary's Order.

20,763. *Chairman*: I suppose the question was whether he could be safely let out when his sentence expired?—That is so.

20,764. *Mr. Snell*: Would he be detained in the criminal establishment then?—Only for a short time.

20,765. *Chairman*: He is not like a person detained during His Majesty's pleasure. It was a case of a person who had a concurrent sentence, the sentence was about to expire, the prison authorities were in doubt as to the wisdom of letting him out on society; you were called in to advise as to the state of his mind; you advised he was insane and consequently when the sentence expired and he walked out of the prison he stepped into the asylum?—That is so.

20,766. *Mr. Jowitt*: Do you say you were under a legal liability in respect of what you did there, Sir Maurice?—Yes, I could not appeal that I had acted in good faith. I had to take his action against me for what I had done. It came up before Mr. Justice Bailhache and went up to the Court of Appeal.

20,767. *Chairman*: What was the result of the case?—He lost his case; he lost it in the Court of Appeal, too. He produced a typewritten copy of a letter, with regard to which Mr. Justice Bailhache said that if I had written it I ought to be in the mental hospital myself, with which I am in agreement; but that letter was the one upon which the plaintiff based his attack upon me. It was a letter alleged to have been written by me to a doctor regarding the Home Secretary, and indeed the case was adjourned for ten days for him to produce further evidence, over the whole of the Whitsuntide recess, so that he should produce this evidence to prove the truth of the letter, which of course he was unable to do; but certainly that is a point for the Commission. It is a very serious matter for medical men, because of course it was my own ignorance.

20,768. I do not know whether the case is reported. We can get the record of it, anyhow?—Yes.

20,769. *Mr. Jowitt*: About what date, Sir Maurice?—It would be about 1921, I think.

20,770. *Chairman*: We can easily trace it with that reference?—G. himself at the present time is doing three years, I think, for defrauding the Irish Relief; he is in prison just now.

20,771. Now coming back to the main topic of our discussion, is a cardinal drawback of the present system that before you get the benefit of mental

treatment you have first to be so pronouncedly insane that you have got to be certified?—That is so; in fact you have to be a very long way advanced in your illness before treatment is available.

20,772. Of course that is contrary to all the ideas of modern preventive medicine?—It is like saying to a person with phthisis: "Yes, you have got phthisis, but I cannot do anything for you until you have cavities in your lungs and you have hæmorrhage and fever; and then I will look after you for the rest of your life."

20,773. That of course is contrary to all the ideas of modern preventive medicine?—Yes; it is wasteful on the economic side for the country, too.

20,774. Now while there are a large number of cases which are transitory, and where the hope of cure is such as would justify you in treating them in a general hospital, I suppose one must always reckon with a considerable proportion of persons who are incurable, at least so far as science has at present progressed?—Yes. The later that cases are treated, the more that comes in; the earlier they are treated the less.

20,775. We appreciate that, but there must of course always be, must there not, persons whose conduct, owing to their mental instability, renders them unfit for ordinary social life, and who must be detained?—Certainly.

20,776. And they will always be a considerable proportion?—Always.

20,777. But a proportion, I take it, which may diminish with the progress of mental science?—Yes, very markedly so.

20,778. I am thinking of the cures which are effected in general paralysis now, which was previously regarded as incurable; so into that region some ray of hope may enter?—Quite.

20,779. But would you then divide the cases broadly, from your point of view, into those which are susceptible of treatment to early recovery without certification, on the one hand, and on the other hand those cases of established mental instability, so far as you know incurable, for whom provision must be made on a permanent basis in a place where they have to reside as well as be treated?—Quite.

20,780. Of course, the essence of a general hospital is not residence, but treatment. The essence of an asylum is generally regarded as residence rather than treatment; at least, we have heard that criticism?—But you ought to have residence for early cases, so that they are not swamped with the chronic insane. That was part of my early experience, when one saw a person who was ill and was going to be so for three or four months, and yet he was going to be exposed to all the terrible suffering of seeing others so ill.

20,781. I must say nothing has impressed me more, and I think I can say so on behalf of my colleagues also, than the undesirability of a case of mental disturbance in its early stages being exposed to association with violent and unpleasant cases, just at a time when the mind is in its most critical state, and when very little may make the difference between turning to cure or proceeding to certain insanity?—I quite agree.

20,782. How is one to get over that, bearing in mind the resources which are available? One can see ideals, of course; but, accommodating oneself to the means at our disposal, how is one to get over that?—Even in the most old-fashioned type of mental hospital I should have thought it was quite possible to have special portions of the hospital set aside, where patients could be taken, until such time as the country can afford to have clinics and special places for them to be taken to apart from the mental hospitals. It ought to be possible to have that done.

20,783. I suppose one may deal with it under the general head of classification of cases?—Yes; it is done; in many mental hospitals they are very well

10 November, 1925.]

Sir MAURICE CRAIG, O.B.E., M.D., F.R.C.P.

[Continued.]

classified now, but, of course, the difficulty is in the old-fashioned buildings.

20,784. And I suppose one may take it that nothing is worse for a person who is upset than to be put in with a lot of other people who are worse than himself?—A patient is terrified of going insane, in a very large number of cases. It is the most common fear in normal life, and it is very markedly the fear where a person is breaking down, and if they are suddenly put into places of that kind they feel, "Now I am going insane."

20,785. Have not many people a dread of institutional treatment of any kind; even the idea of a general hospital or nursing home is distressing to some people?—Yes.

20,786. You know the type of person who wants to be operated on in his own home, and says, "Do not take me to a hospital or nursing home"?—Yes.

20,787. Even that may have in some cases, depending upon the individual temperament, an unhappy effect, may it not?—Yes, it does, even that. Of course, I always put it to a patient, "Now do not put me in difficulties"—that is to say, if his illness is not of such a nature that you cannot prevent it, but if he has got any will power left—"otherwise I may have to take very serious steps, because I am bound to, in your interest." I always talk to patients and tell them I do not want to do it, and I am not going to do it unless I am absolutely forced to do it.

20,788. But again there is another consideration, because there always seem to be two sides to every one of these topics. It may be exceedingly unfortunate for the family life for the case to remain in the home?—Yes; and for the children, very, very serious, of course.

20,789. Therefore removal to an institution may be very desirable?—It is absolutely necessary sometimes, and you have got to do it because it is so serious for the children.

20,790. And also it has often been the home environment which is the pre-disposing cause, and removal from that environment may alleviate the malady?—Yes, quite; many factors come in there.

20,791. Your view is then, I take it, that certification should be the last resort?—Always the last resort.

20,792. And as regards the expedients which should precede certification, that a system of clinics and, if possible, resident wards attached to the general hospitals should be developed?—Yes.

20,793. What would be the attitude of the administration of the general hospitals to any such recommendation?—The difficulties would be, if there were any great supervision required; that is where the hostility would come in. They will not want the hospital brought under any special legal position that would make them appear to be mental hospitals; that would be one of the difficulties.

20,794. But what if we were to assimilate this branch to the treatment of tuberculosis or to the treatment of venereal diseases?—Then I think it would be excellent.

20,795. If we were to do that, that would entail necessarily a certain amount of supervision, because it would involve the expenditure of public money, as you know?—That supervision is quite understood.

20,796. Would you wish independent institutions to be established, such as we have for tuberculosis and venereal diseases, or would you rather have them in association with existing general hospitals?—I do not think the general hospitals would be sufficient, and they are not always located in the right places, because we want them to be in places where the patients can get out of doors, and such like, because the patients may be ill for some months, so that they want gardens for exercise.

20,797. It is one thing to recommend a new type of institution, with the consequent expenditure of money, and it is another thing to recommend the development of existing hospitals with a view to

treating cases of this type. These are two different ways of going about it. You may take the existing general hospitals and invite them to extend their activities and make provision for this type of case specially, or you may say, "We shall start *de novo* and establish special clinics and special wards for this province of medicine"?—I think you will have ultimately to have both.

20,798. *Mr. Mickle*: Would not the increased expenditure for some hospitals be a very serious factor?—Yes, it might be a very serious factor.

20,799. *Chairman*: Supposing a grant were made? One of the projects in contemplation is that, just as there is a grant from public moneys for the treatment of tuberculosis, so also a grant might be made for the treatment in general hospitals of mental cases. The grant in some cases, as with the Infirmary in Edinburgh, is paid over to the Manager of the Infirmary, and they are willing to undertake the treatment of those cases with, no doubt, certain obligations to report and certain liabilities to inspection and supervision. Would that conform to your ideas?—I think it would be a most helpful way of dealing with a certain number of them.

20,800. Of course at the moment we have a very large number of costly institutions which have grown up under the present system. It is not practical to scrap these and substitute an entirely new type of institution right away?—Quite.

20,801. Do you therefore suggest that some use might be made of those existing institutions in what we might call the transitory period?—Yes, where there are several mental hospitals in a County Council area then one or two hospitals might be allocated for special types of cases.

20,802. Of course the development of your project of treatment would naturally diminish the populations of asylums?—It ought to, greatly, I hope.

20,803. It would be a shifting of that population from the one type of institution to the other?—Of course, the general hospitals could not take it. Even with the best will in the world, and public money, they may not have the ground to build upon and the room to put these cases in.

20,804. *Mr. Jowitt*: Taking the existing institution as they stand to-day, have they bed room to take in this number of cases?—The existing general hospitals?

20,805. Yes?—No, they have not.

20,806. Then it is a question of buildings or new buildings and a question of whether they are built by the existing general hospitals or by anybody else?—That is so.

20,807. *Chairman*: Following out *Mr. Jowitt's* point, we have heard some evidence to this effect, that it is rather desirable to have your mental treatment associated with a general hospital, because you are enabled to lay under contribution all the expert advice which you can get in the same building for the physical states that are associated with the mental instability?—Yes, and the ideal thing would be for the general hospital to be the clearing hospital, so that the cases can be thoroughly investigated and passed on to any of the others, and then you would not block your general hospital with cases which may be there for many months, with no necessary benefit from the hospital itself.

20,808. Of course there are specialised hospitals for the treatment of cancer and epilepsy. Do most of the patients reach those special hospitals after having passed through the general hospitals, or do they go direct to them?—Some go direct to them and some are sent.

20,809. *Sir Humphry Rolleston*: With regard to the question that has been raised as to the relation of general hospitals and mental hospitals, would it not be true that any diminution in the number of inhabitants of the mental hospitals which was due to the general hospitals taking such cases would be met by putting back into the mental hospitals the

10 November, 1925.]

Sir MAURICE CRAIG, C.B.E., M.D., F.R.C.P.

[Continued.]

chronic cases which in many instances had drifted off to the Poor Law institutions?—Quite.

20,810. And those Poor Law institutions, if reformed, could perhaps become a kind of general hospital?—Yes. The point is to make your clinics and your general hospitals clearing hospitals for these early cases.

20,811. *Chairman*: I want to take up one point with you on this aspect of the matter, Sir Maurice. It has been suggested that a type of institution which received only certified cases of the kind we are now contemplating, that is to say, the established cases and the chronic cases, would be so dismal a place, a place where the inhabitants had abandoned all hope, that it might have a very depressing and unhappy effect. It has been put from the other point of view that it is much more encouraging where the population is, in part at least, on the road to recovery, and a certain element of hopefulness arises from that. Is there anything in that?—I have heard that. I am not impressed with it, because after all one has got to do most for those who are breaking down and to prevent it if you can; therefore they must stand first. From the medical standpoint I see it is rather depressing to feel that you are only treating what we speak of as chronic disease. On the other hand, even there it is better to try to get some of those well and throw yourself into saying "They were not chronic, after all." My own feeling is that I do not think that is a strong point, and I should certainly go for segregation of the two separate types in the interests, really, of both.

20,812. And one would assume that the inhabitants of the asylum in the future would be persons who would probably not be susceptible of impressions of that sort?—Yes. A patient gets used to his illness. Emotion dies down after a time.

20,813. Now in a clinic or in the ward of a general hospital would you be able to achieve that classification which you say is so desirable? I mean the prevention of the association of an incipient case with other violent and disturbing cases, which you point out is so unfortunate?—Of course, in a general hospital they could not take the very difficult cases; they would have to have special wards somewhere for those cases.

20,814. What are we to do with those cases, because, as you know, the most violent cases are often the most curable cases?—They would not take them in a general hospital. That is why you may have to have special portions of mental hospitals set apart for dealing with these cases themselves.

20,815. Without certification?—Without certification, yes.

20,816. *Mr. Micklem*: Do you think that the fact of certification is as important from the point of view of the patient as the fact of being sent to an institution and detained there—I mean as regards the stigma?—Certification is the stigma, undoubtedly; that I am certain of, from thirty years' experience.

20,817. Is it not the fact of detention in the institution?—No, it is not that. It is the feeling that "I have been certified." It is the same with the patient who has gone voluntarily to an institution: so long as he has remained voluntarily the whole time, he will not fear anything, but if he has resided in that institution and during his illness it should be decided that he must be certified, then he would be hostile to the new position.

20,818. Supposing he had been simply notified, would notification have the same stigma?—I do not know that it would. I think you will probably have to have some form of notification; I appreciate that.

20,819. *Chairman*: Do you think that from the social point of view the public would be nice to discriminate between the person who was certified and the person who was not certified, or would they simply say, "A.B. has gone to an asylum"?—I think that is ultimately what may come, now.

20,820. On the other hand, no stigma would necessarily be associated with the comment that A.B. had paid a visit to a clinic?—No; that is why, if we could have special institutions, it is so much better.

20,821. *Mr. Micklem*: Take the case of the Maudsley Hospital. If a person has been in a mental hospital for two or three weeks, is there a stigma attached?—No, but Dr. Mapother may be better able to answer that question than myself. I have known persons go there and they do not feel any stigma.

20,822. *Mr. Jowitt*: There you have neither certification nor compulsory detention?—Quite.

20,823. *Chairman*: But you have an institution?—Yes. A person does not mind being treated for a mental or nervous breakdown, but does strongly object to being treated as a person of unsound mind.

20,824. *Mr. Jowitt*: Or as being compulsorily detained?—Or as being compulsorily detained.

20,825. *Chairman*: Deprived of liberty?—Deprived of liberty, that is it.

20,826. Now with regard to the type of case you referred to a moment ago, the violent case but eminently curable case, you say the clinic could deal with that type of case?—Yes.

20,827. *Sir Humphry Rolleston*: From the point of view rather of our profession, supposing in cases of that kind you could largely obviate certification: would not the necessary control which must arise in a sudden emergency, for example in recurrent insanity, expose the medical officer to charges of assault?—It never has done. It is only common assault, after all, even if you detain a person in his own house or a nursing home. I have never known a case; I have asked many, many persons; I have never seen one in the papers. But it must have been done hundreds and hundreds of times, and yet no person takes any steps there.

20,828. *Mr. Jowitt*: It is not common assault; it is false imprisonment?—No one takes any steps, because they appreciate the justice of it.

20,829. *Chairman*: I have not yet got your scheme into my mind. We will take a concrete case. There is in a home a person who has suddenly developed, shall we say, acute maniacal tendencies; the doctor, the panel doctor or private medical attendant, is called in. Would you suggest that that case should never be certified right away, but should in the first place be taken to such a clinic as you have in mind?—Yes, that would be the first step.

20,830. For the purpose, if necessary, of detention there, because I am assuming a maniacal case that is obstreperous?—But he is not hostile to detention.

20,831. But he may be?—Yes, he might be, but he is not a very hostile person. He is hostile one moment and tractable the next.

20,832. I think you would need to contemplate that those clinics would require to be vested with some power?—I think you would, certainly.

20,833. Some power of infringing liberty, if necessary?—Yes.

20,834. But the safeguard to the public might be in this, that it is only temporary?—Yes.

20,835. The infringement of liberty which follows upon certification is of a more or less permanent type. I do not think the public would resent so much a temporary infringement of liberty, where it was merely incidental to treatment, provided it was sufficiently safeguarded by notification?—Quite. Medical men do not want to keep patients who are constantly demanding their liberty. The danger there would be that they would be sent to the mental hospital earlier. No medical man likes to be constantly keeping a person who is demanding his liberty; so the danger would not be very great on the public side.

Sir Ernest Hiley: Mr. Chairman, the illustration you have given us was where the panel doctor was the person who actively induced the patient to go to the clinic. What is going to be the position where the relieving officer is the person who is called in?

10 November, 1925.]

Sir MAURICE CRAIG, C.B.E., M.D., F.R.C.P.

[Continued.]

20,836. *Chairman*: Have you considered that, Sir Maurice? The relieving officer is often the intermediary, as you know?—He would have to be, in the event of it being a Poor Law case, so most of the panel doctors could only notify the relieving officer.

20,837. Of course, the relieving officer, for his own protection, would have to call in a justice or some such person?—Not if the law allowed him simply to take the medical man's instruction. As the law stands at present, he has got to.

20,838. Would you remove a patient or secure the removal of a patient to the workhouse?—If there were a clinic he ought to remove him straight to the clinic.

20,839. And still be responsible for him?—And be responsible for such time as he is there.

20,840. But if we were to go a little deeper into it, do you think the relieving officer ought to have any functions with regard to insane cases or incipient cases?—No. There must be someone else; or let the relations do it themselves. The panel doctor will not take it. There would be persons who would not understand what to do. There must be someone who is responsible.

20,841. Supposing this branch of medicine were made the concern of the local authority, as tuberculosis and venereal diseases are. They would naturally have a certifying doctor?—Quite.

20,842. Would the natural course not be to call in that doctor at once? The panel doctor would notify the local authority's department, who would naturally send at once their doctor to examine the case, and if that doctor was satisfied that the case was one which ought to be removed, could not he send the ambulance for it?—Quite.

20,843. Is not the relieving officer only brought in for two reasons; one is that at present there is no machinery for getting the patient away, and the other is that he is the representative of the Poor Law, because the patient is going to be chargeable to the Poor Law afterwards?—I am not enamoured of the relieving officer being brought in.

20,844. We had some very interesting evidence from Glasgow of Dr. Carswell's experience there. He was certifying doctor there, and he told us he was called up at all hours of the day and night to go and see cases reported to him. He went at once and decided to the best of his ability the proper destination of the case. Some machinery of that sort is rather attractive, because it would eliminate to a large extent the elements which you wish to eliminate?—Yes, it practically keeps it on a very much better basis altogether.

20,845. Then as some of the cases could not be treated in a general hospital, does your mind rather favour the idea of a separate clinic where all classes of patients could be treated, even violent patients?—Yes.

20,846. Of course there are *pros* and *cons* there. If it is not in association with a general hospital it will tend to develop a special reputation, which you wish to avoid if you can?—But still I think the public would soon learn the difference. I do not think there is any great difficulty there.

20,847. At that stage, through which we shall assume that all patients will have passed before certification—at that stage, what measure of power would you think it necessary for the doctor in charge of the clinic to possess in order to restrain patients contrary to their wishes, but in their interests?—That would be what I call the third class.

20,848. Yes?—Then I think in that case there ought to be a form of notification; he has this patient there for treatment.

20,849. All that I think the public would require would be some assurance that there would be no abuse or no room for abuse of that power?—Quite.

20,850. True, the control would be limited for a certain period, but if there were notification to the Board of Control that such a case had been received and that such measures would be required in that case, do you think that the authority of the medical man in charge, subject to that notification, ought to be sufficient, or would you use the law at that stage at all?—I do not think so.

20,851. You think the law could be dispensed with at that stage?—I think it could be dispensed with.

20,852. Always subject to this, that it would be for a limited period?—Yes.

20,853. Then the persons who have reached your clinic would subsequently, I suppose, either leave the clinic cured or relieved, or, if their malady progressed, would find themselves ultimately certified?—Yes.

20,854. Now would you be averse from permitting certification to take place in such institutions?—In the clinic itself?

20,855. On the view that these are places where the patients should only be subjected to some provisional detention and to some less rigid form of supervision?—Yes.

20,856. Of course one has to allow for sentiment to some extent in these matters. You are dealing with a highly sensitive medium, and you have therefore to some extent to take into account public feeling, even although the scientific man may regard it as immaterial?—Yes. If there were a place where a patient could go for a few weeks—I mean it is a very materialistic outlook simply to move a person from a hospital into a private place, like a condemned cell; then the person might know that it was a half-way house. It is very, very difficult.

20,857. I do not think it would appeal very much to a more balanced mind, but it has been put forward as a consideration that it is undesirable that an institution which professes to be a home for treatment should ever develop itself into a place where patients are certified, so that they have that menace hanging over them when they are in?—But I am thinking of the patient still, and that is when a patient is seriously ill. Merely to be taken out of an institution just because you do not want something to take place in the institution, would be to the disadvantage of that patient and relations, it may be—I feel that the public would be wise enough to see that. If the patients have had their period of residence there and unfortunately they have not got better, and in order that they may be able to be removed to another place, certain proceedings are necessary, my feeling is that the public would accept that.

20,858. Of course one has got to think in terms of the man in the street, and he is rather liable to say this: "Oh, well, if you go in there you will be certified sooner or later, you may take it from me." That point of view, of course, is undesirable, is it not?—But look at it in another way. He may say, "They will take you there and keep you for a certain time and then move you somewhere else, where they will certify you." They could easily say, "Yes, but they take you out of there and put you somewhere else." I should think of the patient every time, and I am certain, as I look at it at the moment (I am open to conviction), it would not be to the advantage of a patient.

20,859. *Mr. Jowitt*: But you want to attract people to go to these places?—Yes, and certification is the last thing we want to resort to.

20,860. You want to attract them to go at a very early stage?—Yes.

20,861. Does not it occur to you that if it becomes known that certification takes place in that building, people will think they are flies walking into the spider's parlour, and they will be frightened to death of going to the place?—Then I should recommend, in order to meet that difficulty, that there should be one more stage; that is to say, when he has

10 November, 1925.]

Sir MAURICE CRAIG, C.B.E., M.D., F.R.C.P.

[Continued.]

stayed in that institution for a certain length of time he shall be moved to the mental hospital, but under a provisional order which is capable of lasting for another three months or whatever it may be, and then if he does not get better in that time he should be certified. I mean, I should make another step.

20,862. *Chairman*: I do not think the public will appreciate that refinement?—I do not think they will appreciate it, unless they appreciate the good will in the institution itself.

20,863. Of course we can never hope to eliminate from the public mind a certain apprehension of mental disease?—No. Of course there is no reason why they should not go to a mental hospital for a length of time under a provisional order, too, and in many ways it might be a real advantage to the patient, because the patient might get well during that phase.

20,864. We have your view, without pursuing the matter too much into detail, that there should be facilities for the treatment of early cases, preferably in special clinics and wards, in every centre of population?—Yes.

20,865. And that these are places where the patients should only be subjected to some provisional detention and to some less rigid form of supervision?—Yes.

20,866. Then the asylum proper would be still the place to which the established and chronic case of insanity would have to go?—Yes.

20,867. I am interested in your classification of the three types: the willing type, the non-volitional type, and the unwilling type. As regards the willing type, that is to say, a person who is able to co-operate in his or her own treatment, is it your view that they should be admissible to any one of the different types of institutions?—They should go anywhere they like to go. Some patients would like to go back to the mental hospital if they got well there before, but they ought to be allowed to go in freely.

20,868. But these people would be residents on a voluntary basis?—Yes.

20,869. Now we have heard something of the possible dangers of that course. We have heard suggestions that persons entering an institution on the voluntary basis have subsequently been certified, and one is a little puzzled with this case. Willingness is of itself a matter of degree. A patient who enters an institution willingly may unfortunately become worse, and really have very little will left at all: what are you to do with that type of case? Are you to regard the initial will under which that person entered the institution as persisting, or are you to take some steps at the stage when the person is either willing or unwilling?—I put that very question to a certain person. Of course, it came into one of the Mental Treatment Bills when certain notifications had to be made. I asked the question: "Supposing that this is the last act he does in his consciousness—to say 'I would like to go there'—and he passes in a few hours into a confusion of mind? Is that to stand?"

20,870. That is the point. Is he still a willing resident if he has no will at all?—The answer was "Yes." This was the legal view. We will take that as a proper position. Looking at it myself, I think it is quite a proper way of looking at it. One would say: "As long as he had consciousness, he appreciated his illness, and I do not think he ought to be certified. I think he ought to be allowed to reside there on the voluntary basis."

20,871. Such a person, of course, in the case you figure, could not be permitted to be at large, manifestly?—No, certainly not.

20,872. And if the patient indicated a desire to leave the institution, having entered as a willing patient, of course, technically, he would be entitled to leave at any moment?—Yes.

20,873. On the other hand, the disease might have so progressed that the medical superintendent would

have to say: "Oh, this patient, however willing originally, and however much entitled to the privileges of a willing patient originally, is no longer in a state to call upon me to release him, and I must restrain him."—Yes.

20,874. Supposing a willing patient has gone into an institution, confusion of mind has ensued, and the patient says: "I want to go out; furthermore, I propose to throw myself in front of the first train I see; I am determined to do that": in these circumstances a doctor would within 24 or 48 or 72 hours, or whatever the period was in law, have to release that patient. What is he to do?—I think he ought to detain the patient then, under the original position. But if the Legislature considered that there ought to be a notification that he had done so, it would be quite proper; but that patient ought not to be certified; I feel certain about that.

20,875. But is not the purpose of the interval of 24, 48 or 72 hours which must precede the emergence of the patient into ordinary life intended just to prevent risks of that sort and to enable the staff to take steps to secure certification, if necessary?—That is as the law stands to-day.

20,876. Yes, but is not that desirable?—I think there ought now to be a provisional stage brought in to deal with the position that has arisen. I would have a provisional stage there also.

20,877. Manifestly, the detention is necessary in such a case?—Absolutely.

20,878. Then the non-volitional patient is a very puzzling person; the person who is not really able to take any interest in his own case, who is not obstructive, but is after all really, as you may call him, a parcel of goods?—Quite.

20,879. With no will of his own?—Yes.

20,880. Are you to substitute the will of somebody else for that person?—Yes, I think that is the proper thing to do. Whatever you do, it has got to be the will of that other person who is going to take the steps that are necessary to bring about some result; that is to say, whether you are going to have him certified or not, it is some other person who takes the steps, and the law accepts that to-day. Therefore I think that if the law would accept a notification from that person, it would be the proper way to do it. My own feeling is that they need not even notify. They simply ought to say: "I wish this patient to be treated in this place," and leave it at that.

20,881. There, again, of course, if there were any certification or notification, it would be all on a provisional basis?—Yes.

20,882. But you think that such cases might be dealt with without any certification at all for a time?—Yes, I think so, perfectly safely.

20,883. Then would the release be on the application of the person whose substituted will had been invoked? Who is to control the career of that person in future?—I suppose the person who is in *loco parentis* would be responsible the whole time.

20,884. Then the obstructive case must, of course, be subjected to some measure of legal restraint?—Yes.

20,885. And in that case you contemplate a provisional stage before the final stage?—Yes.

20,886. But you talk of the possible abolition of certification: do you really contemplate that? I see one of your sentences is prefaced with the words "If certification is abolished"?—I only meant abolition for the early stages. I am sorry. That is badly worded.

20,887. There must be a certain class, I suppose, with regard to whose state of mind there must be some solemnity and some final ascertainment of their position?—Yes. That sentence ought to be corrected.

20,888. *Mr. Jowitt*: There is always, of course, the question of the care of property. You may have a man detained and deliberately not certified. He may be quite unfit to look after either himself or his property?—At the present time, of course, the two are in absolutely different courts and different hands.

10 November, 1925.]

SIR MAURICE CRAIG, C.B.E., M.D., F.R.C.P.

[Continued.]

20,889. But would you deprive a man who is detained and not certified of the power of dealing with his own property? — Detained, you mean, by provisional order?

20,890. Yes?—Yes. I have always held that if a person is considered to be not responsible for his liberty, it is not safe to allow him to deal with his property. He might claim at any time that he was at that time being treated as a person of unsound mind, and use that as a ground for objecting to some mistake he may have made.

20,891. *Mr. Micklem*: I suppose he would be lawfully detained there?—Yes.

Mr. Jovitt: Supposing he wrote cheques?

20,892. *Mr. Micklem*: He would come naturally under Section 106?—Yes, I think so.

20,893. *Chairman*: The willing case is supposed to be a sane person and still entitled to manage his own affairs. He goes in to the institution and becomes worse, but is not yet certifiable. Is he still to be allowed to sign cheques and execute deeds and so on?—Yes, I think so.

20,894. You cannot prevent that?—I do not think you can prevent it.

20,895. Of course, you can have a certain protection given by the appointment of a receiver, even if a person is not insane?—That is only owing to disease or old age, under sub-section (d) of Section 116; it is limited at present.

20,896. *Sir Humphry Rolleston*: Supposing this attractive scheme of provisional notification is substituted as far as it may be for certification, the question would arise as to how long it would be before this stage of notification carries the same stigma as certification now does?—Yes, that is a point; but then I take it the country will have advanced another stage, and another milestone will be passed, towards understanding even better still mental disorder, and therefore it may be necessary to go one stage further. It would be a big stage further, clearly.

20,897. *Chairman*: Now I want to ask you a question with regard to the administrative side. Do you contemplate the local authorities continuing to interest themselves in these institutions, whatever they may in future be?—Yes, certainly.

20,898. Do you advocate the grant of public monies in aid of this form of treatment?—Yes.

20,899. And have you also now come to be of the opinion that the Board of Control, with possibly some modification of its constitution and powers should remain the supreme authority in this department?—Yes. I have been very much impressed during the last few years by their altered attitude. At one time, as I honestly say in my *précis*, I felt that they were part, if I may say so without offence, of a bureaucratic outlook on things, and that the legal side seemed to be very strongly marked, and there seemed to be rather traditional methods of treatment which were not quite in accord with modern medicine. But they have so absolutely changed of recent years, that I now feel that they have learnt so much the same as physicians and other persons have learnt that they would be most sympathetic towards (I am speaking from the medical side as well as the human side) advancing such a scheme as this; because they have worked under the other scheme, they have seen its limitations, and they have seen the difficulties of it; and they have also seen the benefits of these improved methods.

20,900. Of course, whatever body is placed in charge of this department will necessarily be the target of opprobrium to some extent; all public bodies are?—Yes, and physicians must be, too; that one appreciates.

20,901. Your profession has not suffered much worse than my own in public "dis-estimation," may we say?—Honesty of purpose is the only answer every time. One may fail, of course.

20,902. In the larger world, even in commerce, of course the whole of commerce depends upon credit and good faith, but there are people who are fraudulent?—Perfectly.

20,903. But your considered view is that the Board of Control, with some augmentation on the medical side, should have the supreme authority?—Yes, quite.

20,904. Would you give it more executive power than it possesses now in relation to the local authorities?—I think it ought to have more executive power certainly, because at the present time it must be purely recommending.

20,905. Of course, you know how resentful local authorities are of interference from what they call "Whitehall"?—Quite.

20,906. One has to be careful not to deprive them of the sense of responsibility?—Quite. I mean even if they were not used, certain powers might be given in certain districts.

20,907. Then, for the time being, until your ideal is realised, Sir Maurice, you think the most practical recommendations would take the form of the development of the provisional certification, and the provision of institutions in which incipient cases could be caught early and treated without certification, or, at any rate, with only some modified form of certification?—Yes.

20,908. And all directed to this aim of assimilating the treatment of mental disease to the treatment of physical disease?—Yes; make that the key-note of the whole thing.

20,909. *Mr. Micklem*: I should like to ask you one question, Sir Maurice. I rather gather from the passages towards the end of your *précis* that you are in favour of extending the number of licensed houses?—Not necessarily licensed houses; recognised houses I mean; that is to say, where you have got some form of recognition. Of course, I feel that all nursing homes ought to be registered; and I feel that if they were brought in then the mental homes would come in with them; but I can see that that may be some little time off.

20,910. You suggest that there should be the widest powers for medical men to undertake the supervision of one or two cases?—I do, certainly.

20,911. You recollect the section, Section 315 of the Act, which provides that lunatics are not to be detained except in accordance with the Act. That section you would like to see deleted altogether from the Act, I take it?—That is for certain types of case and the provisional cases; it is only for a certain number of patients.

20,912. Yes; that is to say, the cases that come under Nos. 1 and 2 of your groups?—Yes. I think licensed houses ought to have all the same advantages and powers that outside people have, clearly; so that patients can go in there with absolute freedom, if they wish to; but with the willing patients and with the non-volitional type I think the relations ought to be able to place them where they wish.

20,913. Would there not be some risk of unscrupulous persons using powers over their person and property in those cases, do you think?—They have no power over property at all at the present time. They would be in exactly the same position if they went into a licensed house or mental hospital. If they hold powers of attorney, those powers of attorney could be used for a certain period of time after they have been certified. I do not think there is anything in law against that. I mean, usually after twelve months they seem to feel they ought to have a change, but they frequently are retained.

20,914. *Chairman*: I am afraid that will not quite do in law.—I am only saying what happens in practice; it does happen in practice. Many times a person may come and say to me: "I have been acting under this power of attorney for two or three

10 November, 1925.]

Sir MAURICE CRAIG, C.B.E., M.D., F.R.C.P.

[Continued.]

years, and I am rather unhappy about it because this patient has been ill now for so long." This may not be a legal question, but they clearly do it.

20,915. Take the case where a patient had actually been certified; at that moment, in my opinion, the mandate contained in the power of attorney has fallen, unless specially qualified.

Mr. Jowitt: I respectfully agree.

Witness: It does not say so anywhere in the Act.

20,916. *Chairman*: The point is the persistence of the will. The mandate is always supposed to be inspired by a continuing will on the part of its grantor?—If I may say so, a person in an asylum who is very insane can make a will; there is no question of his sanity or insanity there.

20,917. That is a very special department, as you know, in the case of wills?—Yes; but the fact that he became insane after he had made his will would not invalidate his will, would it?

20,918. Not necessarily; certainly not?—No; and the same with trusts or with deeds that he has made; they still hold if he made them during a period in which he has understanding, mind and judgment. I am interested to hear that powers of attorney cease, but they certainly do not in practice, whatever they do in law.

20,919. I think one has seen that?—Yes.

20,920. *Mr. Micklem*: At the present time it would be impossible for a doctor, for instance in the country, to take in one of these patients, as the law stands?—He is not supposed to take a patient in if the patient is of unsound mind.

20,921. *Chairman*: Without certification?—Without certification.

20,922. *Mr. Micklem*: Your suggestion is that he should be able to take them at the patients' wish or as their friends desire for their benefit; that the present law should be altered?—Yes; that his house should be now recognised as an approved house. I am quite willing that that should be so: that his house must be approved.

20,923. *Chairman*: And if the house is approved, he should not come under the lash of that section?—No; he would not come under that.

20,924. *Miss Madeleine Symons*: Do I gather, Sir Maurice, on the topic of licensed houses, that you do not feel that the system of licensed houses does lead to abuses?—No, I do not think so. One has unsatisfactory reports from certain places at different times, and then they may change and get very good accounts; I mean, it so depends upon the persons themselves; and it is the same with big mental hospitals.

20,925. But you would probably agree, would you, that rather more general suspicion attaches to licensed houses than possibly to public institutions?—I quite agree; that is because of the question of gain to the person concerned.

20,926. That being so, you still do not attach any importance to it?—No. To me it is only giving a reason why that person should behave in that way. My own feeling is that the good licensed house is quite one of the best ways of treating patients; the patients are much more quiet; they have much the best treatment in many many ways; that is, in a good house; of course, you may have one that is not satisfactory. Personally, if I were ill myself, with all my experience, and I have dealt with every class, I would rather be treated in a private institution than in a public one.

20,927. I do not know that I quite followed your reason for thinking that not much importance should be attached to these suspicions. I mean it is rather natural, is it not, that people should think that money is being made out of it?—Yes; but that is true of everything in life; and that is a danger that is common to life.

20,928. But you do not feel that there is any difference between a case where people as it were are

forced to remain while money is being made out of them, and other cases; you think there is no difference in principle?—No; because you are still dealing with the human factor. You have got to presume much in order to make your point good; that is to say, you have got to presume that all the persons and relations are equally of a degraded type, if I may say so; that is, they are perfectly willing for their relation to be with unscrupulous people, which is not true. I mean the very suspicion that these people have to work under makes them better in a sense. You get quite as many scandals, if I may use the word, in the public places as you do in any private place, perhaps more.

20,929. Then there was one question which a member of the audience was very anxious should be put to you, and that was whether, in this rather extended Board of Control that you suggest, you would be in favour of women medical members being included?—Certainly; I think it would be very good in many ways, looking after the details that a woman would want and things like that; it is most important.

20,930. *Mr. Jowitt*: I want to ask you, Sir Maurice, a question or two about the existing system first. I am impressed by the fact that, rightly or wrongly, the medical profession are very apprehensive of the danger which they think attaches to them today. What further specific protection do they want? Do you know?—That is a very difficult question to answer. I mean that medical men, even if they have got protection, are afraid of having their time taken up by actions, and things like that, even where the defence might be perfectly successful. It is most difficult to answer that question. Of course, really, the unrest has been caused by the actions that have taken place; and once you have got an unrest in the profession it is difficult to allay; their point is that this is not a medical proposition and never has been. To certify a patient is nothing to do with medicine, and therefore they say: "Why should we do it, if we do not do it properly?" That is their position.

20,931. Does it come to this: would the medical profession be satisfied supposing the statute made it perfectly plain that they are not liable for giving a certificate, even though they give it negligently, so long as they are honest?—As a profession, we should not like anything which said that we could do a thing negligently as against the public and the public not have redress against us. I should not like that at all. What I do feel is that it should be necessary to prove bad faith.

20,932. I want to see how far the medical profession want protection. Do they want to be protected in the event of dishonesty? Obviously I should say not. Or do they want to be protected in the event of carelessness?—They do not want to be protected in the event of carelessness, clearly.

20,933. *Chairman*: May I intervene there, because it is an interesting topic? It has been suggested to us by some witnesses from the medical side that when a doctor grants a certificate which leads to a magistrate's order, and in which he sets out certain matters of opinion and certain matters of fact, he should enjoy the complete immunity from action which is enjoyed by a witness in giving evidence in court, which is absolute at the present moment. As you know, a witness giving evidence in court may be negligent in his statements—in fact, I think he may do anything but perjure himself. He is absolutely protected because he is supposed to be serving the larger cause of justice; the sanctity of the witness box is so important to the general interests of justice. Now some of the medical evidence we have had has gone the length of suggesting that those opinions and those statements of fact which are contained in certificates should enjoy the absolute immunity which a witness enjoys in the witness box; that would cover everything, even malice. Would you go that length?—No; I personally should prefer it this way:

10 November, 1925.]

SIR MAURICE CRAIG, C.B.E., M.D., F.R.C.P.

[Continued.]

that any court which was going to decide whether an action should take place should be a Judge with two assessors; that there should be assessors, responsible persons, by whom the medical side could be put before the court; I mean persons who are altogether outside the case in question, but who could place the matters before the Judge.

20,934. *Mr. Jowitt*: Because, of course, it is vitally important to us to see that the medical men are not frightened out of this business?—Yes, and, of course, it is vitally important to the public; because it will mean that the doctors will not do it at all.

20,935. Do you think that perhaps medical men would feel greater confidence and greater security if the matter came before a Judge and not a jury? Is that what you are saying?—You mean when the case was tried?

20,936. Yes.—They want protection against the action itself, clearly; which they have got here, but it is not definite enough.

20,937. *Chairman*: Mr. Jowitt's question points to this: that this class of topic is so easily inflamed and can be represented in such a way as to elicit undue sympathy with the jury, and that possibly the medical profession might prefer to go before a Judge?—I quite appreciate that.

20,938. *Mr. Jowitt*: Although, of course, in an individual case, personally, I should like certainly a dishonest doctor and probably a careless doctor to suffer. At the same time the bigger issue is this: that to make this system work satisfactorily we must get the goodwill of the medical profession and their willingness to act?—Quite.

20,939. That is the difficulty I feel. At the present moment I do not quite see what they want?—Of course, they are wanting to keep clear of all these anxieties and troubles and to go on with their work.

Chairman: Yes, but every citizen is open to attack for what he does negligently or does dishonestly?

Mr. Jowitt: Except the Bar.

20,940. *Chairman*: Except the Bar?—We should like the Bar to have this matter, because it is dealing with the liberty of the subject after all, and up to a point the legal people ought to have it; it is their side entirely; it is nothing to do with medicine. Further, if they want to come in on a matter, which clearly they have to come in on in the interests of the public, they ought to take the responsibilities of their function, which is dealing with the liberty of the subject, but they do not do it; they are very careful to leave it to the medical profession, and then to criticise the medical profession on what they have done—I do not say unkindly.

20,941. I think you may take it, Sir Maurice, that we are very sympathetic to any points that may be made before us that would restore the confidence and comfort of the medical profession in discharging this difficult duty?—It is going to be very difficult to restore, because it is getting very, very deep.

Mr. Jowitt: Therefore we are impressed with the necessity of trying to restore it.

20,942. *Chairman*: Yes. If you are to have immunity in degree and not absolutely—?—It would never do.

20,943. The present idea is that you should be able to bring the matter into court and have what is practically a discussion on the relevancy of the allegations, as to whether they are sufficient?—That is the difficulty. Where you get the protection as given under the Act, and then there is a legal way out of it, by saying: "This is not covered by the Act itself," it is very much like saying that you shall go to arbitration on certain contingencies, and then having your action tried in the High Court as to whether it is a proper case for arbitration, even when you have decided between yourselves that there is to be arbitration. I am only pointing out the difficulties

that one sees. The difficulty is to get the wording that really carries what the medical profession want in the way of protection. If this Section 330 carries that protection, they will probably be satisfied.

20,944. *Earl Russell*: Of course, that involves protecting the "black sheep," too? There are "black sheep" in every profession.—I did not mean that; but you have got to prove it is a bad case.

20,945. *Chairman*: But it is very easy to allege bad faith. The trouble is this, that a Court confronted with an allegation of bad faith is practically bound to let the case go on, lest it be true. The Court says: "These allegations, if proved, of course would establish the case, but we cannot say whether they are true or not before they have gone before some tribunal"?—Then comes the question of the provision of something like a Grand Jury, which tries this before.

20,946. A Judge in chambers, possibly?—By Judges in chambers—more than one.

20,947. Would you think that the fiat of the Attorney-General might be any protection?—He is so very over-worked; he might have great difficulties there.

20,948. *Earl Russell*: As the Chairman points out, no tribunal can tell the truth or falsity of these allegations till trial. That is the trouble if once the allegations are made?—Quite.

20,949. *Chairman*: You are very liable to have allegations made by the type of people who are concerned in these cases?—Quite. Of course, it strikes at the very fundamental basis and strikes at law more than medicine, because it strikes at the question of the liberty of the subject; and they are not going to attain liberty, if the medical profession refuse to act, which they will do ultimately.

20,950. We want to devise something which will re-assure the medical profession and which will at the same time effectively deal with those who may be dishonest in these matters?—But that is the question of being able to word the thing legally, so that it cannot be turned aside by simply saying: "We cannot settle this until it has been tried." That is what it comes to.

20,951. You see the legal members of this Commission are puzzled?—I appreciate that absolutely. I also appreciate how serious it is becoming in medicine.

20,952. *Mr. Jowitt*: I am much obliged. Now there is one other matter on the existing system I want to ask you about. I have been over a certain number of mental hospitals and have been very much impressed by the fact (I suppose it is inevitable) that in the reception wards into which new-comers are taken a great deal of noise takes place; there are people moving about, crying out, getting up at night, and so on; in fact, to a person like myself to go through the wards the whole experience is very distressing?—Of course, I am very much in favour of more single rooms and always have been. I have often asked: "How is a person to sleep in a dormitory with a very large number of other persons"? It is what I expressed the very first time I went into Wakefield 30 years ago. Exactly the thing you are saying was the thing I myself noticed; indeed, I spoke about it the first night I went round.

20,953. I ask you because at the last asylum I went over I talked to the medical superintendent about this, and he told me that in his belief it did not worry patients; and he told me that although he had complaints from patients about innumerable things he had never had complaints about these particular things?—I would not say that. Of course, patients vary. Some patients will ask you if they can sleep with others; and even where there is a noise they will sleep better; but many many persons would not sleep, and of course they cannot rest because of it. That has been a point, and I have never understood the building of these mental hospitals, where they have had so many dormitories and so very few single rooms.

10 November, 1925.]

SIR MAURICE CRAIG, C.B.E., M.D., F.R.C.P.

[Continued.]

20,954. *Chairman*: Separate rooms involve more attendants, you must remember?—Yes.

20,955. *Mr. Jowitt*: Of course, if we make any recommendations in this respect we shall very seriously have to consider the question of cost, because if we recommend too much our recommendations become impracticable. Do you think that the advantage of speedier cures and discharges which the community would gain would counterbalance any increased cost there might be in the way of additions to buildings and extra staff?—But you cannot measure human suffering in that way; that is the difficulty.

20,956. I know you cannot?—I do think you would get economic advantages too, because patients would get better.

20,957. *Earl Russell*: From the purely medical point of view, which you can tell us about, do you think that to the new patient coming into this noisy ward it is harmful and retards progress?—Certainly.

20,958. *Mr. Jowitt*: And so far as we can, from a financial point of view, it is undesirable to have it, if we can avoid it, because we are driving him over the border-line?—Yes.

20,959. *Chairman*: There is a credit side of the account as well as a debit side?—Yes.

20,960. *Mr. Jowitt*: So much for the existing system. Then with regard to your suggestions, you suggest the establishment of clinics, as you call them. They are to be places, I gather, not where people go merely to ask advice, but where they go to reside?—Yes.

20,961. They are to be run at the expense of the municipality—is that your idea?—A great many of them would be, yes—most of them.

20,962. And cases that want help or assistance in the early stages would either go voluntarily or would be recommended by some official?—Yes.

20,963. That is your idea?—Yes.

20,964. Then you do realise, do you not, the great importance of popularising those institutions?—Yes.

20,965. And making them trusted by the community as a whole?—Yes.

20,966. Does it occur to you that if there is a danger of certification or of compulsory detention in those institutions they will not be popular? It is the tendency, may I say?—I do not think you will ever escape from need for detention, because you will never get a number of patients together without having some that you will require to detain in a sense.

20,967. But if you want to popularise the institutions, it is desirable to limit that as much as you possibly can?—I agree absolutely; and the same with certification.

20,968. Supposing you have got, as I believe you often get in the early stages, an acute case, a maniacal case if you like, that very often comes on very suddenly, does it not?—Some of them do.

20,969. Do you anticipate that such a case as that would go to one of your clinics?—They ought to have a ward where they could take them quite easily; it would be a separate room.

20,970. You do anticipate that those cases should go there?—Yes. In the general hospitals you may not be able to do it, but in a clinic, yes, you ought to take those cases easily.

20,971. Will you help me to this extent: supposing you had a rule at the clinic that anybody might go out on 48 hours' notice, as a matter of practice how far do you suppose people would avail themselves of that power?—Most of your "willing" and "non-volitional" would not avail themselves of it. The difficult ones would be those who became very much worse and yet retained some volitional power.

20,972. I think we had some information given us with regard to Maudsley. Would it be comparatively quite exceptional for anybody to demand to go out?—I think so. Personally, looking after people in private, I very rarely get it.

20,973. *Mrs. Mathew*: I should like to ask, Sir Maurice, whether you have in your mind a design for an ideal asylum; you probably have your views?—An ideal place is practically like a hospital, with departments and specialised people there, attending the patients.

20,974. But I mean as to buildings?—Not too big; I do not want large-sized buildings. When we took the Cassel Hospital and we considered our numbers, we decided that we would get somewhere about 60 or 70, but of course, there is a very great difficulty in cost; I appreciate that; I mean it is almost prohibitive to run places like that. On the other hand we took 200 to 300, in the time of the military hospitals; that was the number we came to the conclusion was best handled—about 250 to 300, I think.

20,975. Was the Cassel Hospital built for the purpose?—No, it was adapted.

20,976. From a military hospital?—It was adapted from a private house.

20,977. Then another question I want to ask is this. Is part of your objection to treating a large number of patients together the fact that they so often, and, indeed, generally, have a stereotyped diet?—Yes. Of course all the things are important; and also the difficulty of getting a large enough medical staff to deal with them. You want to have a large medical staff for your acute cases.

20,978. How many do you suppose?—We put it down at about one doctor to 30 or to 50 patients.

20,979. Not more than 50?—No. A medical man could scarcely deal with it.

20,980. *Chairman*: You are dealing with acute cases, not with chronic cases?—I am only dealing with the acute cases.

20,981. *Sir Humphry Rolleston*: With regard to the present general reluctance on the part of the medical profession to certify and indeed to have much to do with cases of mental disorder, do you think that it might be advisable to have a specialised class of medical officers to deal with such cases in districts, like the tuberculosis officers and the venereal disease officers—I mean they will be conversant with the matter?—Yes; he would be very very helpful, clearly, to the general class of patient; he might be most valuable.

20,982. We have had some evidence, I rather think from the British Medical Association, deprecating a step of that kind?—He would not have to be in practice himself, clearly, or other practitioners would not like it; but if he were merely one whom they could call in for special work always in the district, he would be very helpful.

20,983. And to do what notification or certification was necessary?—Yes.

20,984. You think, on the whole, it might be advisable?—It should not be compulsory, it might be optional; but it might get over one of the difficulties that we were discussing, because a person who was holding a public position might be considered more trustworthy than a general practitioner, who might be get-at-able by the public or someone else.

20,985. *Sir Ernest Hiley*: Sir Maurice, would you have any objection to the scale of charges in licensed houses being subject to some supervision?—The difficulty in the scale of charges is largely the question of supervision; it is the cost of nursing very largely, because where you have got to have special nurses, and then there is their keep, it always raises the cost enormously.

20,986. But you would not object to the Board of Control, or whatever the Central Authority might be, having authority to prescribe a scale of charges?—I do not know about "prescribe." I think they ought to know; I think they do to-day; they always have been able to ask what a patient pays and to see whether he is getting what he ought to get; I think that is done to-day; certainly it is done as

10 November, 1925.]

SIR MAURICE CRAIG, C.B.E., M.D., F.R.C.P.

[Continued.]

far as the Master in Lunacy is concerned, because it comes under the audit; everything goes before him.

20,987. You would not object to an audit of the accounts of the licensed house?—No. I do not think they themselves would object.

20,988. *Chairman*: It is a private enterprise, you must remember, in one aspect of it, very often conducted by a limited company. Do you fully appreciate the import of Sir Ernest's question—it might involve having their accounts published?—Publication might be an objectionable thing. I do not know that that is absolutely necessary, so long as it is known to certain departments.

20,989. You would not object to the Board of Control having the results of the audit placed before them?—I should not think they would have any objection.

20,990. But you do recognise that it is desirable that some form of supervision of the accounts of the institution should take place, because there appears to be very little supervision of the financial arrangements at present?—Quite. I do not see what objection they would have to that.

20,991. There is always a certain objection on the part of private enterprise to have its affairs made public?—Yes; but is it necessary to make them public if they are known to the department itself? I do think perhaps it would be objectionable in some ways. I mean one patient may be paying much more than another, and he may think that the other patient is getting the same advantages as he is.

20,992. But an official audit, you think, ought not to be resented, the results of which would be communicated to a responsible body entitled to criticise?—Quite. I do not think there would be any objection to that.

20,993. *Sir Ernest Hilcy*: Just one other question, Sir Maurice. One of the members of your profession told us here that in his view it was impossible adequately to treat an insane patient in a private house?—My experience is that in many ways they are the best, because you see the best licensed homes allow any medical person to go in; they allow the patient's own medical practitioner; you can send down any bacteriologist, or any person to see or to do anything. That is the reason why I said that I should like to be treated in one of them, because I should be able to get the best; of course, it is more costly.

Mr. Parker (representing the National Society for Lunacy Reform): I do not know, Sir, whether you think it would be proper to put to Sir Maurice a question on the present training given to medical students before taking their qualifying degree. I understand that is a matter upon which the Commission have been very desirous of having evidence; and in a report of the Council of Mental Hygiene I notice that Sir Maurice, as Chairman, has made an exhaustive enquiry into the examination papers set during the last four years. The conclusion is that "Some two-thirds of the medical students who qualified during the years 1921-24 were not required to show any knowledge whatever in their written papers on the subject of mental diseases."

20,994. *Chairman*: We have had that report, and I recognise the passage you have just quoted, Mr.

Parker. I think it is quite proper to ask Sir Maurice, who has had large experience as an examiner in this very subject, to explain in a sentence, if he can, what his views are upon the desirability of improved education?—We do feel that. The whole attitude of the public and everyone towards mental medicine really goes back into the education of the medical students; that is, it is at present treated as something apart from physical disease.

20,995. It is not only the public, but the profession also?—Yes; and what we want to do is to get it absolutely in line with physical medicine, and we would like to see mental diseases taught by the general physician in the ward itself.

20,996. One knows that the medical curriculum is being steadily increased and the student after all can only assimilate a certain amount, even in a five-year course, and he is a very hard-worked man nowadays. Would you consider that psychiatry should form part of the ordinary curriculum, or should it be a specialty, a post-graduate subject—I mean in any development of it? I suppose, every student must take some of it; but would you consider that further development should be in the form of research or post-graduate work? And just before you answer that, you must link that up with this, that if only some doctors are going to have the benefit of those fuller courses and special research, then it may be necessary to select only such doctors to exercise the functions of the Act. What is your view, Sir Maurice, as to the place of this subject in the curriculum?—Of course, I am fully aware of the overburdened life of the medical student, but in that the mental side comes into every disease in life and you have got no disease that has not got its reflection in the mental activities of a person suffering, and may, indeed, be the element which decides whether he is going ultimately to recover or not, it is absolutely essential that every medical person should know something about mind and its work.

20,997. Then you would give it more prominence in the medical course than it possesses just now, even if it were necessary to curtail some other branch of medicine?—Yes. We are proposing at Guy's to give one course a year on psycho-neuroses, on the earlier stages, so that every student has a course on that, and ultimately one hopes to see the mind side dealt with, as I say, in every case.

20,998. Of course, medicine, like every other science, is becoming so large now that specialist training is developing. Is this a subject which can be adequately mastered by a student in his ordinary curriculum, or is it one of those subjects which requires a specialist training?—If he is going to do specialist work eventually, he wants a specialist course.

20,999. But the moment he is capped and sent out into the world, he can certify at any moment?—Yes; but everything should be done to advance the study of the mind.

21,000. Just to conclude the matter, would you rather have an expansion of the study as a special subject, or would you rather have it more fully dealt with in the ordinary curriculum?—I think it must mean both.

Chairman: Sir Maurice, we are greatly indebted to you for your attendance here this morning and for the most interesting and helpful evidence that you have been good enough to give us.

(The Witness withdrew.)

Dr. FREDERICK LUCTEN GOLLA, M.B., F.R.C.P., called and examined.

21,001. *Chairman*: Dr. Golla, you hold the qualifications of Bachelor of Medicine, Bachelor of Surgery of Oxford, and you are a Fellow of the Royal College of Physicians of London?—Yes.

21,002. You are Pathologist and Director of the Pathological Laboratory in the Mental Hospitals Department of the London County Council?—Yes.

21,003. And I understand that you are here to-day to give us your views on the topic of research in psychiatry?—Yes.

21,004. First of all, may I take it that your general conclusion is that it is desirable that there should be facilities for pathological research, not only in individual mental hospitals, but also at central institutions throughout the country?—Yes.

[November, 1925.]

Dr. FREDERICK LUCIEN GOLLA.

[Continued.]

21,005. Your contemplation, I take it, is a system whereby you would have throughout the country at certain points central laboratories at work?—Yes.

21,006. Which would be resorted to for assistance and advice and training by all the staffs of the different asylums?—Yes.

21,007. At the same time you contemplate that each mental institution would have its own pathological equipment, but not developed, of course, to anything like the same extent as the central institutions which you have in view?—That is so.

21,008. Is that the method which is pursued by the London County Council who have one central laboratory and pathological institution to which all the asylums under the charge of the London County Council can resort for assistance?—Yes.

21,009. I wish you would just tell us quite informally (we have read your *précis*, of course) of the scheme under which you work here in London; it would be useful?—We have the central laboratory with a pathologist in charge, who acts as director of research for the work done in the laboratories of the various mental hospitals.

21,010. Where does that official work?—At the Maudsley Hospital.

21,011. And you are the official?—Yes.

21,012. So you are the pivot, I take it, of the whole system?—Yes.

21,013. Your work is carried on entirely at Maudsley?—Yes.

21,014. And do you carry on there both ordinary routine work and research work?—Yes.

21,015. What staff have you?—I have three skilled assistants, and then we have a system of seconding for three month periods four men from the various mental hospitals.

21,016. Are the three you have mentioned qualified doctors who are whole-time officials?—The three assistants are trained scientific workers but not qualified doctors. They are whole-time officials.

21,017. That constitutes the permanent and nucleus staff?—That, together with the clerical assistants and others.

21,018. Then you have told us that you have doctors seconded from the institutions of the County Council. How many of them do you have at a time with you?—Four at a time.

21,019. Are they drawn from all the mental hospitals under the charge of the London County Council?—Yes.

21,020. For what period are they with you?—They have a three months period.

21,021. On what principle are they selected?—They are selected by the superintendents on their own application.

21,022. Turning first to your work, what exactly is the sphere of your labours?—Primarily I have the direction of the routine work of the laboratory, which receives specimens from the various mental hospitals, and questions as to work that they are not quite competent to undertake themselves.

21,023. Do they address questions to you and send you specimens for examination?—Yes.

21,024. And do you conduct tests for them?—Yes.

21,025. Do you conduct, for example, the Wasserman test?—Yes.

21,026. Are all the Wasserman tests for the London County Council conducted at your laboratory?—They are all done at our laboratory.

21,027. That is routine work. In addition to carrying out that central routine work, do you also engage in independent research, or research initiated by yourself?—Yes, I engage in my own research work, and then I have the supervision of the research work that is being done at all the various mental hospitals and of people who work in my own laboratory.

21,028. Do you suggest topics that might be fruitfully investigated at the different institutions, and do you get the results of the investigations made there?—Yes.

21,029. Then what are the departments at Maudsley in your own charge?—We have a department for physiological psychology where we are investigating the physiological concomitants of mental disturbance.

21,030. Is that clinical work, or is that post-mortem work?—No, it is all experimental work on normal and pathological cases.

21,031. That is the physiological side. What other departments have you?—We have a biochemical department where we are investigating the changes of metabolism that occur in various mental disorders. Then we have a bacteriological department where we do these Wasserman tests, investigations of that nature and other questions. Then we have as part of the physiological-psychological department a department where we deal purely with questions of psychiatry. In addition to that, we keep a record of all the family histories of the 25,000 cases that go to the various mental hospitals which are related to one another. That is to say, we have a central bureau, and we note down all their inter-relationships, and we have got valuable material there. At present we are collecting it; it has been collecting for 10 years or so.

21,032. You are accumulating data?—Yes.

21,033. Is that work in your opinion of great importance for the furtherance of this branch of medical science?—I think it is of very great importance. What I was trying to convey in the *précis* of evidence I offered is how desirable it is for the ordinary medical officer to be encouraged to investigate cases. It always seems that a hospital for mental diseases is like establishing a hospital outside and taking in only people who have a high temperature. Similarly a disturbed conduct is only a symptom, and it is a symptom that characterises a great number of bodily disturbances, they are very slight disturbances; they are very difficult to find out, and it is only in the last few years that we have been accumulating evidence which has enabled us to make any progress in this matter. Their metabolism is different from other people's, and their reaction is different from other people's.

21,034. Then your work would assist in two ways. It would assist in diagnosis, and it would assist also in the suggestion of remedies?—Quite so. I do not think at present it is possible to have any system of diagnosis based on conduct, that is to say, on mental phenomena. We are only just beginning to touch the point when you can say that certain people with mental disorder really belong to some disease. They are simply unbalanced mentally, but they are people who have a certain bodily disease and can be treated as such.

21,035. Would you say, from your general knowledge, that the scientific investigation of this disease has lagged behind the scientific investigation of other manifestations of human disease?—Enormously. In fact we are only just beginning, and possibly the thing that has put us off for a long time was the discovery that the brain had to do with thinking. Most of these disorders of conduct are symptoms of bodily disturbance just like a person who has drunk too much, or a person suffering from typhoid fever.

21,036. Are you able to associate mental disturbance with various toxins, for example?—Yes.

21,037. Do you think there is a very fruitful field for investigation opening up before you?—I think it is enormous.

21,038. How long have you been engaged in this branch of medicine?—I was physician at St. George's, where I chiefly had to do with neurology, up to the war; and after that I felt I wanted to concentrate more on the research aspect; and I succeeded Sir Frederick Mott at the Maudsley hospital about two years ago.

21,039. So that your work is really only at its inception?—Yes.

21,040. But do you already feel satisfied that along those lines very fruitful possibilities may emerge?—I think we have got most astounding indications

10 November, 1925.]

Dr. FREDERICK LUCIEN GOLLA.

[Continued.]

even within the last few months. For instance, with regard to one type of insanity, dementia precox, one discovered that quite a simple abnormality of reaction is associated with it just as truly as the Wasserman reaction is associated with syphilis.

21,041. Now you spoke of the encouragement to the medical officers of institutions throughout the area of the London County Council. Do you find that they respond to the stimulus of three months' association with you?—Yes, I have been very encouraged with the results one has obtained so far. Of course, the difficulty has been rather to get them to feel that the research work and the work they do in their own laboratories will be considered as part of their duty as medical officers. There is rather a tendency to think that when they have been round the wards that includes all their duty. Various Committees of the London County Council have backed me up very much in that, and they have given them to understand that it is just as much part of their duty to investigate cases in the laboratory as it is to see them in the wards.

21,042. And do you find that they are responsive to your stimulus?—Yes, on the whole.

21,043. You have four of them for three months at a time, so that 16 of them will pass through your hands in the year?—Yes.

21,044. How many medical officers are there altogether apart from the superintendents who, I suppose, do not come to you? What is the number of the assistant medical officers in the London County Council area?—I should think somewhere between 70 and 80.

21,045. So that it will take about six years for them all to have had a three months' period with you?—Yes, but a lot of them do not stay. We get occasionally quite brilliant young men who just tide over a year or two, and then go into other branches of medicine.

21,046. Then is it part of your effort to communicate to those who are seconded to your establishment the importance of looking at the science of psychiatry from the experimental and from the laboratory point of view as well as merely from the clinical point of view?—Yes.

21,047. It is interesting that you should tell us that your view is that this branch of science has lagged so far behind, because there is a popular impression that these institutions are rather residences than places of cure; but science, I take it, has not hitherto really enabled the practitioners to any extent to resort to methods of treating insanity because its nature was not known?—That is so, Sir.

21,048. Apart from restraint of conduct and ameliorative influences of one sort or another, has there been any great development along the lines of curative treatment either by drugs or otherwise?—No, only within the last few years one has begun to detect symptoms to some extent; it is only beginning.

21,049. Then the medical side of insanity in your view has a great deal of arrears to make up?—I think it has, enormously; it is practically beginning.

21,050. And the way that can be done is by the institution of a properly equipped system of laboratories in charge of specialists who are engaged not only in routine but also in higher research work?—At a central institution; but at the mental hospitals I should leave the work in the hands of the medical officer under the supervision of the central laboratory.

21,051. Just take that aspect of it. You do not contemplate the cessation of the existing laboratories which we know exist in each of the London County Council asylums, but you think that co-ordination of those with a central institution would be advisable?—Yes, that is what we are doing at present in the County Council area.

21,052. And a certain coming and going between the officials and association and consultation between them?—Yes.

21,053. You would need to have a certain demarcation of the spheres of the central laboratory and the local laboratory, would you not? You do not want

them duplicating work?—No, I do not think there is very much danger of duplication. The great trouble is to keep in touch with the young men whom we train, and to suggest research work after they leave us. That means constantly writing round and going and seeing them, and encouraging them as much as possible, and putting recent discoveries before them; it means a great deal of correspondence.

21,054. Do you recommend that the same system should be adopted in other parts of the country as you have initiated in London?—Yes.

21,055. How many institutions would you contemplate throughout the country; how many would reasonably cover the country, do you think?—I think a group of four or five counties together might support one institution. It would be a question of a relatively small number of these central institutions; but what I think is very much to be deprecated is that county councils with isolated laboratories and mental hospital should set up a local pathologist, or some official to do research work in their own mental hospital. They will never be able to pay a man sufficiently well to attract a person with sufficient knowledge, and I do not think there is any prospect that the work that would be done would be worth anything. It is a type of work that means a very broad knowledge of a great many various aspects.

21,056. Of course a lot of amateur research going on in various departments would be of very little use?—I think so, very little.

21,057. At present, if in the provinces it is necessary to have a Wasserman test, where is that done?—They generally have an arrangement with some local institution who do the tests at a small fee.

21,058. Perhaps one of the provincial Universities or something like that?—Yes, very often. In most of the big cities there are what they call research institutions. They are simply commercial laboratories for doing tests for typhoid and Wasserman tests.

21,059. But you would contemplate at the centre, so to speak, of each group of four or five counties a central institution where a skilled pathologist would be installed and would carry on all the testing and routine work for his district, and at the same time afford means of training and research such as you do in London to members of the staffs of the mental hospitals?—Yes.

21,060. Is there much research work done at the present moment outside London?—There is very little. At Birmingham a certain amount is being done under the direction of Sir Frederick Mott, and some work is being done at Cardiff.

21,061. Then as regards apparatus, is expensive apparatus required for your work?—I think one could fit up an adequate laboratory at any mental hospital the same as we did in the London County Council area for £300—possibly a little less. The central laboratory of course would be more expensive to run; that should have a lot of apparatus which is expensive and which it could lend out, if necessary, to the various hospitals.

21,062. Supposing, for example, one of the young men seconded to you showed special aptitude for research, as you hope, but had to return to duties at his own asylum, would you be prepared to give him apparatus to carry on that particular branch of research in his own institution?—Yes, that is what I do at present. I lend him the apparatus, and any chemicals or mixtures he cannot make easily we forward to him.

21,063. In that way you are able to stimulate him in his work?—Yes, and we keep him supplied with the latest results and medical literature.

21,064. I think in addition to your permanent staff and your seconded members you have voluntary workers, have you not, at Maudsley?—Yes.

21,065. Are they skilled persons carrying on research work on their own resources?—Yes, they are medical men and women, four or five; sometimes we have foreigners; at the present time we have some from the United States; we sometimes have Japanese, and a very small number of English people.

10 November, 1925.]

Dr. FREDERICK LUCIEN GOLLA.

[Continued.]

21,066. And I think you have one studentship which is the result of a bequest of Dr. Maudsley?—Yes.

21,067. Have you monthly re-unions of all your officers of the different County Council Institutions?—Yes; we endeavour to get them to come up and have informal discussions. I think that is one of the most valuable parts of the work, and that is what they miss so much in the provinces; they are absolutely isolated.

21,068. And do you find that this conception of the pathology of insanity is useful; not only does it make the medical staff realise that they are there to cure disease, but is it also appreciated from the patients' point of view?—I think so, very much; they feel that something is being done, and they very often co-operate; and I also notice that the atmosphere in a hospital where there is a lot of that sort of work taking place is very very different from a place where there is no investigation going on.

21,069. Does the patient feel that his case is being studied?—Yes.

21,070. And is that in itself encouraging?—Yes.

21,071. Have you considered on the administrative side how this work should be financed? How is your work financed?—We are financed entirely by the County Council.

21,072. Do they find not only the salaries of the staff, but also the apparatus and the accommodation?—Yes.

21,073. Out of public money?—Yes.

21,074. Of course, Maudsley is in a very special position, as we know. It is dealt with by a special Act of Parliament?—Yes.

21,075. Would you be in favour of local authorities being authorised by Parliament to make grants in aid of research to comparable institutions such as yours?—Yes; I think so, as long as such grants were under some Central Authority, to see that the money was not wasted.

21,076. Do you think that such expenditure might possibly prove remunerative in the end because of its results in enabling mental disease to be checked?—I think there is no doubt it would, in some aspects; it is almost doing so now. For instance, the malarial treatment of general paralysis enabled them to send out a number of cases; they are no longer charges on the asylum; that is the result of quite recent work.

21,077. Just one modern discovery has resulted in that practical benefit?—Yes.

21,078. *Earl Russell*: Do you regard that treatment as proved, as the result of your experience?—I think so. I was very much prejudiced against it when it started; it did not fit in with my ideas.

Earl Russell: I have heard people say that they will not have anything to do with it.

Chairman: I think, Dr. Golla, you have given us your views generally, and unless you have anything to add I do not propose to detain you, though my colleagues may have some further questions to ask you.

21,079. *Mr. Mickleth*: You say, Dr. Golla, that there is practically no research work being done in this country apart from what you are doing in London and that which is being done at Birmingham and Cardiff?—I instanced those as the principal centres; there is a certain amount being done, of course, elsewhere, but very very little.

21,080. I suppose most of the mental hospitals have good laboratories, have they not?—No; very few of them.

21,081. All the London ones have?—Yes.

21,082. And the better ones in the provinces?—Yes; but many large mental hospitals have no laboratories at all. I occasionally have young men from the provinces who come up to see me and work with me who say they have neither the facilities to do the work, nor are they allowed to; it is not part of their duty.

21,083. *Miss Madeleine Symons*: You remarked incidentally, I think, Dr. Golla, that you got a good

many brilliant young men from the asylums, but that many of them did not stay. Have you formed a view as to a reason for that?—I think it is really so much a question of what one is trying to counteract in initiating research work. They do not like a man with any scientific attainments to spend his time simply being a custodian of people. He does not find he has enough spare time or any real recognition of his efforts if he tries to do original work of his own. He sees the prizes go, or they did in the past, to people who are purely concerned with administration, and he is rather disgusted and seeks other fields.

21,084. And you feel still in a great many cases that is the position?—I am afraid so, particularly in the provinces. I think it is very, very much less in the County Council service, because we are beginning to let it be understood that original thought and original work do count in promotion.

21,085. And you think that these developments you have suggested to us would both attract and keep better men?—I think so.

21,086. *Mr. Jowitt*: How do we compare with regard to foreign countries in this matter of research?—On the whole, we are very much behind.

21,087. Was the malarial treatment a discovery of ours?—No; it was chiefly worked out in Vienna.

21,088. And other countries have been going on with this thing for some time, have they?—Yes; but of course practically no country has had very much work done in psychiatry, because people have been so hypnotised with the psychological aspect that they have forgotten the bodily disturbances.

21,089. I have no doubt you have some means of keeping in touch with foreign developments and so on?—Yes.

21,090. *Sir Humphry Rolleston*: When you say we are not so forward as some people, is it not largely because of the help that has been given in places like Holland in institutions and so on?—Yes.

21,091. What you really want is more endowment, is it not?—I do not think personally I want any more endowments.

21,092. *Mrs. Mathew*: You do not concern yourself at all with the training of nurses at Maudsley, Dr. Golla, do you?—No; that is the department of the Superintendent and Medical Officers there; but we are often brought into contact with nurses in these cases whose metabolism we are investigating, and we find that the nurses take a very keen interest in any work that is being done. They offer themselves as victims to have control experiments done on.

21,093. *Sir Humphry Rolleston*: I think you might perhaps make a point of the enormous saving that does result and probably has resulted in the past in the prevention of epidemics, such as colitis, which results from having skilled bacteriological supervision. What is the position about colitis?—Enteric fever and dysentery are practically non-existent at present. There are a few cases of carriers; we get a few cases coming up from year to year; but at the present moment I do not think there is a single case suffering from dysentery in asylums.

21,094. That is an enormous saving in money and in life?—Yes. Of course the same was true of typhoid.

21,095. Do you envisage any scheme of a travelling pathologist who would go round investigating cases of that kind in the same way as officials of the Local Government Board used to do?—I think it is much better now in the hands of the central laboratory; we have weekly reports.

Sir Humphry Rolleston: There is one small point, Mr. Chairman, and that was when you were asking Dr. Golla about his position he said he had succeeded Sir Frederick Mott two years ago. He did not mention that he had been working with him for a long time, and it might appear that

10 November, 1925.]

Dr. FREDERICK LUCIEN GOLLA.

[Continued.]

Dr. Golla's first invasion of pathology was two years ago.

21,096. *Chairman*: We do not wish Dr. Golla to go down to history as such a novice as that! (*To the Witness*): You might give us your experience, Dr. Golla.—It was in 1918 when I came back from the War that I started at Maudsley; but previously to that I had been doing original work on the physiology of

the nervous system practically from the time I was a student.

21,097. How long were you in association with Sir Frederick Mott before you succeeded him?—From 1918 to 1923.

21,098. And before that again you had shown your special interest in this subject by independent work and study?—Yes.

Chairman: Thank you very much.

(*The Witness withdrew.*)

(*After a short adjournment.*)

ALFRED FRANK TREDGOLD, Esq., M.D., F.R.S. (Edinburgh), Miss FLORENCE ANDREW and Miss EVELYN FOX, called and examined.

21,099. *Chairman*: This afternoon we have with us representatives of the Central Association for Mental Welfare, and they have deputed Dr. Alfred Frank Tredgold, Chairman of the Medical Committee of the Association, Miss Florence Andrew, Secretary of the South-West Lancashire Association for Mental Welfare, and Miss Evelyn Fox, Honorary Secretary of the Central Association, to represent the Association before us; and we are very glad to have their assistance in our deliberations. The Association has been good enough to place before us the printed memorandum of the evidence, Dr. Tredgold, which you desire to give.—(*Dr. Tredgold*): That is so.

21,100. You appreciate, I notice, that we have already had before us a very large volume of evidence dealing with most of the topics to which you advert?—Yes, with the exception of one, we thought.

21,101. If you please. I think the most useful thing we could do would be to amplify now any of the topics you desire to develop, because you may assume that we have all read the Memorandum and have it before us.—I think the topic that we desired to draw particular attention to was that on page 4 of our printed memorandum of evidence relating to adolescent mental disorder. This Association, of course, has been in existence for 12 years, as we state, and I think we may say that the experience of those 12 years has been to show us conclusively that there is a type of case which we call adolescent mental disorder which is not capable of being dealt with either under the Mental Deficiency Act or the Lunacy Act, and which, as far as I can see, you have not hitherto had much evidence about.

21,102. You have furnished us with a series of illustrative cases which we have read, and I must say that they impressed me as very striking—very trying and difficult cases for which there is, apparently, no adequate provision just now?—That is so; that is the point we wanted to bring before you. That is our main point.

21,103. The ordinary certified case is provided for?—That is so.

21,104. But the type of case which you are specially concerned with is really at the present moment almost uncared for?—Yes.

21,105. What are the practical suggestions of the Association as to that type of case: the type of mental disorder which is scarcely certifiable, and which at the present moment, as you suggest, is really not provided for?—Our practical suggestions are contained in the recommendations on page 6. We realise that possibly some of these cases would be dealt with under the Mental Treatment Bill if that Bill became an Act, but comparatively few of them.

21,106. That is the voluntary cases?—Yes, and we think that for most of them some special form of institution is needed, an institution which shall be capable of dealing with them over a fairly long period of time running into years, and which should also provide them with training, and with some sort of occupation as well as medical treatment.

21,107. I suppose there are really two types of cases, are there not? There is the type which is recoverable, and which with the passing away of the

stage of adolescence may possibly emerge into quite efficient citizenship on the one hand, and, on the other hand, there is the type that is permanently deficient, and must always have a certain amount of shelter and assistance?—That is so. We have rather tried to separate those cases in our evidence, and under the heading of adolescent mental disorder we are dealing in the main with the recoverable type of case. Of course there would be some who would subsequently turn out to be cases of dementia praecox, or incurable insanity; but we think with regard to the great bulk of them, if proper means were provided, they would be curable and would be capable of returning to social life.

21,108. One has to remember this, that multiplication of institutions means the multiplication of the cost, and one is anxious to consider how any of your proposals could work in with others that have been brought before us. It appears to be recognised on all hands that some form of permanent asylum will always be necessary for the chronic type of case; but we have heard a good deal of evidence on the desirability of establishing clinics and institutions in association with general hospitals where incipient cases, or cases short of certification, might be treated. But your type is a little different, as it occurs to me, and I should like your view on this. You seem rather to contemplate the home than the hospital?—Yes. We have in view a rather different type of case altogether, and I think perhaps a type of case of which this Association has rather special experience; probably these cases in any number would not come before any other body; it is a type of case which breaks down during adolescence, and possibly there is some hereditary tendency, but the main thing is the stress of adolescence and the environment at that time. They break down and for a period of years they are quite asocial or anti-social; they are suffering from mental disorder, but that mental disorder is not of a kind which can be certified, and we do not think that the ordinary treatment at a clinic such as would be suitable for cases of incipient insanity would be adequate. We think they must have treatment, but that treatment must be combined with home life in a small home of about 20 persons where each person could be under the personal supervision of an understanding superintendent, where they could receive industrial training of some kind or other, and at the same time where they could be afforded opportunities for the development of their character, which is essential if they are to become efficient when they get back into normal life.

21,109. The degree of deficiency, you say, is short of certification?—Yes.

21,110. Are they persons whom you could not describe as of unsound mind?—Yes, I think they are.

21,111. On the other hand, you rather indicate that they are a menace to themselves and a menace to society in their present condition?—Yes.

21,112. You see your suggestion would mean that we should have to have yet a third type of institution: the asylum, the general hospital or clinic, and a type of home?—Yes.

10 November, 1925.] ALFRED FRANK TREDGOLD, Esq., M.D., F.R.S. (Edinburgh), [Continued.
Miss FLORENCE ANDREW and Miss EVELYN FOX.

21,113. Possibly intermediate between those two, or at any rate different from those two, where cases of that sort might be received?—Yes.

21,114. Do you contemplate that the cases would pass out ultimately into the world?—Yes, we do. I may say that at a very large and very well attended meeting of the Medical Council we faced this question. We realised that we were proposing another type of home altogether.

21,115. That is just the point; we should like to hear you upon it?—We realised it, and we faced the question. We realised that the only way of dealing with these cases in a satisfactory manner was to provide a different type of home altogether, which should not be an asylum and which should not be an ordinary clinic.

21,116. I notice in your efforts to assist a number of those cases you have been able from time to time to get them into different types of homes or institutions of one sort or another?—Yes.

21,117. I gather they were mostly charitable institutions?—Yes, all of them, I think.

21,118. How far do you think that this type of case can be met by charitable efforts?—I think probably Miss Fox will be able to give you better information on that point, because she is more concerned with the practical administration of the Association.

21,119. It is a very important point, as you will appreciate. Perhaps, Miss Fox, you will give us your experience?—(Miss Fox): Judging from our practical experience in getting these cases cared for in the existing homes and institutions, those homes and institutions, as they are at present financed, are unable to deal with the cases in at all a satisfactory way. They have a large percentage of mixed cases coming from all sorts of different places, and of a different type very often; they are run on very economical lines; they cannot provide the rather special surroundings and the rather special staffing that this class of case requires, if it is to be returned to normal life in the course of a few years.

21,120. But you do not think that ordinary philanthropic effort could cope with it?—No, because philanthropic effort generally wants to see a very definite end to its exertions; and in the case of the homes which we have tried the longest time allowed, I think, is for two years, and in some instances it is obvious that a girl wants rather more than that in a special surrounding; it may be three or four years. The period of instability lasts a considerable time in some of these cases.

21,121. What do you do with a case where the instability persists past adolescence into mature life?—At present there is nothing done, but I should imagine in future that those cases when they had had every opportunity of training would have to be referred for treatment probably under the provisions of the Mental Treatment Bill. If they persist for ever it is obvious that no training home can cope with them for ever.

21,122. I am afraid there must be a certain percentage of the cases which will remain unstable, notwithstanding the best training and treatment that you give them?—Yes, there must be some.

21,123. And yet will always be short of certification?—I think so.

21,124. A very difficult type of case to deal with?—Very difficult; but I think the percentage would be very much smaller if the young person from 14 upwards can be given special training, with the aim of returning that person to ordinary life.

21,125. You regard that particular stage of life as one where there is the greatest risk to stability of mind, and therefore a stage at which some protection might be devised for the weaker vessels?—Yes.

21,126. Do you find that there are no institutions at the present moment which you can resort to for such cases?—Practically none. Miss Andrews' Association in Liverpool has just started a small experiment on those lines; and there are just a few —

perhaps three or four homes I know of in the country—where by chance the superintendent is particularly interested in this type of case, and does make a special effort to deal with them; but it is not easy to do so with a lot of other cases, because where you might want a certain form of discipline for the normal girl you might need to have something quite different with the abnormal girl who is wrestling with special temperamental difficulties; it is not always easy to manage them both together.

21,127. Suppose it were possible to establish institutions such as you figure, would you require some power of compulsory detention?—No.

21,128. Because I could imagine that that type of undisciplined young man or young woman is just the type who might go into your home and leave again in a few days?—I think there would be a risk of that with some of the cases, but I think that one would be able to have a very large number who would remain, provided the environment of the home was of the right sort.

21,129. Then you contemplate that it should be purely voluntary treatment?—Yes, at present we think it ought to be voluntary.

21,130. Miss Madeleine Symons: Do you find, or do you think, Miss Fox, that a good many cases of the type you have in mind, in so far as they are under 16, find their way now into institutions like industrial schools and reformatories?—Yes, I think they do. We have no statistics as to the proportion.

21,131. May I ask you on that, do you advocate for children of that kind that they should be placed in the special homes that you are suggesting to us, or do you advocate that they might have better facilities for treatment in the existing institutions?—It seems to me that both are really needed. You really want some industrial schools that lay themselves out for these temperamental cases, but I think even then there would be a few cases that would benefit by being moved to such a specialised place as I suggest—not all, because of course your aim is to keep the surroundings as normal as possible, and one does not wish to withdraw any individual, however handicapped, from the society of his normal fellows if it is possible for him to remain with them to his advantage. I think there are some who cannot remain with the ordinary boy and girl, and who do benefit by the quite different discipline.

Chairman: I think Miss Symons' suggestion is that, without starting new institutions, some adaptation and possibly an extension of the industrial school system might go far to meet your difficulty.

21,132. Miss Madeleine Symons: I was really wondering what the view of the Association was on it: whether they agree that the type of case they have in mind does find its way there; whether they were satisfied with the treatment received there, whether they wished to suggest further treatment in those institutions, or whether such cases should be all removed into homes?—I do not think we could make any statement so sweeping as that they should all go, but I do not think that having special industrial schools for these types of cases would meet the need, even of the industrial school population; I think you want something else besides.

21,133. Chairman: Have you any conception of the number of cases of this sort in the country as a whole?—No.

21,134. But in the experience of your own Association during the period of its operations have you come in contact with a large number of cases of this type?—We think that probably 10 per cent. of the cases which are referred to the Association belong to the uncertifiable type of case; that is as near as we can go.

21,135. That is only of those cases that come actually within your own cognisance?—Yes, we have had about 34,000.

21,136. Ten per cent. would be 3,000 or 4,000?—Yes, but then I do not think that represents the proportion there is, because some of our Associations are called Associations for the Mentally Defec-

10 November, 1925.] ALFRED FRANK TREDGOLD, Esq., M.D., F.R.S. (Edinburgh), [Continued.
Miss FLORENCE ANDREW and Miss EVELYN FOX.

tive, and that would mean that many of these borderland cases would not come to them.

21,137. If you take the typical cases you put before us they seem extraordinarily difficult to deal with. They are not all children, by the way. I notice that some of the cases are over 20?—Yes; they started younger.

21,138. But would people of that sort be disposed voluntarily to remain in a home where they would be subjected to a type of discipline that they might not welcome, however good it was for them? I mean you are assuming it is all to be voluntary?—Yes, we think that of the cases with which we have had to deal a really considerable proportion of them would stop voluntarily, and I think Miss Andrew, who has actually sent some of these cases to a home, agrees with that.

21,139. Some cases of course are amenable and others are not really amenable to treatment?—Yes; but on looking over the sort of cases that we have had, they have received such unsuitable treatment—not from anybody's fault—that most of them have constantly run away, and I do not think they would have done so if it had been possible to place them in the right environment when they were still young. We pick them up too late very often.

(Dr. Tredgold): With reference to that point may I say this: this was a matter which was very carefully considered by the Committee, because there are one or two members who took the view that it would be quite impossible to get these people to remain in an institution and that we ought to apply for some power of detention.

21,140. That was what was troubling my mind at the moment, Dr. Tredgold.—Quite so. That subject was very carefully considered; we had got a great deal of experience, and the conclusion that we came to was this, that on the whole, if the superintendent was sympathetic, and if the atmosphere was suitable, the majority of cases would stay in the homes; there would be some who would not be detained and who would go away, but we felt that on the whole it was better to lose that small number rather than to attempt to apply for powers of detention for a totally new class who were entirely outside the Lunacy Act. We felt it was quite impossible to ask that Parliament should give powers to detain another class of person, who was not suffering from the amount of mental disorder which would justify his being dealt with under the Lunacy Act; and we felt that the number of cases that would refuse to stay would be comparatively small.

21,141. Then how would you propose to reach and discover this class of case?—We have no difficulty about that; I mean they are applying to the Association almost daily.

21,142. The relatives, I suppose?—Yes, there is no difficulty about reaching them. (Miss Fox): And the homes have them. All these voluntary homes, of which there is a very large number in the country, especially the preventive and rescue homes, and certain homes for boys, are always referring cases to us because they cannot deal with them; they are not in the least mentally defective but they are unmanageable, and I think if there was any provision possible those cases would go to the specialised homes instead of being in the scattered homes. I think also a great many would probably come through the observation wards.

21,143. At present is the only type of place to which such young people can be sent some voluntary home run as a charity?—Yes. In those homes there is a considerable proportion of cases at the moment which are paid for by boards of guardians; in the main they are the cases that are chargeable to the guardians.

21,144. But how do you suggest that your homes would be better able to manage those incorrigible or unmanageable cases than the existing institutions?—No existing institutions take these cases specially. The charitable funds are provided for

rescue and preventive work, perhaps for one type of case, and perhaps for another; and none are provided for this special type of case; therefore they have all sorts, and they cannot adapt their work to all sorts of cases.

21,145. Then your homes would be adapted to deal specially with this type of case?—Yes.

21,146. As to the financing of it, I see that you propose that the local authorities should be empowered to establish such homes?—Or to contract.

21,147. And you contemplate that the money should come, in part at least, through a grant from the Exchequer?—Yes.

21,148. So that the institutions would be partly on the rates and partly on the Votes?—Yes.

21,149. Where would you have the institutions situated; what would be the distribution of these homes?—The majority of them, I suppose, would be in or near the vicinity probably of towns, because, after all, the majority of these people would have come from urban areas, and they have got to be trained for the work which they would naturally turn to. Some would have to be in the country, probably, but I think the majority would be where the voluntary homes are now.

21,150. That is to say, distributed among the centres of population?—Yes.

21,151. In the towns, or would you suggest that they should be in the country adjoining the towns?—I think that would be better and healthier; it would give them more scope for outdoor work. But you have got to realise that the girls do not like outdoor work as a whole; they will not go to it afterwards.

21,152. Do you not think that this particular province of good work could be covered by charitable effort?—No, I think charitable effort has recognised the need for it, but it has not covered it.

21,153. I should rather have gathered from what you have said that some of the charitable efforts had been possibly a little misconceived in the existing institutions, and that what you really wanted was a new direction for charity?—I should not like to say that; but they have not aimed at catering for this special class of case. There are many others for which they cater in different ways.

21,154. What I meant was this: it is a modern development to appreciate this kind of social defect?—Yes.

21,155. If that was brought sufficiently prominently before the public, would not the public respond as they have responded in the past in the other cases?—I do not think they would. Of course, one has got to realise that they are responding less and less.

21,156. Perhaps the means of response are being curtailed?—That may be so; but there is very much more difficulty in raising funds for any charitable work now, and it is almost impossible to raise funds for any new development.

21,157. Have you considered at all what the expense of such homes would be?—Yes. I think the expense would be rather higher than the ordinary rescue and preventive home. It is very hard to say, but I should think it would vary from 18s. to 25s. a week; I could not say really. It would depend upon what arrangements were made.

21,158. 18s. to 25s. all in? Does that include establishment charges and everything?—Yes, I should think about that, judging from what is paid at present for those sort of homes.

21,159. Would that include also payment in respect of medical attendants and teachers?—It would include some payments, but I should imagine they would probably go to clinics for treatment.

21,160. But you would require a teaching staff and materials, of course, for any trades you were teaching, would you not?—Yes, you would have to have opportunities for very varied industrial training.

10 November, 1925.] ALFRED FRANK TREDGOLD, Esq., M.D., F.R.S. (Edinburgh), [Continued.
MISS FLORENCE ANDREW and MISS EVELYN FOX.

21,161. That means paid teachers, does it not?—Yes, but not skilled craftsmen, or teachers of young children under Board of Education Regulations.

21,162. Would the work done in your institutions be a source of revenue? Would the young people who did that work get the produce of their labours, or would it be done on behalf of the institution?—If you have a small home, and you have, say, 20 to 25 of these rather difficult young people, you cannot set them all to the same sort of work, because one of the methods of treatment is to give them the right type of practical training. Therefore I should think that the money that would be got from that work would be very small.

21,163. Have you considered whether this work could not be covered by the Mental Deficiency Act?—No; they are not in any way certifiable under the Mental Deficiency Act.

Mr. Jowitt: Does this come within our terms of reference, Mr. Chairman?

21,164. *Chairman*: I doubt very much if it does. It only comes within our reference in so far as evidence is being offered to us upon the mild forms of insanity which occur in adolescence and how they should be treated. (*To the Witness*): Of course we cannot deal, as you understand, with mental deficiency?—We carefully excluded any reference to it. It has nothing whatever to do with mental deficiency.

21,165. That is what I cannot quite understand, because these people seem to me to be at least temporarily mentally deficient?—I do not think you can be temporarily mentally deficient.

21,166. Can you not?—I trust not; mental deficiency implies some permanence in the condition.

21,167. Probably organic, or something of that sort?—If it is mental deficiency it is permanent.

21,168. What you have in mind is really a mild form of insanity incidental to a particular period of life?—Yes, mental disorder. I do not know that insanity connotes a legal form.

21,169. A mild form of mental disorder incidental to adolescence—is it that class of case?—Yes. (*Dr. Tredgold*): Yes, that is so. We definitely exclude cases of mental deficiency, and we want to make that point quite clear, that none of these cases are cases that can be dealt with under the Mental Deficiency Act.

21,170. Mr. Micklem: In the illustrations you give us of several cases, are not many of them cases which come directly under the Mental Deficiency Act?—I think you will find in all those cases, whilst (on the face of it) it is suggested that they are mentally defective, none of them have been proved to be capable of being dealt with under that Act. I think that applies to all the cases we have put forward—that in actual practice they cannot be dealt with under that Act.

21,171. It is not easy to follow that. The cases that are given on the face of them look very much as though they were precisely covered by the Act—some of them?—I quite agree they do, but in actual practice they cannot be dealt with. I think I am correct in saying that several of them we tried to put under the Mental Deficiency Act. (*Miss Fox*): We have taken the cases that no one would certify.

21,172. Mr. Jowitt: Take a case like your case "E," there seems to be nothing the matter with the case except what happens to everybody who leads an immoral life. I suppose, any criminal tendency is due to mental disturbance?—This case "E" has been seen by various specialists, and though they said she was not certifiable they were quite certain she wanted some treatment.

21,173. *Sir Humphry Rolleston*: Do you take cases of dementia præcox?—(*Dr. Tredgold*): We have excluded cases of dementia præcox; I do not think there are any of those cases here. I may say that all these cases have been selected from a very large number, and in all of them there has been no doubt as to mental abnormality. It is perhaps rather difficult to express that in the brief notes which we have given

you, but the cases have come before the Association because of definite mental abnormality.

21,174. Mr. Jowitt: Is it in your view a symptom of mental abnormality that a girl employed at a photographer's should go outside the shop?—(*Miss Fox*): This girl has had I do not know how many different places and she has been seen by several specialists, as her conduct was such that nothing could be done to her; she has been seen by a great number of specialists who said that she was not certifiable in any way.

21,175. Mr. Micklem: But so many of these cases seem to me to be cases of what the common person would call vicious or criminal disposition, on which punishment has very little effect, and they want looking after. *Prima facie* a case of that kind would come under the Mental Deficiency Act?—In selecting these cases I do not think there was one who was not examined by more than one expert as to the possibility of certification under the Act.

21,176. Was not that certification under the Lunacy Act?—Yes, and the Mental Deficiency Act also.

21,177. *Chairman*: The four classes under the Mental Deficiency Act are idiots, imbeciles, feeble-minded persons and moral imbeciles—in each case with a definition?—Yes.

21,178. Moral imbeciles are defined as "persons who from an early age display some permanent mental defect coupled with strong vicious or criminal propensities on which punishment has had little or no deterrent effect." Some of these cases are not unlike that description?—(*Dr. Tredgold*): That may be so, Sir, but, as a matter of fact, I have no hesitation in saying that none of these cases could be dealt with as moral imbeciles, and I go further and say that none of them could be dealt with under the Mental Deficiency Act. I think one has to distinguish very carefully between mental defect and mental disorder. If they could be dealt with under the Mental Deficiency Act we should be only too glad, because our difficulties would be very much lessened; but it was because we find in actual practice that they are not mentally defective but suffering from mental disorder—in other words because we find that they cannot be dealt with under the existing Act—that we ventured to place them before you as a special class for consideration. It seems to me that with regard to vicious and criminal propensities the position is this: Whilst vicious and criminal propensities one may regard perhaps as the unfettered sway of certain lower instincts—we will put it that way—when the control is inoperative, then one's natural instincts tend to have unfettered sway and may manifest themselves in vicious or criminal misconduct. That may arise in the case of the mental defective as a result of the non-development of control; he has never acquired control over those instincts; he has been mentally defective from birth or an early age. But the type of case we have in mind here is where conduct at one time has been good and normal and has conformed to the laws of society, but the control has broken down as a result of mental disorder or disturbance, and whilst it has broken down then we have this misconduct. I think one does want very clearly to distinguish between those two cases: the type of case in which the person has not only never developed control, but is incapable of developing control, and the person who has at one time had control, but whose control has broken down. We suggest that these cases, whilst they are not capable of being certified under the Lunacy Act for practical purposes, nevertheless do come within the terms of your reference in this particular term: "The extent to which provision is or should be made in England and Wales for the treatment without certification of persons suffering from mental disorder." We hold the opinion very definitely that they are suffering from mental disorder.

10 November, 1925.] ALFRED FRANK TREDGOLD, Esq., M.D., F.R.S. (Edinburgh), [Continued.
Miss FLORENCE ANDREW and Miss EVELYN FOX.

21,179. Of course there is a school which regards all vicious propensities as indicative of a certain amount of mental disorder?—Yes.

21,180. *Mr. Jowitt*: Does the doctor accept that view?—That is rather another question.

21,181. Do you accept that view?—I do not know that I would, because I think that certain vicious and criminal manifestations are due to this: the individual carefully balances the consequences and decides whether it is going to be to his advantage to commit this particular crime or not, and whether he is likely to be found out or not. It is a case of carefully balancing the consequences. If he decides that on the whole he is not likely to be found out, and he will reap a material advantage from committing the crime, then he deliberately takes the risks.

21,182. *Chairman*: I do not think very many philosophise the situation quite so carefully as that. It is instinctive, I am afraid, in a good many cases. —Yes, but on more than one occasion I have heard an accused person actually use that expression in accounting for the delinquencies. "Well," he said, "I just thought it over, and I decided to take the risk," and I think that is what a lot of criminals do.

21,183. *Mr. Jowitt*: May we get this clear, which seems absolutely fundamental to your position. I go back to case "E." Here we have a case of a girl who is quite unable to stay long in a situation, who goes as a help to somebody and only stays two weeks, and then as a companion to an elderly lady, where she stayed three weeks; she then goes to a photographer's shop and looks out of the window instead of attending to her business, and finally runs away and lives with a man somewhere. Suppose I told you those facts about any girl, would you draw the conclusion that that girl was in any way suffering from mental disorder and ought to be placed under restraint?—A case where a girl does that, in spite of careful upbringing, may I add—

21,184. If you like, certainly. In spite of the careful upbringing, she is unable to stay longer than about a fortnight in any situation, neglects her opportunities when she goes into business, and, if you like, is found periodically living with men. Would you predicate on those facts some type of mental disorder?—In other words, she is following a line of conduct which is greatly to her disadvantage?

21,185. Certainly.—I should say, on the face of it, that that implies some mental failing of some kind or other, to my mind.

21,186. *Chairman*: This class of case is a little difficult to describe. One is quite familiar with the type of child who is obviously dull and unresponsive to stimuli and unreceptive of education; that is, no doubt, the typical mental defective. Then you may have, of course, the child who is really of unsound mind. But in this class of case you apparently infer abnormality of mental state from unsatisfactory conduct, if one may put it in general terms?—Yes.

21,187. Unreliability of conduct evidenced by untruthfulness and petty thefts; and from that kind of social abnormalities you infer that that person is suffering from some form of mental disorder?—Yes.

21,188. It is not the generally accepted view that that is necessarily mental disorder, is it? It is, in a sense, mental disorder, because it means that the person does not conform to ordinary standards of conduct; but is it disease?—I think I should certainly take this view, that if you have a child who has been well brought up, whose environment has been satisfactory, where she has been subject to good example and good precept, and yet, in spite of that, she has persistently given trouble, she cannot conform to the standards of the home, she cannot conform to the standards of society, she breaks the law, she has no idea of personal cleanliness, she is dirty in herself, and she embarks upon a course of conduct that is obviously to her disadvantage—in other words, which entails some sort of punishment—I

should certainly conclude that there was something wrong with that person's mind. One would want to know more details to decide what was wrong, but I think one would certainly conclude that there was something wrong.

21,189. And the cure, according to you, would be found in a species of moral discipline?—Assuming that that state of mind was due to a disorder, the cure would be found in treatment, in prolonged training and supervision in such a home as we suggest. If it were due to an absence of any capacity for developing control, in other words, if the person were a moral imbecile, then I do not think anything would cure it, because I regard the moral imbecile as incurable.

21,190. Where would you accommodate a case of that type?—I think there is only one thing to do with a moral imbecile, and that is to get him under control, the sooner the better. From what I have seen of them I think they are absolutely incurable.

21,191. Then this class of disease you are contemplating, this mental disorder, is not the type which would be appropriate for treatment in a general hospital?—No.

21,192. If this young woman to whom *Mr. Jowitt* refers, had gone to a hospital they would have said "There is nothing wrong with you, what are you here for?"?—Yes.

21,193. Then you would say "Oh, but this person's conduct is so unreliable, so unsatisfactory, that there must be something wrong with her mental make up"?

21,194. *Sir Humphry Rolleston*: I gather that the probabilities are that institutional treatment would put these people more or less into a position of being released after ten years or so?—We should hope they would be released before that.

21,195. But do you imagine that in the case of these young women you would get a similar relapse at about the age of 45 to 50?—I think it is possible that one might.

21,196. It is one of the examples of puerperal disorder?—Quite so. I think it is quite likely that at the other end of life one might get a similar relapse.

21,197. Are those cases provided for?—I suppose not. They are not provided for.

21,198. And you would be prepared to take up those cases?—Certainly. I think they would be provided for by very similar institutions to those which we suggest.

21,199. *Chairman*: Of course you may have a disturbance in the case of boys at puberty also, may you not?—One does have the same disturbance. Of course we are speaking here from experience as an Association, and in actual practice most of the cases are girls, but undoubtedly one does have the same condition in boys.

21,200. Some of the instances you give here are of boys and men?—Yes, some are. In private practice I see quite a number of those cases. Boys in well-to-do circumstances, boys attending public schools or the Universities may break down in the same way.

21,201. We have the mental deficient on the one side, we have persons of unsound mind on the other, and you say there is a category that falls between the two, neither mentally deficient nor of unsound mind, but exhibiting at one phase of life such abnormality as to require special treatment?—That is so, Sir. I put it this way: that to be capable of being dealt with under the Lunacy Act a person has got to suffer from a particular kind of disorder of mind which amounts to unsoundness of mind or legal insanity. We say that there is a type of mental disorder which is short of that, which nevertheless is a disorder of mind which affects a person's conduct, which renders him in need of treatment and which is curable, but yet which practically cannot be certified as a case of unsound mind.

10 November, 1925.] ALFRED FRANK TREDGOLD, Esq., M.D., F.R.S. (Edinburgh), [Continued.
Miss FLORENCE ANDREW and Miss EVELYN FOX.

21,202. *Mr. Micklem*: And towards whom you would not exercise any compulsion?—No, we do not suggest any powers of detention.

21,203. *Sir Ernest Hiley*: Notwithstanding that they are morally depraved?—Well, some of them are morally depraved. I do not know. Moral depravity is rather a difficult term to define.

21,204. *Chairman*: But I can see a great difficulty in Sir Ernest's point. Suppose you take in what we call commonly a bad boy or a bad girl who was unamenable to discipline, and was exercising a very bad influence upon others; you could not very well send that child away, because the whole reason why the child is there is that it has those manifestations. How are you going to handle a case of that sort without any compulsory power. Supposing the child is 14 or 15 years of age: you could not very well resort to corporal punishment with a girl of that age. What would you do?—One can say this, that in such a case as you suggest if one really considered that the amount of mental disorder was such as to make the child quite asocial or anti-social, to disturb his conduct to that extent, one would have to consider then whether that person could not be dealt with under the existing Lunacy Act. It seems to me quite possible that in some of those cases you would have to deal with them under the Lunacy Act.

21,205. What powers would you seek to have conferred to you in the way of disciplinary measures?—I take it that the powers would be those that are given to a guardian. I am not quite certain what are the legal powers of a guardian.

21,206. You would be dealing with children of a larger growth; they would not be of a school age, they would be of a rather older age, 15 to 20 is about the range, is it not?—There is a somewhat analogous instance I think in the case of approved homes under the Mental Deficiency Act. There are approved homes, and in those homes there are certain feeble-minded persons without any detention order, and yet I am told that, although they could go away if they wished to-morrow, it is exceedingly rare for them to leave the home. I think myself that, after all, these people are human beings; they are capable of appreciating sympathy and understanding, and I think the majority of them, if the superintendent were suitably chosen, and if the environment were satisfactory, would stay. We quite admit that some of them would not.

21,207. *Mr. Micklem*: Are they not just the class who do not understand the kindly and sympathetic treatment, because in many of these instances that you give, every possible thing seems to have been done for them, and they have thrown it over on every occasion?—I do not think that is our experience. (*Miss Fox*): Our experience is that we tried all sorts of unsuitable methods, because with very few exceptions we could not find the suitable ones. They went to unsuitable places, and every effort was made to try and get something for them, but we could not get the right environment.

21,208. *Chairman*: It may be that the reason was that they were temporarily unfit for any form of settled occupation, because certainly one or two of them seem to have tried their hands at almost everything with unsatisfactory results?—Yes.

21,209. *Mr. Jowitt*: Do not you think they are just the class of rather vicious people who might benefit enormously from the value of homely discipline?—But they would have discipline in these homes.

21,210. I should have thought if they went into these homes and were able to go out whenever they wanted to, that is just the one thing you could not possibly secure for them?—As a fact, a great many of these types of cases do go to these voluntary homes, and, although, of course, they can all leave at any moment, I think our experience is that they do not leave at any moment.

21,211. Is the discipline severe and strict?—In some places, but it is not the severity of the discipline, it is the quality of the discipline. It is not necessarily a severe discipline that is the right training for them; it may be in some cases; I think it is in some cases; some cases I think are just dreadfully spoiled, and they do require discipline; but in many other cases I think they are wrestling with their own temperaments, and therefore the discipline which is needed is one which will help them to discipline themselves.

21,212. *Chairman*: Please do not imagine for a moment that we underestimate the difficulty of this type of case, but the immediate problem is whether the proper way to deal with it is the provision of a new type of rate-aided homes; that is really putting it in its simplest form; a new type of mental institution which would not be strictly a mental institution, but would have as its objective the correcting of certain faults of conduct and mind resulting possibly from early neglect and so on, which was unfitting these people for the ordinary duties of citizenship. That would be your aim: to correct these things by reasonably disciplined life and by good moral influences and regular employment. We are really concerned with the question of how that is to be achieved. It does strike one as the kind of thing which is, if I may put it without offence, so indefinite in its scope that the less rigid bounds of charity might meet the case more readily than some official scheme with all that an official scheme means. Of course, officialism always means a certain sacrifice of independence, and you cannot do what you like when you are dealing with public money, whereas in the administration of charity a much wider discretion is given. I suppose your fundamental answer is, "Well, we have not the money"?—Might I ask Miss Andrew, who has had experience of raising money for these purposes, to deal with that matter?

21,213. Yes, we should like to hear Miss Andrew's views. You are connected with the South West Lancashire Association, Miss Andrew?—(*Miss Andrew*): Yes, I have had experience in South West Lancashire, and I have consulted 12 charitable institutions where they have been dealing with all these types of girls for a number of years. The time has now come when they do recognise them as a type of case for which they can no longer provide. They are themselves considering setting aside one house as an experiment where they would gather together these cases. We have tried associating them in one home; four definite cases of this kind out of a total of 16, and we have found that they really cannot be associated, not to benefit them. The other difficulty arises from the length of time for which it is necessary to keep them. The longest time you expect to keep a girl of that type in a home is two years, and that is not long enough.

21,214. Are those institutions you are speaking of all voluntary institutions?—Yes, all voluntary institutions.

21,215. Are they managing to get along in spite of the difficulty of getting money?—Do you mean as regard these cases?

21,216. As regards all their cases?—The difficulty of raising money is acute; we are finding it more difficult every year; but the great difficulty is that the managers of these homes are recognising them as a class and refusing to take them.

21,217. Is that because they are so unmanageable?—Yes; because they think they cannot get the best results by mixing them.

21,218. Do these cases in your experience yield to treatment; do you find you get moral recoveries?—A proportion do yield to treatment.

21,219. Is it hopeful work?—I think it is, yes.

21,220. *Sir Ernest Hiley*: About how many cases do you get a year in your Association, Miss Andrew?—I should think in any year in the last three years we have had at least 40 to 50.

10 November, 1925.] ALFRED FRANK TREDGOLD, Esq., M.D., F.R.S. (Edinburgh),
Miss FLORENCE ANDREW and Miss EVELYN FOX.

[Continued.]

21,221. And that takes in Liverpool and all that populous part there?—Yes; we might have had a larger number, but we would not accept them as cases that we felt we could help.

21,222. *Chairman*: Do you think there are many more that have not come under your notice?—I know there are, because we are consulted as to which cases we will take.

21,223. *Mr. Micklem*: Have you 12 homes in that district?—No. Those are rescue and preventive homes, Salvation Army homes and homes of that type.

21,224. *Chairman*: You have been studying their methods, and you tell us that these people are experiencing difficulty in dealing with this particular class of case you have in mind?—Yes, they are referring them to our Association.

21,225. And your Association has not got any homes, I understand?—No; except that we have raised the money to support these beds in an existing home.

21,226. Then all you can do at the moment is to assist with advice?—Yes, and place them where we can.

21,227. Try to find employment for them in suitable circumstances and give them good advice and encouragement, and I suppose exercise a certain amount of surveillance over their future so far as they will permit it?—Yes; it always means a change of environment of some kind.

21,228. *Miss Madeleine Symons*: How do you arrange about the advice? Do you have in every centre doctors attached to your Association who examine cases referred to you?—We usually ask the advice of a doctor who is likely to know them. In the experiment I spoke of, there we had the advice of the medical superintendent of the mental hospital.

21,229. I mean if people come to you, or if parents of these young people come to you, have you certain doctors who do this work for you?—Yes, we have certain doctors to whom we can refer cases of this kind; sometimes voluntarily, and sometimes we pay fees.

21,230. *Sir Humphry Rolleston*: Have you any kind of estimate (of course it would be purely provisional) of what the number would be that would have to be provided for?—(*Dr. Tredgold*): I am afraid we could not give that.

21,231. *Sir Ernest Hiley*: What is the nearest you have got to the estimate?—The nearest we have got was the number of cases coming before the Association, and that amounts in the course of the past 12 years to something between 3,000 and 4,000. But, of course, one has got to remember in regard to this, that until the past few years, the last two years I think, the Association has been rather particularly identified with mental defectives; it was called the Central Association for Mental Defectives; so that in those early days these cases would not come before us at all. It is only within the last two years that its scope has been enlarged.

21,232. *Chairman*: I think, *Dr. Tredgold*, we understand the point you wish to bring before us to-day, and the difficulty which you have experienced in dealing with this particular type of case. I need scarcely say that we will give every consideration to the memorandum you have put before us; but unless you have any further point that you wish to develop I was not going to pursue it with you?—I do not think I have anything further to add.

21,233. Now do you desire to refer to the other topic of your memorandum, which deals with the psychological examination of persons charged with offences?—We would like to draw attention to that, *Sir*. We do feel that if anything is to be done, or before anything can be done, with regard to the treatment of these cases, they have got to be recognised and diagnosed, and we do feel that at present the facilities for the diagnosis of mental abnormality

in cases that come before the Courts are totally inadequate. We have no doubt that a very considerable number of the cases of delinquency are due to mental abnormality. As I say, we think that some means should be established whereby those facts could be ascertained.

21,234. That, of course, is a topic of much general interest which is being largely discussed at present: the relation of the young criminal to mental disorder?—Yes; but the point that we rather wanted to insist upon, as I say, is that at present there is practically a complete absence of any means of finding out whether they are mentally abnormal or not. We think there ought to be some better means of examining these cases which come before the Courts.

21,235. Better machinery made available to the presiding magistrate?—Yes.

21,236. *Sir Humphry Rolleston*: I should be rather interested if *Dr. Tredgold* would give us any information as to how an epidemic of encephalitis is likely to affect this problem, and whether the problem may not be made much more urgent in the future than during the last seven or eight years?—With regard to that I have no hesitation in saying that it is being made much more urgent now.

21,237. *Chairman*: You allude to that in paragraph 13 of your memorandum?—Yes. We have an increasing number of cases coming before us, and the problem is really at the present time a very acute one; and, of course, if the epidemic is going to continue it is going to become much more serious; at the present moment it is a very great problem indeed. I see children who before having had an attack of encephalitis were perfectly well behaved and moral children in every way. After an attack of encephalitis they become absolute little fiends, they are uncontrollable, they lose all affection for their parents, they become liars, they become thieves, and there is no doing anything with them. I see quite a large number of children of that type at my clinic, and they are constantly coming before us.

21,238. *Chairman*: It is a very grave social menace?—Very grave.

Sir Humphry Rolleston: There is a point which has occurred to many members of the Commission, and that is whether this need is not really one that might be met by adding to and modifying the Bill with regard to mental disorder.

21,239. *Chairman*: The same idea was passing through my mind, too, *Sir Humphry*: whether the existing definitions may not be too rigid. It is very undesirable to start, if you can avoid it, new and different types of institutions; because the multiplication of institutions does not always mean necessarily the multiplication of benefit?—No.

21,240. If it were possible to fit your type of case, which we recognise, into one or other of the existing schemes, or, indeed, into any of those schemes modified as we may recommend (because, of course, we have in view a number of modifications of the existing system)—if we could fit in your homes suitably into the *cadre* of the administrative system without starting a new system of homes and a new bureaucracy, it would be the better plan; but it is not very easy to devise it?—No, we quite appreciate your point. All we are desirous about is getting treatment of some kind.

21,241. You are here to urge upon us the importance of catering for this class of case?—Yes. (*Miss Fox*): Might I say one word about that point? We did look through the old Mental Treatment Bill, and it seemed to us that with very small adaptations the Bill could be made to cover what we have in mind. The question of time and of hospitals with a training basis seemed to us as if it would meet the need.

21,242. I see your point, *Miss Fox*. That Bill, of course, did contemplate a certain number of approved institutions?—It did.

10 November, 1925.] ALFRED FRANK TREDGOLD, Esq., M.D., F.R.S. (Edinburgh),
Miss FLORENCE ANDREW and Miss EVELYN FOX.

[Continued.]

21,243. And you think that possibly along the lines of that Bill might be found the solution?—Very minor alterations as it came out of the House of Lords would make it possible to take in this type of case. Of course, it gives what we suggest should be given—a power and not a duty to authorities to deal with them, two very different things, and it does away with that bureaucratic element which you referred to, Sir, and means generally the use of what is available rather than the creation of new things.

21,244. That is a very useful suggestion, Miss Fox, that we will take note of. There is one other thing I wanted to ask you. There is another society called the National Council for Mental Hygiene whose prospectus I have looked through. It seems to cover to some extent very much the same type of work as yours, a certain number of distinguished persons are members of both associations. What is the frontier between your spheres? Do you co-operate?—Yes, we are strongly represented on both associations. The Mental Hygiene Society is going to cover absolutely the whole work, and is rather more a propagandist body than we are. One of our main things is to do practical work in different parts of the country; but there is no real division between the two.

21,245. We have had evidence from them already, and quite a number of their recommendations chime with your own ideas on this point.—Yes, I am on their committee.

21,246. *Mr. Micklem*: Dr. Tredgold, have you considered whether these are cases which should come under the jurisdiction of the Board of Control?—(*Dr. Tredgold*): The cases that I am alluding to, do you mean?

21,247. Yes.—I should say they do not, inasmuch as they do not come within either the Mental Deficiency Act or the Lunacy Act.

21,248. That is just what I was thinking. Supposing the Mental Deficiency Act were amended in some way to bring in this class of case, or the Mental Treatment Bill were passed, then they would naturally come under the Board of Control?—Then they would come under the Board of Control, certainly.

21,249. That you would contemplate?—Yes, that we should contemplate. I think we allude to that in one of the paragraphs.—(*Miss Fox*): Yes, we say they ought to be registered by the Ministry of Health.—(*Dr. Tredgold*): But that was rather in view of the Board of Control being a department of the Ministry of Health.

21,250. There is just one other point I would like to mention. *Mr. Jowitt* will know more than I do about the High Court, and so on; but you must remember that in cases that come before the magistrates in the country, they are very careful to enquire as far as they can into the antecedents of these children, before passing any sentences and dealing with them on probation. It is the commonest thing now to proceed on those lines?—It is a very much more common thing than it was, but I think I am correct in saying that even now there are many cases that are not dealt with on that

line at all, where for the lack of evidence a defective is not treated as a defective but is sentenced to prison. I think we have quite a large number of cases that we could put before you showing that.

21,251. *Chairman*: The recent Act may help that, may it not, *Dr. Tredgold*, in providing for much more extended probation work?—That is so; I think it probably would.

21,252. *Mr. Micklem*: In many cases there is a missionary attached to the Court, and before any convictions are decided upon enquiries are made?—Yes, there is a much greater tendency for that to be done now, but I am afraid it is not done so often as it should be.

21,253. *Miss Madeleine Symons*: I take it that in connection with the medical examination of children you are advocating something rather on the lines of the Belgian system?—Yes. My own idea was that any child, who is before the Court in charge of the Court missionary for an offence, should be referred to the medical man for examination, and that sentence should not be passed until the Court is in possession of the evidence as to the state of the child's mind, and as to whether he is suffering from any mental defect or mental disorder; that is what we have in mind, I think.

21,254. *Mr. Jowitt*: These are just the sort of children in many cases whom one has seen sent to Borstal, are they not?—Yes.

21,255. And I think it is common knowledge now that Borstal has proved a very successful experiment?—Of course they do not take mental defectives at Borstal.

21,256. These are not mental defectives, are they?—No, that is so undoubtedly, and I think there is no doubt that Borstal does meet the needs of this particular type, the delinquent type, because before they can get to Borstal they have got to commit an offence.

21,257. I should like to see if you have really got any adequate justification for saying that you can deal with these cases without the discipline which Borstal involves. You have come across these cases being treated in homes?—Yes.

21,258. Can you say from your own experience that they do not want to leave the homes?—Yes, I can say that from my experience of very high grade feeble-minded cases. I can say that from my experience of some of these cases that I have met with in rescue homes and preventive homes. They have been quite content to stay there, but the homes have not been suitable for their proper treatment.

21,259. In other words, so long as you have the right sort of personality in charge of the home, even although there is no strict discipline, the personality may effect the cure, and at the same time may make the person willing to stay?—I think that is so. Of course we do realise that there will be a certain proportion who will not be amenable, and there is no way of getting control over those except by a detention order. We quite realise that.

Chairman: Then it only remains to thank you for your kindness in coming here this afternoon, and for your valuable evidence.

The Witnesses withdrew.

Adjourned.

5, OLD PALACE YARD,
WESTMINSTER, S.W.1.

FORTY-FIRST DAY.

Thursday, 10th December, 1925.

MEMBERS PRESENT :

THE RIGHT HON. H. P. MACMILLAN, K.C. (*Chairman*).

THE EARL RUSSELL,

SIR HUMPHRY ROLLESTON, BART., K.C.B., M.D.

SIR ERNEST HILEY, K.B.E.

SIR DAVID DRUMMOND, C.B.E., M.D.

MR. N. MICKLEM, K.C.

MR. H. SNELL, M.P.

MRS. C. J. MATHEW.

MISS MADELEINE SYMONS.

MR. P. BARTER (*Secretary*).

MR. W. FAIRLEY (*Assistant Secretary*).

Further Evidence (on behalf of the Board of Control) of Sir FREDERICK J. WILLIS, K.B.E., C.B.,
Mr. S. J. FRASER MACLEOD, K.C., and Dr. C. H. BOND, C.B.E., D.Sc., M.D., F.R.C.P.

21,260. *Chairman*: Perhaps I should inform the public that the purpose of our meeting this afternoon is to take the evidence of Sir Frederick Willis, Chairman of the Board of Control, and his colleagues, upon certain questions of a general character with regard to which we desire to ascertain their views, in supplement of the evidence which we had from the Board of Control at the outset of our proceedings. The sitting this afternoon will be quite brief, and will be confined to those particular topics.

Sir Frederick, we have had already the advantage of evidence from the Board of Control; but now, as we are approaching the conclusion of our investigation, we have thought it right to ask you to be good enough to attend again and to express to us your views on certain general questions that have emerged in the course of our enquiry. In particular we wish to have the views of the Board on the incipient case and the voluntary case; and I think the most convenient course will be for you yourself to state to us the considered opinion of the Board on these matters?—(*Sir Frederick Willis*): Yes. I might say that we have very fully discussed this matter at the Board of Control, and all my colleagues are in agreement with the views which I will put before you on this point.

21,261. You see we feel that on this matter we may possibly find it necessary to make recommendations of a novel character. This is to some extent a development of the existing law; and we are anxious to see that any recommendations which we make may be practicable.—*Quite*. Our views are based, of course, on an immense amount of experience in dealing with cases of mental disorder, and, as I say, we are all in agreement. Shall I read this summary of our views?

21,262. I think that would be the most convenient course, if you please?—"For the purpose of settling the procedure to be adopted for the treatment of persons suffering from mental illness, it is desirable that patients should be divided into the following three classes (1) Voluntary. (2) Non-Volitional but passive. (3) Resistant." We have taken those terms from the Questionnaire which you addressed to us. We rather think we should prefer to call them "Willing," "Non-Volitional," "Unwilling," but it

is the same thing. "As regards the voluntary case, the willing case, we suggest the patient might be received for treatment on his own written application, or, if a minor under the age of 18, on the written application of his parent or guardian, accompanied by one medical recommendation, and we suggest that the case might be received in any mental hospital, registered hospital, licensed house, general hospital, nursing home, or private care, subject to the following conditions."

21,263. Will you pause there just a moment? On the classification of the three types of cases, the willing case is comparatively easy to appreciate, because that is the case where the patient realises the situation, is desirous of treatment, and is willing to submit to the conditions of treatment?—*Quite*.

21,264. On the other hand, the non-volitional case, which is passive and is not able to participate at all in treatment, is in rather a peculiar position, because the exercise of any restraint on such a case is, strictly speaking, illegal; it is not done with the co-operation of the patient. It is treating a person who has no volition, without authority, so to speak?—Of course we are suggesting that authority should be given in an Act of Parliament.

21,265. Yes. The resistant case, or the unwilling case, is comparatively easy. It is a symptom of the ailment in that case that the behaviour or conduct is so deranged that certain restraint is necessary in proper cases?—*Yes*.

21,266. But the non-volitional, or intermediate, case is rather a peculiar one, because there is neither resistance nor non-resistance; the patient is more or less in a negative condition. It would not be proper to treat such cases without some authority?—*No*.

21,267. In the voluntary case you have the authority of the patients themselves; in the non-volitional case there is no authority at all, unless you borrow an authority from a relative, as has been suggested?—*Yes, or from a public official*.

21,268. Or from a public official. Then one other observation occurs to me on this. You say that the voluntary cases, the first class, might be received not only into institutions of all kinds, but into nursing homes, or private care. In regard to the

10 December, 1925.]

Sir FREDERICK J. WILLIS, K.B.E., C.B.

[Continued.]

nursing home I am sensible of a practical difficulty. You cannot classify patients very well into mental and non-mental; in point of fact there is no such scientific line of demarcation. How are you going to say of a patient who goes to an ordinary medical nursing home, but who is to some extent mentally disturbed, that this is a mental case and that another is not a mental case. Are you contemplating nursing homes of a particular type,—neurasthenic nursing homes?—I suppose you would get the designation from the medical attendant. He would say "I think So-and-So ought to go into a nursing home, and I suggest such and such nursing home is a suitable place."

21,269. That would be one of the ordinary private homes?—Yes, or even a new type of nursing home eventually.

21,270. But at the present moment, if the case is not a certifiable case there is nothing to prevent any citizen going into a nursing home, if he or she wishes?—The difficulty is this. Under the present Lunacy Act you may not take a person of unsound mind for treatment. Some of these voluntary cases are clearly cases of unsound mind, although they have got volition; and probably it would be illegal, as the law at present stands, to take them into a nursing home although they said they wanted to go in.

21,271. Do you think there is such a clear line of demarcation between the cases that you could say to the person who wanted to go into a nursing home "You are a mental case," and to another one "You are a physical case"?—I quite think if the law were altered as we are suggesting it should be altered, a certain number of these cases would be treated, and these conditions we have laid down would not be observed because a doctor would say "I do not consider this is a mental case at all." Of course that goes on to-day. There is a very great deal of treatment carried on to-day which is not admitted by the law.

21,272. You suggest a certain code prescribing restrictions in regard to such cases. If that is to be imposed in a nursing home, which is an institution run for profit by a doctor or nurse or somebody else, I have a little difficulty in seeing how you are to say of the various patients in the nursing home "This is a person receiving ordinary treatment for physical ailment," and "This is a mental case to which certain special requirements attach." Can you get the line of demarcation between the patients?—Is your difficulty this, that the medical man in charge might say "I am not going to do any of these things that you suggest for the voluntary mental case, because I do not put this case in that category"?—

21,273. Yes. The voluntary case is a case where the patient generally signs some document saying he is willing to receive treatment. I could imagine a person who was conducting a nursing home in perfectly good faith saying "I do not think this is a person from whom I should exact that requirement." Another medical man might say "Well, you know, I think the mental disturbance which is a concomitant of the disease in this case is so marked that you ought to have that precaution taken." How is one to get a classification, particularly in the cases we are figuring here which are not marked cases of mental disturbance?—I do not think by any Act of Parliament you can secure uniform action in those cases by all doctors. One doctor may say "The Act provides that voluntary cases may be treated in this nursing home; I shall notify that case." Another doctor would say "Well, notwithstanding that Act of Parliament, I do not consider this case as belonging to that category, and I am not going to take that action." That is inevitable.

21,274. It would provide a safeguard, however, to what is regarded at present as rather a menace. In a case where the doctor was apprehensive of mental symptoms developing he would at once report, and so the difficulty would be obviated?—Quite. That is all we ask, that that case shall be notified to the

Board of Control, with a copy of the medical recommendation on which the case was received.

21,275. When you say that voluntary cases would be receivable in a nursing home you are contemplating the ordinary nursing home which we all know; but, because of the symptoms which the case is exhibiting, certain additional precautions should be available?—Yes.

21,276. *Sir David Drummond*: I should like to know exactly what class of case Sir Frederick is referring to now?—I am inclined to think myself it is incapable of very precise definition. At present the Act of Parliament allows voluntary boarders to be received into registered hospitals and licensed houses.

21,277. *Chairman*: That is fairly easy; once they are in that place they are under a code, so to speak?—Yes, but one doctor would say: "I think this case ought to go as a voluntary boarder"; another doctor would say: "I do not regard this as a mental case at all; I am not going to take any steps." That sort of thing is inevitable, I think; but if you made the law, as we suggest, and you then found that really serious cases were being treated without any notification or visitation and so on, you could quite fairly, I think, then drop on the medical man concerned. Because you had provided a code which was quite a lax code, it did not hamper him to observe it, and he had failed to observe it; whereas at present my difficulty is that under the law the case cannot be treated at all unless it is certified.

21,278. *Earl Russell*: The object of the procedure is to enable the doctor to treat him without fear?—That is the object.

21,279. *Sir David Drummond*: But in practice that would break down, I take it; because it would be impossible to indicate in an individual case, that this was a case to be notified, and this was not to be notified?—Would it be impossible?

21,280. I take it so?—I should have thought the doctor would say: "This is a case suffering from mental disorder, but it is a case with volition, and the patient himself understands that he is suffering from a certain mental illness, and wants to go to such and such a place and be treated there."

21,281. *Earl Russell*: Does it not work in this way, that the doctor, if he has any apprehension, can put himself right by notifying the Board of Control, and by that means he is not committing a breach of the law?—That is so.

21,282. *Chairman*: Would there still be reluctance to notify the Board of Control, and so more or less publish the fact that there was some mental affection involved, just as there is now a certain reluctance in bringing about certification?—On that point, Sir, I have discussed these proposals not only with my colleagues but with three or four doctors who are practising in connection with these cases, and they have said they would be quite content with this code, that they would work it, and that it would be useful for them; and that they would feel greatly relieved. I can mention to you privately the names of the medical men I have consulted about this, if you like.

21,283. I can quite understand that, at present, a doctor who has a home and a patient in it who might be regarded by somebody as of an unsound mind, is in an uncomfortable position because he is liable to prosecution. He could protect himself in future in any such case by the precautions which I see you suggest here, which are precautions conceived not only in his interests but in those of a patient?—Quite.

Sir David Drummond: I am afraid that the fact that all these cases are to be notified would militate largely against the early treatment of some of them.

Chairman: That is what I was wanting to put to Sir Frederick. There might be a similar reluctance to notify as there is a reluctance to certify.

21,284. *Earl Russell*: Notification is not public in any sense really?—(*Mr. Macleod*): What would happen

10 December, 1925.]

Sir FREDERICK J. WILLIS, K.B.E., C.B.

[Continued.]

in practice is this: Somebody feels himself mentally unstable; he goes to his own medical man and says: "What course do you think I should adopt?" The medical man says: "I recommend you to be treated as a person whose mind is unsettled. I give you a recommendation to go as a voluntary boarder." On that we get notification to us.

21,285. *Chairman*: You would wish him to be able to go to an ordinary nursing home which would not be a nursing home specially for mental cases, so that it might be said among his friends, "He has just gone to a nursing home"?—The same as we say he can go into private care. (*Sir Frederick Willis*): Nobody would know about it at all.

21,286. *Sir David Drummond*: The answer to that is that these patients will insist that they are not mentally affected, but that they are sleepless, and this, that and the other. For that reason they come to the nursing home?—(*Mr. Macleod*): They need not go as voluntary boarders; it is only because they are mentally affected in some way that they go to these nursing homes as voluntary boarders. They need not go as voluntary boarders at all.

21,287. *Chairman*: But what about the case where they fail, as Sir David says, to recognise their own condition? Their condition may be, as all will accept, a condition of mental disturbance. The patient does not recognise that and says, "Oh no, it is my digestion which is wrong"?—He need not go as a voluntary boarder. (*Sir Frederick Willis*): Supposing you were a doctor dealing with that case you need not say to the patient, "You are mentally affected." You, as the doctor, would simply say: "I think you ought to go into such a nursing home; you want rest. If you write and request that Doctor So-and-So will take you into his nursing home, I will see you get a bed there"—and that is all the patient would know about it. That is all we ask. The case would go into that nursing home on that request, with a written recommendation from his own doctor that it was a desirable thing that he should go there for treatment. The patient knows nothing about that at all.

21,288. *Earl Russell*: And is treated as having voluntarily consented to a form of treatment of which he has no real apprehension?—Yes.

21,289. *Chairman*: I am not sure that I like that way of setting about it, Sir Frederick. I think it would be a great pity if people were not able to go to a nursing home when they want to go to a nursing home for rest and treatment, because the person who conducts the home is afraid of the consequences if the illness happens to have mental symptoms. I can quite see how in the case of registered hospitals, or licensed houses, a voluntary patient could go in there on his own application quite easily; but I have much more difficulty with regard to the private nursing home as to how you could devise a method which would not deter people from going there?—But you would not meet the needs of the situation if you limited the places to the registered hospitals and licensed houses. You must throw the nursing home open, or single care open to that case; otherwise you are really not meeting what is needed.

21,290. I fully recognise that point of view. I think it would be most undesirable if people could not get treatment in nursing homes; but my difficulty is this, that in the nursing homes there will then be cases some of which are mental and some of which are physical cases. With regard to the mental cases a different duty is imposed upon the owner of the establishment from that imposed upon him with regard to the physical cases. You may go in there, and the doctor in charge visits you, and you may have your operation, and then you come out; but how is one to say which of the cases are those with regard to which special precautions are to be taken?—I think the medical man concerned with the thing must decide that for himself.

21,291. Suppose he recognises that this is a case where these precautions are appropriate; he ought to see the patient and say, "Now in your case I am afraid I must ask you to give me your written consent

to stay here because the law requires that"?—We do not suggest we should have his written consent to stay there; we suggest he shall have the right to leave that place at any time on giving 72 hours' notice.

Earl Russell: That is all founded on a written consent to enter the home.

21,292. *Chairman*: All the patients in a nursing home can get up out of bed and walk out of the door at any moment?—Quite, but that is of the very essence of our recommendation, that there is no detention here. If a case goes in voluntarily and still maintains his volition, he shall at any time have the right to leave on 72 hours' notice.

21,293. But you are going to exact from certain of the patients who enter the nursing home a requirement which you are not going to exact from other patients. If I go into a nursing home to-morrow I am received there without any requirement at all. On the other hand, you are figuring a class of case where a patient desirous of going into a nursing home, and willingly, is required to sign a consent beforehand?—Yes.

21,294. What I want to know is this: How are you going to classify these people? How are you going to say to one person who knocks at the door of a nursing home "I will take you in if you will agree in writing to stay here," and to the other applicant "Come along in; we do not require any consent in your case"?—I should have thought the medical man in charge of the case would know which was a case of mental illness and which was not. He would know whether the patient was coming in to have his appendix removed, or whether he was suffering from insomnia, hearing noises, and so on.

21,295. *Sir David Drummond*: Is it not your point that all cases of neurasthenia are to be notified?—I do not know what Dr. Bond would say about that. (*Dr. Bond*): I would rather not answer that question quite like that, Sir David. I would rather say that where the doctor regards the case as possessing mental symptoms, he should use these provisions mainly with the object of protecting himself, as was said just now, lest the case should turn out differently, when the rigours of the existing Lunacy Act would be applicable. It is the fear of the rigours of the existing Lunacy Act which prevents early treatment. If those could be wiped away by this very simple procedure, we believe that many more cases would receive early treatment than do to-day. But how we can lay down exactly which cases it is going to apply to I think would pass the wit of man. It is a question of diagnosis and medical opinion, and I should be very sorry to see any attempt to schedule the exact cases on their symptoms or to attempt to demarcate.

21,296. If you cannot, how is the practitioner to do it?—I take it that where he is so sure that there is no necessity to take advantage of these new provisions, he will not attempt to do so. But where he now hesitates, or rather where the holder, the receiver, the householder, now hesitates, is because of the terrors of the Lunacy Act.

21,297. *Earl Russell*: Let me put this to you—it is a question of degree after all. In the early stages it is very difficult to say which case you think will require notification, and which will not, but should I not be right in saying that it is quite a long step from that doubtful stage to a stage where you think it necessary to institute proceedings under Section 315?—Surely.

21,298. *Sir David Drummond*: Not in every case, as Dr. Bond will know; there is no long interval?—You mean sometimes there is a sudden breakdown?

21,299. Yes, sometimes a case comes in without practically any indications of the kind Lord Russell is referring to?—I think the point there, if I may say so, is that at present we (unfortunately) are the prosecutors in those cases; and I do not think that any case of the kind that Lord Russell or yourself has just mentioned has ever reached that stage of prosecution. We have never attempted to visit the provisions of the Lunacy Act upon a sudden evolution of mental symptoms like that.

10 December, 1925.]

Sir FREDERICK J. WILLIS, K.B.E., C.B.

[Continued.]

21,300. But the provisions are there?—The provisions are there; but the trouble is that to put a case as the law now stands on a proper footing, the only course when those symptoms come on is full certification, and that is the thing that people resent so much; whereas under the simpler procedure these terrors will be gone.

Chairman: Let me put it in this way: I think perhaps the difficulty is met. The voluntary patient is a patient who realises the necessity for treatment; therefore he must realise that to some extent he is suffering from mental derangement. There are many people who are technically quite sane, and who recognise they are temporarily suffering from some instability or upset. The essence of the voluntary case is that such a person recognises that he requires mental treatment and willingly agrees to undergo that treatment. Therefore to such a person there would be no difficulty in the doctor putting this requirement: "If you wish to receive treatment in a nursing home then you must of course, because the law says it, sign a document which states your willingness." That is all it comes to.

Earl Russell: "For my protection."

Chairman: "For my protection"—and that having been done, the difficulty seems to me to disappear.

Sir Ernest Hiley: Does the patient understand that he is going to submit to a three days' detention?

21,301. *Chairman:* I take it the form will make these things abundantly clear; it certainly ought to. The case assumes that the patient has sufficient intelligence to appreciate these things and says "I am quite willing to submit myself to these conditions." But that is not a case of taking patients into a home and saying nothing about the conditions or anything else, and not letting them know that there has been some procedure about them?—(*Sir Frederick Willis:*) I was only thinking that probably in some cases it is undesirable to tell them anything.

Earl Russell: What would be said to you, Sir Frederick, in civil matters if you asked a man to exercise his volition on a subject which you did not explain to him?

21,302. *Chairman:* I do not think that is practicable. It is of the essence of the voluntary system that the patient voluntarily submits to something he is told?—We suggest that he should make a written application to go there.

21,303. That is looking at it from the point of view of the patient himself, who is willing to submit to certain terms which are made clear to him. If, on the other hand, a patient does not recognise his condition and presents himself at a nursing home, in that case it would be for the doctor to say "I am afraid I cannot take your case unless you agree to treatment in my establishment; because your case is the type of case I am not now allowed to receive except in the status of a voluntary patient, and if you are coming into my place you must read this over and see whether you can agree to it?"—Yes.

Sir Humphry Rolleston: Would the voluntary patient know that he was going to be notified?

21,304. *Chairman:* I think he ought to know that?—(*Sir Frederick Willis:*) Why should he know that?

21,305. *Earl Russell:* I wonder if he need know that. It does not affect him or his treatment; it is really a provision for his protection?—I should have thought it was unduly alarming him to say "If you go in there your name will be notified to the Board of Control."

Sir Humphry Rolleston: I think if I went into a nursing home and found I was notified without having been warned, I should have felt my liberty had been interfered with.

21,306. *Chairman:* Are you not entitled to know what are the consequences of your acts? If you are asked to do something, are you not entitled to know what that means? If a patient does not know what is the consequence of becoming a voluntary patient, and that in particular one of the consequences is that he shall have his name recorded in the archives of the Board of Control, may he not say afterwards "If I had known that, I am not at all sure that I should

have signed that document?"—We want to facilitate his treatment in the easiest way one justifiably can.

Sir Ernest Hiley: If he happens to get scarlet fever and calls in his doctor, the doctor is under an obligation to notify, but he never says anything about it to a patient.

Chairman: That is quite true.

Sir David Drummond: That is rather a different matter.

21,307. *Earl Russell:* There is this difference: that in a scarlet fever case things unpleasant to the patient do not happen in consequence of the notification, whereas they might in the other case?—Nothing happens in this case.

Chairman: The question as to whether there should be notification or not we can consider, but we might proceed now to obtain from you in detail what is the code which you think should be made applicable to a voluntary patient for the protection on the one hand of himself, and, on the other hand, of the owner of the nursing home or establishment?—We suggest the voluntary patient shall make a written application to be received, or, if a minor under the age of 18, on the written application of his parent or guardian. And these are the conditions we suggest: "That notification of the admission of the case together with a copy of the medical recommendation is sent to the Board of Control; and that a medical report on the case should be sent to the Board within seven days of the admission, and thereafter at intervals of six months."

21,308. *Earl Russell:* Do you suggest there must be a medical recommendation before the patient goes in, even when he or she is of full age?—Yes, we do suggest that.

21,309. That would not meet the case of a poor patient going to a county asylum and saying: "I know I am going to be bad and would like to be taken in here." Have such patients to be sent away to find a panel doctor, when there is a superintendent there quite competent to decide? I do not want to prevent a person getting treatment?—None of us does. I should think in that sort of case it would be quite easy to get a medical recommendation.

Mr. Snell: What would you do? A person in that state of mind and anxiety asks for admission and shelter and protection?

21,310. *Earl Russell:* Yes; they throw themselves on your mercy?—I should be quite willing myself to say in that case that the medical superintendent or any doctor on his staff could, for the purpose of this Act, make the recommendation.

21,311. If you say that, that would meet the point?—I should say that in the case of a public institution, certainly.

21,312. *Chairman:* Of course that would happen in the case of a public institution. People do not present themselves at the doors of nursing homes in that way. Even in the case of public institutions that comparatively rarely happens, because in an ordinary case a person would have had attention from a doctor?—Yes, but there would be no objection to saying that the recommendation could be made by one of the doctors at the public institution. It is different in the case of a private profit-making place.

21,313. Then there has to be the medical report within seven days. What class of report are you suggesting? Is that to be a report on the mental state of the patient?—I should think so. "Each report should contain a statement that the patient is in need of further treatment and is willing to remain." The doctor making that statement would be responsible for the accuracy of it.

21,314. *Mr. Micklem:* That means each six monthly report; not the first?—Yes. I should think that in the case of every one, even at the end of the seven days, a doctor ought to make that statement.

21,315. They have not had any treatment you see: you say "further" treatment?—He has had seven days' treatment.

21,316. If it were made at the end of seven days, yes, but it may be made at the beginning?—Yes.

10 December, 1925.]

Sir FREDERICK J. WILLIS, K.B.E., C.B.

[Continued.]

21,317. *Chairman*: It is within seven days?—Yes. Of course our condition was mainly designed for the six monthly reports obviously.

21,318. *Miss Madeleine Symons*: Do you mean, Sir Frederick, that the statement that the patient is willing to remain should be made every six months by the patient, or by the doctor?—By the doctor—that he should take the responsibility of saying so. Then our next condition is: “That the Board of Control should have the right to inspect the institution or place where the patient is receiving treatment.”

21,319. *Chairman*: Should they have a duty?—I think they should have a duty.

21,320. A duty to inspect also?—Yes.

21,321. Then it would come to this, that no person could receive a case for voluntary treatment in a nursing home, unless that place had been inspected and really, in effect, licensed by the Board of Control?—No.

Earl Russell: Not previously.

21,322. *Chairman*: Suppose the Board do go and visit and are dissatisfied with the conditions, what sanctions are to attach to that?—We have the right to order the discharge of any patient if, when we visit it, we consider the case unsuitable to remain on that footing.

21,323. You are told there is a person there, a voluntary patient; you are told about the condition of that patient in the medical report that you receive; you have a right, perhaps a duty, it might be, to go and inspect that place, and if you are dissatisfied with the place, then you are to be empowered to order the removal of the patient from that place?—Yes.

21,324. *Sir David Drummond*: Do you propose to see the patient?—No. We do not say that, you know. The main object of taking a power to inspect is to satisfy ourselves that the place is being run in a *bonâ fide* manner. That is the main object, as I look at it: to see that there is nothing wrong going on; but we should have power to see the patient.

21,325. *Chairman*: I think that is essential?—Of course we are very anxious not to do anything for this class of patient that is going to interfere with the treatment of the patient in any way.

Earl Russell: I quite agree, but, on the other hand, it surely would be proper that you should satisfy yourself of his willingness in some way; you could not do that without seeing him very well?—Quite.

21,326. *Chairman*: You should at least have the power to do it?—Yes.

21,327. I agree with Lord Russell. I think the last thing you want to do is to bother people in nursing homes?—Certainly. As we look at it, we want the minimum number of safeguards necessary. We feel that some safeguards are necessary for dealing with this type of illness, and we want the minimum that will afford real security.

21,328. Now you touch in your next paragraph a really rather difficult case. I see you suggest as a further condition: “That if at any time the patient ceases to possess real volition and this condition continues, he should within a month be dealt with under the provisions relating to the passive or resistant cases or be discharged.” It is very difficult to say at what moment a voluntary patient may cease to be a voluntary patient?—I quite realise that it is sometimes very difficult.

21,329. In a case which is going from bad to worse, the degree of volition may vary from day to day. How are you to say when the continuing will has really ceased and the patient has passed from being a willing resident of the institution to a person who has ceased to have any volition?—There is obviously no sharp line, but some of the physicians whom I saw said to me, “We will see a patient to-day, and the patient says he is going to leave the place; then we talk to the patient and say, ‘If you will leave it until to-morrow—I shall be coming to-morrow, and we will see about it.’ We come the next day and the patient says, ‘I am quite content; I am going to remain on. I see it is the best thing for me.’” We do not want

to compel people to be removed merely because of a whim as it were.

21,330. You see the voluntary character may expire at any moment. The consent may cease to operate because the person is incapable of consent. The whole idea is continuing consent, and there comes a moment in the course of the disease where the person is really not capable of a consent at all?—(*Mr. Macleod*): That same question arises now to a certain extent under Section 20 of the Act of 1891, because it says there: “If the Commissioners after enquiry are of opinion that the mental state of any boarder received into a licensed house or hospital is such as to render him unfit to remain as a boarder, they may order the manager of the licensed house or hospital either to remove such boarder, or to take steps to obtain an order for his reception as a patient into the licensed house or hospital.”

21,331. *Chairman*: That is a very useful reference?—That is a question we have so frequently to decide now. We have to try and find out, visiting there, if in fact a patient has volition. I went to see a patient who I was told had volition. He was in bed and had two attendants waiting on him. I said “Now you came here for treatment.” He said “No, I do not want treatment.” I said “Why are you here?” He said “I have been persecuted by so-and-so.” He added “They are all in the next room now picking raisins,” or something of that sort. So I came to the conclusion that he had no volition whatever; but the doctor told me he had; he said “You will find in two or three hours’ time the man is as rational as you are and wants to remain.” I said “I will let it stand over.” The report came in the next day to say that in the meantime the condition had cleared up; the patient realised his position perfectly and he desired to remain.

21,332. *Earl Russell*: And did you go and see him again?—Dr. Bond did.

21,333. *Mr. Snell*: Was it a case of recurrent trouble?—(*Dr. Bond*): Yes, evanescent symptoms.

21,334. *Chairman*: This was not a certified case?—(*Mr. Macleod*): No—a voluntary boarder. The point I had to decide was whether he was fit to remain as a voluntary boarder.

21,335. That is a curious case; it is not a case of a gradual degeneration of the will power, but it is a case of ups and downs?—Yes, evanescence.

21,336. Sometimes capable, and sometimes incapable of consent?—Yes, but that, I think, frequently arises in the course of our visits to licensed houses and hospitals.

Earl Russell: An interesting example.

Chairman: And what are you to do with a case of that sort?

21,337. *Earl Russell*: That is one of your reasons for the 72 hours?—Quite. (*Dr. Bond*): And one of the reasons for experienced inspection. One might add, with a knowledge of this case and many others like him, that he himself would be the first to say that one of the worst outrages one could have practised upon him was to order his certification.

21,338. *Chairman*: Then the last of the conditions you propose is: “That the patient has a right to leave the institution or place at any time on giving 72 hours’ notice in writing and in the case of a minor under the age of 18 the notice should only be given by his parent or guardian.” There has been some controversy as to whether 72 hours is a necessary period?—(*Sir Frederick Willis*): The reason for giving the 72 hours’ notice is to allow of time to communicate with the friends, if the case is serious and cannot be dealt with in some other way. We think anything less than that does not allow sufficient time—a Sunday might intervene of course. (*Mr. Macleod*): It is now only 24 hours, and that means in some cases you cannot communicate with the friends.

21,339. I do not think there is very much in the difference between 24 and 72 hours?—(*Sir Frederick Willis*): No. That is our only reason for suggesting 72 hours.

10 December, 1925.]

Sir FREDERICK J. WILLIS, K.B.E., C.B.

[Continued.]

21,340. To enable communication to be effected with the relatives?—Yes. Our experience is that 24 hours is frequently insufficient.

21,341. One can imagine that being so. Take the case of a person who had entered an institution as a voluntary patient, a typical case of a voluntary patient; the illness has unfortunately progressed; the patient is entitled to leave at once if there were no limitation of time; he goes up to the medical superintendent and says "I propose to walk out now." The medical superintendent says "You are entitled to if you like," and the patient may say "I am going straight out to throw myself into the canal." The medical superintendent would have no power to restrain him at all, except the general power of preventing a person committing a felony. In this case if there were a period of 24, 36, 48, or 72 hours the doctor would say probably "I think you had better think it over," and in the meantime he would get into communication with the relatives and say the case had unfortunately developed suicidal tendencies, and they had better get the case moved and dealt with elsewhere?—Yes.

21,342. A moratorium of some sort is necessary?—Yes.

21,343. *Mr. Micklem*: You would not want this moratorium to apply to a recovered patient?—No.

21,344. *Chairman*: If the medical superintendent were satisfied that a voluntary patient was quite well, you would not insist, as a matter of form, that the patient should stay out the 72 hours?—No, he would be discharged then at once. I do not think we have mentioned that point.

Mr. Micklem: It is not dealt with in those regulations.

21,345. *Chairman*: But suppose the voluntary patient instead of coming along and suggesting he was going to commit suicide, said "I want to go away; I really have benefited so much that I am quite well," and the medical superintendent says "I think you are completely restored now; I shall not insist on keeping you here for 72 hours; you may go now." Would you contemplate that case?—I should certainly allow a medical superintendent that power if he were satisfied about the case.

21,346. Then it is not necessary that they should live out the 72 hours, so to speak?—No. (*Dr. Bond*): Under the 24 hours' notice, no medical superintendent if he is satisfied on the lines you have sketched out, hesitates for a moment to let the patient go at once.

21,347. It is a power to retain for 24 hours in a case where it is advisable to do so?—(*Sir Frederick Willis*): Yes.

21,348. Then the patient is really free to go out at any moment subject only to this—if the medical superintendent thinks it is desirable in the interests of the case to detain the case for 72 or 24 hours, he is bound to do so.

21,349. *Earl Russell*: You allow as in the other case a barring notice for 72 hours?—Yes.

21,350. *Chairman*: We may now pass to the non-volitional case. Where do you think such cases should be receivable?—There we say "into any mental hospital or registered hospital, and if the institution or place has previously been approved by the Board for the reception of such cases, then into any licensed house, general hospital, nursing home, or private care."

21,351. In this case the approval of the nursing home, general hospital, or licensed house, must precede the reception of a case?—Yes.

21,352. Is that because the case is a more serious case?—Yes; it cannot at all look after itself, that is to say, the case we are now thinking of; we have to be satisfied that the place is being run properly, and we should not give our approval unless we were satisfied.

21,353. These would really be approved houses?—Approved houses.

Sir David Drummond: I thought it was proposed that all houses should be approved?

21,354. *Chairman*: Not for the voluntary case, I think?—No. For the non-volitional case we should

be willing to entertain an application from any nursing home. We say "any licensed house, general hospital, nursing home, or private care." Any of those can say "We want to take this type of case; will you approve our doing so?" We should make our enquiries about the application, and if we were satisfied we should give our approval.

21,355. But an antecedent approval is not necessary for a patient who is voluntarily there?—No. Here we suggest that the application should be made by a relative or friend or public official for the reception of this case, and there should be two medical recommendations.

21,356. In this case the patient, of course, is brought?—Yes.

21,357. Why do you think that two medical recommendations would be necessary? This is not certification of course at all?—No. We think it is a further safeguard. There is no magistrate; there is no formality of that kind brought in; and we felt it was quite reasonable in that case to say there ought to be two medical recommendations.

21,358. *Earl Russell*: And no exercise of volition by the patient, of course?—No exercise of volition by the patient at all. That is the essential difference in the two cases.

21,359. *Sir David Drummond*: Is not this a case that is so pronounced that only one certificate is necessary? Anybody could indicate the nature of the case?—We want to get away from a justice's order as far as ever we can; we want to dispense with formal certification; and we are suggesting these other safeguards which, in our view, are quite adequate for the protection of the patient. We think that with the non-volitional case it is a certain safeguard to have those two medical recommendations.

21,360. *Chairman*: This, of course, would apply to a pauper patient as well as to a private patient?—Yes.

21,361. Here again you desiderate notice to the Board?—Immediately; and that copies of the two medical recommendations should be sent to the Board; that we get a medical report on the case within seven days of admission; and that the institution should be open to the inspection of the Board. More or less, these conditions now are the same as we have specified for the other cases.

21,362. *Earl Russell*: (c) is a new one?—(c) is a new one, "That the Board has the right to order the discharge of the patient from the passive class should they consider him unsuitable to remain on that footing."

21,363. *Chairman*: Then: "That the person on whose application the patient was received for treatment should at any time have the right to remove the case on giving 24 hours' notice." That is the petitioner as we call him?—Yes.

21,364. *Earl Russell*: There you go back to what I rather dislike in the policy of the existing Act. You are making the petitioner the custodian of the person of this lunatic. Ought he to be the sole custodian of this person without some authority saying that he may have it? Is it right to give him the sole power of disposal of this non-volitional man or woman, and of taking him or her to any other place at 24 hours' notice? It is a very large power to give to one private person?—(*Dr. Bond*): He has been given the power to get him there with the aid of two medical recommendations.

21,365. That is quite a different thing to the power to take him away and more or less to do what he likes with him?—(*Sir Frederick Willis*): Our reason for that is this: that we do not want there to be any detention of these cases. In our view real detention should only take place after a justice has authorised it; and giving the person on whose application you have received the case the right to take the case away seemed to us necessary if you are going to maintain the principle that there is to be no detention of the uncertified case. (*Mr. Macleod*): Somebody must look after the patient; that is the whole thing.

10 December, 1925.]

SIR FREDERICK J. WILLIS, K.B.E., C.B.

[Continued.]

21,366. *Chairman*: And, of course, this is entirely a non-volitional case?—(*Sir Frederick Willis*): Yes.

21,367. *Earl Russell*: Of course the person who does take him away would be subject to all the legal penalties if he had him treated in some improper place?—Absolutely.

21,368. *Mr. Micklem*: You do not provide for the six-monthly reports in this case?—No, because the case is only there for six months in the first instance, under this procedure; or he may be there for a year. "We think that the non-volitional but passive patient should only be received on this footing for a period of six months in the first instance, but that there should be power to extend the period for a further six months, if two independent medical practitioners recommend that in the interest of the patient such further period of treatment under the conditions obtaining is desirable, and if copies of the two medical reports are furnished to the Board. If, after being treated under these conditions for a year it is considered that the patient should be detained for further care and treatment, he should only be detained if fully certified."

21,369. *Chairman*: Of course, with this class of case, the non-volitional case, if there is no recovery within six months, or even a year, it is pretty obvious that it is a pronounced case, is it not?—In most cases it would be quite obvious, I think; at any rate, that is the greatest latitude we felt justified in suggesting.

21,370. This case has escaped certification altogether up to date. There has been no necessity to get the warrant of restraint which certification gives you, because the patient is not resisting?—Quite.

21,371. Then you provide for the case of the patient recovering volition?—Yes.

21,372. He is a non-volitional patient, uncertified; he recovers volition while there; probably in the course of his convalescence?—Quite.

21,373. What is to be done then? You cannot dispose of him after that merely as a non-volitional case, and so I see you propose that he should be allowed to leave on giving 72 hours' notice; in short, he is passed over into the category of a voluntary patient?—That is the position; that is what we suggest.

21,374. Without, however, ever having signed any document?—Quite; an application was made for him, by his relative or friend, before he went in.

21,375. In this case he would *ex hypothesi* go to the medical superintendent and say "I want to leave," and the medical superintendent would have to gauge whether or not he really was making an intelligent request. If he was, but was still, in the opinion of the medical superintendent, dangerous in any way, the medical superintendent would say "Very good; you can leave, but you must wait 72 hours more," and that would give him an opportunity of taking any steps that were necessary in the patient's interest?—Quite; that is it.

21,376. Supposing your non-volitional case becomes an obstreperous and resistant case, there again you would enquire, and I see you propose that he would have to be dealt with by certification?—Yes, that is our position: "That if at any time the non-volitional but passive case becomes a resistant case, he must within a month thereof be dealt with under the provisions relating to the resistant case or be discharged."

21,377. *Mr. Micklem*: When you speak there of two independent medical practitioners, do you mean independent of each other, or independent of the home?—Independent of the home. I think, possibly, if you are dealing with a public institution, they might be two of the medical practitioners on the staff of that institution; but if you are dealing with a profit-making place, then I should certainly say they ought to be independent practitioners.

21,378. *Chairman*: Then I think we may pass to the third class of case, the resistant case. What is your view of that case? We have dealt with the voluntary case and the non-volitional case, and now we come to the last case of the resistant patient?—We suggest there: "That the resistant case should only be

detained after full certification on a petition signed by a relative, friend or public official and an order signed by a judicial authority, subject to the following limitations: that a case may be received on a provisional order signed by a relative, friend or public official and accompanied by one medical certificate. Under this provisional order and certificate the patient may be detained for a period of 14 days if, in the opinion of the medical officer of the institution or place, or, in the case of patients in single care, the medical attendant, the case needs detention for that period. A copy of the provisional order and certificate should be sent to the Board on admission. If at the expiration of the 14 days the medical officer or medical attendant aforesaid should be of opinion that the patient should be detained for a further period of 14 days for purposes of observation and treatment, the patient may be detained accordingly provided the doctor certifies in writing that this further detention is desirable. A copy of this certificate should be furnished to the Board."

21,379. This is all designed to postpone certification?—Entirely. Then we suggest that "during that provisional stage these cases should only be received where suitable accommodation and expert medical treatment and nursing are available. They might go to any public mental hospital, registered hospital, or licensed house, and, if the institution or place had previously been approved by the Board for the reception of cases under a provisional order and certificate, in any general hospital, nursing home or single care or Poor Law institution."

21,380. And the limit of that period of provisional treatment and detention is 28 days?—28 days.

21,381. Two periods of 14 days?—Yes.

21,382. Now I suppose you recognise it is necessary to retain means of dealing with urgent cases—emergency cases?—Yes; it is essential to have some means of dealing with them such as you have now got under Section 20 of the Lunacy Act.

21,383. But in their case you would contemplate a provisional order which would not amount to a full certification, and you would give those emergency cases the benefit of the postponement of certification and the possibility of recovery without certification?—Yes.

21,384. Then as to the fully certifiable case, if the provisional order expires and the patient has not recovered, in such a case the full certification should ensue, I suppose?—It should ensue then, whatever you decide is to be the full certification.

21,385. Then it would become the last resort instead of the first resort?—That is our view, yes.

21,386. And as to the places where the fully certified cases should be dealt with, what is your view?—We suggest that: "they should be dealt with in public mental hospitals, registered hospitals, licensed houses, or in single care"; that is, of course, as at present. "They might also be received in Poor Law institutions or nursing homes, provided they have been previously approved by the Board of Control." We consider that the public responsibility for providing for all mental cases should rest with the visiting committee of the local authority and not with the guardians of the poor, and if any Poor Law accommodation is used it should be used in pursuance of a contract between the visiting committee and the guardians. Of course, as you know, at present most of these cases go straight to the workhouse, and unfortunately the arrangements are frequently very unsuitable for the reception of these cases. We want the public responsibility placed on the county council through its visiting committee.

21,387. *Mr. Micklem*: Would there not be a little risk under this provisional order that you suggest? That order is not the order of any authority; it is an order of a relative with one medical certificate?—Yes.

21,388. Would that be binding upon an institution? You take it without any judicial authority; you just get the direction of a relative and one doctor. Do you say that every institution should be bound

10 December, 1925.]

SIR FREDERICK J. WILLIS, K.B.E., C.B.

[Continued.]

to accept those cases?—Do you mean every public institution should be bound to accept those cases?

21,389. Yes?—I think they should, if they have been approved as suitable for the reception of those cases.

21,390. Yes, but would there not be some, at all events, slight risk, that cases might be certified by a relative who had an object in doing it, and a doctor?—Do you mean that the medical officer of the institution or place should not have a right to say "I do not consider this case is insane at all, and I will not take it"?

21,391. Yes, or to say "I want something better than an order by" say a wife or a husband?—No, he would not be entitled to say that, I think, if the case was clearly insane.

21,392. But I am assuming a case where subsequently it was said the man was not insane at all?—We have not very fully dealt with that in this answer, but, if that case, after being admitted, was in the opinion of the medical superintendent sane, it would be the duty of that medical superintendent at once to discharge the case; but your question was: Would a medical superintendent think this sufficient authority, the order of the relative or friend?

21,393. I was rather asking, should it be a sufficient authority, a mere order of that kind without any judicial authority at all?—I think it should, always preserving the right of the medical superintendent to say: "This case is not insane at all." He should always preserve that right. (*Mr. Macleod*): What we say is this "Under this provisional order and certificate the patient may be detained for a period of 14 days if in the opinion of the medical officer of the institution or place, or, in the case of patients in single care, the medical attendant, the case needs detention for that period." He only keeps him for that time if he thinks it necessary.

21,394. What is in my mind is this: there is in the minds of some of the public, let us say a minority of the public, a view that people may get put away too easily. Is not this introducing a plan by which there might be some risk of their being put away easily?—(*Sir Frederick Willis*): Of course, it exists now.

(*Mr. Macleod*): This is introduced to try and prevent certification.

21,395. But you must now get an order?—Not in an urgency case; they can keep them for seven days. (*Dr. Bond*): Section 20 is without a doctor at all.

21,396. *Chairman*: Of course this is only an authority of brief duration, 14 days only?—(*Sir Frederick Willis*): Yes, and of course we limit the places to which these cases can be taken. We suggest a public mental hospital, a registered hospital, or a licensed house, or, subject to our previous approval, certain other places.

21,397. *Mr. Micklem*: But Section 20 is a very different one. Section 20 invokes a public officer. The case suggested is that of a private person with some special object in getting rid of the patient?—(*Mr. Macleod*): But look at Section 11 of the Act of 1890.

Earl Russell: You and I can have a man taken to an institution and kept there if he is a lunatic. It is Section 11, sub-section (1). He may be received and detained as a single patient on an urgency order made, possibly, by the husband or wife.

Mr. Micklem: But under that Act that must be either preceded or followed immediately by a petition.

Earl Russell: But for seven days you can detain the patient.

21,398. *Mr. Micklem*: But in the meantime you must have presented a petition for certification?—(*Sir Frederick Willis*): Not for seven days; you can keep him for seven days on an urgency order. (*Mr. Macleod*): You cannot keep the case for more than seven days unless you get a petition and an order of a justice; but if in the meantime the patient recovers, the superintendent discharges him.

21,399. *Chairman*: The only question is whether you should base this power of detention upon a justice's order?—(*Sir Frederick Willis*): That is what we do not want. We want to give a clear 28 days for observation.

21,400. For medical treatment, detached from the legal aspect as far as possible, but with certain powers or restraint?—There will be full power of restraint during that time, if necessary.

Chairman: I think you have now given us your views on these topics, and that concludes our public sitting to-day. We are much obliged to you.

(The Witnesses withdrew.)

(Adjourned to to-morrow at 10.30 a.m.)

5, OLD PALACE YARD,

WESTMINSTER, S.W.1.

FORTY-SECOND DAY.

Friday, 11th December, 1925.

MEMBERS PRESENT :

THE RIGHT HON. H. P. MACMILLAN, K.C. (*Chairman*).

SIR DAVID DRUMMOND, C.B.E., M.D.

MR. N. MICKLEM, K.C.

MR. H. SNELL, M.P.

MRS. C. J. MATHEW.

MISS MADELEINE SYMONS.

MR. P. BARTER (*Secretary*).

MR. W. FAIRLEY (*Assistant Secretary*).

Mr. H. W. S. FRANCIS, O.B.E. (Assistant Secretary of the Ministry of Health), called and examined.

21,401. *Chairman*: We had hoped this morning to have the attendance of Mr. Brock, Principal Assistant Secretary of the Ministry of Health. Unfortunately we have just learned that owing to indisposition he will not be able to be present to-day. He has already furnished us, however, with some information in writing, which will be considered by the Commission. We have with us Mr. Francis, Assistant Secretary of the Ministry of Health, whose province, I understand, is particularly related to the Poor Law?—Yes.

21,402. Mr. Francis, you have of course appreciated that under the existing code of lunacy administration in this country there exists an intimate relationship between Lunacy and the Poor Law?—Yes.

21,403. The Royal Commission in the course of their investigations have been considering the general question of that relationship and possible modifications of it. We shall be glad this morning if you can assist us with any observations which the Minister, through you, may desire to make on the question of extricating, so far as possible, the lunacy administration from Poor Law administration. We have appreciated that there is a feeling, as matters stand just now, that there is an unfortunate element of pauperisation associated with lunacy; and we naturally desire to consider whether that can be modified or altered in any way. In the course of our consideration of the matter one or two practical points have arisen, and it is upon these that I think your assistance will be of value to us. Take, for example, the question of accommodation. A considerable number of patients at present are accommodated, are they not, in Poor Law institutions?—Yes, both certified and uncertified.

21,404. And are these patients directly under the charge of the guardians?—Yes.

21,405. Now, first of all, as regards this accommodation, that also is provided by the guardians, I take it?—Yes.

21,406. And accordingly the patients who are inmates of those institutions are regarded as paupers who are receiving treatment because of the ailment which has overtaken them?—They are paupers.

21,407. They are paupers; but I take it that of those who are found in those Poor Law infirmaries some are persons who had become paupers before the onset of the malady?—Yes.

21,408. While others have become paupers because of their having become mentally afflicted?—Certainly.

21,409. There seems to me to be a certain distinction between the two cases because, of course, a pauper who is already a pauper may become mentally afflicted just as he may have any other illness, and then he is sent, I suppose to the infirmary, or to the lunacy ward of a Poor Law institution?—Yes, probably; he is kept in whatever ward seems to be appropriate for him; I cannot put it more precisely than that.

21,410. On the other hand, take the case of a person who has had hitherto no relation to the Poor Law; in consequence of his becoming mentally afflicted, the existing machinery seems to have the result of rendering him a pauper and consigning him to Poor Law administration?—The existing Poor Law machinery provides for the use of the Poor Law institutions as the receiving houses for lunatics.

21,411. And the fact that he is received in a Poor Law institution stamps him under the Statute as a person who is then a pauper?—He is a pauper; I should not say it stamps him.

21,412. He is a pauper by reason of the fact that he receives Poor Law relief in that shape?—Yes.

21,413. As regards the accommodation, provision is made, is there not, in Section 26 of the Act of 1890 for the lunacy authority, in other words, the visitors, with the consent of the Local Government Board and the Commissioners, and subject to such regulations as they may respectively prescribe, making arrangements with the guardians of any union for the reception into the workhouse of any chronic lunatics not being dangerous who are in the asylum and have been selected for that purpose. Is that taken advantage of to any extent?—I do not think there is a very large number of agreements under that section. Most of the lunatics in workhouses are there under other provisions of the Act.

21,414. They are persons who have not been in asylums at all?—I would not say that. I think they may quite well have been in asylums, but they are not discharged under this section.

21,415. What I am anxious to get at for the moment is where does your lunatic population in your Poor Law institutions come from?—It would have, I think, three elements: the element that come into

11 December, 1925.]

Mr. H. W. S. FRANCIS, O.B.E.

[Continued.]

the workhouse as a receiving house which may be on their way to an asylum, or which may be discharged without going to an asylum; the second element would be the person who is already a pauper, possibly in a workhouse, who becomes insane; and the third element would be people who are moved from the asylum, discharged from the asylum, and go back to the workhouse, where they are maintained, not under Section 26, but under other provisions of the Act.

21,416. The patient who is received and kept in the workhouse may be under Section 24?—Yes.

21,417. Where statutory provision is made for the patient being received in the workhouse and remaining in the workhouse subject to certain statutory precautions?—Yes. The difference between Section 26 and the other provisions is, I think, that Section 26 keeps the lunatic in slightly closer touch with the lunacy administration—the county administration.

21,418. Because he continues to be a patient on the books of the asylum?—Yes.

21,419. The other two cases are different, obviously?—Yes.

21,420. Now if it were thought desirable to extricate the lunacy administration from its present association with the Poor Law, having regard to the existing accommodation, it might be necessary, might it not, still to use Poor Law premises for mental patients?—I should think almost certainly, to some extent.

21,421. Just because you could not have a complete fresh outfit of premises? — You could not have a complete new outfit of premises, and it is impossible at present to arrange for the conversion of Poor Law workhouses into county institutions for lunatics.

21,422. Now have you any practical suggestion as to how that accommodation could be used, under a system by which the lunacy administration should be in the hands of the local authorities rather than of the Poor Law?—It would have to be by the use of Section 26.

21,423. Then would these Poor Law premises so used become *ad hoc* branches of the local authority's lunacy system?—I think the section requires a little more development to make that completely so.

21,424. That is what might be helpful. If the idea was that lunatics should not be accommodated in Poor Law premises but should be accommodated in premises which belonged to or, at least, were under the control of the local authorities, to achieve that you need to enter into different relationships with the Poor Law authorities?—Rather different. A parallel would be the use of Poor Law institutions for the reception of maternity cases which are sent there by the local authority.

21,425. That is an interesting analogy. Take a maternity case that is sent to a Poor Law institution: that case is not pauperised, is it?—I am not quite sure what you mean—it is not entered on the books of the guardians as a person receiving relief from them.

21,426. It is not characterised as a rate-aided case?—It probably is one.

21,427. It is receiving benefit from an institution which is rate-aided?—If the cost is borne completely by the local authority then, I think, you could say it could not be characterised as aided from the poor rates, though it is aided from some other rate. I am not quite sure there is any substantial difference.

21,428. If arrangements were made under Section 26, with possibly some amplification of the provisions of that section, whereby patients could be received in existing Poor Law institutions, would these persons so relieved necessarily become paupers in the full sense of the term?—If the lunacy authority pays for them, they would not be chargeable to the rate raised for the guardians' purposes.

21,429. In these circumstances would a payment have to be made to the guardians for the use of the accommodation?—Quite clearly.

21,430. Then the premises really become transferred from Poor Law accommodation to asylum accommodation?—The form would probably be a lease of a certain

part of the institution to the lunacy authority, the terms of the lease providing that the guardians shall staff and maintain the leased part of the institution and the patients in it, but reserving to the lunacy authority certain powers for the benefit of the inmates, which at present they have not got.

21,431. Who would do the staffing in that case?—The guardians. It is not an essential part of the system, but it almost inevitably would happen.

21,432. Would they be paid by the guardians?—Certainly.

21,433. Would the guardians be recouped for that expenditure on staff?—Yes. We could not agree to the arrangement on any other basis.

21,434. So that the premises would be rented and the staff would be paid apart from Poor Law administration altogether?—The staff would be paid by the guardians, and the whole cost of the place, staff, feeding and everything else recouped to the guardians by the lunacy authority.

21,435. So that the expense of this administration would not fall upon the guardians at all?—No.

21,436. In the first place, the expenditure would be theirs, but as they would be entirely indemnified it would not really be expenditure chargeable to the guardians' rate?—No.

21,437. Provision is made in Section 261 for a visiting committee actually taking a lease of premises?—Yes, but that I think refers to the whole premises rather, does it not?

21,438. Well it says "any land or buildings which they are authorised to purchase" and they may take a lease thereof. Of course they might not be authorised to purchase the Poor Law premises?—No.

21,439. However, that is a matter of machinery; but do you think that with some modification of the statute such arrangements could be satisfactorily worked?—They could be.

21,440. It would become a matter really of administrative machinery?—Yes. Of course the success of any scheme of the kind depends upon a certain reasonableness on the part of both authorities.

21,441. However it would be quite easy to provide the necessary machinery if the policy was thought to be desirable?—Quite easy.

21,442. And you think it could work in well enough with the existing Poor Law machinery?—Yes. One feature of it would probably be that the guardians would expect the lunacy authorities to take over lunatics, who are in the workhouse and perhaps would not have been sent to the asylum.

21,443. Do you recognise any distinction or do you apprehend any difficulty, from the existence of that class of persons who are already in receipt of poor relief and become mentally afflicted while there in that state, as distinguished from those who would be sent there by the asylum authorities, or would have reached the institution simply in consequence of their affliction?—I do not quite see why there should be substantial difficulty. It seems to me quite arguable that if these people become lunatics, and there is a lunacy authority under whose care they are placed, that authority can quite properly pay for them.

21,444. During the time that they are afflicted?—Certainly.

21,445. And then if the patient, who initially was a pauper and became mentally afflicted and as such came under the visiting committee or other local authority for lunacy, recovered, he or she would simply return to the category of a pauper in the poorhouse?—Either become independent or have to come for relief from the guardians.

21,446. You do not apprehend any difficulty as between these various classes; you think the accommodation could be utilised for all those classes, the common ground being that they are all mentally afflicted?—Is not that the basis of classification which you must use once you are approaching it as a lunacy matter?

21,447. Yes, I follow that. By that means, I take it, the stigma, as it is called, of pauperisation could be eliminated, could it not?—So far as it exists.

11 December, 1925.]

Mr. H. W. S. FRANCIS, O.B.E.

[Continued.]

21,448. There is another matter which comes, I think, within your purview, Mr. Francis, arising from the question of the chargeability of patients. At the present moment, of course, there is a code which deals with the chargeability of pauper patients?—Yes.

21,449. Would it be necessary, do you think, to alter the scheme of chargeability to any extent?—Quite clearly. At present the bulk of the lunatics are union cases, and are chargeable to the union. You want to say that they are lunacy cases which are for the lunacy authority. It seems to me that they must become chargeable to the lunacy authority's area as a whole, and not to a part of it.

21,450. Just as at present the lunacy authority has charge of, and is financially responsible for, the lunatics within their area?—Yes.

21,451. So their responsibility would be expanded to include all types of lunatics, whether they were Poor Law cases or not?—I do not think that is quite so; the lunacy authority at present is not responsible for all the lunatics in its area; the lunacy authority is responsible only for maintaining institutions to which lunatics are sent by the Poor Law authorities, and the lunatics are chargeable to the Poor Law authorities, the union area. If you wish to separate the connection between lunacy and poor law, you must say the responsibility of the lunacy authority is to extend to all lunatics in the area. It is possible that you might have a difficulty over the willingness of the lunacy authority to accept a charge for what they would call a lunatic that did not belong to them. That could be got over, if grants are going to be increased to the lunacy authority, by saying that it is a condition of the increased grant that they should take these cases without raising any question.

21,452. Let us just understand this a little more clearly. The lunacy authority is responsible for the provision of accommodation, is it not?—At present, yes.

21,453. It must provide adequate accommodation?—Yes.

21,454. And then the patients which reach the asylum reach it at present through the machinery of the Poor Law?—Yes.

21,455. Then for the maintenance of the patients in the institution, which has been provided by the local authority, is the Poor Law responsible?—Yes.

21,456. Does the Poor Law pay over to the lunacy authority the cost of the maintenance of the paupers?—Yes.

21,457. There is a grant, of course, in addition?—Yes.

21,458. If the responsibility for the maintenance of the population of the mental institutions were taken over by the lunacy authority, then the Poor Law would be relieved of that expense?—Entirely.

21,459. Are you figuring, if that were done, that the lunacy authority would require to receive some assistance from some source?—No, I do not know that that is so. It depends upon what is proposed. If the Commission do propose that there should be larger grants, then a condition of those grants might be that, say, Bedford is not to raise any question with regard to a lunatic found in Bedford though the man properly belongs to Gloucester.

21,460. But in the case figured would not the Poor Law authority be relieved of a considerable expenditure?—Certainly.

21,461. Mr. Mickle: There would be no question of settlement at all, would there?—I do not think there ought to be.

21,462. Chairman: The responsibility would just rest where it fell?—Yes.

21,463. But if there was that large relief to the Poor Law authorities by reason of their being exonerated from the responsibility of maintaining the lunatics, and that burden were transferred to the lunacy authority, do you regard that as being merely a question of nominal transference of liability, since

the ratepayer ultimately responsible would be the same person?—It is a matter purely of form, except so far as you have a larger area of charge and a rather more equalised charge.

21,464. There might be a diminution in the guardians' rate, but there would be a corresponding increase in the lunacy rate?—There would be a diminution in the guardians' part of the poor rate, and an increase in the lunacy part of the poor rate.

21,465. They are both parts of the poor rate at present?—Yes.

21,466. But as an incident of any such re-arrangement, do you contemplate that a claim might be made for increased grants?—I have not really considered that. Most developments in local government seem to involve a demand for increased grants.

21,467. I am afraid that is so?—If the Commission are considering grants of that kind then that condition could be attached.

21,468. But I gather that as a question of administration you would favour the lunacy authority being responsible for all cases arising in its area, irrespective of Poor Law settlement?—Yes, quite irrespective of Poor Law settlement.

21,469. At present the relieving officer, who is a Poor Law official, has very important functions to discharge under the Lunacy Act, has he not?—Yes.

21,470. Have you any views as to how those services, at present rendered by the relieving officer, would be rendered if a change such as we have been discussing were instituted?—It does not seem to me that the matter presents any substantial difficulty. The relieving officers and the guardians have their places in lunacy law, because at the time of the development of the lunacy law the guardians were the only authority of a simple single form working all over England and Wales.

21,471. It was an existing machinery?—It was an existing machinery to which it was obviously easy to assign anything of the kind. They were also the only machine which possessed a relieving officer responsible for every district in the country. The position is totally changed now.

21,472. You might just develop that a little, Mr. Francis, and tell us how you are looking at the development?—I am not at the moment saying whether the Poor Law machine is the right one or not.

21,473. We are contemplating possibilities?—If you approach the subject now, you have a number of possible alternative machines which could be used.

21,474. We should be very glad to hear your views upon that. Without committing your Ministry in any way, one would like to hear the possibilities of the situation?—One possibility is that the Lunacy authority itself should do the work.

21,475. The whole work?—The whole work.

21,476. Not merely providing premises, but looking after and maintaining the lunatic population?—Yes. The situation is completely altered by the motor car and the telephone.

21,477. How have these modern innovations altered the situation?—You have the difficult case which has to be dealt with at once for which you require someone to be on the spot. I am thinking of the case of a man who goes suddenly violently off his head; you have got to get a neighbour to sit with him, and you get hold of the relieving officer as the responsible officer as quickly as you can.

21,478. Who is on the spot?—Pretty well. You send for the relieving officer; you telephone for him. It would not take very much longer to telephone to the asylum and have an attendant arrive with an ambulance, if required.

21,479. Yes, but one difficulty still occurs to me, and that is that the relieving officer, being as you have said a localised official, has special knowledge of the population under his charge, and is in touch with the people?—Yes.

21,480. Must not there always be somebody at hand even to send for the ambulance and who can be referred to at once in the case of an emergency?—

11 December, 1925.]

Mr. H. W. S. FRANCIS, O.B.E.

[Continued.]

There are the police and the medical officers of health in larger areas, of course.

21,481. I am just thinking of it practically. Suppose such a case as you have figured arises, what is the unhappy husband or wife or son or daughter to do; to whom are they to refer in their difficulty?—At present they go to the relieving officer, I understand. And they know him.

21,482. They know him, and he takes charge of the situation and tells them what ought to be done. Suppose it were not the relieving officer, whom would you substitute to perform that really very important function?—I should have thought the medical officer of health.

21,483. Then take a county area; the medical officer of health is probably in the county town, not in touch really with the population, that may be scattered through his area, to the same extent?—The medical officer for a rural district should be in touch.

21,484. *Sir David Drummond*: But the panel doctor would be the first official to be called in?—The panel doctor, of course, is more easily available.

21,485. He would be called in, in the first instance, and it is he who sets matters moving?—Yes.

21,486. *Chairman*: I was just trying to figure out practically how the thing would work. Supposing the relieving officer were no longer the person to whom people referred in their difficulties?—I believe at the present time it is more often a doctor who says you must send for a relieving officer.

21,487. In that case the doctor, instead of saying you must send for a relieving officer, would say you must send for the official of the asylum?—Yes.

21,488. Then would you contemplate that in cases where accommodation was sufficient the patient should be taken direct to the mental institution, without passing through the Poor Law institution at all?—Yes, assuming you have a development of this practice under Section 26. If that section were largely applied, there would be receiving houses available.

21,489. They would be the same premises, but they would be labelled differently, and under different administration?—That appears to be a great object of reform now.

21,490. Then in that case, on the panel doctor or the medical officer of health seeing the case and regarding it as an emergency case, steps could be taken at once by communicating with an institution for the reception of that case?—Yes.

21,491. *Mr. Micklem*: That would mean, would it not, providing at the Poor Law institution something further than is suggested in Section 26, which only deals with chronic patients?—Yes. I was assuming a development of the Section.

21,492. *Chairman*: But whatever development took place in the Poor Law, even if the Poor Law is abolished as such, would there not always have to be some official still corresponding to the relieving officer, even if his name were changed and his duties were different?—There would certainly be relieving officers all over the country. I was considering the point that there was a desire to get the Poor Law entirely out of lunacy.

21,493. That is a suggestion that we are discussing?—If that is desired, it can be done. I am not going to say there may not be inconveniences about it; there certainly will be inconveniences about any change.

21,494. I do not know whether the relieving officer who is still under any system of reform to continue to exist could not still be used in another capacity. He might have to double an appointment; he might be a Poor Law relieving officer and a lunacy officer?—There is no change in the situation there; the relieving officer's lunacy duties are always held to be distinct from his Poor Law duties.

21,495. They are?—They are now.

21,496. But they are discharged by him under the same name?—Yes, they are assigned to him under that name.

21,497. And he is, of course, just paid as the holder of one office?—Yes. He frequently receives three or more salaries, but there is no separate salary for lunacy work, as a rule.

21,498. That, of course, rather tends to give the impression that it is mixed up with the Poor Law, does it not?—So it is.

21,499. The practical difficulty I was really envisaging just now is how you could get hold of any person who was so closely in touch as the relieving officer is at present, and so well known in the district as the person to whom you could refer in such a difficulty?—That, of course, would be a difficulty, so far as you are thinking of a case where no doctor comes in; but as soon as the doctor comes in I should imagine that the medical officer of health, or his representatives, are better known to the doctor than the relieving officer is.

21,500. Then you would contemplate that the doctor who was called in, in the first instance, would, if he thought the case required immediate treatment, communicate with the medical officer of health, who would then put the appropriate machinery in motion?—Yes.

21,501. You see some cases have to be dealt with at very short notice?—Of course.

21,502. And you want to have the machinery at hand and available with the least possible delay, do you not?—The machinery consists of somebody to take care of the patient in the house for the moment.

21,503. Putting it in its simplest way: to tell the poor people what they had got to do; that is what we all want to know when we get into a difficulty?—I should have thought the doctor would do that.

Sir David Drummond: In practice there is often great delay at present; the relieving officer is away attending to some other matter. Hours, and sometimes quite half a day or more, would elapse before the relieving officer can deal with these cases. That is one of the complaints in practice in populous districts, that the relieving officer is unable to deal with the case promptly; he has too many duties.

21,504. *Chairman*: Of course he cannot be everywhere at once, but I am afraid that would apply to any official?—That would apply to every system.

21,505. You cannot have a man standing by, so to speak?—If you had a man standing by, he might have two cases at once, of course.

21,506. That is a practical difficulty which just has to be met. But it is the substitution of someone to perform the duties of the relieving officer that is a little puzzling us, because he seems to be such an important functionary under the existing law?—All I was suggesting was that there are alternative machineries all over the place now; you are not bound to the Poor Law in the way you were.

21,507. Just because of the growth, since the original lunacy law was framed, of those other systems of administration?—Yes.

21,508. And you think they might be called in aid and adapted for this purpose?—Yes; I see no reason why it should not be done.

21,509. That really is the practical conclusion of the matter. On the whole you suggest the medical officer of health and his staff as affording the alternative machinery?—I should have thought that was the first line of enquiry at any rate.

21,510. At the present moment what is the relation of the central lunacy authority, the Board of Control, to the workhouse accommodation in which mental cases are treated?—The Board of Control inspect all workhouses in which there are lunatics at the different prescribed intervals, and they report to the Minister, who communicates with the guardians on the report. The reason for that of course is that the workhouse is only partially a place for lunatics. There are other considerations.

21,511. The Board of Control can only inspect that portion of the workhouse premises which is specially dedicated to the treatment of mental cases?—They are primarily concerned to inspect that portion.

11 December, 1925.]

MR. H. W. S. FRANCIS, O.B.E.

[Continued.]

21,512. So that already in a sense part of the Poor Law accommodation is dedicated to mental treatment, and is under the control of the lunacy authorities?—Yes.

21,513. It might not present any very great difficulty just to carry that process further and separate it from the guardians' immediate province?—I think you would have great difficulty, if you cannot make arrangements for the guardians to staff and maintain the wards, possibly as the agents of the lunacy authority.

21,514. And that, of course, might well arise, might it not, in cases where you are dealing with rural areas, where it would be impossible to have a separate staff for the very small number of cases involved?—Even if you had a larger number of cases it is very difficult to have two staffs or two masters in one institution.

21,515. Of course this might be merely a temporary arrangement pending more complete severance of the two, but one has to deal with the thing practically. At the present moment, if the workhouse accommodation were cut off altogether, there would not be sufficient accommodation for mental cases in this country?—I believe not.

21,516. And therefore the existing accommodation would certainly for a time have to be used; and then comes the question that you put as to the staffing, and your suggestion is that the premises might be taken under Section 26, and the staffing done by arrangement with the existing workhouse authority?—So long as the whole cost is borne by some other authority, I think you would find that the stigma of pauperism would not be raised; and there would of course be arrangements for other purposes.

21,517. You speak of arrangements for other purposes—are there any analogies that you can suggest to us?—I suggest maternity cases. I am not saying there are a large number of them; it is a question of the best arrangement being made where local circumstances indicate the use of Poor Law premises.

21,518. Can you give us a clue as to where we shall find the arrangements made with relation to maternity cases?—Edmonton would be a good example.

21,519. What is the arrangement obtaining there?—The guardians have provided a maternity ward in the ordinary course. By agreement with the district council they receive in that maternity ward—I am not quite sure whether it is even in a separate ward—but they receive certain patients who are sent by the district council, who come in by a different door, and are then treated and fed with the other inmates.

21,520. And what is the financial arrangement?—The district council pays.

21,521. Pays for the maintenance?—Yes.

21,522. Do they make any contribution to the establishment charges of the institution?—Their contribution is supposed to cover the whole cost.

21,523. Are there any other analogies besides the maternity case?—There are some instances, I think, where tuberculosis cases are received in that way.

21,524. I have no doubt we can ascertain how that is done in practice quite easily?—Yes.

21,525. Now you pointed out that the Board of Control report the result of their inspection of workhouse premises direct to the Minister?—Yes.

21,526. And then the Minister in turn communicates with the guardians?—Yes.

21,527. If arrangements such as we have been discussing were initiated and the lunacy authority leased premises from the guardians and recouped the guardians for the cost of maintenance of lunacy cases, there would, of course, still have to be inspection by the Board of Control, would there not?—Yes.

21,528. In such cases would you contemplate that the results of the inspection would still be reported to the Minister?—Yes, certainly the Minister should know; but I do not see any reason why the Board of Control should not communicate directly with the lunacy authority.

21,529. But not with the guardians?—But not with the guardians. Perhaps I may say that in certain institutions which take nothing but mental cases arrangements have already been made with the Board of Control by which our inspectors do not go there at all; the Board of Control do the inspection.

21,530. There is a point which is more or less incidental, but perhaps you might give us your view upon it, Mr. Francis, because it has been brought to our notice, namely, the position of patients in institutions in relation to their old age pensions. What is the position at present in that matter?—The old age pension is payable during not more than three months' stay in a Poor Law institution, if that stay is for medical treatment; substantially that is the position.

21,531. And if the patient remains longer than the three months is the Old Age Pension suspended?—It stops, yes.

21,532. *Mr. Snell*: The guardians in that case take it, do they?—At the end of the three months?

21,533. Yes?—No; it stops.

21,534. *Chairman*: It is absolutely suspended. I think, Mr. Snell. May not rather serious hardship result from that, Mr. Francis?—I believe the ground of the rule is that where a person is being maintained at public cost there is no reason for paying twice over.

21,535. *Mr. Snell*: But he presumably has to keep his lodgings going or his home. What happens?—I am afraid I do not know. I do not imagine that they do perhaps keep lodgings going, where you have a person over 70 going into a workhouse or infirmary for more than three months.

21,536. You think his other expenses would cease, as a general rule?—As a general rule.

21,537. *Miss Madeleine Symons*: But supposing a man had a small pension, from another source, you would not necessarily take it all from him—I mean the guardians would not?—The guardians would not necessarily take it all.

21,538. Does it not seem rather curious that if it happens to be an old age pension it should automatically stop; if it happens to be any other form of pension it should be decided on its merits?—I suppose the Treasury would say they do not see why they should pay an old age pension to relieve the rates.

21,539. *Chairman*: But suppose the patient has saved a little money, perhaps has saved £200 or £300, and is in enjoyment of an old age pension as well, and is able thus to carry on; the patient becomes mentally afflicted and is kept for more than three months in a mental institution; the pension automatically ceases; and then, I take it, the guardians would have recourse to the savings of that patient, the £200 or £300 I have figured, and exhaust it?—Yes.

21,540. And the patient, assuming recovery, would be restored to ordinary life with the whole of his savings gone, and be in a very much worse position financially than if he had not suffered this ailment at all?—That might happen.

21,541. Does not that seem rather hard?—I am not concerned, on behalf of the Minister, to defend the arrangement. The arrangement represents a compromise which was made in 1919, and was embodied in the Old Age Pension Act of that year.

21,542. Of course there may be two rival theories coming into conflict there: one being that the old age pension, being a payment from public money, the patient who is receiving the benefit of public money in residence and treatment in an institution should not draw both?—Quite.

21,543. The other view, of course, may be that the pension is a quite independent right?—But it is not, as the law stands.

21,544. As the law stands it is not treated as an independent right?—It is not a right.

21,545. *Mr. Micklem*: You mean the 1919 Act makes it not a right?—It settles the question. You have no right to it after three months.

11 December, 1925.]

Mr. H. W. S. FRANCIS, O.B.E.

[Continued.]

21,546. *Chairman*: That is rather reasoning in a circle. Apart from the fact that the statute peremptorily says that your old age pension shall terminate at the end of three months, if the patient had not had to go to the mental institution of course he would have continued to draw his old age pension?—Yes.

21,547. *Mr. Micklem*: When you say it was a compromise, between whom was it a compromise—the Treasury and the local authorities?—I think one might say 'Yes.'

Mr. Micklem: Not between the parties interested.

21,548. *Chairman*: Is there not an answer to the point that Mr. Francis is putting? Mr. Francis says the patient is being paid for out of public money, and therefore it is anomalous that at the same time the patient should be receiving public money; but if in point of fact the patient is not being paid for out of public money, but is being paid for out of his own £200 or £300 of savings, then that patient is not being maintained by public money at all; he is being maintained by his own money?—Perhaps I might suggest that you should hear evidence from the Treasury on the subject.

21,549. You are referring us to a very stony quarter; but I wanted to put the point because it is naturally a point related in some respects to the pauperization of the patient?—The Ministry would be quite glad if the present limitation were withdrawn; but they would feel great diffidence in supporting its withdrawal for lunatics and not for other persons in public institutions.

21,550. *Mr. Snell*: Does this argument of yours apply to cases where there is a contributory pension scheme under the new Act?—The same rule exactly has been applied, I believe.

21,551. So that a man might have paid for many years, and yet in three months his pension would stop?—Yes.

Chairman: It would operate a forfeiture of his pension, and, in addition to that, he might be maintaining himself out of his own savings, because the guardians recoup themselves.

Mr. Snell: Yes.

21,552. *Chairman*: *Prima facie* there seems a hardship there. I merely wanted to draw attention to it, because we are concerned to see that the persons who are unfortunately afflicted in this way are not distressed during their confinement, and possibly have their recovery retarded, by financial anxiety. I can well conceive a person, who had a small amount of capital saved which he is looking forward to living upon, being very much worried by the thought that that fund was being gradually dissipated; and when the patient returned to ordinary life this would all be gone, and gone to recoup the guardians, while at the same time the pension had been stopped because the guardians were supposed to be paying for the patient. There seems to be an anomaly there?—I can see, if I may say so, that that applies more to pensions under the new Act because they are young people; but I should have thought that the cases of people over 70 drawing old age pensions in which that was a substantial consideration, would be few.

Chairman: However I wanted to put it to you in order to show that it was a matter that had been brought under our notice, and, *prima facie*, it seems to involve some hardship. These are all the matters I want to ask you about, Mr. Francis, and perhaps my colleagues may now wish to ask you further questions.

21,553. *Miss Madeleine Symons*: Mr. Francis, you were telling us about the practical possibilities of continuing to use the Poor Law accommodation if the responsibility were transferred to the lunacy authority; but could you give us your opinion on the present position? Do you think that the accommodation and treatment and facilities for observation are in all cases generally satisfactory, as provided by the guardians?—I should have thought generally they reached a fair standard. In some

instances they are very good; in some instances I am afraid they are not good.

21,554. That is what I was wondering, frankly. Assuming that you considered an alteration of the authority necessary, are you satisfied that a mere change of name is all that is needed?—Whether there is or is not a change of name, I know of instances in which, if it were not for the present need of economy, I should be putting pressure upon the guardians to improve their accommodation.

21,555. I was asking you that, because earlier on we had evidence of that kind from Poor Law witnesses themselves, and I wondered what your view about it was?—I do not think I can say more than that the present need for economy in public money does prevent securing improvements for which otherwise the Ministry would be pressing.

21,556. Otherwise you would be in favour of an improved scheme of receiving houses, whatever the accommodation was?—The accommodation certainly requires improvement in some respects.

21,557. *Chairman*: And if the premises were taken over under Section 26 by the lunacy authority, the duty would then pass to them to see that the accommodation was made adequate and the treatment was improved where necessary?—And to pay for it.

21,558. *Mrs. Mathew*: I should like to pursue that question, in order to bring the treatment of lunatics up to a certain standard. If the Ministry of Health made a grant, would they not be able to enforce a certain measure of improvement in the treatment and care of the patients?—I do not think the position would be very different in that respect. You would get the advantage of a rather closer application of experts' ideas to the guardians' institution than you get now; but on the question of making improvements the difficulty is, when you can afford to press it, to get the local authority to pay for it; that difficulty will still arise.

21,559. *Chairman*: You think their activities might be stimulated?—Of course if you like to pay for it, that is a different thing.

21,560. *Mrs. Mathew*: I think it might encourage them to a higher standard in some of the rural or backward areas?—I think there would be that substantial advantage: that you would get experts in closer touch with the thing.

21,561. And a better standard all round—to bring it up to a better level?—In some instances, yes. I am not prepared to say that it is bad all round.

21,562. *Chairman*: I do not know whether you would say that the status of the new lunacy authority might be a rather higher one than that of the guardians? I do not know whether that is a question really upon which you could speak?—No, I should not like to say that. They are very largely, of course (allowing for the fact that the lunacy authority has smaller numbers) the same people in the country areas.

21,563. *Sir David Drummond*: It appears to me that there is a great want of uniformity throughout the country in these workhouses in relation to the accommodation for lunatics. What steps would be taken to bring up the standard so that there would be a greater uniformity?—Is there a greater lack of uniformity than there is between the lunatic asylums in the country?

21,564. I think so. In some of the country workhouses things are far from right?—I do not know about that. This proposal, if it is carried out, that the lunacy authority should themselves control the accommodation in the workhouses, would of course meet that to a certain extent.

21,565. Quite so. That is your answer to the question?—Yes. Apart from that, the workhouses are inspected by the Board of Control at present, and I know of no case in which their recommendations for the improvement of the accommodation have been turned down by the Minister. No doubt there have been cases in which they have been unable to agree with the guardians.

11 December, 1925.]

Mr. H. W. S. FRANCIS, O.B.E.

[Continued.]

21,566. *Chairman*: There is no sanction attaching at present. I mean if the guardians simply resolutely say "We are not going to do it" notwithstanding the fact that the Board of Control think there should be an improvement, and the Minister approves of it, there is no drive behind it?—There is only a sanction which is very difficult to enforce. We can issue an Order of the Minister requiring them to make alterations, and then we can *mandamus* them to obey the order.

21,567. And if they do not obey?—I do not know.

21,568. One often wants to pursue a thing to see what is the ultimate sanction, because although the ultimate sanction may not often be used it is useful to have something in reserve; but at the moment

there does not seem to be any direct *compulsitor* available?—There is no direct *compulsitor* available. We can issue an Order.

21,569. And perhaps in one sense it would not be desirable to introduce a *compulsitor* to make people spend money which they have not got? — One can imagine what the position of the country would be if Sir Edwin Chadwick had compulsory power to put all his ideas into effect.

Chairman: We are much obliged to you for your attendance, Mr. Francis. We are sorry not to have heard Mr. Brock this morning: but we shall use the contributions he has made to us in writing; and we are indebted to you for your evidence on the Poor Law.

(The Witness withdrew.)

(Adjourned.)

ROYAL COMMISSION ON LUNACY AND MENTAL DISORDER.

INDEX AND APPENDICES

TO THE

MINUTES OF EVIDENCE

TAKEN BEFORE THE

ROYAL COMMISSION ON LUNACY AND MENTAL
DISORDER.

PART III.



LONDON :

PRINTED & PUBLISHED BY HIS MAJESTY'S STATIONERY OFFICE.

To be purchased directly from H.M. STATIONERY OFFICE at the following addresses :

Adastral House, Kingsway, London, W.C.2 ; York Street, Manchester ;

1, St. Andrew's Crescent, Cardiff ; or 120, George Street, Edinburgh ;

or through any Bookseller.

1926

Price 10s. 6d. Net.

TABLE OF CONTENTS.

APPENDICES.

Appendix.	Page.
I. Analysis of principal statutory provisions	939
II. Reception documents returned after examination by Board of Control	940
III. Particulars of patients allowed leave of absence on trial during 1923	941
IV. Prosecutions under the Lunacy Acts during the 5 years 1919-1923	941
V. Return of inquisitions held since 1890	941
VI. Powers and duties transferred to the Minister of Health under the Transfer of Powers Order 1920	942
VII. Statement of disposal of mental cases admitted to Bethnal Green Workhouse, 1st January 1923 to 30th September 1924... ..	943
VIII. Mental cases reported in 1923 in the Birmingham Union	943
IX. Costs of visits for certification and removal in the Birmingham Union	943
X. List of mental patients admitted to Lambeth Infirmary from general hospitals between 31st March and 10th November, 1924	944
XI. Statistics of patients dealt with during 1923 in mental wards of Salford Union Infirmary	944
XII. Analysis of cases admitted to mental wards of Poor Law Institutions, Southampton Union, during year ended 30th September, 1924	945
XIII. Maudsley Hospital: Extract from the London County Council (Parks, etc.) Act, 1915... ..	945
XIII(A). City of London Mental Hospital: Extract from the City of London (Various Powers) Act, 1924	945
XIV. Particulars of patients admitted to London County Mental Hospitals, during 1923, who were found to be "not insane"	946
XV. Statement as to complaints during 1923 affecting the treatment of patients in London County Mental Hospitals which necessitated formal inquiry	948
XVI. Re-admission statistics, Rubery Hill and Hollymoor Mental Hospital, Birmingham	949
XVII. Average duration of residence of voluntary boarders, The Retreat, York	950
XVIII. Summary of mental patients dealt with by relieving officers during 1916-1924 in Leeds, Rochdale and Sheffield Unions	951
XIX. Letter from the Medical Superintendent of Camberwell House	951
XX. Statement as to admission of voluntary boarders to The Old Manor, Salisbury, 1923 and 1924	951
XXI. Patients discharged recovered, Claybury Mental Hospital, 1920-1924	952
XXII. Memorandum of evidence by the British Medical Association	952
XXIII. Statistics of deaths and discharges within short periods of detention during 1923 at the Lancashire Mental Hospitals	960
XXIV. Memorandum of evidence by the Medico-Psychological Association	960
XXV. Memorandum of evidence by the National Council for Mental Hygiene	967
XXVI. Statement of income and expenditure of the Maudsley Hospital for the financial year 1924-25	970

INDEX.

Index to Subjects	971
Index to Witnesses	1006

APPENDIX I.

Question 4

ANALYSIS OF THE PRINCIPAL STATUTORY PROVISIONS.

I.

PRIVATE PATIENTS.

- How Admitted* ... (1) Urgency Order. Ss. 11, 28, 29 (3).
 (2) Order on Petition. Ss. 4-8, S. 28.
 (3) By Summary Reception Order under S. 13—but see S. 3, Lunacy Act, 1891.
- On and After Admission.* (1) Notice of Admission and copy documents to Board within one clear day and medical statement between 2nd and 7th day. Rule 8 (3).
 (2) Amendment of documents. S. 34.
 (3) Month-end report. S. 39, and Rule 9.
 (4) Special Report and Certificate to continue Order. S. 38 (1890) and S. 7 (1891).
 (5) Commissioners can call for report at any time (Rule 35).
 (6) Single patients only—Report (Rule 17) by Medical Attendant in January of each year and whenever required by the Commissioners. S. 45.
- Case Books and Medical records.* Rules 1-3 (1906). 4, 10-13, and 16 (1895).
- Visitation of New Cases.* (1) By Commissioners. S. 39.
 (2) By Visitors of licensed houses. S. 39.
 (3) By members of Managing Committees of registered hospitals. S. 39.
 (4) By members of Visiting Committees of mental hospitals. S. 188.
 (5) Single patients—by the Commissioners, a Medical Visitor, or some other competent person. S. 39 (5), (6).
- General Visitation* ... (1) By Commissioners. Ss. 187, 191, 197 and 198 ; right to request private interview. S. 42 (1) (b).
 (2) By Visitors to licensed houses. S. 193.
 (3) By Visiting Committees. S. 188.
 (4) Single patients—by Medical Attendant. S. 44.
- Special Visits* ... (1) By Petitioner or someone appointed by him. S. 5 (3) ; by friends. S. 47.
 (2) By two Commissioners. S. 75 (In a hospital or licensed house or in single care).
 (3) By competent person by order of Commissioners. S. 204.
 (4) By Commissioner or other person by direction of Lord Chancellor or a Secretary of State. S. 205.
 (5) By two medical practitioners by order of Commissioners. S. 49.
 (6) By Chancery Visitors on direction of Master. Ss. 183, 184.
 (7) Special visit by Commissioners or Visitors to licensed houses to hold enquiry on oath. S. 332.
- Correspondence* ... (1) Correspondence. S. 41.
 (2) Notices. S. 42.
- Leave of Absence* ... (1) On trial (public mental hospitals) S. 55 (1) (8).
 (2) On trial or for health (hospitals or licensed houses) S. 55 (3) and (4) ; and S. 9 (1) Lunacy Act, 1891.
 (3) For 48 hours (hospitals and licensed houses) S. 55 (7).
 (4) Single patients—S. 56. S. 10 (Lunacy Act, 1891).
 (5) For 4 days granted by Medical Superintendent of public mental hospital—by regulations made under S. 275 (5).
- Discharges from Certificates.* (1) By Petitioner, etc. S. 72 (1) and (2).
 (2) By Commissioners. Ss. 34 (2), 38 (6) (a), 39 (9), 49, 72 (3), 75.
 (3) By Managing Committee of registered hospital. S. 39 (7).
 (4) By Visitors of licensed houses. S. 78—after 2 visits.
 (5) By 3 members of Visiting Committee. Ss. 77 (1), 38 (6) (b), 39 (7) ; and by 2 members of Visiting Committee on advice of Medical Officer. S. 77 (2).
 (6) By operation of law—
 (a) After notice of recovery—from hospital, licensed house or single care. S. 83.
 (b) After escape. S. 85.
 (c) Failure to return within 14 days after expiry of leave on trial. S. 55 (8).
 (d) Lapse of reception order. S. 38 (7) ; lapse of urgency order. S. 11 (6).
 (7) After legal proceedings under writ of Habeas Corpus.
 (8) Of alien by Secretary of State. S. 71.
 (9) Right of patient to copy of reception documents on discharge. S. 82.

N.B. References to Sections mean Sections in the Lunacy Act 1890, unless otherwise specified.

References to Rules mean Rules made by the Commissioners in Lunacy, dated 26th June 1895, unless otherwise specified.

II.

RATE-AIDED PATIENTS.

(a) *In County and Borough Mental Hospitals.*

(No Rate-aided Patients now in either Registered Hospitals or Licensed Houses.)

- How Admitted* ... On Summary Reception Orders.
 Ss. 13, 28.
 Ss. 16, 28.
 Ss. 22. Power to allow a relation or friend to take charge of a lunatic.
 Ss. 23, 28, 60. Power of Commissioners to make reception order.
- On and After Admission.* (1) Notice of Admission and copy documents and medical statement to be sent between 2nd and 7th day (Rule 3 (3)).
 (2) Amendment of documents. S. 34.
 (3) No month-end report required.
 (4) Special Report and Certificate to continue Order. S. 38 (1890) and S. 7 (1891).
 (5) Commissioners can call for report at any time (Rule 35).

<i>Case Books and Medical Records.</i>	Rules 1-3 (1906) ; 4, 10-13, and 16 (1895).
<i>Visitation of New Cases.</i>	By Visiting Committees. S. 188.
<i>General Visitation ...</i>	(1) By Visiting Committees. S. 188. (2) By Guardians and medical practitioner appointed by them. S. 201. (3) By Commissioners. S. 187.
<i>Special Visits ...</i>	(1) By competent person by order of Commissioners. S. 204. (2) By two medical practitioners by order of Commissioners. S. 49. (3) By friends. S. 47. (4) Special visit by Commissioners to hold enquiry on oath. S. 332.
<i>Correspondence ...</i>	S. 41.
<i>Leave of Absence ...</i>	(1) On trial. S. 55 (1), (2), (8). (2) For 4 days granted by Medical Superintendent of public mental hospital—by regulations made under S. 275 (5).
<i>Boarding-out with Friends.</i>	S. 57.
<i>Discharges from Certificates.</i>	(1) By 3 members of Visiting Committee. Ss. 77 (1), 38 (6) (b) ; and by 2 members of Visiting Committee on advice of Medical Officer. S. 77 (2). (2) By Commissioners. Ss. 34, 49. (3) By 2 members of Visiting Committee to care of friends. S. 79. (4) By Visiting Committee to Poor Law Institution. S. 25. (5) By operation of law— (a) After escape. S. 85. (b) Failure to return within 14 days after expiry of leave on trial. S. 55 (8). (c) Lapse of reception order. S. 38 (7). (6) After proceedings by writ of Habeas Corpus. (7) Right of patient to copy of reception documents on discharge. S. 82.

(b) *In Poor-Law Institutions.*

<i>How Admitted ...</i>	S. 20 (temporarily). S. 21 (temporarily). S. 24, Ss. 4 & 5 (1891) (for detention). S. 25 (from mental hospital). S. 26 (from mental hospital).
<i>After Admission ...</i>	Return to be made by Medical Officer quarterly—Rule 32.
<i>Books and Records...</i>	S. 54 —by Visiting Guardians.
<i>General Visitation ...</i>	S. 54 —by Guardians. S. 202—by Medical Officer of Institution. S. 203—by Commissioners.
<i>Special Visits ...</i>	S. 204—by competent person by Order of Commissioners. S. 47 —by friends.
<i>Discharge ...</i>	S. 81 —by Guardians.

N.B.—References to Sections mean Sections in the Lunacy Act, 1890, unless otherwise specified.

References to Rules mean Rules made by the Commissioners in Lunacy, dated 26th June, 1895, unless otherwise specified.

NOTE.—Since this statement was prepared, the Commissioners' Rules of 26th June, 1895, and 31st October, 1906, have been superseded by revised Rules dated 7th January, 1925. These Rules are designed to effect some simplification of the records and returns, but do not affect in substance the safeguards provided under the previous Rules.

APPENDIX II.

Questions 186 & 229.

RECEPTION DOCUMENTS RETURNED AFTER EXAMINATION BY BOARD OF CONTROL.

The following is a Summary of the result of the Examination of Reception Documents by the Board during the period 11th February to 11th April, 1925.

The number of Admissions in the period was approximately 3,400 in number.

The certificates returned during the period were 92 in number. These are divided into three classes:—

- (1) Cases in which the facts indicative of insanity stated by the certifiers to be observed by them at the time of examination did not seem to the Board to justify compulsory detention.
- (2) Cases in which, though symptoms indicative of insanity were observed, there might in the absence of further evidence be room for doubt as to the need for detention.
- (3) Cases in which the certificates indicated insanity, but amplification was desirable.

In Class (1), in three cases the certificate was un-amended, and the Board wrote recommending that the patient should be discharged and, if necessary, re-certified. One of the patients was discharged "Recovered," one was re-certified, and the third died before further action could be taken.

In Classes (2) and (3) all the certificates were amended with six exceptions. In these six cases the doctors were unable to amplify the certificates, but the Board did not consider that this was in itself sufficient to invalidate them, having regard to the other particulars in the documents which pointed to the need for certification. It should be added that although the patients were admitted to Mental Hospitals in February or March of this year, none has since improved sufficiently to warrant discharge.

24 August, 1925.

APPENDIX III.

Question 464.

PARTICULARS OF PATIENTS ALLOWED LEAVE OF ABSENCE ON TRIAL DURING THE YEAR 1923.
(Obtained from six typical County and Borough Mental Hospitals.)

Name of Institution.	Total Number of Patients on Jan. 1, 1923.	Total Number allowed leave on trial during 1923.	Number whose leave was followed by discharge.		Number returned to the Institution as being found unfit for discharge or to remain on trial.		Died whilst on trial.
			Recovered.	Relieved.	During the period of trial.	On expiry of leave on trial.	
Essex : Brentwood	1,686	188	33	141	12	2	—
London : Bexley	2,099	108	80	17	10	1	—
East Sussex	1,135	94	79	—	11	3	1
Yorks, W.R. : Wadsley	1,554	202	142	45	15	—	—
Birmingham : Winson Green	762	100	74	12	14	—	—
Nottingham City	842	105	90	4	10	1	—
Total	8,078	797	498	219	72	7	1

APPENDIX IV.

APPENDIX V.

Question 683.

Question 1028.

PROSECUTIONS UNDER THE LUNACY ACTS DURING THE
5 YEARS, 1919-1923.

A. On Order of Board of Control	13	} 22
B. At instance of Visiting Committees	9	

Ill-treatment of Patients.

(A) Six prosecutions on Order of Board of Control, involving seven persons.	1890	...	...	68	3	71
	1891	...	...	51	1	52
	1892	...	...	39	4	43
	1893	...	...	32	2	34
	1894	...	...	45	3	48
(B) Eight prosecutions at instance of Visiting Com- mittees, involving eight persons.	1895	...	...	42	4	46
	1896	...	...	37	3	40
	1897	...	...	39	4	43
	1898	...	...	29	3	32
	1899	...	...	24	5	29

Stealing from a Patient.

One prosecution at instance of Visiting Committee, involving two persons.	1900	...	...	15	4	19
	1901	...	...	7	2	9
	1902	...	...	14	2	16
	1903	...	...	13	Nil	13
	1904	...	...	14	2	16

Illegal receptions (Section 315 of Lunacy Act, 1890).

Six prosecutions on Order of Board of Control, in- volving six persons.	1905	...	...	18	1	19
	1906	...	...	15	2	17
	1907	...	...	28	2	30
	1908	...	...	19	1	20
	1909	...	...	8	Nil	8

*Omission to transmit documents to Board
(Section 316).*

One prosecution on Order of Board of Control, in- volving one person.	1910	...	...	6	Nil	6
	1911	...	...	5	Nil	5
	1912	...	...	5	Nil	5
	1913	...	...	Nil	Nil	Nil
	1914	...	...	3	Nil	3
	1915	...	...	1	Nil	1
	1916	...	...	Nil	Nil	Nil
	1917	...	...	Nil	Nil	Nil
	1918	...	...	Nil	Nil	Nil
	1919	...	...	3	Nil	3
	1920	...	...	1	Nil	1
	1921	...	...	Nil	Nil	Nil
	1922	...	...	1	Nil	1
	1923	...	...	2	Nil	2

RETURN OF INQUISITIONS HELD SINCE 1890.						
Year.			Without Juries.	With Juries.	Number of Inquisitions each year with and without Juries.	
1890	...	...	68	3	71	
1891	...	...	51	1	52	
1892	...	...	39	4	43	
1893	...	...	32	2	34	
1894	...	...	45	3	48	
1895	...	...	42	4	46	
1896	...	...	37	3	40	
1897	...	...	39	4	43	
1898	...	...	29	3	32	
1899	...	...	24	5	29	
1900	...	...	15	4	19	
1901	...	...	7	2	9	
1902	...	...	14	2	16	
1903	...	...	13	Nil	13	
1904	...	...	14	2	16	
1905	...	...	18	1	19	
1906	...	...	15	2	17	
1907	...	...	28	2	30	
1908	...	...	19	1	20	
1909	...	...	8	Nil	8	
1910	...	...	6	Nil	6	
1911	...	...	5	Nil	5	
1912	...	...	5	Nil	5	
1913	...	...	Nil	Nil	Nil	
1914	...	...	3	Nil	3	
1915	...	...	1	Nil	1	
1916	...	...	Nil	Nil	Nil	
1917	...	...	Nil	Nil	Nil	
1918	...	...	Nil	Nil	Nil	
1919	...	...	3	Nil	3	
1920	...	...	1	Nil	1	
1921	...	...	Nil	Nil	Nil	
1922	...	...	1	Nil	1	
1923	...	...	2	Nil	2	
			584	48	Grand } 632 Total }	

Inquisition cases at 31st December, 1923-221.

Trials of Issue.

1906	...	...	1
1910	...	...	1

APPENDIX VI.

Question 1473.

POWERS AND DUTIES TRANSFERRED TO THE MINISTER UNDER THE TRANSFER OF POWERS ORDER, 1920.

1. *Personal*.—The powers of the Minister in regard to the lunatic personally are as follows:—

Lunacy Act, 1890.

Section 33.—Power to direct a medical Commissioner or visitor to visit a patient with a view to signing reception certificate (such Commissioner or visitor being otherwise debarred from signing such a certificate).

Section 41 (1).—The manager of every institution is required to forward unopened all letters addressed to the Minister (among others).

Section 43 (2).—Power to direct a medical Commissioner or visitor to visit a patient in a hospital or licensed house to attend him professionally.

2. *Local Authorities and Visiting Committees*.—The powers of the Minister of Health in regard to the activities of local authorities and visiting committees are:—

Lunacy Act, 1890.

Section 242 (3).—Approval required to any agreement by local authorities to unite for the purpose of providing asylum accommodation.

Section 243 (4).—Approval required to contracts between a County Borough Council and visiting committees for the reception of pauper lunatics into their asylum.

Section 247.—The Minister may require a local authority to provide asylum accommodation in case of default.

Section 250.—Power to sanction the variation of any agreement between local authorities to unite.

Section 254 (2) and (4).—Approval required to plans and contracts of visiting committees for the purchase of lands and buildings and for the erection, restoration and enlargement of buildings; and power vested in the Minister to determine differences between local authorities in regard to the approval of any such plan or contract.

Section 255.—Approval required to the provision in an asylum of accommodation for private lunatics.

Section 258 (1).—Consent required to the provision made for the burial of lunatics dying in an asylum.

Section 265.—Consent required to the retention and appropriation of land or buildings not required for asylum purposes.

Section 267 (1) and (4).—Consent required to the dissolution of an agreement to unite and to the division of property held for the purposes of the agreement among the several local authorities.

Section 268 (1).—Consent required to the cancellation of contracts for the purpose or exchange of lands by visiting committee.

Section 269 (4) and (5).—Consent required to the making of a contract or determination

thereof by a visiting committee for the reception of lunatics in a licensed house or asylum of another visiting committee. Minister has power to determine such a contract.

Section 272.—The Minister is empowered to approve with or without modification or to refuse approval to any agreement contract or plan requiring approval under the Lunacy Act.

Section 275 (1) and (2).—Approval required to the general rules which the visiting committee must make for the government of their asylum. Any alteration or variation in the rules requires the Minister's approval.

Section 276 (1) (c).—Approval required if a local authority wish to appoint as superintendent of an asylum some one other than a medical officer.

3. *Powers of the Minister in relation to the Board of Control*.

(a) *Direct powers*.

Mental Deficiency Act.

Section 22, Subsections (2), (3), (5), (6), (7) and (8).—It rests with the Minister to recommend the non-legal commissioners of the Board of Control for appointment by His Majesty; to appoint the Chairman of the Board; to make regulations as to administrative committee and procedure of the Board; to determine with the consent of the Treasury the salaries of commissioners, to determine the term of office of unpaid commissioners.

Section 23.—The Minister, subject to the concurrence of the Treasury, approves the appointment, number and salaries of secretary, inspectors, officers and servants of the Board of Control.

(b) *Overriding powers*.

Lunacy Act, 1890.

Section 226.—Sanction of the Minister required to regulations made by Board of Control for the government of any licensed house.

Section 231.—On an application for registration of a hospital for lunatics, the Board of Control submit a report to the Minister of Health if they are of opinion that registration should not be granted, and the Minister decides finally thereon. If registration is granted, the Minister of Health approves the regulations for the management of the hospital.

Section 237 (3).—Consent of the Minister required to Order of Board that a registered hospital be closed.

4. *Power to direct prosecution*.

Lunacy Act, 1890.

Section 328.—The Minister may direct the Attorney-General to prosecute any person alleged to have committed a misdemeanour under the Act.

APPENDIX VII.

Question 1669.

STATEMENT showing the number of Persons admitted to the Workhouse of an East London Parish (Population 118,000) under Section 20 of the Lunacy Act, 1890, from 1st January, 1923, to 30th September, 1924, with the result of observation and detention ; also the number of days during which the person remained.
(NOTE.—These persons are not “detained” in the legal sense after the period authorised by law. They remain as patients for treatment or observation with their consent or that of their relatives.)

Discharged or Certified :						Certified.		Discharged.	
						Male.	Female.	Male.	Female.
Within three days	...	...	...	...	...	25	26	7	1
On 5th day	...	...	...	...	...	—	—	2	1
" 6th "	...	...	...	...	...	—	—	3	1
" 7th "	...	...	...	...	...	1	—	2	1
" 8th "	...	...	...	...	...	—	2	4	—
" 9th "	...	...	...	...	...	1	—	3	—
" 10th "	...	...	...	...	...	2	—	3	—
" 11th "	...	...	...	...	...	—	1	2	—
" 12th "	...	...	...	...	...	2	1	3	1
" 13th "	...	...	...	...	...	1	—	2	—
" 14th "	...	...	...	...	...	1	1	3	2
" 15th "	...	...	...	...	...	1	—	—	—
" 16th "	...	...	...	...	...	—	1	1	1
" 17th "	...	...	...	...	...	—	—	2	1
" 18th "	...	...	...	...	...	2	—	1	—
" 19th "	...	...	...	...	...	—	—	—	2
" 20th "	...	...	...	...	...	—	1	—	—
" 21st "	...	...	...	...	...	—	1	1	3
" 22nd "	...	...	...	...	...	—	—	—	—
" 23rd "	...	...	...	...	...	—	—	1	—
" 24th "	...	...	...	...	...	—	—	1	1
" 25th "	...	...	...	...	...	—	—	—	—
" 26th "	...	...	...	...	...	—	—	2	1
" 27th "	...	...	...	...	...	—	—	—	—
" 28th "	...	...	...	...	...	—	—	—	—
" 29th "	...	...	...	...	...	—	—	—	—
" 30th "	...	...	...	...	...	—	—	—	1
" 43rd "	...	...	...	...	...	—	—	—	1
" 60th "	...	...	...	...	...	—	—	—	1
						36	34	43	19

132

Notes.—(a) 120 admitted by Relieving Officers ; 13 admitted by Police.
(b) During the same period 34 persons (9 male and 25 female) were the subject of Reception Orders from among the ordinary inmates of the Workhouse or Hospital. A considerable number of these inmates would also be under observation, but no figures of these are available. In both these classes there would be included persons who had originally been admitted under Section 20.

APPENDIX VIII.

Question 2288.

BIRMINGHAM UNION.

Mental cases reported in the year 1923.

Total number reported to Relieving Officer in the year 1923	...	...	...	...	...	638
Medically examined at home :—						
Certified, Winson Green Asylum	...	...	...	...	...	222
Certified, Rubery Hill Asylum	...	...	...	...	...	299
Not certified	...	...	...	...	...	106
Removed to Erdington Workhouse under Section 21...	...	...	...	...	11	
Of whom were certified	...	...	...	...	...	3
And not certified	...	...	...	...	...	8
Total certified	...	...	...	...	...	524
Total not certified	...	...	...	...	...	114
Total reported as above	...	...	...	...	...	638

APPENDIX IX.

Question 2304.

BIRMINGHAM UNION.

Costs of Visits for Certification and Removal.

									£	s.	d.
Per case visited by Medical Officer to the Justices	...	...	...	...	...	...	...	...	1	11	6
Per case visited by District Medical Officers attached to the Union	...	...	...	...	...	...	...	...	1	1	0
Relieving Officer's Assistant	...	...	...	...	...	...	...	...	0	2	6
Taxi-fare, Winson Green Asylum (on average)	...	...	...	...	...	...	...	...	0	8	6
Taxi-fare, Rubery Hill Asylum (on average)...	...	...	...	...	...	...	...	...	0	18	0
Magistrate's Official Fee (not personal)	...	...	...	...	...	...	...	...	0	5	0

APPENDIX X.

Question 2787.

LIST OF PATIENTS ADMITTED TO LAMBETH INFIRMARY UNDER SECTION 20, LUNACY ACT, FROM GENERAL HOSPITALS BETWEEN 31ST MARCH AND 10TH NOVEMBER, 1924.

From St. Thomas's Hospital.

1. A.R.H., male, aged 31, admitted 1.5.24, suffering from ? lymphadenoma; very violent; certified, order suspended; transferred to Banstead 20.5.24, as mental disorder did not clear up and there was no suitable accommodation here; physical condition had improved.

2. T.W., male, aged 41, admitted 5.6.24, suffering from fractured base and concussion; certified, order suspended and allowed to lapse; took his discharge 8.7.24.

3. A.H.W.A., male, 25, admitted 27.6.24, suffering from diabetes and insanity; certified and transferred to Banstead 7.7.24.

4. E.B., female, aged 60, admitted 11.7.24, suffering from insanity; certified and transferred to Cane Hill 23.7.24.

5. E.L.M.C., female, aged 45, admitted 20.5.24, suffering from mental disorder of a harmless type; certified, order suspended; re-certified under Section 24 and transferred to Tooting Bec 15.7.24.

6. H.G., male, aged 32, admitted 30th July suffering from general paralysis of the insane; certified and transferred to Cane Hill on the 2nd August.

7. W.S., female, aged 50, admitted 1.8.24, suffering from alcoholism; took her discharge 7.8.24.

8. W.B., male, aged 47, suffering from carcinoma of rectum; admitted 9th August; certified and transferred to West Park 15.8.24.

9. A.G., male 29, admitted 11.8.24, suffering from gonorrhoeal arthritis and mental disorder; certified, order suspended and allowed to lapse; still in hospital.

10. G.L., male, aged 59, admitted 24.9.24, suffering from acute glaucoma and some mental disorder; not certified; remaining in hospital pending settlement.

From King's College Hospital.

1. L.R., female, aged 38, admitted 18th August, suffering from pernicious anaemia and mental disorder; certified, order suspended, unfit for removal; died 28th August; formally reported to the Coroner, no inquest held. This was a case which it was considered proper for the hospital authorities to detain as she was, in the medical officer's opinion, unfit to be removed here. She was placed on the Danger List on admission and is believed to have been on the Danger List while at King's College.

2. G.F.O., male, aged 67, admitted 1.11.24, suffering from uraemia and mental disorder; certified, order suspended, unfit to be removed to mental hospital.

3. F.W., male, aged 50, admitted 10th October, suffering from fractured base and concussion of brain; certified—re-certified as harmless and transferred to Tooting Bec 27.10.24.

APPENDIX XI.

Question 3119.

SALFORD UNION INFIRMARY.

Mental Wards.

Revised Statistics of Patients dealt with during 1923.

	Male.	Female.	Total.
Admissions—			
(a) On 3 Day Order (Sec. 20)...	200	171	371
(b) On Justice's Order (Sec. 21) ...	2	10	12
(c) On Resident M.O.'s Order (Sec. 24 (1))...	38	49	87
	240	230	470
Placed on Permanent Detention—			
(a) During 3 Day Order ...	—	—	—
(b) During 17 days ...	59	44	103
Transferred to Asylum—			
(a) During 3 Day Order ...	14	27	41
(b) During 17 days ...	29	43	72
Died—			
(a) During 3 Day Order ...	5	2	7
(b) During 17 days ...	11	14	25
Discharged—			
1. To care of Relatives—			
(a) During 3 Day Order ...	26	1	27
(b) During 17 days ...	31	31	62
2. To General Wards—			
(a) During 3 Day Order ...	22	7	29
(b) During 17 days ...	16	39	55
3. To Poor Law Institution—			
(a) During 3 Day Order ...	4	4	8
(b) During 17 days ...	23	18	41
	240	230	470
Patients on Permanent Detention—			
1. Transferred to Asylum ...	11	8	19
2. Died ...	18	13	31
3. Discharged—			
(a) To care of Relatives ...	8	2	10
(b) To General Wards ...	5	2	7
(c) To Poor Law Institution ...	—	—	—

APPENDIX XII.

Question 3468.

SOUTHAMPTON UNION.

Analysis of cases of alleged lunatics admitted to the mental wards of the Poor Law Institutions during the year ended 30th September, 1924.

Total number admitted during the year, 306.

	Within 3 days.	Within 7 days.	Within 14 days.	Within 17 days.
Discharged to Mental Hospital	23	28	19	16
" " Union Infirmary	8	4	7	6
" care of friends	16	9	14	9
" recovered	7	10	9	10
" to Institution	1	4	5	6
Died	4	—	—	4
Placed under Detention Order (Section 24)	—	—	10	48
Totals	59	55	64	99
				277
Total analysed above				277
Aliens admitted under Deportation Law, U.S.A.				29
				306

Note.—Two only of the aliens were transferred to a mental hospital. The remainder were removed to their own country by the shipping company.

APPENDIX XIII.

Question 4930.

Extract from the London County Council (Parks, &c.) Act, 1915.

PART III.

MAUDSLEY HOSPITAL.

6.—(1) The visiting committee of the Council may, if they think fit, receive and lodge as a boarder and maintain and treat at the Maudsley Hospital on such terms and conditions as to payment and otherwise as they may determine any person suffering from incipient insanity or mental infirmity who is desirous of voluntarily submitting himself to treatment therefor.

(2) The Council may, if they think fit, defray the whole or any part of the expenses of the maintenance and treatment in the said hospital of any such person as a voluntary boarder.

(3) Rules made under Sub-section (1) of Section 338 of the Lunacy Act, 1890, may prescribe the books,

entries, reports, notices and other documents to be kept and made in respect of boarders in the said hospital.

(4) A voluntary boarder in the said hospital shall be at liberty to leave the said hospital on giving 24 hours' notice of his intention to do so.

7. Notwithstanding anything contained in Section 276 of the Lunacy Act, 1890, the medical superintendent of the Maudsley Hospital shall not be required to reside therein so long as arrangements approved by the Board of Control are made for his residence elsewhere.

APPENDIX XIII(a).

Extract from the City of London (Various Powers) Act, 1924.

PART V.

MENTAL HOSPITALS.

8.—(1) The Visiting Committee of the Corporation may, if they think fit, receive and lodge as a boarder and maintain and treat at any mental hospital now or hereafter belonging to the Corporation, and on such terms and conditions as to payment and otherwise as they may determine any person suffering from incipient insanity or mental infirmity who is desirous of voluntarily submitting himself to treatment therefor.

(2) The Corporation may, if they think fit, defray the whole or any part of the expenses of the main-

tenance and treatment in any such hospital of any such person as a voluntary boarder.

(3) Rules made under Sub-section (1) of Section 338 of the Lunacy Act, 1890, shall prescribe the books, entries, reports, notices and other documents to be kept and made in respect of boarders in any such hospital.

(4) A voluntary boarder in any such hospital shall be at liberty to leave the hospital on giving forty-eight hours' notice of his intention to do so.

APPENDIX XIV.

Question 5015.

LONDON COUNTY MENTAL HOSPITALS.

Particulars of six patients admitted during 1923 who were found to be "not insane."

Mental Hospital.	Sex of Patient.	Admitted from.	Date of Admission.	Date of Discharge.	Facts indicating insanity as appearing on Reception Order.	Mental Hospitals' Medical Superintendents' grounds for conclusion that patient should not be detained as insane.
Bexley	Female	H.M. Prison, Holloway, as a criminal patient	2.3.23	18.5.23	Violent—Delusions of persecution, says that all officers of the prison are against her and want to do her injury. Will not converse rationally, is quite unreasonable and morbidly suspicious. (Facts communicated by others) Hospital lady superintendent states patient has been very violent, broken her crockery and considers everybody is against her and that her illness (gastritis) has been caused by neglect of nurses.	After prolonged observation the Medical Superintendent reported that patient's conduct had been correct and she had given no trouble of any kind. Her explanation of conduct at Holloway was that she believed she was unfairly prevented from seeing Prison Committee for the purpose of making complaints against the officials and she regarded her certification as an attempt to discredit her accusations of improper treatment. He regarded the patient as a borderland case; an abnormal personality of the querulent type and although she might eventually develop definite symptoms she was not then insane and was not a fit and proper person to be detained in a mental hospital. Representations were made to the Home Secretary and patient was returned to prison. The patient gained weight and improved physically during stay at the mental hospital.
Banstead	Male	Kensington Infirmary	6.3.23	9.4.23	Excited. States he was going to end his life. Made rambling statements about the police and people in the street. (Communicated by others) Police constable says he saw patient wandering about and speaking to passers-by. He questioned him and he said he was going to do himself in. Infirmary attendant says patient is excitable and very loquacious.	On March 13th, 1923, Medical Superintendent reported to Commissioners that patient was loquacious but coherent and had been well behaved since his admission. Patient stated that when found loitering in a London square he was trying to attract the attention of his fiancée, a servant there. His razor was found on him at the police station and when asked by the officer whether he meant to do himself in he replied, in bravado, that he did. The Medical Superintendent reported to the Commissioners, 21 days afterwards, that the patient had remained coherent and rational, had behaved well and would be recommended for discharge as "not insane." His discharge took place on 9th April, 1923. <i>Note.</i> —Patient was previously a patient at Banstead and was transferred to Hanwell Mental Hospital (June, 1913, to end of 1919). His mother had been a patient at Banstead.
Banstead	Female	Lambeth Infirmary	28.11.23	6.12.23	Patient sullen and morose, refused to be examined or have any treatment which is absolutely necessary for her health and for the unborn child. (No facts communicated by others)	Medical Superintendent reported to Commissioners that patient's behaviour since admission had been correct and she presented no signs of mental disorder. She was pregnant and admitted that she objected to vulval examination by a nurse at the Infirmary. She was recommended to the Sub-Committee for discharge as "not insane" which took effect on the 6th December, 1923.
Banstead	Female	Lambeth Infirmary	8.9.23	24.9.23	Has suffered from encephalitis lethargica; is very irresponsible, irritable, and cannot control herself; has contracted gonorrhoea and syphilis, and is pregnant. (No facts communicated by others)	The Medical Superintendent in report to Commissioners stated that since admission the patient's behaviour had been correct and her conversation normal. She stated that she was 7 months pregnant; that she had been an in-patient in the Infirmary since June, 1923, undergoing anti-syphilitical treatment. Recently she got "fed up," lost her temper with a nurse and threw her medicine card on the floor. Patient's condition remained as when admitted; quite rational, showing no signs of irritability whatever. Cheerful and grateful for whatever is done for her. Discharged (24.9.23) "not insane."

Cane Hill	...	Female	Woolwich Infirmary	2.5.23	11.5.23	<p>Patient says that her husband is lazy and useless, that she has to do all the work of her house and business and that he does nothing; is incensed against him in every respect and will not see or speak to him here (the infirmary).</p> <p>The Board of Control asked that further facts should be stated. The certifying doctor replied that he had "nothing further to add to his certificate."</p> <p>This was communicated to the Board of Control but no further action was taken as the patient was discharged.</p> <p>(Facts communicated by others)</p> <p>Her husband says that she has been violent and "maniac" for some time past, shouting at her neighbours, abusing people who go to their shop, suspicious of every woman who goes there, and throws things at him when he is serving them.</p> <p>Deluded that everyone in London is down upon him saying "there he goes" in disparaging fashion and refusing to be sociable with him. Feels distressed and desperate and not able to be responsible for what he might do to himself owing to everybody's attitude towards him. Shows considerable emotion when describing all this constant suffering for same thing over the last three months.</p> <p>(Communicated by others)</p> <p>Brother-in-law states patient has suffered from attacks of malaria frequently since his discharge from the Army in 1919. In these attacks appears to be semi-conscious, is not violent to himself or others. Patient was in India for 7 or 8 years. Malaria was cause of his discharge from Army. Usually he is quite quiet and inoffensive.</p> <p>Co-worker states patient came to report for duty and asked to see Superintendent and in his presence made rambling statements about being followed, of people talking about him. Wanted to be put away from everybody and if he had a pistol would shoot himself.</p>
Cane Hill	...	Male	Wandsworth Infirmary	25.9.23	11.10.23	<p>The Medical Superintendent formed the opinion that there had probably been some trouble between the patient and her husband, but he was unable to find any mental symptoms which would justify her detention in a mental hospital. Her conduct and behaviour from time of admission to the date on which he examined her (9.5.23) had been rational and exemplary.</p> <p>The Clerk to the Guardians was communicated with by telephone, informed that the patient had been found not insane, and asked to arrange for her removal.</p> <p>Medical Superintendent unable to find any symptoms of insanity. According to the notes of the ward and the Medical Officer's examination after admission the patient had shown no such signs except that he had been rather sleepless for the first two nights after admission. The Medical Superintendent formed the opinion that the man had had a slight delirious attack, probably the result of his malaria, which had passed off.</p> <p>The attention of the Guardians was not called to the case, as between the date of the patient's admission and discharge he was transferred to the "Service" class and classified as a private patient.</p> <p>He was discharged 16 days after admission.</p>

APPENDIX XV.

Question 5049.

LONDON COUNTY MENTAL HOSPITALS.

Statement as to complaints made during the year 1923 affecting the treatment of patients which necessitated formal enquiry.

Name of Hospital.	Date of complaint.	Nature of complaint.	By whom made.	Whether complaint originated from patient.	Action taken thereon by hospital sub-committee.
Banstead ...	29-1-23	Patient (F.) slapped.	A probationer nurse.	No.	Probationer nurse dismissed.
	19-6-23	Patient (F.) struck.	A nurse.	No.	No evidence that the nurse deliberately struck the patient.
Bexley ...	6-1-23	Patient's (F.) face smacked.	Head female nurse.	No.	Nurse dismissed.
	8-1-23	Patient's (F.) head struck.	Head female nurse.	No.	Nurse dismissed.
	1-7-23	Patient (M) told his mother that he had been cruelly treated and banged on floor by male nurses.	Patient.	Yes.	Reported to sub-committee who found that there was no truth in the allegations.
	6-8-23	Patient's (F.) head banged on floor.	Four other patients.	Other patients.	Reported to sub-committee, who found that nurse used undue force, not amounting to ill-treatment.
	28-8-23	Patient's (F.) hair pulled and patient smacked.	Three other patients.	Other patients.	Nurse reduced in rank. Reported to sub-committee. Case "not proven."
Cane Hill ...	5-11-23 and onwards	Gross ill-treatment of patient (F.).	An uncle by marriage.	It is believed that it did.	The Sub-Committee (who saw the patient) were quite satisfied that the allegations of ill-treatment were baseless.
Claybury ...	2-12-23	Twisting of patient's (F.) wrist.	A probationer nurse.	No.	A full enquiry was made by the medical superintendent; all the nurses concerned being seen and the charges investigated.
Colney Hatch	17-8-23	Alleged ill-treatment of patient (M.).	An assistant doctor who reported that he had seen a male staff nurse striking the patient.	No.	The medical superintendent came to the conclusion that there was not sufficient evidence to support the charges and so reported to the Sub-Committee.
					Staff nurse suspended from 17-8-23 by acting medical superintendent. The Sub-Committee after investigation were satisfied that the staff nurse in question struck the patient.
Hanwell ...	27-3-23	Accused of throwing a porringer of water over naked patient (M.) who was standing by bathroom door.	An inspector.	No.	The nurse's suspension was confirmed, but in view of his previous excellent record the suspension was removed from 31-8-23 and the nurse re-instated in the service from the latter date.
					The nurse was not paid wages during the 14 days he was suspended.
					The Sub-Committee decided that as there was no direct evidence that nurse threw water over the patient he should be given the benefit of the doubt.
					Nurse informed that had there been evidence he would have been dismissed.

Name of Hospital.	Date of complaint.	Nature of complaint.	By whom made.	Whether complaint originated from patient.	Action taken thereon by hospital sub-committee.
Hanwell ...	14-7-23	Accused of striking patient (M.) with fist on the jaw. Patient sustained fracture of jaw.	Patient to the medical superintendent.	Yes.	The sub-committee were of opinion that the accusation made by patient was groundless.
Horton ...	29-4-23	Patient (F.) hit by a nurse.	A nurse.	No.	The sub-committee thought the complaint was groundless.
	30-4-23	Patient (F.) smacked by a nurse (acting charge nurse).	A nurse.	No.	The sub-committee reduced the acting charge nurse to rank of probationer.
	20-9-23	Patient (F.) seized by the hair and shaken by a temporary probationer nurse.	Assistant matron.	No.	Sub-committee not very satisfied with evidence, but concluded that nurse was "unsuitable"; nurse's services terminated.
Long Grove	28-2-23	Patient (M.) roughly handled and ill-treated by staff.	Patient's mother.	Yes.	Sub-committee found that there had been no ill-treatment.
	16-3-23	Patient(F.) "tapped" on the head with a slipper, with which patient was about to smash a pane of glass.	Another patient who reported to Head Nurse before the accused nurse had the opportunity.	No.	Nurse reprimanded and cautioned.
	8-5-23	Patient's (F.) face smacked.	Patient.	Yes.	Nurse seen by the medical superintendent and given a week's notice as being unsuitable.
	12-8-23	Patient (M) roughly treated by night nurse, which resulted in injury to patient's scrotum.	Patient.	—	Sub-committee satisfied injury was self-inflicted but admonished night charge and acting day charge nurses for failure to report promptly and in the proper manner an injury sustained by a patient.

APPENDIX XVI.

Question 5380.

RUBERY HILL AND HOLLYMOOR MENTAL HOSPITAL, BIRMINGHAM.

1,421 Beds.

Re-admission Statistics.

During the year 1924, 60 persons who had been previously discharged were re-admitted to the hospital after certification. Some of these were certified more than once in the course of that year. The 60 persons thus provided 65 cases of re-admission: 25 male cases and 40 female cases. The intervals between the discharge and re-admission in respect of these 65 cases are set out in the following table:—

—	M.	F.	T.
After 12 -20 years ...	4	2	6
" 9 -12 " ...	—	3	3
" 6 - 7 " ...	2	—	2
" 4 - 5 " ...	2	2	4
" 2 - 3 " ...	5	2	7
" 1½ - 2 " ...	—	3	3
" 1 - 1½ " ...	2	6	8
One year and under ...	10	22	32
	25	40	65

One year and under re-admissions.

During 1924, 29 persons, 19 females and 10 males, who had been unable to stay out 12 months and under were re-admitted, making 32 re-admissions, 10 male and 22 female, on recertification, after total

discharge which, in some cases, followed a period of trial.

16 re-admissions had one previous certification, 50 per cent.

9 re-admissions had two previous certifications.

5 " " three " "

1 " " four " "

1 " " five " "

A total of 32 re-admissions had had 53 previous certifications.

Ages of Persons Re-admitted on the last Admission.

29 persons who had been unable to stay out one year and under were aged on re-admission as set out in the following age group:—

—	M.	F.	T.
Over 70 years ...	—	1	1
Between 60-70 years of age	2	2	4
" 50-60 " "	1	5	6
" 40-50 " "	3	4	7
" 30-40 " "	2	3	5
" 20-30 " "	2	3	5
" 15-20 " "	—	1	1
	10	19	29

Locale of Re-admissions on Recertification.

Of the 32 re-admissions—
26 came directly from their homes.
3 came directly from the lock-up.
3 came directly from the Guardians Institutions.

Duration of the Non-Certified state outside.

3	stayed out less than one month	After discharge from Hospital Books.
6	“ “ one month	
6	“ “ two months	
5	“ “ four months	
4	“ “ six months	
1	“ “ eight months	
5	“ “ ten months	
2	“ “ twelve months	
32		

Fifteen of the above re-admissions had been discharged from the books after a month's trial.
In one case, if the trial period were added, the patient then would be regarded as having stayed out more than a year. In one of the cases, discharged from another Hospital, the trial period had been 13 weeks.

Condition on Previous Discharge.

Of the 32 re-admissions four had previously been discharged from other hospitals, and in order to give the figures for comparison with the totals on another page of discharges from this hospital, the following figures are submitted concerning the 28 discharged previously from here:

—	Recovered.	Relieved.	Not Improved.
Male ...	7	3	—
Female ...	9	8	1
	16	11	1

Of the 16 “Recovered” cases, 13 had been discharged after a month's trial. The remaining three were discharged outright, two to go to the Guardians.
Of those in the “Relieved” category, two had been discharged after a month's trial.

Those discharged and re-admitted during 1924.

—	Recovered.	Relieved.	Not Improved.
Male ...	3	2	—
Female ...	6	7	1
	9	9	1

Relation of Special Treatment to Discharges and Re-admission.

In three males and five females permission had been given by relatives and patients to deal with chronic septic foci and they had shown sufficient improvement following to warrant a month's trial although it was recognised that other foci existed.

All, except one male and one female, were better physically and mentally on re-admission than on the previous admission, e.g., J.E.A.

	st. lbs.
Weight on former admission ...	7 13
On discharge	9 1½
Weight on present admission ...	8 10½

In one of these cases, who, with her trial period, stayed out a year pregnancy occurred and this added physical stress undoubtedly was responsible for the breakdown. The remaining cases were either unsuitable for or refused special treatment, when offered.

APPENDIX XVII.

Question 5845.

THE RETREAT, YORK.

Average Duration of Residence of Voluntary Boarders.

Between 1st January, 1920, and 31st December, 1924, 232 voluntary boarders were admitted to the Retreat.

Of these, 86 stayed under 1 month.
37 “ from 1 to 2 months.
31 “ “ 2 “ 3 “
35 “ “ 3 “ 6 “
5 “ “ 6 “ 9 “
3 “ “ 9 “ 12 “
4 “ over a year.
201

Of the 31 remaining on 31st December, 1924,
9 had been in residence over a year.
4 “ “ “ “ from 6 to 12 months.
10 “ “ “ “ “ 3 “ 6 “
7 “ “ “ “ “ 1 “ 3 “
1 “ “ “ “ “ under 1 month.

The average duration of stay of those boarders who entered and left the Retreat within the period from 1st January, 1920, to 31st December, 1924, was 2 months 3 weeks.

APPENDIX XVIII.

APPENDIX XIX.

Question 6299.

TOWNSHIP OF LEEDS.

Lunacy Act, 1890.

Summary of Patients dealt with by the various District Relieving Officers during the years ended 31st March.

Period.	Number of Patients Certified.			Cases not Certified.	Total Number of Patients dealt with.
	Sec. 13.	Sec. 14.	Sec. 24.		
1916 ...	16	138	55	47	256
1917 ...	8	136	92	42	278
1918 ...	2	122	65	56	245
1919 ...	1	129	17	40	187
1920 ...	15	139	48	43	245
1921 ...	26	169	67	54	316
1922 ...	29	160	29	46	264
1923 ...	17	178	53	26	274
1924 ...	16	140	29	35	220
	130	1,311	455	389	2,285

ROCHDALE UNION.

Lunacy Act, 1890.

Summary of patients dealt with by the Lunacy Officers of the Rochdale Union during the years 1916-1924.

Period.	Number of Patients Certified.			Cases not Certified.	Total Number dealt with.
	Sec. 13.	Sec. 14.	Sec. 24.		
1916 ...	0	40	22	2	64
1917 ...	2	35	21	1	59
1918 ...	1	28	12	1	42
1919 ...	2	35	10	1	48
1920 ...	1	37	22	0	60
1921 ...	0	40	10	1	51
1922 ...	6	61	9	1	77
1923 ...	19	34	24	7	84
1924 ...	29	13	7	9	58
	60	323	137	23	543

SHEFFIELD UNION.

Lunacy Act, 1890.

Summary of patients dealt with by the various District Relieving Officers during the period commencing 11th January, 1916, and ending 17th December, 1924.

Period.	Number of patients Certified.			Patients not certified.	Total Number of patients dealt with.
	Sec. 13.	Sec. 14.	Sec. 24.		
1916 ...	12	157	73	52	294
1917 ...	9	136	70	30	245
1918 ...	14	170	47	23	254
1919 ...	11	163	49	28	251
1920 ...	18	165	62	33	278
1921 ...	23	219	43	34	319
1922 ...	18	243	32	38	331
1923 ...	17	231	25	51	324
1924 ...	11	207	24	105	347
Total ..	133	1,691	425	394	2,643

Question 6463.

Camberwell House.
27th October, 1925.

DEAR SIR,

ON a perusal of the evidence, which I had the honour of giving before the Royal Commission on the 16th of December last, I desire, in order to avoid misconception, to modify certain replies which I then gave. It is the fact that I am not, and never have been, a medical proprietor of Camberwell House, or of any other licensed house, but it is right to mention that, in recognition of 30 years' service, as Assistant Medical Officer and Medical Superintendent, I was permitted to acquire at par 1,996 £1 shares in the company, and these shares I have since held; and further, that as part of my emoluments I receive a bonus of 10 per cent. on the profits of Camberwell House, which bonus has in recent years substantially exceeded my salary. I do not, however, on this account regard myself as a medical proprietor, having in view that I am engaged, paid, and can be dismissed by the Directors of the Company, and that, not being a Director myself, I have no voice, except an advisory one, in the allocation of the profits of the Company.

Yours faithfully,
(Signed) FRANCIS H. EDWARDS.

The Secretary,
Royal Commission on Lunacy
and Mental Disorder,
Ministry of Health,
Whitehall, S.W.1.

APPENDIX XX.

Question 6876.

THE OLD MANOR, SALISBURY.

Voluntary Boarders.

	1923.		1924.	
	M.	F.	M.	F.
Admitted during the Quarter ended :—				
March	6	6	5	7
June	4	7	6	4
September	2	8	4	9
December	—	2	2	8
	12	23	17	28
	35		45	

Although the admissions during the year 1924 were only ten more than during the year 1923, the number of applications during the latter part of 1924 for Voluntary Boarders, who from the descriptions given were unsuitable, was far in excess of any previous year.

APPENDIX XXI.

Questions 7196 & 7547.
CLAYBURY MENTAL HOSPITAL.
Patients discharged recovered during the years 1920
to 1924, inclusive.

	Totals.			
	M.	F.	T.	
Under 1 month .	3	—	3	} Maximum quin- quennium (3 to 8 months).
1 to 2 months ...	9	2	11	
2 " 3 " ...	29	20	49	
3 " 4 " ...	35	36	71	
4 " 5 " ...	33	43	76	
5 " 6 " ...	26	57	83	
6 " 7 " ...	21	38	59	
7 " 8 " ...	21	46	67	
8 " 9 " ...	19	28	47	
9 " 10 " ...	13	15	28	
10 " 11 " ...	6	16	22	
11 " 12 " ...	9	16	25	
12 " 15 " ...	19	20	39	
15 " 18 " ...	10	23	33	
18 " 21 " ...	13	13	26	
21 " 24 " ...	8	15	23	
2 " 3 years ...	12	25	37	
3 " 4 " ...	9	12	21	
4 " 5 " ...	10	6	16	
5 " 6 " ...	6	8	14	
6 " 7 " ...	3	4	7	
7 " 8 " ...	2	2	4	
8 " 9 " ...	1	3	4	
9 " 10 " ...	2	2	4	
10 " 15 " ...	7	6	13	
15 " 20 " ...	1	5	6	
20 " 25 " ...	1	—	1	
25 " 30 " ...	—	3	3	
	328	464	792	

APPENDIX XXII.

Question 7796.
MEMORANDUM OF THE EVIDENCE TO BE GIVEN ON
BEHALF OF THE BRITISH MEDICAL ASSOCIATION.

INTRODUCTORY.

1. The British Medical Association is a voluntary organisation of the medical profession; it comprises representatives of every form of medical practice and includes both practitioners who deal with the mentally disordered in various special ways and those who meet such patients in the usual course of general practice. The Members of the Association, now numbering over 28,400, are organised throughout the British Empire in local units called Divisions and in combinations of Divisions called Branches. By means of this local machinery, and with the help of its weekly organ, the *British Medical Journal*, the Association is able to inform and to collect the opinions of the main body of the medical profession, and in preparing this Memorandum the Council of the Association has utilised the experience and views of every type of medical practitioner.

2. When the Council of the Association learned that a Royal Commission on Lunacy and Mental Disorder (as regards England and Wales) was to be set up by the Government, it appointed a Special Committee to consider possible modifications of the Lunacy Laws, to prepare evidence for submission on behalf of the Association to the Royal Commission, and to appoint witnesses to give such evidence.

3. The personnel of the Special Committee is as follows:—

- R. Langdon-Down, M.B., B.Chir., M.R.C.P. (London), Member, Med. Psychol. Assn., Chairman of Lunacy Law Committee, B.M.A.
G. F. Barham, M.D., Member, Med. Psychol. Assn., Med. Supt. London Co. Ment. Hosp., Claybury.
R. A. Bolam, O.B.E., LL.D., M.D., F.R.C.P. (Newcastle-on-Tyne). Chairman of Council, B.M.A.
*J. W. Bone, M.B., C.M. (Luton).
*H. B. Brackenbury, M.R.C.S., L.R.C.P. (Hornsey). Chairman of Representative Body, B.M.A., Vice-Pres. Cent. Assn. Mental Welfare.
F. H. Edwards, M.D., M.R.C.P. (London). Member, Med. Psychol. Assn., Med. Supt. Camberwell House.
J. Basil Hall, M.B., M.Chir., F.R.C.S. (Bradford). President B.M.A.
N. Bishop Harman, M.B., B.Chir., F.R.C.S. (London). Treasurer B.M.A.
Bernard Hart, M.D. (London). Member, Med. Psychol. Assn., late Med. Supt. Northumberland House Asylum.
C. O. Hawthorne, M.D., F.R.C.P., F.R.F.P. & S. (London). Cons. Phys. Hampstead & N.W. London Hospital.
*J. A. Macdonald, LL.D., M.D. (Taunton). Cons. Phys. Taunton and Somerset Hospital.
E. W. G. Masterman, M.D., F.R.C.S. (London). Med. Supt. St. Giles Hospital.
*Christine Murrell, M.D. in Mental Diseases & Psychology (London). Late Clin. Asst. Northld. Co. Asylum.
*Sir Alfred J. Rice-Oxley, C.B.E., M.D. (London).
A. F. Tredgold, M.D. (London).
*E. B. Turner, F.R.C.S. (London).
Sir Jenner Verrall, LL.D., L.R.C.P., M.R.C.S. (Leatherhead). Cons. Surg. Sussex Co. Hospital.

4. The Association in approaching the questions submitted to the Royal Commission has endeavoured to keep in mind the principle that the interests of the patient as a sick person should be the first consideration. Subject to this principle the Association desires to give due weight to the claims of the public as a whole for protection against any improper restriction of individual liberty on the one hand and against the risks which attach to the inefficient control of persons of unsound mind on the other. In addition are to be considered the claims of the medical profession for adequate safeguards in carrying out the difficult and responsible duties placed in the hands of its individual members.

5. The Committee invited and has received and considered suggestions from Medical Superintendents of Poor Law Infirmaries and has had also the assistance and collaboration of several representative general practitioners of great experience.

6. On a previous occasion (viz. in April, 1912) the Association laid before the Government proposals dealing with the treatment of patients suffering from mental disorder in its early stages, but for the purpose of the present enquiry the subject has been fully and freely re-considered.

PRINCIPAL OBJECTS FAVOURED.

7. The principal objects favoured in this Memorandum are briefly as follows:—

- (a) To meet, as far as possible, the susceptibilities of the public with a view to minimise the objections which prevent patients from accepting proper treatment at the earliest possible moment. (*Vide* paras. 24-26.)
(b) To avoid the need for a formal Reception Order for mental patients whose symptoms though acute are likely to be short lived, in the hope that the recovery of the patient may render such an Order unnecessary. (*Vide* paras. 40-44.)

*. In General Practice.

(c) To provide opportunities for the treatment, on a voluntary basis and under approved conditions, of suitable patients whether in one of the existing types of institution or in hospitals or clinics or under private care. (*Vide* paras. 36-39.)

(d) To urge the provision and continuation of such kinds of accommodation as shall supply the needs of patients suffering from different forms and degrees of mental disorder; to meet the position created by differences in the social and financial status of such patients; and to advocate, if the ends here defined require it, the removal of the ban on any increase in the number of "licensed houses."—(Section 207 (6) of the Lunacy Act, 1890.) (*Vide* paras. 52-55.)

(e) To secure as far as possible uniformity of procedure in the certification alike of private and of other patients, and in particular to affirm the advisability of two medical certificates for submission to any judicial authority who is asked to issue a Reception Order. (*Vide* para. 71 (g).)

(f) To claim for practitioners who sign medical certificates under the Lunacy Act the immunities granted to witnesses in Courts of Law. (*Vide* para. 58.)

(g) To amend the wording and procedure of the Reception Order and the accompanying documents as hereinafter explained in detail. (*Vide* paras. 30-35.)

(h) To revise the existing conditions under which voluntary boarders may be accepted. (*Vide* paras. 36-39.)

(i) To make suitable provision for the after-care of patients leaving institutions, with special regard to collaboration between the patient's private medical attendant and the authorities who may have had charge of the patient. (*Vide* para. 48.)

(j) To preserve the unity of central administration, except in so far as the administration of property is concerned. (*Vide* para. 19.)

8. The Association recognises that mental disorders differ from other ailments in that the proper treatment of the patient may necessitate, either for his own good or for the protection of his family or the public, interference with his liberty of action; and, further, that the patient may be prevented by the nature of his illness from forming a proper judgment on the measures necessary for his welfare. Consequently in the scheme of treatment there must be introduced safeguards which are not necessary in dealing with ordinary bodily ailments where the mind is not affected.

9. Those engaged in the preparation of this memorandum who were not fully familiar with the law on the subject have been much impressed by the numerous and effective provisions designed for the due protection of the patient's rights. (Appendix D.) Where the law appears to be defective is in the unsatisfactory character of its terminology, in the differences made in the treatment of patients because of differences in social or financial standing, in a failure to regard the person of unsound mind primarily as a patient—a sick person, and in the failure to provide adequate facilities for treatment without a Reception Order.

TERMINOLOGY.

10. Any reconsideration of the Lunacy Acts suggests some elucidation and amendment of the terminology employed. For example, for various reasons a general desire has been expressed that the term "lunatic" should be discarded, and by the passing of the Mental Deficiency Act, 1913, the inclusion of the term "idiot" in the Lunacy Acts is rendered both superfluous and anomalous. The word "pauper," although clearly enough defined in the Lunacy Act of 1890, is objectionable on account

of its wider significance outside the Act, and its use, in existing circumstances, is frequently unjust.

Again, the substitution of the term "mental hospital" for the old term "asylum" may be justified because it expresses better the modern attitude towards the treatment of mental disorder.

11. Of the two main divisions of mental abnormality, viz., mental deficiency and mental disorder, the Commission is, it is understood, concerned only with the latter, and this memorandum accordingly confines itself to the discussion of mental disorder, using this term to cover all kinds and degrees of departure from the normal other than mental deficiency.

Within this division many types and forms have been recognised by medical writers, but for the present purpose medical classification, subdivision and definition, so far from being helpful would be a hindrance.

What has to be considered from the point of view of law and administration is rather the practical measures and arrangements that are called for by any individual case and not the precise nosological classification of the patient's disorder.

12. Broadly speaking, from this point of view there are mental disorders which call for measures of control, and others for which, at all events in some stages, measures of control are not necessary although other kinds of treatment may be required. "Mental disorders" will thus include both grave and mild cases, and the very beginnings of disorder on the one hand and its latest manifestations on the other.

13. It is convenient that some brief and acceptable name should be given to each of these two groups.

14. In the Lunacy Acts the name given to a patient who is a proper person to be taken charge of and detained for care and treatment is "lunatic." If the term "lunatic" is dropped, as is here suggested, the expression "of unsound mind," which is used in the Act alternatively to "lunatic," would seem to be the most suitable one for this group.

15. As, however, there has been a tendency of recent years to use the expression in a somewhat lax and general way it would seem best to give it a precise definition and to confine its use to the particular group of cases now under consideration.

16. The definition suggested is:—

" 'Persons of unsound mind' means persons who by reason of mental disorder may properly be taken charge of and detained for care and treatment."

17. Mental disorder would thus be divided into two groups, viz., (a) the "mentally unsound," and (b) the "mentally ailing," the former being those proper to be taken charge of and detained, if necessary, and the latter not requiring detention.

18. The need for such definitions is particularly emphasised when the provisions of Section 315 of the Lunacy Act, 1890, are considered. Here, unless the phrase "a person of unsound mind" were limited as in the above definition, the Section would forbid the reception and treatment in nursing homes or patients who though mentally disordered do not require detention or control.

19. Form 16 of the Lunacy Act, 1890—the certificate dealing with a person entitled to payments from a public department—states that he is "by reason of mental disability unable to manage his affairs." This expression seems a useful one where it is intended to indicate the need for measures of control of the patient's property and affairs, but not necessarily of his person; and it might well be used in place of the expression "of unsound mind" in Section 116 (e) of the Lunacy Act, 1890.

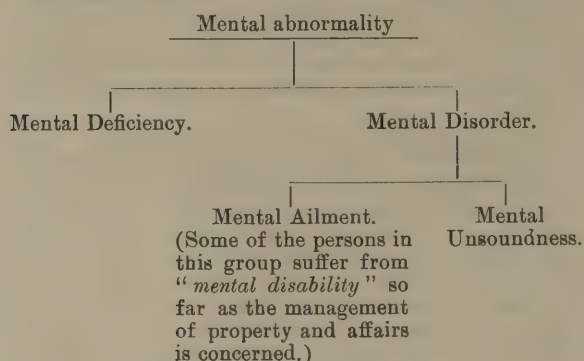
20. "Mental infirmity arising from disease or age" is an expression used in Section 116 (d), and as it seems to mean much the same as "mental disability" the latter might well take its place for the sake of uniformity.

21. Such a nomenclature as is suggested in paragraphs 12 to 20 would not be at variance with pre-

sent usage, is valuable from the point of clearness, distinguishes between different types of arrangement for treatment and gives due consideration to the susceptibilities of patients and their friends. In addition, it gives a definitely recognised place to those cases which are neither normal in mind nor so mentally disordered as to require measures of control.

22. Accordingly, it is suggested that any future Act should be called the "Mental Disorders Act," and in it the words "lunatic" and "pauper" should not be used.

23. The following scheme shows what is intended in tabular form:—



CRITICISM OF PRESENT PROCEDURE.

24. More important, however, than the terms used, if the best possible is to be done for those who are mentally disordered, are the arrangements provided and the conditions governing them.

25. The reluctance of patients and their friends to accept treatment under existing arrangements is ascribed partly to unwillingness to enter a place known to be devoted to the treatment of persons of unsound mind and partly to unwillingness to apply for a Reception Order by a judicial authority with its necessary formalities and consequences. (As an example of the kind of thing which should be avoided, the Association would suggest that any patient who is being treated in a Poor Law Infirmary and whose maintenance, in part or in whole, is refunded either by himself or on his behalf, should not be compelled to wear clothing provided by the Poor Law Guardians.) The Reception Order undoubtedly puts a seal of a formal and semi-public nature on the patient's mental disorder, and this will permanently stamp him, even though his disorder may have been of comparatively brief duration and one from which he may have made complete recovery.

26. The avoidance of an undeserved stigma, by allowing less formal arrangements for suitable cases, is much to be desired, but it must always be borne in mind that the associations springing from any arrangement will depend in the long run upon the actual facts and usage and not upon any verbal description or sympathetic intention. Escape from stigma is practically impossible where the stigma is justified by the facts.

TYPES OF PATIENTS TO BE DEALT WITH.

27. One difficulty in dealing with mental disorders is that they present so great a variety of conditions. Thus the most lasting and grave forms of mental unsoundness may at their onset present only a mild type of mental disturbance. On the other hand, some of the most acute forms may be of only temporary duration, almost sure to recover and possibly unlikely to recur. Then again some of the forms are marked by a natural tendency to remission and recurrence with intervals of apparent mental health; others, and these perhaps the most dangerous forms of mental disorder, are very difficult to detect and are carefully concealed by the patient for long periods; there are also chronic forms which present no dangerous or conspicuously objectionable characters.

NEED FOR MORE FLEXIBILITY IN ARRANGEMENTS: PROPOSED PROVISIONAL ORDER.

28. It is clear that if the best possible is to be done for the patient as a sick person the facilities for treatment and the types of accommodation must be sufficiently various to suit the conditions defined in paragraph 27.

29. Another reason for urging the need of flexibility is the frequent difficulty and uncertainty of diagnosis and prognosis, and the claim for fuller opportunities for research if treatment is to be placed on a more secure basis.

30. There is already a procedure by Urgency Order provided for in the Act, and in practice a large proportion, approximating to 60 per cent. in some institutions, of the private patients admitted to institutions are admitted in the first instance on this Order, on the ground that it is expedient for the welfare of the patient that he should be forthwith placed under care and treatment.

31. The Order in this case is made, not by a judicial authority, but by someone closely related to the patient. Some such power is essential to enable immediate steps to be taken when delay would be dangerous or harmful, but it would be sufficient for safety and convenience that the duration of such an Order should be say "three days," for clearly it is desirable that at the earliest possible moment there should be judicial authority for a measure which means the loss of personal liberty.

32. It would, however, be a great advantage to the patient that such an Order should be capable of extension, on the approval of a judicial authority, for a further 28 days. This would provide opportunity for observation and possible recovery before submitting a petition for a formal Reception Order, and there is reason to believe that in many cases a Reception Order would then not be necessary.

33. If this plan were adopted it would appear best to call such an Order a Provisional Order, and that such Order should supersede the present Urgency Order. The exact form which it is suggested this Provisional Order and the accompanying papers should take is appended hereto (*vide* Appendix B).

34. The Provisional Order made by a relative, or where necessary by a Relieving Officer, would expire automatically at the end of three days, unless it were endorsed by a judicial authority whereby its validity would be continued for a further period of 28 days. Wherever possible this Order should be signed by the judicial authority prior to the admission of the patient and in no case later than three days after admission. At the expiration of a Provisional Order the patient must be discharged unless he is either placed under a Reception Order or becomes a Voluntary Boarder.

35. In support of this proposal it may be pointed out that in the existing provisions for so-called "pauper patients" there is opportunity for a period of observation of 17 days before a formal Reception Order is made, and there is evidence from experienced medical practitioners that a number of patients who come under observation in this way get well and go home before this period has elapsed, without a Reception Order having been made.

VOLUNTARY BOARDERS.

36. The Association advises that the provision enabling registered hospitals and licensed houses to receive suitable patients as voluntary boarders should be extended, under suitable conditions, to the County and County Borough Asylums. In each individual case the arrangement would require the approval of the medical superintendent or his deputy.

37. The advantages of the voluntary boarder system are that it is subject to the consent of the patient and provides for his care and treatment for so long as this may be necessary; in addition, it avoids or postpones the necessity for a Reception Order. It is valuable, too, as a transition measure when the patient is recovering from his illness and discharge from the Reception Order is justifiable

but the patient still requires treatment. The use of this system has steadily increased in recent years, many patients being now received as Voluntary Boarders who formerly would have been dealt with under a Reception Order.

38. A condition of the present procedure, whereby the reception of a Voluntary Boarder into a licensed house has to depend on permission being obtained beforehand from the Board of Control, or in the case of a registered hospital from two members of the Visiting Committee, appears unnecessary, although it is fully recognised that the present form of notification and report on Voluntary Boarders should be maintained.

39. In the interest of the patient it is desirable that the notice to leave should be extended to 72 hours.

TEMPORARY BOARDERS.

40. The Mental Treatment Bill of 1923 introduced a new proposal, namely, the temporary treatment of mental disorder without a Reception Order under the Lunacy Acts in an approved institution on the recommendation of a medical practitioner, subject to the consent of the patient or to his being incapable of volition. The period of treatment is limited to six months, subject to the power to extend the treatment for a further six months when recovery within that period is reasonably probable.

41. The institutions which may be approved under this Bill include, in addition to institutions under the Lunacy Act, hospitals or parts of hospitals outside the Lunacy Acts, and institutions that may hereafter be established by Visiting Committees. For admission thereto the Recommendation of the doctor declares that the patient shows symptoms of mental disorder.

42. There is in the Bill no definition of the term "mental disorder," but presumably it is intended to be used in the sense already defined in this document and to include both persons of "unsound mind" and the "mentally ailing."

If this is so it would enable acute cases and others which are likely to be brief in duration to be received and detained without the formality of a Reception Order, not only in the institutions at present recognised under the Lunacy Act but also in ordinary hospitals not so recognised.

43. The Association finds itself in agreement with this proposal, at least so far as it goes. It is necessary, however, to point out that although the Mental Treatment Bill is based on the consent of the patient (and even extends to the case where the patient is incapable of volition) and applies to institutions managed by a Visiting Committee, it does not effect the same result as would come about from extending the Voluntary Boarder principle to the County and County Borough Asylums. If this were done, and if the Provisional Order which is suggested above were available, there would appear to be no special object in applying the provisions of the Mental Treatment Bill to the existing institutions. The Voluntary Boarder principle might easily be made to cover all the consenting cases and it would in fact go further, in that it is indefinite in its duration and is applicable not only during the first six or twelve months of treatment but also during convalescence if so desired, and in these respects the proposals in the Bill would not be an adequate substitute.

44. The application of the provisions of the Bill to include patients for the time being incapable of volition is a valuable provision, as it includes cases which would not otherwise gain the advantage of these temporary arrangements, although they might be provided for under the Provisional Order as suggested in paragraphs 30-34.

45. In the Mental Treatment Bill the expression "incapable of volition" is used to describe certain patients who may come under its provisions. This expression, in practice, will not always be easy of interpretation, and it is suggested that the actual facts on which judgment of the incapacity must be

based, namely, that the patient does not, when given the choice, exercise it, would be preferable as the basis of the definition. It is, therefore, suggested that Section 4 (1) (a) of the Bill should be modified to read somewhat as follows:—

"(a) A recommendation for treatment shall only be given under this Section in respect of a person who either is willing to submit to treatment or does not express unwillingness to submit to treatment, or in whose case, if he is a minor, consent to his reception as a patient has been given by his parent or guardian, and every such recommendation shall state whether the person in respect of whom it is given is willing to submit to treatment or does not express unwillingness to submit to treatment or is a minor on whose behalf the necessary consent by his guardians has been given, as the case may be";

and that Section 4 (5) be amended to read somewhat as follows:—

"(5) Where the person to be received as a patient has not definitely expressed his willingness to be received or is a minor, there must be annexed to the Recommendation for treatment a statement signed by a Justice of the Peace to the effect set out in Part II of the Schedule to this Act."

If in fact the patient resists being dealt with under this provision he cannot enjoy its advantages and must be dealt with otherwise.

46. The proposal to recognise non-registered hospitals for the reception and temporary treatment of cases of mental disorder is one that the medical profession welcomes on the ground that it will be valuable for purposes of education and research and will tend to link up the study of mental disorders with general medicine. It will undoubtedly be welcomed also by many patients.

47. The Association is of opinion that in addition to the institutions recognised in the Mental Treatment Bill there should be the power to approve under this Bill:—(a) houses which are supported wholly or partly by voluntary contributions or which are privately owned, for the reception of patients under the provision of the Bill; and (b) the reception as single patients under the Bill in houses not so approved, provided that a medical practitioner gives a written recommendation in each case, stating that suitable treatment can be obtained for the patient in the proposed house.

48. It is urged that the principle of permitting "After-care" Homes and Convalescent Homes at the seaside or elsewhere in connection with County and County Borough Mental Hospitals should be recognised.

49. It should be possible upon the Order of the petitioner, without the consent of the Board of Control being first obtained, to remove a patient detained under Order in his own house or in "single care" to an institution, if and when the mental condition of the patient renders this course advisable; the fact of removal in any such case to be reported to the Commissioners. Similar powers already exist for the committee of the person in "lunatics so found."

50. Reference has already been made in paragraph 40 to the fact that cases of mental disorder may lawfully be received if they are not "lunatics" or "alleged lunatics." Whether or not it is proper to receive, outside the Act, a patient who is suffering from mental disorder, is not always an easy question to decide, and a mistake on the part of the person receiving such a patient may result in a prosecution.

51. It is possible that institutions under Visiting Committees may come to include what have been described as clinics both with beds and with consultative arrangements for out-patients on lines comparable to Venereal Disease Clinics. It is hardly likely that these would be established except in large centres of population where there is no ordinary hospital provision for these cases.

The development of centres of this type would be of assistance for the purpose of getting expert opinion

for certification and other purposes, and might well take the place of the receiving wards of workhouses for the reception of patients in the first instance.

VALUE OF VARIETY IN TYPE OF INSTITUTIONS.

52. That the variety of provision which at present exists for the treatment of patients should be continued seems very much to be desired. There are facilities for private patients on various scales in the licensed houses, registered hospitals and publicly maintained institutions, or under single care. Patients needing assistance from public sources or from charitable foundations are provided for in the public institutions and in the registered hospitals.

53. Some sections of the population prefer public management, some private. Each type of institution has a good record of work done and of trustworthy management under official supervision.

54. The Association is satisfied that there exists a desire in the community generally that many patients should be able to be treated otherwise than in public institutions, and should the existing veto on the setting up of new licensed houses or the extension of existing licensed houses result in the diminution or inadequacy of this provision it may be necessary to repeal this veto or to provide extended facilities for the treatment of patients in small numbers in private hands under proper safeguards. The opinion of practitioners in general practice in various parts of the country has been sought on this point, and the unanimously expressed opinion is in favour of the continuance of such provision, as meeting the wishes both of patients and of patients' friends.

55. The scheme contained in Appendix C shows the grouping of patients suffering from mental disorders from the point of view of the administrative measures possible for dealing with them and for bringing them under treatment in accordance with the foregoing suggestions.

CERTIFICATION.

56. When care and control are deemed necessary and the various methods of securing treatment by voluntary consent are not available an Order of some kind becomes necessary, whether it be the proposed Provisional Order, or the full Reception Order, a Detention Order, or an Urgency Order.

In all these cases the Order must be justified by evidence and this must of course include medical evidence in the form of a certificate or certificates.

57. It has become customary to speak of "certification" as being the fact which deprives a patient of his freedom, whereas of course the formal authority is in all cases the Order, and this is made not by the certifying doctor but by the judicial authority or, in the case of the Urgency Order, by a relative. Therefore whenever a person is medically examined it should be understood that the fee paid to the examining medical practitioner is for the fact of having conducted the medical examination and not for having certified the patient as insane.

58. While it is desired to guard against the elevation of the medical certificate to a position of authority which it does not possess, there is no wish to under-estimate the great importance of the certificate as evidence.

Indeed it is desired to insist upon its being given very definitely the status of evidence; and therefore, that the protection which witnesses in Courts of Law are entitled to receive shall be extended to the practitioner who signs a certificate under the Lunacy Acts. (*Vide* Appendix A).

59. It is recognised that the function of the medical practitioner does not intrude on the power of the magistrate. The doctor simply contributes to the evidence on which the magistrate bases his judicial decision, acting as the representative of the law.

It is in harmony with this view that the Association, while not wishing to dictate the duties to be laid upon the magistrate, favours his interviewing the patient, so that the patient may present his view of the position. Incidentally, this would have the additional advantage of rendering unnecessary

the presentation to the patient, after his admission, of the form notifying his right to see a magistrate.

60. In these proposals the Association aims to secure that there shall be judicial authority for detention, the only exception being during the first three days, when it may be unavoidable that the onus should be placed upon a relative, or on a Poor Law Officer. (*Vide* paras. 31-34.)

61. It is in accordance with the principle of placing the real responsibility where it properly rests, viz., on the judicial authority who makes the Order, that it is suggested that the duration of the Urgency Order or Provisional Order should in the first instance, when it is for reasons of avoiding delay made by a near relative, only be valid for three days instead of for a week as at present.

62. A question has been raised as to the qualifications that should be required of the judicial authority. All that the Association feels entitled to say on this point is that it is essential to the welfare of the patient as well as to the convenience of the medical practitioner that access to the judicial authority qualified to sign the Reception Order should be near at hand and readily obtained.

63. With regard to Section 43 of the Lunacy Act and Form 8 thereof, while it is considered that one of the medical practitioners signing the medical certificate should, whenever practicable, be the usual medical attendant of the patient, this condition should be abrogated in those "single-care" cases where it is intended that the usual medical attendant should continue to be the "medical attendant" of the patient.

64. The certificate of a doctor in principle consists of three elements namely:—

- (i) Observations by the doctor himself, at the time of examination, of conduct or behaviour of an abnormal kind (using the term conduct in a wide sense to include all modes of self-expression). These observations may be supported by other observations made on previous occasions and by observations reported by other persons (whose names are given);
- (ii) The conclusion that such behaviour is due to mental disorder; and
- (iii) The further conclusion that the mental disorder is of such a nature or degree that the patient is a proper person to be taken charge of and detained for care and treatment.

65. The Association does not support the suggestion that second certificates should be signed by specially approved practitioners.

SUGGESTED AMENDMENT OF CERTIFICATES AND FORMS.

66. The actual form and wording of the Petition, Statement of Particulars, Certificates, and Reception Order require amendment.—

- (a) It is suggested that the terms "lunatic" and "idiot" should be omitted throughout and that in place thereof the phrase "a person of unsound mind" should be used. Even the phrase "alleged to be of unsound mind" should be omitted, except where its use is essential;
- (b) It is proposed to alter the Statement of Particulars in the following respects:—
 - (i) To substitute "whether previous history of mental disorder" for "whether first attack";
 - (ii) To substitute "Age at onset of mental disorder" for "Age on first attack";
 - (iii) To substitute "When and where previously under treatment for mental disorder" for "When and where previously under care and treatment as a lunatic, idiot, or person of unsound mind"; and
 - (iv) To substitute "Duration of present illness" for "Duration of existing attack."

67. In the certificate (Form 8) it is suggested that:—

In para. 2 "separately from any other practitioner" be deleted. This would be following the proposal in the Mental Treatment Bill and would facilitate the formation of a sound and well-grounded opinion. Evidence of mental unsoundness is sometimes difficult to elicit, and a joint examination would spare the patient undue annoyance.

3 (a) should read:—

"Facts pointing to this conclusion observed by myself at the time of examination, viz.":—

3 (b) should read:—"Facts observed by myself on previous occasions."

3 (c) should read:—"Statements communicated by others."

68. The Reception Order might be more explicit and correspond more closely with the medical certificates thus:—

"I authorise you to receive, take into your charge, and detain A.B., etc."

69. There is some uncertainty at present as to the right of the medical officer or medical attendant to administer medical treatment to a patient under a reception order against the patient's wishes, even though the friends approve of the treatment proposed; this uncertainty should be cleared up.

PROTECTION OF PATIENTS.

70. After a careful consideration of the subject, the Association is firmly of opinion that the obstacles to the improper reception or detention of patients in institutions under the Lunacy Acts are such as to render improper reception or detention practically impossible, and the evidence received from medical practitioners resident in various quarters is unanimous that such cases do not in practice arise (*vide* Appendix D).

From the evidence which the Association has received it would appear that, so far from there being any risk of patients being detained too long in institutions (as has been alleged), the risk is rather that, owing largely to pressure from patients' relatives and friends, discharge may sometimes be premature.

POOR LAW PATIENTS.

71. Subjoined are a number of recommendations for amendment of the law affecting Poor Law infirmaries and so-called "pauper patients":—

(a) "Observation wards" for mental cases should be in a separate infirmary or Poor Law hospital and not in the workhouse.

(b) A medical officer should not have the power, given him by Section 24 of the Lunacy Acts, to detain a patient for 14 days "against his will" without the authority of a justice.

(c) It should be made clear in any future legislation that the institutions for lunatics referred to in Section 16 of the Lunacy Act, 1890, include a Poor Law infirmary or hospital. This would enable many cases of senile dementia, which at present have to be sent to the county or county borough asylums, to receive treatment in the wards of Poor Law infirmaries or hospitals.

(d) While no general statement can be made as to the suitability of Poor Law workhouses for the reception of patients of unsound mind (the accommodation provided in such institutions varying widely), the continued detention of patients in these institutions is to be deprecated.

(e) The provision of clinics or reception houses in places where they would be convenient, or of better accommodation in workhouse infirmaries, would avoid the necessity of placing patients in unsuitable companionship as now apparently happens in the "insane" wards of the workhouses.

(f) It is unfortunate that patients with "mental disorders" should have to invoke the machinery of the Poor Law in order to obtain treatment, and the avoidance of this procedure could be secured by the direct admission of patients to recognised mental hospitals.

(g) For removal to an asylum of a so-called "pauper patient" only one medical certificate is at present required (except in the case of patients dealt with under Section 13 of the Lunacy Act, 1890). Whether the procedure of certification is made uniform for all patients or not, the Association considers that two medical certificates should be required by law in all cases.

MISCELLANEOUS.

72. *Bona fide* communications to constables, relieving officers or overseers initiating proceedings under Sections 13 (i), 15 (i), and 20 of the Lunacy Act, 1890, should be privileged.

73. The right to see a magistrate is accorded to all patients placed under Order except those dealt with under Section 13 of the Lunacy Act, 1890, and this is an anomaly which should be removed.

74. In the interests of the patients, the classification of patients suffering from various mental disorders should, as far as possible, be effected, and this with as little delay as possible.

75. It is urged that no person not charged with an offence against the law should be examined with regard to the state of his mind in a public Court as is at present allowed and is, as a matter of fact, sometimes done.

76. Powers of forcible entry in order to visit, examine or remove a person who is deemed to be of "unsound mind" should be granted to magistrates in connection with cases arising under Sections 13 (2) and 20 of the Lunacy Act, 1890.

TYPES OF ACCOMMODATION FOR PATIENTS SUFFERING FROM MENTAL DISORDER.

77. The following types of accommodation for persons suffering from mental disorder are suggested:—

- (i) Non-registered hospitals or parts of or adjuncts to hospitals, voluntary or Poor Law.
- (ii) Institutions or clinics or homes established, or to be established, by Local Authorities.
- (iii) Homes to be founded on a charitable or semi-charitable foundation.
- (iv) Recognised homes on a purely private basis for several patients.
- (v) Publicly maintained mental hospitals and specialised wards of Poor Law hospitals;
- (vi) Registered mental hospitals;
- (vii) Private (licensed) mental hospitals; and the approved annexes, of (v), (vi), and (vii);
- (viii) Private houses for single patients.

CLASSIFICATION AND ALLOCATION OF PATIENTS.

78. For those who are of "unsound mind" and for whom measures of control have become desirable it should be open to adopt various methods of procedure:—

- (A) Voluntary,
 - (a) by the patient's act,
 - (b) by the action of a friend or relative where the patient does not refuse or where he is a minor.
- (B) Compulsory by the action of a relative or relieving officer,
 - (a) as a temporary or provisional measure for three days,
 - (b) as a temporary or provisional measure for a month with the approval of a judicial authority.
- (C) Compulsory by the order of a judicial authority under the Reception Order.

"Compulsory (c)" patients of unsound mind may be received in (v.), (vi.), (vii.) and (viii.).

"Compulsory (b)" patients may be received in (i.), (ii.), (iii.), (iv.), (v.), (vi.), (vii.) and (viii.).

"Voluntary (A)" patients of unsound mind may be received in (v.), (vi.), (vii.) and (viii.), and also in (i.), (ii.), (iii.) and (iv.).

The "Mentally Ailing" but not of unsound mind may be received in (i.), (ii.), (iii.), (iv.) and (viii.), and as Voluntary Boarders with the approval of the Medical Superintendent in (v.), (vi.) and (vii.).

APPENDIX A.

CONSIDERATIONS WHICH SUPPORT THE CLAIM THAT THE CERTIFYING PRACTITIONER SHOULD ENJOY THE IMMUNITIES OF A WITNESS.

NOTE.—The quotations are from the Lunacy Act, 1890, the *italics* being introduced for purposes of emphasis.

1. Section 4. Sub-section (1).

A person shall not be received or detained as a lunatic, &c., "*unless under a reception order made by a Judicial Authority.*"

2. Section 9. Sub-section (2).

"Judicial Authority shall . . . have the same jurisdiction and power as regards *summoning and examination of witnesses, the administration of oaths*, and otherwise, as if he were acting in the exercise of his ordinary jurisdiction."

3. Section 28. Sub-section (4).

"*Every medical certificate made under and for the purpose of this Act shall be evidence of the facts therein appearing and of the judgment therein stated to have been formed by the certifying medical practitioners on such facts, as if the matters therein appearing had been verified on oath.*"

4. If the judicial authority signs a Reception Order without personally seeing *the patient* the medical officer of the institution must inform the patient that he *has the right to claim an audience with some other Judicial Authority*, who after such audience must report to the Commissioners in order that these "may take such steps as may be necessary to give effect to the report." Section 8 (3). Should the medical officer think that such an audience might be prejudicial to the patient he will not tell the patient of its possibility, but he must certify his opinion to the Commissioners. Section 8 (1).

NOTE.—The powers of the judicial authority to visit the patient to make various inquiries, to summon other witnesses (Section 6) to administer oaths (Section 9 (2) show that *medical certificates are not per se conclusive*, that is, the certificates are evidence, not judgment.

5. Further, when an alleged lunatic demands a jury in the case of an "inquisition" the Judge by personal examination may decide whether the alleged lunatic is mentally competent to form and express a wish for a jury (Section 91).

6. Again, without a Jury, the "Masters" (barristers) shall "*personally examine the alleged lunatic and take such evidence as they think fit in order to ascertain whether he is of sound mind or not.*" Section 92.

7. Where *the Masters certify* in one direction or the other the certificate shall have the same effect as an inquisition taken upon the oath of a jury. Section 93.

NOTE.—The above rules and practices show that the principle accepted in the Lunacy Act is that the responsibility for defining a person to be (or not to be) of unsound mind rests with an appropriate legal officer and not with a member (or members) of the medical profession. These may, as may other persons, give evidence, and this evidence (in whole or in part) must be in the form of a prescribed certificate. It is for the duly constituted judicial authority to consider the medical certificates together with any other evidence he may think advisable, and after consideration to give his decision. Upon this

decision the whole of the future action relative to the patient depends. In a word, the medical practitioner gives evidence; the judicial authority pronounces judgment; the medical practitioner is a witness; the judicial authority is a judge. Hence the claim by the practitioner for the immunities of a witness is strictly in accord with the whole tenour of the Lunacy Act.

APPENDIX B.

PROPOSED PROVISIONAL ORDER FOR DETENTION.

I, the undersigned,..... being a Justice of the Peace for..... having visited (a)..... do hereby authorise h detention for observation, care and treatment for a period not exceeding Twenty-eight days from this date.

DATED this.....day of.....192 .
Signed.....

A Justice of the Peace for
(or as the case may be.)
To the Medical Superintendent,
.....Hospital,
Recognised Home
(or as the case may be.)

N.B.—Wherever possible this Order should be signed prior to the admission of the Patient and in no case later than 3 days after admission.

FORM OF PROVISIONAL ORDER FOR THE RECEPTION OF A PATIENT, WITH MEDICAL CERTIFICATE AND STATEMENT ACCOMPANYING PROVISIONAL ORDER.

I, the undersigned, being a Person Twenty-one years of age, hereby authorise you to receive (a) as a Patient into your Hospital, &c. for observation, care, and treatment, whom I last saw at on the day of 192 .

I am not related to or connected with the Person signing the Certificate which accompanies this Order in any of the ways mentioned in the Margin (b). Subjoined hereto is a Statement of Particulars relating to the said (a)

SIGNED:
Name and Christian }
Name at length }
Rank, Profession, or }
Occupation (if any) }
Full Postal Address
How related to or connected }
with the Patient (c) }

DATED thisday of192 .
To the Medical Superintendent,
.....Hospital, &c.

STATEMENT OF PARTICULARS REFERRED TO IN THE ANNEXED ORDER.

If any Particulars are not known, the fact is to be so stated.

The following is a Statement of Particulars relating to the said (a)
Name of Patient, with Christian Name at length
Sex and Age

(a) Name of Patient.

(b) Husband, wife, father, father-in-law, mother, mother-in-law, son, son-in-law, daughter, daughter-in-law, brother, brother-in-law, sister, sister-in-law, partner or assistant, or in the case of a rate-aided patient this may be signed by a relieving officer where no relative is available or willing to act.

(c) If not the husband or wife, or a relative of the Patient, the person signing to state as briefly as possible—(1) Why the Order is not signed by the husband or wife, or a relative of the Patient.

(2) His or her connection with the Patient, and the circumstances under which he or she signs.

Married, Single or Widowed
 Rank, Profession, or previous occupation (if any)
 Religious Persuasion
 Residence at or immediately previous to the date hereof
 Whether previous history of mental disorder
 Age at onset of mental disorder
 When and where previously under care and treatment for mental disorder
 Duration of present illness
 Supposed cause
 Whether subject to Epilepsy
 Whether suicidal
 Whether dangerous to others and in what way

Names, Christian Names and Full Postal Addresses of one or more Relatives of the Patient

Name of the Person to whom }
 Notice of Death to be sent, }
 and full Postal Address, if }
 not already given }
 Name and Full Postal Address }
 of the usual Medical Attendant }
 of the Patient }

SIGNED (d)
 Name, with Christian }
 Name at length }
 Rank, Profession or Occupation (if any) }
 How related to or otherwise connected with }
 the Patient }

STATEMENT ACCOMPANYING PROVISIONAL ORDER.

I, the undersigned, being a Registered Medical Practitioner, do hereby certify that it is expedient for the welfare of the said (†)

that the said
 should be forthwith placed under care and treatment.

My reasons for this conclusion are as follows

DATED this day of
 One thousand nine hundred and twenty

(SIGNED)
 of (e)

N.B.—It is desirable that this Certificate be signed by the usual Medical Attendant.

(d) When the Petitioner or person signing an Urgency Order is not the person who signs the statement, add the following particulars concerning the person who signs the statement.

† Or for the public safety, as the case may be.

(e) Insert full postal address.

APPENDIX C.

SCHEME FOR CLASSIFICATION OF PATIENTS SUFFERING FROM MENTAL DISORDERS.

Patients not needing to be taken charge of and detained for care and treatment, *i.e.*, not "of unsound mind" but suffering from lesser mental ailments, including simple senile dementia.

Patients proper to be taken charge of and detained for care and treatment, *i.e.*, "of unsound mind."

Patients needing treatment but not in homes, institutions or hospitals.

Patients needing treatment in suitable homes, institutions or hospitals.

Those patients who give consent to the necessary measures of treatment:—

(a) Voluntary Boarders (under Lunacy Act).

(b) Temporary Boarders by consent (as provided in Mental Treatment Bill).

Temporary Boarders who are minors or who when given the choice do not refuse to submit to the necessary measures of treatment and are likely to make early recovery.

Those who refuse consent and for whom therefore compulsory measures are necessary.

Patients for whom immediate measures are necessary for safety or for their welfare. Provisional Order valid for 3 days made by near relative or relieving officer.

Patients in regard to whom the final decision is not clear and in whose case a period of observation is desirable. Provisional Order validated for a further 28 days by the Justice.

Patients in need of continued control—Reception Order.

APPENDIX D.

PROTECTION OF ALLEGED LUNATIC.

(Note.—The references are to the Lunacy Act, 1890)
1. Judicial Authority may decide to see patient and may postpone decision to secure this. Section 6 (1).

2. In the meantime may make enquiries of or concerning the lunatic, and may visit him. Section 6 (1), (2).

3. At hearing may have lunatic, and person appointed by lunatic, present. Section 6 (3).

4. May adjourn for 14 days, and may at continued hearing summon any person to attend before him. Section 6 (4).

5. All persons bound to secrecy save lunatic and his friend. Section 6 (5).

6. Judicial Authority may put witnesses on oath. Section 9 (2).

7. Where Petition granted forthwith and patient not seen by judicial authority, the medical officer (institution) must within 24 hours inform him in writing, of his right, to see or be seen by a judicial authority other than the one who has granted the Petition. If the medical officer, however, thinks that such a visit would be prejudicial to the patient, he will not tell the patient of this right, but he must certify his opinion to the Commissioners. Section 8 (1).

8. The judicial authority who sees the patient on the claim under No. 7 shall be entitled to see all the papers in the case and shall send to the Commissioners a report, and “the Commissioners shall take

such steps as may be necessary to give effect to the report.” Section 8 (3).

9. The medical officer one month after reception of patient shall send to the Commissioners (and to the Visitors) a report as to the mental and bodily condition of the patient. After reception of this report one or more of the Commissioners shall visit the patient and shall report whether the detention of the patient is or is not proper (Section 39 (2) and (3)). Similarly, one or more of the Visitors will visit the patient and if in doubt as to the propriety of his detention will report to the Commissioners who must make all necessary enquiries. Section 39 (4).

10. If the Commissioners in any case under this Section 39 determine that a patient ought to be discharged, they may make an order for his discharge.

11. Letters by patients to Lord Chancellor, Commissioners, etc., must be forwarded unopened; and notices to this effect must be posted in the institution; also of right of patient to request personal and private interview with a Commissioner or Visitor. Section 42 (1).

12. A medical practitioner who has signed a certificate for a reception order in the case of a private patient shall not be the regular professional attendant of the patient while detained under the order. Section 43 (1).

13. Any Commissioner or Visitor may give an order for patient to be visited by any relation or friend, or by any medical or other person whom any relation or friend desires to be admitted to him. If any manager or officer prevents or obstructs such admission he is liable to a penalty not exceeding £20. Section 47 (1), (3).

APPENDIX XXIII.

Question 13,123.

LANCASHIRE MENTAL HOSPITALS.

Statistics of Deaths and Discharges within short periods of Detention, for the year 1923.

Hospital.	New Cases Admitted.	Within 3 months.		Within 6 months.		Within 9 months.		Within 12 months.	
		Died.	Discharged.	Died.	Discharged.	Died.	Discharged.	Died.	Discharged.
Lancaster ...	365	31	5	3	17	6	12	5	10
Rainhill... ..	447	36	41	19	59	11	15	5	10
Whittingham ...	439	45	10	28	58	13	52	6	32
Prestwich ...	439	44	48	18	65	9	32	6	17
Winwick ...	1,096	53	2	37	62	19	63	13	36

APPENDIX XXIV.

Question 16,599.

MEDICO-PSYCHOLOGICAL ASSOCIATION OF GREAT BRITAIN AND IRELAND.

MEMORANDUM OF THE EVIDENCE TO BE GIVEN ON BEHALF OF THE ASSOCIATION.

INTRODUCTION.

The Medico-Psychological Association of Great Britain and Ireland dates back to the year 1841, having for its objects the intercommunication on all matters calculated to improve the care, treatment and recovery of patients suffering from mental disorder, and the collaboration of research into the elucidation of the causes and prevention of insanity. In later years its activities have extended to the education and examination of medical men and women, and nurses engaged in the practice of psychiatry.

The Association consists of between 700 and 800 medical practitioners who are actively interested in the progress of psychiatry throughout the British Empire. The Ordinary or Subscribing Members are mostly medical superintendents or medical officers of mental hospitals, public and private, medical officers under the Prison Commission and county and borough education authorities, professors and lecturers in psychiatry attached to the universities and teaching schools of the Kingdom, and medical men and women in consulting or general practice. The Association

has also 14 Corresponding Members living in foreign countries, and 30 Honorary Members. The Association comprises three Divisions for England and Wales, a Division for Scotland, and a Division for Ireland.

Quarterly general, as well as biennial divisional meetings are held for the discussion of papers, which, with other proceedings, are incorporated in a quarterly publication—*The Journal of Mental Science*. This Journal has existed since the year 1853. The Association has an annually elected President and other Officers of its Council, also a Parliamentary, an Educational, and other Committees. Since 1892 examinations have been held for its Certificate in Psychological Medicine, which has been given to 379 medical men, and at times an Honours Examination has been conducted for the Gaskell Prize. The Certificate of the Association is the forerunner of the Diplomas in Psychological Medicine recently instituted by many of the Universities and Conjoint College Boards. The Association originated, and for many years has actively promoted, the training of mental nurses. Since 1891 examinations have been regularly held for its Certificate in Mental Nursing, which has been awarded to more than eighteen thousand male and female nurses. Since 1917 the Association has also examined nurses for proficiency in training mental defectives, and 193 of such certificates have been granted. The Association is regarded by the medical profession as the leading representative body concerned with psychiatry in this country.

The preparation of evidence to be given on behalf of the Association was entrusted to a Committee consisting of the following members:

- *R. H. COLE, M.D., F.R.C.P. (Chairman), Physician for and Lecturer on Mental Diseases, St. Mary's Hospital, London; Examiner in Mental Diseases and Psychology, University of London. Chairman of the Parliamentary Committee of the Association.
- W. BROOKS KEITH, M.C., M.D. (Secretary), Medical Superintendent, St. Audrey's Hospital, Melton, Suffolk. Secretary of the Parliamentary Committee of the Association.
- J. CHAMBERS, M.A., M.D., Medical Superintendent, The Priory, Roehampton, London. Treasurer of the Association. Formerly Lecturer on Mental Diseases, Middlesex Hospital, and Co-Editor of the *Journal of Mental Science*.
- *M. A. COLLINS, O.B.E., M.D., Medical Superintendent, Kent County Mental Hospital, Chartham. Former General Secretary of the Association.
- R. EAGER, O.B.E., M.D., Medical Superintendent, Devon County Mental Hospital, Exminster.
- F. H. EDWARDS, M.D., M.R.C.P., Medical Superintendent, Camberwell House, London.
- *E. GOODALL, O.B.E., M.D., F.R.C.P., Physician for Out-Patients in Psychiatry, Cardiff Royal Infirmary; Lecturer on Mental Disorders, Welsh National School of Medicine; Medical Superintendent, Cardiff Mental Hospital, Whitchurch. Former Co-Editor of the *Journal of Mental Science*. Ex-President of the Association.
- P. T. HUGHES, M.B., Lecturer on Mental Diseases, Birmingham University; Medical Superintendent, Worcester County Mental Hospital, Bromsgrove.
- *J. R. LORD, C.B.E., M.B., Medical Superintendent, Horton Mental Hospital, Epsom. Co-Editor of the *Journal of Mental Science*.
- E. MAPOTHER, M.D., M.R.C.P., F.R.C.S., Physician and Lecturer for Psychological Medicine, King's College Hospital; Medical Superintendent, The Maudsley Hospital, Denmark Hill, London.

*W. F. MENZIES, B.Sc., M.D., F.R.C.P., Medical Superintendent, Stafford County Mental Hospital, Cheddleton. Former President of the Association.

*Sir FREDERICK W. MOTT, K.B.E., LL.D., M.D., F.R.C.P., F.R.S., Consulting Physician, Charing Cross Hospital; Lecturer on Morbid Psychology and Hon. Director of Research, University and City of Birmingham; Examiner in Neurology, University of London; late Pathologist, London County Mental Hospitals. President-Elect of the Association.

BEDFORD PIERCE, M.D., F.R.C.P., Consulting Physician, The Retreat, York. Former President of the Association.

R. C. STEWART, M.R.C.S., Medical Superintendent, Leicester County Mental Hospital, Narborough.

H. WOLSELEY-LEWIS, M.D., F.R.C.S., Medical Superintendent, Kent County Mental Hospital, Barming Heath. Ex-Chairman of the Parliamentary Committee of the Association.

*R. WORTH, O.B.E., M.B., Medical Superintendent, Springfield Mental Hospital, Tooting, London. General Secretary of the Association.

The Association has for many years been alive to the backward position in many respects of psychiatry in the United Kingdom, and not a few circumstances, such as the apathy and prejudices of the public as regards the insane, reflected in the reluctance of Imperial and local authorities to commit themselves to further expenditure, and the fact that progress in certain directions would require action on the part of the Legislature before it could materialize, have militated against any real advance being made in many matters the Association has very much at heart.

REPORT OF THE STATUS OF BRITISH PSYCHIATRY COMMITTEE.

This stagnation, although it had received constant attention from the Association, its Council and several Standing Committees, was the subject of inquiry by a special committee appointed in 1911 to consider the "Status of British Psychiatry and of Medical Officers." That Committee took a wide view of their reference, and their Interim Report, published in 1913, set forth in no uncertain manner the grave defects psychiatry laboured under in Great Britain and Ireland. Chief among these were:

- (a) The absence of proper provision for the early treatment of incipient and undeveloped cases of mental disorder.
- (b) The few facilities there existed for the study of psychiatry and for research.

That Committee, among other measures, recommended:

That "clinics for mental disorders" in connection with the universities, medical schools and general hospitals should be established.

That as a general principle the admission to all mental institutions should be on a voluntary basis and without loss of civil rights.

That there should be power, if found necessary, to detain for a limited period incipient cases, such being notified to the Board of Control (hereinafterwards called the "Board of Mental Health," *vide* Recommendation 17).

That admissions should be direct into mental institutions, without reference to the Poor Law authorities.

That the use of "urgency orders" (hereinafterwards called "provisional orders," *vide* Recommendation 31) should be widened.

REPORT OF THE ENGLISH LUNACY LEGISLATION SUB-COMMITTEE.

With a view to giving effect to some of the recommendations of that Committee, many of which would necessitate emendation of the existing Lunacy Acts,

* Appointed witnesses.

* Appointed witnesses.

the Association in 1918 appointed the "English Lunacy Legislation Sub-Committee," which reported late in the same year.

That Report has had a wide circulation amongst the authorities concerned, and in the light of reconsideration after a lapse of six years is found to require but slight emendation. The Report was published in order to promote a Bill to facilitate the temporary treatment of incipient mental disorders without certification. The main principles in the Report involved the establishment of psychiatric clinics, associated wherever possible with general hospitals, the admission of voluntary boarders (hereinafterwards called voluntary patients) to be extended to rate-supported mental hospitals, and the recognition of the need of further provision for paying patients. These principles, and other supplementary proposals, were generally accepted, and in the main are to be found incorporated in the Mental Treatment Bill of 1923 (with provision for after-care and research). This Bill, for reasons which were not political, failed to reach the Statute Book.

THE EXISTING LUNACY ACTS.

The Association is of opinion that the vast majority of the community, including patients, is grateful for the protection afforded by the existing Lunacy Acts, and that the safeguards they provide against abuses and illegal detention have on the whole proved satisfactory.

These Acts have, however, failed to keep pace with medical progress, especially in regard to the treatment of the initial and more curable stage of mental disorders.

The Association, therefore, welcomed the appointment of a Royal Commission on Lunacy and Mental Disorder as an opportunity of stating its views in regard to amendment of the Lunacy Acts for England and Wales and, more especially, the principles involved in the reception, treatment, care and discharge of patients in institutions, and hopes that the Royal Commission will impress upon the Government the necessity of proceeding with a Mental Treatment Bill in harmony with the aspirations of the Association as set forth in this memorandum.

THE STATUS AND EDUCATION OF MEDICAL OFFICERS AND NURSES.

The Association notes with satisfaction that an increasing number of medical officers are granted study-leave, and obtain diplomas in psychological medicine, and that a large number of mental nurses now hold the Certificate in Mental Nursing of the Association.

SUMMARY OF RECOMMENDATIONS.

It is convenient here, before proceeding to set forth in *extenso* the Association's recommendations, to summarize the chief guiding principles upon which they are based.

The Association is of the opinion:

That "clinics for mental disorders," preferably in connection with the universities, medical schools and general hospitals, should be established.

That the reception into mental institutions of patients, whether of the private (hereinafterwards called "paying patients") or of the pauper (hereinafterwards called "rate-aided patients") class, should follow a similar procedure.

That a considerable proportion of admissions to mental institutions should be dealt with on a voluntary basis, so that such voluntary treatment should be extended to the rate-aided class, for which legislative sanction has already established precedents at the Maudsley Hospital and at the City of London Mental Hospital.

That special legal machinery should be devised for treating early non-volitional cases.

That a "provisional order" should be instituted as an intermediary measure before the usual "judicial order" for detention is enforced.

That when such detention is necessary for the cure or care of patients, medical certification should take place as constituting evidence, but that the authority for detention, discharge and continuation, *i.e.*, renewal, of orders should entail the responsibility of some authorised person not acting in a medical capacity.

That a broader conception should be taken of the functions of both the central and local authorities for "lunacy" or mental health administration.

That the Poor Law authorities should be superseded by the local authorities in regard to the care, treatment and maintenance of necessitous patients suffering from mental disorders.

SUMMARY OF MATTERS OF FACT.

1. There are very few facilities for patients who are threatened with mental breakdown to obtain skilled treatment. As a rule they do not obtain it until certification takes place. But early symptoms of disorder often occur long before certification is possible.

2. Owing to efficient treatment being delayed the most valuable time for adopting measures to secure early recovery is lost.

3. There is strong objection to certification in itself on the part of the public, which is alive to the material and moral damage which it so often inflicts on the patient and his relatives, so that even when certification has become possible they refuse to resort to it, and thus still further postpone the adoption of efficient treatment.

4. In cases where certification has to be resorted to, the subsequent course of events often shows that this might have been avoided with advantage if there had been facilities for treatment under other conditions.

5. The experience gathered as the result of the war has opened the eyes of the public and the medical profession in a fresh way to the difficulties and needs of these cases.

6. Many medical practitioners, having had no opportunity of gaining knowledge of the manifestations and treatment of mental disorders in their early stages, fail to recognise the seriousness of the condition and to secure for their patients efficient treatment. They are also often deterred, by the necessity of certifying the patient, from advising suitable treatment. This unwillingness may be due to a genuine and proper doubt whether the condition is sufficiently definite to justify this procedure or to a natural reluctance to cause distress to the patient and his friends. In some cases direct evidence of insanity cannot be obtained at any particular interview, and certification and treatment are thus delayed.

7. In many early cases advantage would be taken of the opportunity for treatment were the voluntary patient system, with some modification of procedure, extended to rate-supported mental hospitals.

8. Many persons of the well-to-do classes, who are the subjects of mental disorder and are certifiable, are now placed in private houses and nursing homes without an order having been obtained for their reception. No intimation of their admission is given to the Board of Mental Health. No precautions are necessarily taken to ascertain that the conditions are favourable for the patient, or that efficient treatment is thus being obtained for him. It is felt that while many cases may be treated in private houses and nursing homes quite properly, provision should be made to give the competent authority the opportunity of ascertaining that houses and homes in which such patients are received are suitable for the purpose, and that the persons in charge are competent to treat cases of mental disorder.

RECOMMENDATIONS.

Recommendations 1 to 15, 24, 25, 41, 44, 51 and 53 were made by the English Legislation Sub-Committee of the Association, and with some emendations have again been adopted.

Recommendations 16 to 23, 26 to 40, 42, 43, 45 to 50, 52, and 54 to 58 are the outcome of the more recent deliberations of the Special Committee appointed to prepare this memorandum, the Parliamentary Committee and the Council, and were adopted at a General Meeting of the Association held on November 20, 1924.

Recommendation 1: The Association considers that the opportunity is afforded now for a further revision of the Lunacy Acts for England and Wales.

Although some desire to see the Lunacy Acts entirely re-cast, with abolition of the justice's order and other legal formalities, the majority are satisfied that such far-reaching changes are not expedient, and that the reforms most urgently needed could be obtained by an Amending Bill.

As the Association cannot but think that all, with experience of the subject, agree that the Law now presses hardly on certain cases, rate-aided and paying alike, is not abreast of modern requirements and aspirations, and is not working in the best interests of the State, it has endeavoured to frame proposals to meet these defects.

In doing so, it has kept in mind on the one hand the practical convenience and view-point and possible prejudice of those for whose benefit the measures suggested are intended, and on the other the necessity of winning the support of instructed lay opinion, the medical profession and the constituted authorities.

Psychiatric Clinics and Research Laboratories.

Recommendation 2: That clinics be established by local authorities for the treatment of nervous and mental diseases in their early stages; and that in the organisation of clinics special provision be made for children.

Recommendation 3: That voluntary patients should be received and also that provision be made for the reception of non-volitional patients for a limited time without certification in such a psychiatric clinic. (*Vide* Recommendation 58 (a) (c).)

Recommendation 4: That such a clinic should be where possible an annexe to a general hospital or housed in a special building.

Recommendation 5: That such a clinic should be adequately staffed and the medical and nursing personnel should include special staff trained in psychiatric work.

Recommendation 6: That it should be the duty of local authorities to provide and maintain clinics either themselves or by arrangement with voluntary organisations for the purpose (*vide* Recommendation 58 (a)).

Recommendation 7: That the supervisory committee or committee of management of such a clinic should be a special committee of the local statutory committee of mental health.

Recommendation 8: That the inspection and approval of the buildings used for such clinics should be the duty of the central Government Department. (For definition see Recommendations 16 and 17.)

Recommendation 9: That it is desirable that neighbouring mental hospitals should be enabled to establish and maintain joint laboratories for research (*vide* Recommendation 58 (a)).

Psychiatric clinics aim at providing facilities for treatment of which ailing members of the public will be ready to avail themselves at the earliest possible moment, even when the condition is merely what is commonly described as one of "disordered nerves." This necessitates as complete a dissociation as possible from the existing statutory requirements for dealing with the insane.

It also necessitates the provision of facilities similar in character and equal in completeness to those

Recommendations 1 to 15, 24, 25, 41, 44, 51 and 53 thoroughly well-found and well-staffed clinic for both in-patients and out-patients. These facilities must be brought as near to the homes of the people as possible. They should therefore be established all over the country in large centres of population, preferably in connection with general hospitals, so that the people may easily obtain treatment or seek advice and so be encouraged to obtain instruction in mental hygiene at a stage when preventive measures are possible, and thus escape in many cases a serious breakdown, to the advantage both of themselves and the community; for thus would be retained as workers those who otherwise become a burden to their fellows.

No mere extension of the voluntary patient system in the mental hospitals (which is much to be desired on other grounds) would meet these requirements. Nor is it probable that any arrangements that might be made with general hospitals throughout the country would alone be sufficient.

Just as in ordinary hospitals some cases of delirium and excitement with loss of control occasionally occur and are dealt with without any great difficulty, so similarly cases of mental disease in their early stages where the symptoms are likely to subside under proper treatment would be received and suitably provided for in the proposed clinics.

The decision whether a case is or is not suitable for treatment in such a clinic would depend upon practical convenience and the nature and duration of the symptoms.

In large towns clinics should be part of, or annexes of, or failing these, affiliated to the general hospitals for many important reasons, not least among them being that students may have opportunities of studying those early stages of mental disorder which as practitioners they will be called upon to treat. Nurses undergoing hospital training could also take advantage of these opportunities to acquire a general knowledge of mental cases.

Clinics would also provide a valuable field for post-graduate work and for scientific research with the necessary laboratory accommodation.

Special clinics to act as "clearing houses" may be necessary in large districts, but it is hoped that if the bulk of the occurring mental disorder were overtaken while in its early stages, such "clearing houses" would be a disappearing factor in the mental health service of the country. Admission of suitable cases direct to mental hospitals is part of the policy of the Association.

As the Association is anxious to emphasize the necessity for the establishment of psychiatric clinics and research laboratories by local authorities, further detailed evidence on this important matter will be found in *Appendices I and II.

Voluntary Patients in Mental Hospitals.

Recommendation 10: That mental hospitals should be encouraged to admit patients as voluntary patients without loss of civil rights on their signing an application to that effect addressed to the medical officer of the institution, provided:

- (a) That there is accommodation approved of by the central Government department and the applicants are suitable persons.
- (b) That they should be required to give 72 hours' notice in writing of their desire to leave the institution, after the expiry of which period they must cease to reside as such; further provided that, before the notice expires, the patient does not intimate in writing his desire to withdraw the notice.

Recommendation 11: That regulations should be made setting out the conditions on which the medical officer may admit voluntary patients.

* Not re-produced.

Under the present Lunacy Acts patients may be received as voluntary patients in registered hospitals and licensed houses. This facility should be extended to suitable persons, whether of the paying or rate-aided class, desirous of placing themselves under treatment in the county or borough mental hospitals.

Many patients who have recovered in a rate-supported mental hospital from a previous attack, and are on the verge of a relapse, wish to place themselves under mental hospital care again, but are, at present, unable to do so until they become certifiably insane, and then they must be referred to the relieving officer.

There will no doubt be other cases unable to afford the expense of a registered hospital or licensed house who will prefer to apply direct to a rate-supported mental hospital for treatment in the first instance, if they can do so under the conditions attaching to voluntary patients. Their admission thereto would depend upon their suitability.

The Board of Mental Health should be informed of all persons received as voluntary patients into mental hospitals, but their previous consent thereto, or that of the justices in the case of the licensed houses, seems unnecessary and interferes with the utility of the plan, as many patients object to making written application to the Board of Mental Health or the justices for permission, as at present required; moreover, no such requirement obtains in the case of the registered hospitals.

Further, there appears to be no good reason why this mode of admission should be reserved for persons who cannot be certified as insane, as it conflicts with the fundamental principle that treatment should be begun at the earliest possible moment. It should be sufficient for anyone, being aware of his mental illness, voluntarily to sign a document expressing his desire to be admitted as a voluntary patient to a mental hospital for purposes of treatment.

For practical convenience it is much to be desired that the notice required to be given by voluntary patients of their intention to leave should be increased from 24 to 72 hours.

The reform suggested has long been advocated, and has met with practically no opposition.

Further Provision for Paying Patients.

Recommendation 12: That the central Government department should have power (a) to approve homes which are supported wholly or partly by voluntary contributions or which are privately owned, in which it shall be lawful to receive without certification more than one paying patient suffering from mental disease in its early stages, and (b) to give legal sanction to the reception without certification of such patients as single patients in houses not so approved, provided that a medical practitioner gives a written recommendation in each case, stating that suitable treatment can be obtained for the patient in the proposed house.

Recommendation 13: That on any such patient being received into or ceasing to reside in any approved (or recognized) home, or as a single patient in a house not so approved, the fact shall be intimated to the central Government department.

Recommendation 14: That it should be possible to transfer the jurisdiction for licensing a house from one authority to another on good reason being shown.

Recommendation 15: That certified patients and voluntary patients should be permitted reception direct to the branch establishments of registered hospitals and licensed houses.

It has to be recognized that the objection to certification in the early and curable stages of mental disorder is strongly felt by all classes, and the temptation, for those who can afford it, to send

patients to unrecognized places of treatment is very great both for the patient's friends and their medical advisers. Those who receive such patients knowingly run the risk of prosecution, and there is no guarantee that they can or do give suitable care or treatment to the patients. The treatment of certain cases of mental disorder in suitable private houses and nursing homes is undoubtedly desirable, and the true interests of the patients should be obtainable in conformity with the law.

Where residential treatment is conducted for payment in the case of patients suffering from mental disorder which is deemed to be temporary, but who may be considered certifiable, it is desirable that the fact of their reception should be brought to the cognizance of the central authority. It is hoped that with this safeguard facilities may be granted for the treatment for payment by private persons or voluntary associations of early, undeveloped and recoverable cases of mental disease without the drawbacks attaching to certification.

It is suggested that the Board of Mental Health should be empowered to give legal sanction to the treatment of this group of cases without certification. This can only be done by provisions limiting the application of Section 315 of the Lunacy Act, 1890, which imposes penalties on those receiving persons of unsound mind for payment without certification. It is not proposed to do away with this Section, and as its enforcement is in the hands of the Board of Mental Health, it is practically necessary to give any powers over-riding its application to the same body.

The Central Authority.

Recommendation 16: That all matters of mental health be centralized in the Board of Control as the Government department under the Minister of Health and Lord Chancellor.

Recommendation 17: That such Government department or central authority be designated the "Board of Mental Health," instead of the present term "Board of Control," and that such Board should be increased in its medical personnel.

Recommendation 18: That at the statutory visits made to all mental institutions, public and private, and to patients in single care, one at least of the commissioners of the Board of Mental Health should be a medical commissioner.

Recommendation 19: That in making appointments of Medical Commissioners of the Board of Mental Health, it is important to take into consideration not only experience in mental disorders, but also experience in general medicine, and status in the medical profession.

Recommendation 20: That the remuneration of the medical members of the Board of Mental Health should be increased. The State should require the medical members of the Board to be of the highest standard of scientific and professional attainments.

The Local Authority.

Recommendation 21: That the management of all rate-supported institutions for the care and treatment of mental disorders and mental defect be vested in one statutory committee of mental health of a local authority.

Recommendation 22: That the statutory committee should direct all matters relating to mental health in the area, having regard to both voluntary and certified patients in rate-aided institutions, whether in clinics, mental hospitals, or elsewhere.

Recommendation 23: That the county or borough rate be utilized to support the maintenance of necessitous patients as well as that of the fabric of public mental institutions, and that

such rate be supplemented by a Government grant, payable upon the certificate of the Board of Mental Health, which grant should extend to the provision for research, special medical and nursing training, and after-care.

Legal Formalities, etc.

Recommendation 24: That the existing Lunacy Acts should be called the Mental Disorders Acts, and an amending Act the Mental Treatment Act.

Recommendation 25: (a) That the words "lunacy" and "lunatics" be discontinued and the words "mental disorders" and "persons of unsound mind" be substituted.

(b) That instead of the word "asylum" the words "mental hospital" be used—county, city, or borough, as may be.

(c) That the word "rate-aided" be used instead of the word "pauper."

Recommendation 26: That patients who need care and treatment for mental disease at the public expense should not, on that account, be termed, or be regarded as, paupers.

Recommendation 27: That in-patient voluntary treatment be legalized in rate-supported mental hospitals as well as in clinics, and that the maintenance charges in necessitous cases be defrayed out of public funds by the statutory committee.

Recommendation 28: That rate-aided patients requiring certification be afforded similar procedure as obtains with paying patients, *viz.*, the protection of *two* medical certificates on petition for a judicial reception order, instead of a summary reception order on one certificate which is the usual practice at present.

Recommendation 29: That when a relative or friend of a rate-aided patient is unable or unwilling to act as petitioner, an officer of the local authority, or other suitable officer, may be the petitioner entrusted with the duties of carrying out the requisite formalities.

Recommendation 30: That it should be made possible for rate-aided patients as well as paying patients to be admitted to mental hospitals under a "provisional order" (*vide* Recommendation 31-35).

Recommendation 31: That the present system of urgency procedure for all unwilling patients might with advantage be superseded by the institution of a provisional order.

Recommendation 32: That a provisional order may be used not only on the ground of urgency, but so as to provide means of temporary care, observation and treatment under safe conditions.

Recommendation 33: That a provisional order with statement of particulars should be signed by a relative or friend, or by an officer of the local authority, authorizing the reception of a patient for temporary care, observation and treatment.

Recommendation 34: That a provisional order should be accompanied by a medical certificate in special form, specifying facts and reasons indicating that a patient is a proper person for temporary care, observation and treatment.

Recommendation 35: That a provisional order and certificate should last three days, but be capable of extension in suitable cases for a further period not exceeding twenty-eight days, provided such extension is sanctioned by a judicial authority, or by two members of the visiting committee of a public mental institution, who may direct a further examination by another medical practitioner.

Recommendation 36: That when a provisional order and certificate is about to expire, the following three courses should be considered, according to the exigencies of the case, namely: (a) that the patient be discharged; (b) that the patient may remain voluntarily, or be dealt with, if a non-volitional case, under some such procedure as that projected in Section 4 of the

Mental Treatment Bill, 1923; (c) that a judicial reception order for detention be obtained on petition with two medical certificates.

Recommendation 37: That verbal alterations in the present form of petition for a reception order are desirable, *viz.*, the deletion of the words "lunacy" and "lunatic or idiot" in the margin; the substitution of "mental hospital" for "asylum," and "provisional order" for "urgency order"; and in the statement of particulars accompanying a petition or provisional order, the substitution of "whether previous history of mental disorder" for "whether first attack," "age at the onset of mental disorder" for "age on first attack," "when and where previously under care and treatment for mental disorder" for "when and where previously under care and treatment as a lunatic, idiot, or person of unsound mind," "duration of present mental disorder" for "duration of existing attack," and the addition of questions as to the length of residence at present address if such is not the usual place of abode, and as to the maiden name of a patient who is a married woman or widow.

Recommendation 38: That in the medical certificates (Form 8) used on petition, the words "separately from any other practitioner" be deleted as also in Section 29 (2) of the Lunacy Act, 1890; that a lettered space be inserted for "facts observed by the medical practitioner on previous occasions," and an additional lettered space giving his reasons for the necessity of detention.

Recommendation 39: That in the reception orders (Forms 3, 4, 12, 15) the words "authorize (direct) you to receive and detain" be substituted for "authorize (direct) you to receive."

Recommendation 40: That it is desirable that a judicial reception order should be made by a justice specially appointed in all cases, and who has seen the patient, and that the difficulties of procuring the services of a justice in certain areas should be remedied.

Recommendation 41: That where no criminal offence is charged it is undesirable that justices should in court conduct the examination of mental cases for the purpose of making reception orders.

Recommendation 42: That the present special report and certificate required to continue a reception order at stated intervals should be countersigned by a judicial authority, or two members of the visiting committee of a public mental hospital, and that the latest date of signature should be the end of the existing quarter in which the special report falls due.

Recommendation 43: That a copy of such special report and certificate thus countersigned be accessible to a discharged patient, on appeal to the Board of Mental Health, as in the case of the original reception document.

Recommendation 44: (a) That there is much need of simplification of forms under the existing Lunacy Acts.

(b) That intervals in time require uniformity and where convenient should be defined in hours.

(c) That the duration and lapsing of "reception orders" require amendment.

Recommendation 45: That leave of absence on trial or for health should be encouraged, and that no ambiguity should occur to prevent the return at any time of a certified patient to the institution or house if the petitioner or medical officer deems such return expedient.

Recommendation 46: That the discharge of rate-aided certified patients should, as in the case of certified private patients, be vested in the petitioner, but that in the former case six days' notice in writing should be given to the medical officer of a rate-supported mental hospital by the petitioner, desiring the discharge of a patient, and that if the medical officer considers that it is not in the interest of the patient or of the public that the patient should be discharged, he should

then be permitted to defer the matter for the decision of the visiting committee at its next meeting, which shall have power to over-ride the action of the petitioner.

Recommendation 47: That the existing restriction of discharge of a patient by the certificate of a medical officer under Section 74 of the Lunacy Act, 1890, should be countersigned by a judicial authority or by two members of the visiting committee of a public mental hospital.

Recommendation 48: That Section 75 of the Lunacy Act, 1890, which deals with discharge by two Commissioners, and Section 83 which deals with discharge on recovery, be extended to include rate-aided patients in mental hospitals.

Recommendation 49: That the automatic discharge of a patient by escape after fourteen days is undesirable.

After-care.

Recommendation 50: That the after-care of rate-aided patients should receive due attention, and that the work done by the Mental After-Care Association, or other bodies appointed to deal with after-care, should receive adequate pecuniary recognition by statutory committees.

Poor Law Infirmaries.

Recommendation 51: That it is undesirable that patients alleged to be of unsound mind should be removed to a workhouse or pauper infirmary before their reception in a mental hospital. If an intermediary stage is necessary after the provision of clinics for incipient cases it would be better supplied by a special clinic under the management of the local authority. Practical convenience such as a motor service should be available for the transfer of patients to mental institutions on lines similar to those adopted in the Public Health Service.

Recommendation 52: That a Poor Law infirmary may be regarded as an institution for mental disorders if approved by the Board of Mental Health.

Recommendation 53: That it should be permissible for patients transferred from a mental hospital to a Poor Law institution to be transferred back without re-certification.

Recommendation 54: That the present certificate of a medical officer of a Poor Law infirmary should not as in Section 24 (2) of the Lunacy Act of 1890 be sufficient authority for the detention of a patient for fourteen days, but should require the addition of a provisional order.

Recommendation 55: That reports on mental cases in all Poor Law institutions, as in mental hospitals, should be notified to the Board of Mental Health, and that the arrangements provided for mental cases should be under the management of the statutory committee of mental health of the local authority.

Recommendation 56: That better provision should be made for the care and treatment of senile cases in infirmaries approved by the Board of Mental Health, in order that every effort should be made to avoid the stigma of certification.

Protection to Medical Practitioners and Others.

Recommendation 57: That the protection afforded by Section 330 of the Lunacy Act, 1890, to medical practitioners, and to others engaged in pursuance of the Act, should be extended to stay proceedings at an earlier stage than at present, and that they should receive the same immunity as is given to witnesses in a court of law.

Mental Treatment Bill, 1923.

Recommendation 58: In the event of the Mental Treatment Bill, 1923, as amended by the House of Lords, being again introduced to Parliament, the Association will press for emendation on the following lines:

- (a) Section 2: Subsections (2) and (3) should be obligatory as regards provision of institutions in accordance with Recommendation 6. That the term "institution" should be defined within the meaning of "approved institution" under Section 4 (2). That "voluntary patient" should be substituted for "boarder" in Subsection (3), and that there should be no legal formality necessitating the written application of a voluntary patient for reception to a public mental clinic. That a further Subsection is desirable dealing with voluntary patients in private houses and nursing homes in accordance with Recommendations 12 and 13. That in addition to research in Subsection (5) the expenses of special medical and nursing training should be included in accordance with Recommendation 23.
- (b) Section 3: The Association regards both subsections as opposed to Recommendations 16 to 20.
- (c) Section 4: The Association desires that voluntary patients should be dealt with under Section 2, and that Section 4 should deal only with non-volitional patients, and minors. That extensions for treatment should be permissible for further periods of six months. That this Section should also apply to non-volitional patients, and minors in private houses and nursing homes. That one recommendation from any medical practitioner should be required. That notification to the Board of Mental Health within 24 hours of reception should be a sufficient safeguard, and render an annexed statement by a justice or minister of religion unnecessary.
- (d) Section 5: The Association considers that this Section requires redrafting to distinguish discharge of voluntary patients from non-volitional patients, and minors, and that notice of leaving should be in writing.

Office of the Association,
11, Chandos Street,
Cavendish Square, W. 1;
January, 1925.

APPENDIX XXV.

Question 17,288.

PRÉCIS OF EVIDENCE TO BE GIVEN ON BEHALF OF THE NATIONAL COUNCIL FOR MENTAL HYGIENE BY DR. E. FARQUHAR BUZZARD, M.D., F.R.C.P., DR. H. CRICHTON MILLER, M.D., AND DR. R. WORTH, O.B.E., M.B.

THE NATIONAL COUNCIL FOR MENTAL HYGIENE.

The Council aims at bringing the treatment of mental disorder into the fold of General Medicine. The segregation of cases of mental illness into institutions which are largely divorced from the general hospitals of the country creates the impression that mental illness is something quite different from bodily illness. This divorce in regard to certain types of patient is largely unavoidable at any rate for the present, but whilst mental hospitals will be necessary, there remains a large and most important class of patients for whom at present very little provision is made. Moreover, this class of early, and often recoverable cases, affords the greatest hope of diminishing the incidence of more serious mental disorder, of improving its treatment and of understanding its causation.

There is, in fact, a world-wide movement in this direction. This view is confirmed by the experience of kindred National Societies for Mental Hygiene, and is leading to the formation of clinics or special departments to deal with these patients in connection with general hospitals.

The Council, however, fully realises that such clinics or special departments in general hospitals are not suitable for the treatment of certain forms of mental disorder, by reason of the fact that the majority of such cases are characterised by alteration of conduct of such a nature as to necessitate treatment in special hospitals adapted for the purpose, such as the County and Borough Mental Hospitals.

The subject will be dealt with in the following order:—

- (1) Types of patients to be dealt with.
- (2) Numbers of patients.
- (3) Existing facilities for early treatment for mental disorders.*
- (4), (5), and (6) Recommendations for early treatment for mental disorders.
- (7) The administration of public mental hospitals.
- (8) After-care.

(1) *Types of Patients to be dealt with.*

Patients suffering from mental disorder include:—

- (a) Those cases suffering from mental disorders where the question of certification does not arise. This group includes some patients suffering from neurasthenia anxiety neuroses, hysteria fears and so on.
- (b) Those with mental disorder in which the question of certification arises, but which should not necessarily involve certification because they are either willing to submit to treatment or are non-volitional. (*Vide footnote.*)†
- (c) Those for whom treatment and care is required, and by whom it is refused and for whom obligatory treatment becomes necessary.

(2) *Numbers of patients needing early treatment.*

To gain some idea of the number of those in the early stages of mental disorder needing early treatment it is only necessary to look at:—

(a) *The Report of the Board of Control*, which gives the number of those who have finally succumbed

* The term "Mental Disorder" is used as suggested in the Memorandum of the British Medical Association, i.e. to include "grave and mid cases and the very beginning of disorder on the one hand and its latest manifestation on the other."

† "Non-volitional" is a person who does not express unwillingness to submit to treatment. (British Medical Association.)

and were therefore certified. There were 130,334 patients under certificates on 1st January, 1924, and 18,934 first admissions in 1923. In the large majority of these cases the certifiable stage of the mental disorder was preceded by a period of instability, varying from many years to a few weeks during which it was impossible to certify and therefore, as will be shown later, impossible to secure efficient treatment for those unable to pay.

In addition there were 35,413 mental defectives.

(b) *The Report of the Commissioners of Prisons*, also throws light on this question of numbers needing treatment.

In the year ending 31st March, 1923, there were 1,842 prisoners remanded for report on their mental condition in addition to:—

134 certified insane during sentence,
227 found insane on remand,
55 found insane at time of the trial,
71 certified as mentally defective, during sentence,
165 certified as mentally defective on remand.

Thus in addition to 1,842 persons who gave reason to believe that their mental condition was unsatisfactory, there were:—

416 found to be definitely insane,
236 found to be mentally defective,

i.e., 652 with mental abnormality according to the terminology of the British Medical Association Memorandum.

These 416 insane persons for whom there is at present such woefully inadequate provision for treatment had broken the law while in the incipient or early period of insanity. It is unreasonable to suppose that after the offence they had suddenly leapt into definite insanity from normal health.

It is also probable that a clinic at the general hospitals would have ascertained and notified a considerable percentage of the 236 mental defectives.

Moreover, is it not fair to assume that of the 1,842 persons whose mental condition gave rise to anxiety the majority were in a state of mental instability and had failed to adapt efficiently to life?

The Prison Commissioners quote from a medical report from Birmingham: "There are mental abnormalities other than certifiable insanity and mental defect which are frequently found among offenders." Again: "At the present time Courts often have no alternative but prison." Again: "There can be little doubt that persons suffering from these mental conflicts are liable to be damaged still further physically by imprisonment without full and proper treatment."

We submit that at present this country is lacking in adequate provision for dealing with this situation, and that it is essentially a problem of mental disorder and treatment.

(c) *The Registrar General's Return as to suicides* is another indication of instability which emphasises the numbers requiring, and the need for, early treatment, before certification is possible.

Suicides in 1923:—

Men	2,887
Women	1,062
Total	3,949

These also show a want of adaption which is surely abnormal. With better understanding of mental states and provision of facilities for obtaining help, their number should be lessened.

(d) *Police Returns of attempted suicides.*

In the last issued returns for 1921 there were 1,461 attempted suicides. This records only those taken

into Court, which is, of course, only a fraction of the real number.

(e) *Problems such as illegitimacy, dependency, vagrancy, alcoholism* and so on are in our opinion closely related to these states of minor and early mental disorder and indicative of their wide prevalence, and are in part due to the little treatment available.

(f) *The Report of the Chief Medical Officer of the Ministry of Health for 1923* adds another class of mental sufferers, viz., cases arising as a result of Encephalitis Lethargica. He states that:—"The question of making provision for the special care and treatment of these conditions, more especially the mental after-effects of Encephalitis Lethargica is under consideration of the Ministry." These mental symptoms according to the same Report include:—"Irritability, maniacal outbursts, hebétude, complete change in moral character and self-control, lying and theft, &c." "These symptoms are of all grades of severity; they are usually seen in children or in young adults." The notified cases for 1921—1,470, 1922—454, 1923—1,025, and for the first half only of 1924—3629.

These numbers appear to be increasing and the proposed clinics, if established, could help very materially in dealing with these cases, for diagnosis, treatment and research; thus partly meeting the want which is felt by the Ministry of Health to be urgent.

The statistics given, and the large numbers included under each head, make it clear that the treatment of these cases demands immediate attention.

(3) *Existing Facilities for Early Treatment for Mental Disorders.*

The National Council for Mental Hygiene recently sent out a questionnaire on facilities for treatment to 237 of the more important hospitals and infirmaries in England, Scotland and Wales. 159 replies were received. 135 institutions replied that they had no provision of any description for such treatment. 24 more institutions replied in the affirmative to one or more of the questions (14 had provision for out-patients and 6 had provision for in-patients also). Only 5 of the 237 institutions gave replies indicating that their institutions had facilities, even if limited in scope, for the In-Patient treatment of cases of early mental disorder.

Besides the above, there is some very limited in-patient provision for early treatment of the poorer classes in special hospitals such as "The Maudsley," "The Lady Chichester Hospital," Brighton, and in some of the wards of Hospitals for Nervous Diseases.

It may be objected that these early cases may be treated by their own doctors or by some existing institutions. So far as poorer patients are concerned, the objection is unsound. Many doctors cannot spare the time, even if they possess the qualifications, and the Authorities of the County and Borough Mental Hospitals are not empowered to admit the patients as Voluntary Boarders, even if they seek admission.

(4), (5) and (6) *Recommendations for Early Treatment for Mental Disorders.*

(4) The National Council for Mental Hygiene recommends that skilled treatment for mental disorders in their early stages should be available in clinics belonging to general hospitals, or in special institutions.

(a) *General Hospitals.*

From many points of view the general hospital, assuming that suitable staff and accommodation are provided, is the ideal institution for many of those patients who need treatment, and not compulsory detention.

(i) The general hospital is the natural place for the patient to go to if not well and the mentally sick patient is then like any other patient.

(ii) It is in a central available situation.

(iii) It has facilities for consultation with physicians, surgeons and specialists.

(iv) It has laboratories for exhaustive examination and team work.

(v) Many patients already attend the general hospitals without realising that they are primarily suffering from mental disorder. They will always be found there, helping to swell the "chronic" section of the out-patient Department, as, even when their condition is correctly diagnosed, there exist no means of affording them appropriate treatment. Moreover, these patients may be undermining the mental health of every member of the household in which they live. This is true even of some mild cases and was pointed out long ago by Weir Mitchell:—"Wherever you have a nervous girl you will soon have two sick women."

(vi) A Department including out-patients and in-patients for these cases should be a special department in charge of a suitably qualified physician, as the Eye, Ear, Skin and Venereal Disease Departments are already. It should provide facilities for classification and for other special requirements. Such a department would lead to a better grasp of these states by the medical profession as a whole. The interchange of cases between this and the other departments would tend to show that a number of patients, with apparently other complaints, were really suffering from mental disorders. On the other hand, many cases diagnosed as mental would be shown to be due to physical conditions. Our proposal would benefit the medical students where a medical school is attached to a hospital, also the nursing profession, and would lead to a better understanding of mental cases by the public.

(vii) In general hospitals there is at present no need for routine personal visitation of willing or non-volitional patients by any authority. It would, therefore, seem hardly necessary that the cases we are dealing with should be so visited. We feel that there should be no differentiation between this class and any other class of patients in general hospitals. We appreciate that a grant of money by a public body would carry with it the right of supervision.

(b) *Special Institutions.*

These are required when and where the general hospital is unwilling or unable to undertake the work. In this case it would be wise that the work should be carried on in buildings completely separate from County and Borough Mental Hospitals. Their organisation should approximate as closely as possible to the voluntary hospital principles, and there should be no compulsory detention.

(5) The Council recommends that Voluntary Boarders should be allowed in all County and Borough Mental Hospitals.

It finds itself in complete agreement with the Medico-Psychological Association and the British Medical Association that it is desirable that the Voluntary Boarder system should be extended to rate-aided institutions, and desires to endorse the arguments which these bodies have set before the Commission.

(6) The Council recommends, with regard to provision for early treatment for those who can pay, that medical practitioners should be allowed to treat willing and non-volitional patients without certificates in registered nursing homes or kindred institutions. There is difficulty in obtaining early treatment if a patient be a borderland case or certifiable as insane, and yet the doctor who treats them

in his own home, or his nursing home, does so at his peril, unless they are under certificates. He may be prosecuted and fined. Moreover the doctor is only allowed, even with permission, to take two certified patients, however competent he may be and however anxious other patients may be to place themselves under his care. The same risk is run by the proprietor of any house or home to which patients may wish to go.

Wherever non-volitional cases are received, some form of notification to, or supervision by the Central Authority is, in the opinion of the Council, desirable. But the routine personal inspection of patients as opposed to the inspection of institutions may be detrimental; it should be reduced to a minimum, and should be entirely medical. It is noteworthy that there is no system of supervision or visitation of patients suffering from, say, febrile delirium such as in pneumonia or typhoid, paralytic strokes, or comatose states, all of which conditions may render them non-volitional and as unable to protect themselves from inadequate or careless treatment as even the most advanced cases of mental disorder are. To protect all patients, and in keeping with the principle enunciated above of bringing this treatment into line with General Medicine, we would urge the registration of all nursing homes under the Ministry of Health. We deprecate any special registration of homes which take willing mental patients simply because their condition is thought to have a mental rather than a physical basis. Under such a system of universal registration of nursing homes of every type, abuses can be dealt with by the ordinary process of law and those patients suffering from mental disorder have the widest choice of where they wish to be treated.

(7) *The Administration of Public Mental Hospitals.*

As regards the Administration of Public Mental Hospitals, the Council feels that hospital methods should be adopted to the fullest extent, but they would not wish it to appear that they think that in many cases this is not so already. They urge that the practice of appointing consultants in general medicine and surgery, and their special branches should be universal throughout Public Mental Hospitals, and that the staff of the latter hospitals should be permitted to hold corresponding positions in psychiatry at the general hospitals.

They would also urge that the Central Authority (the Board of Control) should have greater powers to enforce the adoption of such facilities where they do not already exist. They consider that the ordinary medical attendants of patients admitted into Mental Hospitals should be given every facility for keeping in touch with the progress and treatment of their patients and for collaborating in the treatment whenever possible; in this way patients leaving hospital would, on returning to their homes, be enabled to continue after-treatment assisted by the knowledge and experience thus acquired by the general practitioner.

(8) *After Care.*

The Council recognises that in very many cases the recurrence of mental disorder is precipitated by the return to unsuitable home conditions. They consider, therefore, that every assistance and encouragement should be given to after-treatment, such as is at

present given by the After Care Association. They have evidence, in the experience of certain members of the Committee, that where after care is available, permanent mental health is re-established, and, therefore, they urge that the financial authority should generously support any established or recognised organisation which has this After Treatment as its function.

TO SUM UP WE BEG TO SUBMIT:—

1. That the facilities for Early Treatment of Mental Disorder are entirely inadequate.

2. That some idea of the numbers needing treatment can be got from the Reports of the Board of Control, the Prison Commissioners, the Registrar-General's return as to suicides, the Police Report of attempted suicides and the Chief Medical Officer's return as to Encephalitis Lethargica.

3. That problems such as illegitimacy, dependency, and the prevalence of venereal disease, prostitution, vagrancy, alcoholism and so on are closely related to these states of minor early mental disorder and often caused by them.

4. That there appears to be no just reason for omitting the skilled treatment of these patients on a voluntary basis just as in other diseases.

5. That the facilities afforded to medical students for studying the early cases in hospitals (being the ones met constantly and frequently in their subsequent work) and the examination in this subject, are inadequate.

6. That the patients for which increased facilities are required are those suffering from non-certifiable mental disorder, borderland patients, and willing and such non-volitional patients as do not need compulsory detention.

7. That while admitting that inspection of homes and institutions treating non-volitional cases is necessary, this should only be a part of a general system of inspection of all nursing homes.

8. That early treatment, should, if possible, be provided for in a special department of a General Hospital for the sake of the patients, nurses, and the medical profession.

9. That there is a precedent for rate and State-aided clinics in the venereal disease clinics and that financial assistance either from State funds or local rates would ultimately be an economy in money, time and labour, and lead to more happiness and less disease. We, therefore, recommend that clinics and other necessary means for treating mental disorders should receive financial support either from the State or local funds, or both.

10. That as regards Public Mental Hospitals:—

(a) There should be appointed on the staff of these hospitals, consultants in general medicine and surgery, and their special branches.

(b) The Board of Control should have greater power to enforce the adoption of such appointments, and

(c) The patients' own medical attendants should be encouraged to visit them and collaborate with the medical staff as closely as possible.

11. That every assistance and encouragement should be given to after-care.

APPENDIX XXVI.

Question 19,058.

LONDON COUNTY COUNCIL.
Maudsley Hospital.

The following table shows the expenditure and income for the financial year 1924-25. There was an average number of 139 patients resident :—

Provision in estimates, 1924-25.	Sub-head.	Cost during year.	
		Amount.	Per in-patient, weekly.
£		£	s. d.
18,227	Maintenance :—		
9,000	Salaries, wages and uniforms	18,301	50 7·3
4,500	Provisions (including staff)	7,154	19 9·4
1,000	Fuel, lighting and furniture	5,505	15 2·7
2,100	Rates and insurance	1,009	2 9·5
	Miscellaneous	1,918	5 3·7
34,827		33,887	93 8·6
10,800	Less Income :—		
2,000	Maintenance of in-patients	11,498	31 9·6
200	Staff for board and lodging	1,781	4 11·1
	Out-patients	248	0 8·2
	Sales and sundries	77	0 2·6
13,000		13,604	37 7·5
21,827	Net charge to Special County account for main- tenance	20,283	56 1·1
1,740	Repairs to buildings, etc.	1,919	5 3·7

The above figures do not include debt charges which are as follows :—

	Amount.	Per patient weekly.	
		On average number resident (139 in 1924-25).	On total number of beds (157).
	£	s. d.	s. d.
Approximate debt charges on net capital cost (after deducting Maudsley Gift)	3,250	9 0	7 11·3
Decreasing annually by	63	0 2	0 1·8
Approximate debt charges on gross capital cost (without deducting Maudsley Gift)	5,000	13 10	12 2·5
Decreasing annually by	91	0 3	0 2·6

During the year in question 506 patients were admitted as residents.
42 patients paid £6 6s. 0d. a week for private rooms.
53 patients paid £5 a week, the full charge for ward accommodation.
21 patients paid from £2 10s. 0d. a week to £4 4s. 0d.
30 patients paid from £2 a week to £2 5s. 0d.
36 patients paid from £1 a week to £1 10s. 0d.
92 patients paid from 10s. a week to £1.
125 patients paid from 1s. a week to 10s.
66 patients were on the free list.
41 patients were paid for by Boards of Guardians at rates averaging £2 4s. 0d. a week for men and £2 1s. 6d. for women.

INDEX TO SUBJECTS.

Absence, *see* Leave of Absence.

Accommodation :

Classes of institutions, *Willis* ... 64-6, 620-2
Demand overtaking supply, *Beard* ... 19,415-7
Distribution of patients, 1st January, 1924,
Willis ... 67-72
Inadequacy in some cases, and difficulty occasioned
by, *Lidbetter* 1709-20; *Walden* 2083, 2085; *Baly*
2683-97.
proposed Institutions, *Willis* ... 21,386

FOR PRIVATE PATIENTS :

Adequacy, question of, *Willis* 629-34, 642;
Phillips 5980-1; *Parker* 11,300.
Difficulty in case of patients with income up to
£200 a year, *Hildyard* ... 18,242-7
Extension in direction of registered hospital the
best, *Yellowlees* ... 5823-4
Increase needed, *Edwards* ... 6329-32
Limit nearly reached, *Willis* ... 642, 658-9
in Public institutions: *Macleod*, *Bond*, *Willis*
280-2, 633-9, 650-7.
Advocated, *Miss C.* ... 14,405-10, 14,496
Birmingham, *Barnsley* ... 1969-72, 1980-3
Claybury, *Barham* ... 7366-8
Herrison Asylum, *Dorchester*, *Sandhurst* 17,989
Lancashire, *Taggart* ... 13,058-61, 13,270-7
Leicester City Mental Hospital, *Humberstone*,
Dixon ... 3731-4
London County Council Mental hospitals, *see*
that title.
Portsmouth, *Devine* ... 4522-5, 4536-9
would not be Preferred by patients or rela-
tives, *Sandhurst* ... 17,986-92
Scotland, *Rose*, *Marr* 15,048-85, 15,090-2,
15,105-17; *Cole* 17,050.
proposed Types of, *Mapother* ... 18,868
as Near home as possible desirable for paupers,
Hill ... 18,296
Public responsibility should rest on visiting com-
mittee of local authority not with guardians,
Willis ... 21,386

Administration :

Board of Control, *see that title*.

CENTRAL BODY :

Constitution, opinion *re*, and need for legal
element, *Schuster* ... 1006-12, 1037
with District Commissioners would be approved,
Parker ... 10,573-4A, 11,801
Legal and medical members and a business man
advocated, *Parker* ... 10,459-71
with some Localisation, need for, *Parker*
10,441-8, 10,458, 11,801
Local Authorities should have as much freedom as
possible, *Beard* ... 19,547-9
Public suspicion in connection with, *Lovsey* 5280-5
Multiplicity of authorities, *Gibson* ... 12,261-3
SCOTLAND :
by Districts, system, *Rose* 14,940-63; *Marr* 14,943.
general Satisfaction with, *Robertson* 15,928-33
Statutes, *Rose* ... 14,964-7
Smooth working of, from point of view of guardians,
Propert ... 5986-90

Admission :**CONVEYANCE TO MENTAL HOSPITALS :**

Ambulances, suggestion, *Lewis* ... 4645
Personal experience, *Mrs. M.* 13,825-31; *Mr. P.*
14,210; *Mrs. O.* 20,077-81.

DIRECT, TO MENTAL HOSPITALS :

Birmingham, *Barnsley* 1799, 1925, 1929; *Lord*
2264-6, 2279-80; *Lovsey* 5290-2.
Desirable, *Lewis* 4645; *Cole*, *Lord*, *Menzies*
16,967-91; *Boyle* 18,733-4.
Difficulties and objections to, *Usher* 3265-79;
Leach 6089-101.

Documents, *see* Reception Orders and Certificates.

under False pretences, *Barr* ... 7071
Objection to, *Lewis* ... 4645

Admission—cont.

to Mental hospitals at earliest possible moment,
desirable, *Barham* ... 7557-8
of New cases to very large hospitals, question of
advisability, *Leach* ... 6139-42
OF PERSON NOT INSANE :
Procedure, question of, *Lomax* ... 12,977-87
Refusal, *Taggart* ... 13,265-7, 13,269
on Sheriff's Order, Scotland, *Marr* 15,154-82, 15,205
into Various classes of institutions, 1923,
Edwards ... 5330
Admission Ward, *see* Reception ward.

Adolescent Mental Disorder :

special Industrial Schools suitable for some cases,
Fox ... 21,131-2
Nature of cases, *Fox*, *Tredgold* 21,164-200, 21,208.
Number of cases to be dealt with, estimate, *Tred-*
gold ... 21,157-62, 21,230-1
Provision for, and inadequacy of, *Tredgold*, *Fox*,
Andrew 21,101-21, 21,126, 21,142-4, 21,152-6,
21,213-29, 21,240-1.
SPECIAL INSTITUTIONS FOR, WITH TRAINING AND
OCCUPATION AS WELL AS MEDICAL TREATMENT :
Expense, estimate of, *Fox* ... 21,157-62
Scheme, *Tredgold*, *Fox* 21,106-15, 21,122-63,
21,189, 21,202-11, 21,239-43, 21,257-9.
Treatment should be voluntary only, *Fox* 21,130,
21,138-9, 21,207-11; *Tredgold* 21,139-40,
21,202-7, 21,257-9.
Supervision by Board of Control desirable, *Tred-*
gold 21,246-9; *Fox* 21,249.
Work of South-West Lancashire Association for
Mental Welfare, *Andrew* ... 21,213-29
Adolescents, psychological examination of persons
charged with offences, suggestion, *Tredgold*
21,233-5, 21,250-3

After-Care :

Clinics at out-patients' departments essential to,
Boyle ... 18,554-5
Communication between asylum doctor and
doctor at home, suggestion, *Langdon-Down*,
Murrell, *Bone* ... 13,595-600, 13,605-12
Expenditure on, by Local Authorities, provision
in Mental Treatment Bill approved, *Sidney*
19,280, 19,291-3
Facilities for, but patients would not care for,
Devine ... 4383
temporary Financial assistance, need for, *Langdon-*
Down 13,617-20, 13,710-4; *Gardner* 19,285,
19,288.
Financial assistance required and question of
method, *Worth* ... 17,249, 17,252-4, 17,257-61
Homes and convalescent homes, need for, *Langdon-*
Down 13,594, 13,613-4; *Goodall* 17,265-6; *Cole*
17,278-9; *Gardner* 19,281-2.
Need for, *Lidbetter* 1751; *Walden* 2162-7; *White-*
more 3586-7; *Broome Giles* 3664; *Parker* 11,801;
Gardner 19,281-8, 19,295.
Patient's consent must be safeguarded, *Murrell*
13,621-5
Problem of, *Hodgson* ... 13,476
Public provision for, advocated, *Langdon-Down*
13,603
Queen Adelaide Fund, *Keene* 5008; *Lobjoit* 5150;
Worth 17,242-3.
Return to same people as before certification,
objection to, and steps should be taken to
arrange suitable surroundings, *Miss C.* 14,510-21,
14,593
in Scotland, *Rose* ... 15,653-4
Statutory provision for, advocated, *Cole* ... 17,277-8
Suggestion, *Connell* ... 4143, 4190
After-Care Association :
Branch in every Mental Hospital desirable,
Vickers ... 7733-8
Branches, *Vickers* ... 7758-60
Cases assisted by, statistics, *Vickers* 7731-2; *Worth*
17,250.

After-Care Association—cont.

- Clinical out-patients' department, *Worth* 17,249
 Distribution, *Worth* ... 17,255
 Evidence on behalf of, *see Vickers, Miss* 7695-795
 Expenses, 1924, *Vickers* ... 7767
 Finding of employment by, *Vickers* ... 7761-5
 Funds, *Vickers* ... 7697-704, 7787-8
 Homes, *Vickers* 7705-7, 7724-30, 7735-42, 7757, 7783-6; *Worth* 17,249-50; *Cole* 17,279.
 Members, visits to asylums, *Vickers* ... 7747-54
 Relationship between asylums and, *Vickers* 7743-6
 Staff, *Vickers* ... 7708-11
 State assistance desirable, *Sandhurst* ... 18,016-7
 Subscriptions to, by local authorities, *Cole* 17,279
 Visitors, etc., success of, and work seldom resented, *Worth*, 17,262-4; *Lord* 17,270-1.
 Visiting of patients' homes previous to discharge and value of, *Worth*, *Goodall*, *Lord* 17,245-9; 17,265-7.
 Visiting of patients on leave of absence on trial, *Worth* 17,255-6; *Goodall* 17,265.
WORK OF: *Keene* 5008-9; *Vickers* 7712-95.
 Approval of, *Langdon-Down* ... 13,601
 at Cardiff, *Goodall* ... 17,264
 Useful, but cases must be selected with discretion, *Lobjoit* ... 5150-1
 Value of, *Dixon* 4037; *Barham* 7457-60, 7481; *Worth* 17,245-51; *Goodall* 17,265; *Lord* 17,266-71.

Alcoholism:

- Cases brought in under Section 20, dealt with under Lunacy Acts, Lambeth Infirmary, system, *Baly* ... 2746-73
 Certification as result, *Baly* ... 2874-7
 Difficulty of dealing with cases, *Broome Giles* 3709-10
 Edinburgh Royal Infirmary cases, decline, *Comrie*, 16,450-7
 Private cases, difficulty in connection with, and procedure by order of committal to inebriates' home proposed, *Whitemore* ... 3569

Aliens:

- Jurisdiction of Home Office, *Brock* ... 1076
 Position of, *Schuster* ... 1045-7
 Allowances to patients on trial, *see under* Leave of absence on trial.
 Amalgamation of Board of Control Visitors and Visitors in Lunacy, *see under* Visitors under Board of Control.
 Amusement, *see Recreation under* Care and Treatment.
 "Approved homes," suggestion, *Langdon-Down* 7893-6
 Association of Municipal Corporations, evidence on behalf of, *see Beard*, *Sir Lewis* ... 19,412-565

Association of Poor Law Unions:

- Evidence on behalf of, *see Propert*, *Rev. P. S. G., &c.* ... 5982-6309
 Nature of membership, work, &c., *Leach*, *Propert*, 6053-61

Asylums, *see Mental Hospitals.*

Attendants, *see Nursing Staff.*

Attorney, power of, position *re*, *Craig* ... 20,913-9

Baltimore, Phipps Institute, *Mott* 17,149; *Boyle* 18,567-70.

Basingstoke Asylum, villa system, *Sandhurst* 17,860-2

Bathing arrangements, *see under* Care and Treatment.

Bed time, *see under* Care and Treatment.

Belgium, boarding out in, *Boyle* 18,666; *Gardner* 19,237-8.

Bethlem Royal Hospital:

- Accommodation, *Phillips* ... 5862
 Complaints from patients and action on, *Faudel-Phillips* ... 5937-52
 Discharge, expression of appreciation on, *Faudel-Phillips* ... 5962-7
 Free patients, *Phillips* 5865; *Faudel-Phillips* 5865-6.

Bethlem Royal Hospital—cont.

- Interviews with patients after admission, *Faudel-Phillips* ... 5931-6
 Library and Pathological Department, *Phillips* 5919-20
 Name, drawback of, *Faudel-Phillips* ... 5959-60
 Nursing staff, *Phillips* ... 5915, 5918
 Training given at, *Phillips* ... 5974-5
 Uncertified patients, *Phillips* ... 10,307, 10,321
 Voluntary boarders, *Phillips* 5861-75, 5931-3, 5953-6, 10,326-45

Birmingham:

Accommodation, *Barnsley* 1984-90; *Lord* 2264-6.

MENTAL HOSPITALS:

- Admissions generally direct, not through workhouse, *Barnsley* 1799, 1925, 1929; *Lord* 2264-6, 2279-80; *Lorsey* 5290-2.
 Leave of absence on trial, *Lorsey* ... 5366-7
 Readmission, *Graves* ... 5375-80
 Request for complaints during consideration of discharge, and in future request to be made after discharge, *Lorsey* ... 5351-9
 Lunacy Acts, working of, *Lord* ... 2181-304
 Lunatics, number, *Barnsley* ... 1975
 Private patients, accommodation in public asylums. *Barnsley* ... 1969-72, 1980-3
 Research at, *Mott* ... 17,146, 17,152, 17,176-7
 Senile cases, transfer from workhouses to asylums, and objection to, *Lorsey* 5247-9, 5286-8, 5370-4
 Blackburn, health education work, *Beard* ... 19,460

Board of Control:

- Access to, of friends of private patients, *Willis* 607-10
 Assistance in appointment of Medical Superintendent, case of *Willis* ... 926-8
 Associate Medical Commissioners, suggestion. *Menzies*, *Goodall*, *Lord*, *Cole* ... 17,031-9
 Chairman, appointed by Minister of Health. *Brock* ... 1106-8
 Clerical staff, and inadequacy, *Willis* 317, 329, 833-40

COMMISSIONERS:

- should Attend Hospital Committee meetings. *Hodgson* ... 13,474-5
 Attendance at headquarters, system, *Bond* 207-9; *Willis* 209.
 District:
 Inspectors preferred, *Menzies* ... 17,021-7
 Question of, *Parker* 10,469-73, 11,127, 11,801
 Scheme, *Lomax* ... 12,876-94
 Inadequacy of number, *Edwards* ... 6396-8
 Increased number with advisory functions advocated, *Hodgson* ... 13,474
 Legal, appointment by Lord Chancellor, *Schuster* 1025

Medical:

- Appointment by Minister of Health, *Brock* 1106-7, 1189; *Schuster* 1026.
 Women, advocated, *Craig* ... 20,929
 Number proposed, *Menzies* 17,016-7, 17,019-20
 Salary proposed, *Menzies* ... 17,018
 Service under local authority should count towards pension, *Menzies* ... 17,018
 Complaints to, through relatives, *Macleod* 409-11; *Willis* 411.
 Composition, *Willis* ... 5, 7, 724-5
 Consultation by Ministry of Health on receipt of letters from patients, *Brock* 1127-34, 1136-41, 1195
 Control over licensed houses, extent, *Edwards* 6475-6
 not a truly Controlling central body, *Parker* 10,438-40, 10,476
 District Boards, question of, *Hodgson* ... 13,472
 certain Duplication of work with Minister of Health, *Willis* ... 37-8
 Evidence on behalf of, *see Willis*, *Sir Frederick J., K.B.E., C.B., Macleod. S. J. Fraser, K.C., and Bond, Dr. C. H., C.B.E., D.Sc., M.D., F.R.C.P.* 1-944, 21,260-400
 Examination of pauper lunatic on order of, *Willis* 549, 551, 556, 560, 579-85; *Bond* 586-94; *Chubb* 6740-3.

Board of Control—cont.**FUNCTIONS:**

See also Powers and Duties below.

Distinction from those of Visitors in Lunacy, *Schuster* ... 1032-5
 General statement, *Willis* ... 27-31
 Scrutiny of documents, and procedure re, *Macleod*, *Willis*, *Bond* 131-5, 153, 161-201, 204-6, 210-11, 215-34, 251-2, 306-12, 834-7; *Fawcett* 6967-9.
 Visitation, see that title.

Grant-in-aid should be in the hands of, *Gibson* 12,264-78; *Menzies* 17,040-3; *Lord* 17,041.

History, *Willis* ... 4-5

Inquiry on oath, *Macleod* ... 427-32

INSPECTORS:

Appointment of, *Parker* ... 10,456
 Appointment of additional, criticism of proposal in Mental Treatment Bill, *Hodgson* 13,451-64
 District, proposal, *Menzies* 17,016, 17,021-7; *Lord* 17,027-9, 17,030.
 Investigation of allegations of cruelty by, *Willis*, *Macleod* ... 893-904, 912-4
 Letters to, from patients, little result from, *Parker* ... 10,396-406
 Letters to Minister of Health, &c., sent on to, *Willis* ... 38
 Medical side should be strengthened, *Craig* 20,697
 Medical treatment, non-interference with, *Parker* 11,335-43

Members, see Commissioners above.

Metropolitan Licensed houses licensed by, *Willis* 616

Ministry of Health should be Court of Appeal from, *Mr. L.* ... 20,417

Notification to, see that title.

Outlook, improvement in, *Craig* ... 20,697, 20,899

Position of, re administration of Lunacy Acts, *Willis* ... 870-2

POWERS AND DUTIES:

re Buildings, *Willis* 36, 617-8, 728; *Brock* 1087-9, 1098-103; *Keene* 4727-9.

Care of lunatics, *Willis* ... 663-4, 667
 re Clinics, proposals, *Lewis* 4579, 4589, 4637-40, 4685-96; *Mapother* 18,969-70.

statutory Consultative powers advocated, *Miller* 17,403, 17,419-26

Control of research, not desirable, *Mott* 17,182
 re Discharge, see under Discharge.

re Drugs, increase desirable, *Parker* 11,529-30, 11,555-66, 11,801

Increase:

not very Desirable, *Langdon Down* ... 13,706-7
 Objection to, *Taggart* 13,236-40; *Hodgson* 13,394-475; *Sidney* 19,373-5; *Beard* 19,547-52.
 Suggestions, *Mr. H.* 8689-90; *Parker* 11,111-6, 11,801; *Gibson* 12,241-3, 12,264-84; *Lomas* 12,873-5; *Craig* 20,904-6.

re Licensed houses, and suggestion, *Fawcett* 6967-9; *Cole* 17,281, 17,282; *Boyle* 18,707-8, 18,710-8, 18,723-6, 18,736-9, 18,741.

Medical arrangements in mental hospitals, *Willis* 668.

re Non-volitional cases, proposal, *Willis* 21,361, 21,362

re Nursing homes, proposal, *Willis*, &c. 21,274-84, 21,295, 21,303-7, 21,318-27, 21,386

re Pauper patients, *Macleod*, *Bond*, *Willis* 397, 544, 548-60.

re Poor Law Institution cases, *Macleod*, *Willis* 708-711, 713-6, 891-2, 894

re Single care patients, *Willis* ... 661-2

re Treatment, advisory, only, *Willis* ... 938-43

re Voluntary boarders, proposal, *Edwards* 6389-92; *Parker* 10,554-74A, 11,801; *Willis*, &c. 21,274-84, 21,295, 21,303-7, 21,313-27, 21,337.

Reception houses should be under, *Walden* 2093; *Mapother* 18,969-70.

Recommendations by, value of, *Beard* ... 19,550-1

RECORDS OF CASES KEPT: *Macleod*, *Willis* 313-4, 315-8

Disclosure of, under certain circumstances, *Willis* 562, 567, 570, 732-3; *Macleod* 733.

Secrecy of, *Willis* ... 561-75

Board of Control—cont.

Relation to workhouse accommodation, *Francis* 21,510-2, 21,525-9, 21,565

Relations with Lord Chancellor, *Willis*, 729-30; *Schuster* 973-81.

Relations with Minister of Health, *Willis* 728-9; *Brock* 1082-9, 1106-8, 1189-90, 1193-4.

Reconstitution of, 1913, *Parker* ... 10,438

REPORTS:
 further Information in, suggestions, *Leach* 6064-71

on Use of croton oil at Prestwich, criticism, *Parker* ... 11,539

Sanction of, should be required to observation period longer than 14 days, *Whitemore* 3581-4, 3598

subsequent Service under, by Medical Superintendent should count for pension, *Hodgson* 13,477

STAFF:
 position of Minister of Health re, *Brock* 1106, 1189

Reduction proposed in Mental Treatment Bill, *Parker* ... 10,449-54

Supervision of all mental cases by, including early stages, advocated, *Craig* ... 20,697, 20,899-903

Trial leave of absence encouraged by, *Bond* 470; *Willis* 520, 524, 525.

Value of, *Walden* ... 2094-6

Visitation, see that title.

VISITORS:
 Amalgamation with Visitors in Lunacy, question of, *Schuster* ... 1053-6

Overlapping with Visitors in Lunacy, *Schuster* 1054-6

no Difficulty caused, *Willis* ... 39-42

Voluntary boarders attitude re, *Yellowlees* 5745-6, 5749-50

Work of Lord Chancellor re lunacy could be done by, *Willis* ... 43

Boarders, Voluntary, see Voluntary Boarders.

Boarding-out:
 in Belgium, *Boyle* 18,666; *Gardner* 19,237-8.

Clause in amending Lunacy Bill, 1899, *Sidney* 19,246-7

Desirability dependent on case, *Walden* ... 2143-6

Difficulty owing to housing shortage, *Gardner* 19,238-41

Difficulties in connection with, *Walden* ... 2147-9

Encouragement of system desirable, *Willis* 73-8

greater Freedom desirable, *Sidney* 19,233-7, 19,243-4, 19,247; *Gardner* 19,242.

Justice should have power to order, *Parker* 11,124

Names included on books of asylum, *Willis* ... 71-2

Scotch system, uncertified cases, *Marr*, *Rose* 15,472-604; *Robertson* 16,032-5.

careful Selection of cases necessary, *Walden* 2146, 2148

Supervision, District Commissioner would facilitate, *Parker* ... 11,127

System, *Willis* ... 66, 624-6

Value of, *Parker* 11,127-8; *Lomas* 12,775-6.

Visiting by asylum doctor, use of system discouraged by, *Willis* ... 77-8

Borstal, *Tredgold* ... 21,254-6

Boston Psychopathic Hospital, *Goodall* 16,661, 16,683-5, 16,797

British Medical Association, evidence on behalf of, see *Langdon-Down*, *Dr. R.*, etc. 7796-8215, 13,500-13,719.

Broadmoor Criminal Lunatic Asylum, number of cases in, 1st January, 1924, *Willis* ... 67

Buildings:
 Approval of plans, responsibility for, *Willis* 36, 617-8, 728; *Brock* 1087-9, 1098-103; *Keene*, 4727-9.

SIDE ROOMS:
 Bad conditions, *Mr. O.* ... 20,163-4

Deficient light and air in many cases, *Parker* 11,786

Opening on living wards, objection to, *Parker* 11,783-5

more Single rooms desirable, *Craig* ... 20,952-9

Buildings—cont.**VERANDAHS :**

Advocated, <i>Parker</i>	11,677
Scotland, <i>Robertson</i>	16,101, 16,104

VILLA SYSTEM :

Basingstoke Asylum	17,860-2
Extension desirable, <i>Mapother</i> ...	18,993-9001
Extension of, in London County Council mental hospitals, <i>Sidney</i>	19,405-7
for Voluntary patients, suggestion, <i>Gardner</i>	19,144

Camberwell House :

Cases in, numbers, <i>Edwards</i>	6446-50, 6453
Convalescent home, <i>Edwards</i>	6400-5
Correspondence, <i>Edwards</i>	6365-6
Dietary, <i>Edwards</i>	6468
Domestic staff, <i>Edwards</i>	6456
Fees, <i>Edwards</i>	6467
Medical staff, <i>Edwards</i>	6395, 6451-5

NURSING STAFF :

Female nurses assisted by orderlies, <i>Edwards</i> 6414-20, 6457-62; <i>Gibson</i> , 12,135-7.	
---	--

Number, <i>Edwards</i>	6456
Remuneration, <i>Edwards</i>	6469

Visitation, <i>Edwards</i>	6353-64, 6371-3
Voluntary boarders, <i>Edwards</i> 6383-90, 6470-2, 6476	

Cambridge University, clinical teaching not obtainable, *Mott* 17,116; *Goodall* 17,164.

Cane Hill Mental Hospital :

Chaplain, work of, etc., <i>Barns</i>	17,554-629
Padded room, condition of, <i>Hill</i>	18,347-62

Cardiff :

After care, <i>Goodall</i>	17,264
Lunacy Acts, working of, <i>Sanders</i>	2305-447
Mental clinics, possibility of establishing, <i>Goodall</i>	16,847-8
Mental hospital, research, <i>Goodall</i>	17,163
Procedure under Section 13 of Act in, <i>Bond</i> 261-6, 286-7; <i>Sanders</i> 2336-42.	

ROYAL INFIRMARY :

Mental cases as in-patients, <i>Goodall</i> ...	16,821-2
Mental clinics, <i>Sanders</i> 2411-2, 2419-22; <i>Goodall</i> 16,650-1, 16,653, 16,811-48.	

WORKHOUSE, MENTAL CASES :

Accommodation for, <i>Sanders</i>	2342-3
Reception and observation wards, <i>Sanders</i> 2342-50, 2423, 2430-8	

Carmarthen Mental Hospital, medical officers, inadequacy, *Gibson* 11,938-41

Care and Treatment :

Amusement, *see* Recreation below.

Association with violent patients, *Mrs. M.* 13,844-56, 13,939-47

BATHING AND WASHING ARRANGEMENTS : *Dixon* 3956-63; *Barham* 7551-2; *Gibson* 12,389-91; *Wiese* 12,391; *Mrs. M.* 13,952-73, 14,013-26.

Inadequacy of, *Mr. P.* 14,239, 14,253-5; *Mr. M.* 19,985-7; *Mr. O.* 20,155-62.

Privacy :

Arrangements for Scotland, *Marr* ... 14,994-5
Lack of, *Parker* 11,730-1; *Mr. P.* 14,258-63.

Satisfactory, *Miss C.* 14,502

Sharing of, with patients suffering from disease, *Mrs. M.* 14,022-5; *Mr. P.* 14,240-1.

Towels, inadequate supply, *Mrs. M.* 13,963, 13,970-3; *Mr. P.* 14,240-1, 14,256-7; *Miss H.* 19,686-7.

Water not always changed between each patient, *Mr. P.* 14,254-5; *Miss H.* 19,684-7.

Baths and rest in bed, value of, as calmatives, *Robertson* 16,137-8

BED-TIME :

7-7.30, too early, *Gibson* 12,055-64, 12,070-4; *Lomax* 12,991; *Mr. P.* 14,277-8; *Miss C.* 14,482-8.

Freedom *re*, *Dixon* 4045-50; *Connell* 4090.

Improvement in arrangements, *Mr. P.* 14,277-9

Hours of, *Barham* 7332-4; *Parker* 11,777-82; *Blood* 12,065-7; *Wiese* 12,068-9.

Care and Treatment—cont.

Bedding, bad condition, *Mrs. G.* 20,608

Board of Control's powers, *Willis* 663-4

Book should be given to patients to write in, for doctor, *Mrs. G.* 20,611

Brushes and combs, supplied but not used, *Miss H.* 19,694

Canteen, suggestion, *Parker*... .. 11,744

CASE BOOKS :

Access to, relatives should have right of, *Parker* 11,331-4

Entries in, complaint in connection with, *Parker* 11,627-30

CLOTHING :

Bad condition of, *Miss H.* 19,689-96

Improvement advocated, *Gibson* 12,244-6

Inadequacy of, case of, at Hanwell, *Hill* 18,363-4, 18,375; *Glanvill* 18,370, 18,374.

Nature of, etc., *Mrs. M.* 13,974-6, 13,988-95

Provision by institution, dislike of patients and friends to, *Langdon-Down* 7910-9

Satisfactory on the whole, but more uniformity desired, *Hill* 18,376

Uniform, undesirable, *Barham* 7372-3; *Hill* 18,372.

Wearing of own clothing: *Keene* 4805-6

Allowed if suitable, *Barham* 7369-76
should be Allowed as far as possible, *Leach* 6172-3

would be Approved, *Glanvill* 18,371

Communication with patient's family doctor, growing practice, *Willis*... .. 594

COMPLAINTS BY PATIENTS :

see also under Ill-treatment below.

Facilities for making, and action on, *Keene* 4877-908, 4978-89

after Discharge, *Sandhurst* 17,827-9

to Doctor, ill-treatment by attendants as result, *Mrs. Y.* 20,640

Entering of, in book, to be open to inspection of relatives and friends, and reading of copies of complaints to, suggestion, *Mr. L.* 20,420

to Medical Superintendent:

Action on, *Keene* 4881-4
no Attention paid, *Mr. L.* 20,383

Prevention of, not considered possible, *Lobjoit* 5197-202

Procedure on, *Faudel-Phillips* 5937-52; *Sandhurst* 17,863-75.

as Result of spite and pettiness more often than delusions, *Yellowlees* 5691-3

CONTACT WITH OUTSIDE WORLD :

Desirability and extent of, *Devine* 4350-1; *Keene* 4870-908; *Lobjoit* 5091-105; *Barr* 7152-3; *Parker* 10,594-5.

in Licensed houses, *Fawcsett* 6988-9, 7016-23

Scotland, *Marr*, *Rose* 15,376-84

CORRESPONDENCE :**with Authorities :**

Character of letters, *Brock* 1120-1

Forwarded unopened, *Brock* 1096-7

Method of dealing with, at Ministry of Health, *Brock* 1122-41, 1195-208

no Result from, *Mr. H.* 8712-7

Sent on to Board of Control, *Willis*... .. 38

if Censored, should be returned to sender, *Mr. L.* 20,389, 20,395

Complaint in connection with, *Mr. H.* 9092-4

Discretionary power of head of institution, *Bond* 438; *Macleod* 443.

Examination of certain letters before sending on, by Visiting Committee, *Lobjoit* 5103-5

greater Facilities advocated, *Mr. L.* 20,394-404

Forwarding of, to friends, lawyers, etc., practice *re*, *Keene* 4984-9

Interference with, complained of, *Mrs. M.* 14,055-96

Letter writing a safety valve, *Marr*, *Rose* 15,300, 15,303-6.

Method of dealing with, Norfolk County Mental Hospital, *Connell* 4065-8

Care and Treatment—cont.

CORRESPONDENCE—cont.

Post boxes in wards: *Connell* 4065; *Yellowlees*

not Advocated, *Dixon* ... 3955

Desirable in all wards, *Bond* ... 805, 808

in Most asylums, *Macleod* 437; *Bond* 444-5.

Scotland, *Marr* ... 15,298-9

of Private and pauper patients, differentiation

in treatment, *Keene* ... 4900-5

Reading of, by charge nurse in ward, and sub-

mission of letters containing criticism to

doctor, *Mrs. M.* ... 14,090-4

Rights and facilities, *Willis* 433-6; *Bond* 433-9.

Supervision of grievances in connection with and

question of remedy, *Parker* 11,060-86, 11,801

CURATIVE TREATMENT:

Lack of, *Blood*, *Gibson* 12,197-9, 12,201; *Mr. P.*

14,289-95; *Mr. L.* 20,366, 20,380.

Position *re*, *Golla* ... 21,048-9

Dead patients, removal of, complaint *re*, *Mrs. M.*

13,948-9

DENTAL TREATMENT:

Claybury, *Barham* ... 7680-1

Facilities, *Bond* 866; *Dixon* 3988.

no Regular dentist, *Mrs. M.* ... 14,158-61

Salisbury Old Manor, *Chubb* ... 6667-8

York, the Retreat, *Yellowlees* ... 5674

DRUGS:

Administration in food, *Parker* 11,550-6; *Gibson*

12,355-6; *Wiese* 12,356.

Administration in food necessary occasionally,

Robertson ... 16,222-3

Aperients must be adapted to individual case,

Robertson ... 16,174

Complaint of being made to take, *Mrs. G.*

20,579-85

Croton oil:

Administration in food, *Parker* 11,550-6;

Gibson 12,355.

Complaint *re* use of, in some asylums when not

used in others, *Parker* 11,472-84, 11,526-8,

11,531-8

Effects of, *Lomax* ... 12,996-8

at Prestwich, *Parker* ... 11,539-50

for Punitive purposes, *Parker* 11,475-524

Use of, not known, *Blood* ... 12,212

never Used, *Yellowlees* ... 5679

Useful in certain cases, but very seldom,

Robertson ... 16,177-9

Forcible giving of, before other patients,

Mrs. M. ... 13,889-97

Hyscine: *Parker* ... 11,464-8

Injections, *Miss B.* ... 14,887-9

Use of, in certain cases approved, but not con-

tinuously, *Robertson* ... 16,130-6

Nurses' discretion in connection with, *Wiese*,

Gibson ... 12,213-5, 12,428-30

as Punitive measure: *Mrs. M.* ... 13,968-9

Use of, doubted, *Yellowlees* ... 5685-9

Sedative, advantages and disadvantages, *Robert-*

son ... 16,133-6

further Supervision by Board of Control over use

of, desirable, *Parker* ... 11,529-30, 11,555-66,

11,801

Used only when absolutely necessary, *Blood*,

Wiese, *Gibson* ... 12,212-3, 12,215-6

not Utilised, should be returned to dispensary the

same night, *Parker* ... 11,577-8

Weekly dosing, *Parker* 11,567-77; *Gibson*

12,431-3; *Mrs. M.* 13,880, 13,898-910; *Mr. P.*

14,242, 14,295; *Mr. E.* 14,379-82.

York, the Retreat, *Yellowlees* ... 5676-80

Environment question, *Parker* 11,649-54; 11,801.

EXAMINATION (Sec. 49):

proposed Elimination of certain words, *Mr. L.*

20,418-9

Provision for meeting expense of, advocated,

Parker ... 11,103-4, 11,801

EXERCISE:

Facilities inadequate, *Mr. L.* ... 20,339-47

in Grounds, no airing courts (except for

individual cases), Scotland, *Robertson*

16,095-115

Care and Treatment—cont.

EXERCISE—cont.

Grounds, more space required, *Miss C.* 14,502-7

Sub-Committee of Visiting Committee should be

appointed to deal with, *Mr. L.* ... 20,370

Walks into town and country unattended, value

of, *Chubb* ... 6783-6

False teeth, garters, etc., taking away of, at bed-

time, *Mrs. M.* ... 14,029

FOOD:

Artificial feeding, *Barham* ... 7549-50

Breakfast and tea, unsatisfactory, *Gibson*

12,037, 12,229

Complaint *re*, *Parker* 11,714-28, 11,820-5;

Mrs. M. 14,095; *Miss H.* 19,702; *Mr. O.*

20,098-102, 20,107; *Mr. W.* 20,281; *Mr. L.*

20,366-70.

Complaint to Visiting Committee or Medical

Superintendent, less food as punishment,

Mr. L. ... 20,386, 20,390-2

Diet, *Senior* 3225-8; *Usher* 3249-54; *Connell*

4140-1; *Keene* 4747-58, 4955; *Barham* 7631-5;

Mr. P. 14,276; *Sidney*, *Gardner* 19,297-316;

Mr. Q. 20,099-102; *Mr. W.* 20,281.

Exhibited, but inferior food given to patients,

Mr. M. ... 19,853-84

Expenditure on, not increased in proportion to

other expenditure, *Parker* ... 11,715-28

Financial conflict between local authorities and

guardians, *Gibson* ... 12,407-11

Forcible feeding, *Mrs. G.* ... 20,604-5

Improvement in, *Lomax* ... 12,988

Improvement after publication of Dr. Lomax's

book, *Mr. P.* ... 14,275-6

Inspection by Board of Control, but no statutory

power, *Willis*, *Macleod*, *Bond* ... 842-3

Meals, hours of, *Barham* ... 7335-53

Physiologically adequate but dull and improve-

ment desirable, *Mapother* ... 18,992

of Private patients, badness of, case of, *Mr. M.*

19,957-9, 19,962

Scotland, *Rose*, *Marr* ... 15,655-8

Sub-Committee of Visiting Committee should be

appointed to deal with, *Mr. L.* 20,370, 20,372

Supper: *Miss C.* ... 14,489-97

Advocated, *Gibson* 12,229-31, 12,233-40; *Lomax*

12,990-2

London County Council mental hospitals,

Gardner, *Sidney* ... 19,300-1, 19,308-16

no Hairpins and hairbrush, *Mrs. M.* 13,977-81

ILL-TREATMENT, CRUELTY, ETC.:

Allegations of:

Investigation by Board of Control, *Willis*,

Macleod ... 893-904, 912-4

Number, question of, *Willis* ... 903

Bullying, *Mr. B.* ... 14,711-20

Cases of, *Parker* 11,445-7, 11,459-64; *Mr. P.*

14,340-8; *Hill* 18,297, 18,308, 18,312, 18,315;

Miss H. 19,600, 19,613-75; *Mr. M.* 19,885-930,

19,948-55, 19,962; *Mr. O.* 20,109-43; *Mr. W.*

20,282-8, 20,302-3; *Mr. L.* 20,380-6; *Mrs. G.*

20,599, 20,605, 20,607, 20,611-2, 20,613; *Mr. Y.*

20,634-49, 20,659-75.

Cases heard of, *Barns* 17,597-602, 17,607-13

Cases known, but incidents only, no habitual

practice, *Robertson* ... 16,237-9

Charges of systematic ill-treatment unfounded,

Blood, *Gibson*, *Wiese* ... 12,201

Complaints:

if Acted upon removal of patient to another

ward would remove chance of reprisals.

Parker ... 11,441-4

Difficulties, *Parker* 11,432; *Lomax* 12,692

12,704-7

Difficulty of ascertaining truth or otherwise of,

Brock ... 1198-9

Fewer than 15 years ago, *Francis* ... 1285

Method of dealing with *Brock* 1195-208;

Francis, 1295, 1300-50, 1466-70; *Barham*

7240-51.

Possibility of, *Willis* 906-12.

Reprisals, fear of, *Parker* ... 11,434-41

very Seldom heard, *Vickers* ... 7768-78

Care and Treatment—*cont.*ILL-TREATMENT, CRUELTY, ETC.—*cont.*

- Difficulty of doctor discovering, *Lomax* 12,688-707, 12,968-9
- Dismissal of nurses and attendants for, *Macleod* 904-5; *Walden* 2110; *Broome Giles* 3660-4; *Lobjoit* 5095, 5201; *Lovsey* 5275-8.
- Existence of, but no complaints heard during last three years, *Lomax* 12,709-31, 12,754-8, 12,963-73.
- Experience of, *Miss B.* 14,824, 14,823-53, 14,880-4, 14,890-1
- greater Facilities for communication with local police or solicitors advocated, *Mr. L.* ... 20,417
- without Knowledge of authorities, not possible, *Hodgson* ... 13,340-57
- as Means of maintaining discipline, *Parker* 11,448-50
- Minor cases only found, *Walden* ... 2104-5
- Occasional cases possible, *Gibson* ... 12,187-8
- Prevention methods, *Parker* ... 11,451-4
- Prosecutions: *Willis* 899-901; *Marr* 15,010-26, 15,030-2, 15,034.
- Suggestion *re*, *Lomax* ... 12,759-68
- Publicity the only remedy, *Lomax* ... 12,730-1
- for Refusing medicine, *Mr. E.* ... 14,379-83
- Safeguards against, *Connell* ... 4072-9
- Improvement, *Barham* 7653-60; *Vickers* 7755-6.
- Independent medical and legal access to patient, advocated, *Parker* ... 11,801 (24)
- more Individual consideration and classification needed, *Mrs. M.* ... 14,032-4
- Information as to rights, should be provided, *Parker* ... 11,097-102, 11,801
- Institution shops and refreshment room, *Scotland, Marr* ... 15,379

LAVATORY ACCOMMODATION:

- Commode in ward, complaint of, *Mrs. M.* 13,880-8, 13,912
- Inadequacy, *Parker* 11,579; *Mr. P.* 14,241-9; *Mr. O.* 20,153-4; *Mrs. G.* 20,607, 20,611.
- Locking of, at stated periods, complaint of, *Parker* ... 11,579-88
- Nature of, *Mrs. M.* 13,910-14; *Miss C.* 14,502.
- Non-use of, *Miss H.* ... 19,689, 19,693-4
- Sanitary paper:
- Non-provision of, *Parker* ... 11,589-92
- Supply when asked for, *Mr. P.* ... 14,250-2
- Sharing of, with diseased people, *Mrs. G.* 20,611

LOCKED SECLUSION:

- as Punishment, *Mr. Y.* ... 20,680-5
- Scotland, none, Robertson* 16,121-9, 16,202-5
- Lockers desirable, *Mrs. M.* ... 14,008-12
- Magazine written by patients, *Humberstone, Dixon* ... 3778, 3875-9

MECHANICAL RESTRAINT:

- Abolition of, *Scotland, Robertson* ... 16,129
- Advantageous in special cases, *Robertson* 16,165
- Easier to carry out in general hospital, *Comrie* 16,337-8
- Nature of, *Bond* ... 826-8
- Necessary in certain cases, *Comrie* ... 16,337-8
- Padded room not considered as, *Macleod* 825
- Use, extent of, *Bond* 826; *Lord* 16,739.

MEDICAL TREATMENT:

- Facilities and nature of, *Humberstone, Dixon* 3831, 3839-45
- Inadequate, case of, *Brock* ... 1142-62, 1209
- Investigation by Medical Officer of Ministry of Health, *Brock* ... 1128-9, 1142-62
- Non-interference with by Commissioners, *Parker* 11,335-43
- Position of Ministry of Health *re*, *Brock* 1215-6
- Recommendations, *Parker* ... 11,678-93
- Noisy patients, difficulty, *Robertson* ... 16,213-7

NOTICES:

- Distinction between private and pauper patients, *Macleod, Willis* 440-3, 447-51; *Bond* 802-7.
- Posting up of: *Macleod, Bond, Willis* 440-3, 446-9
- in All wards desirable, *Bond* ... 803-8
- no Written notices in *Scotland, Marr* 15,286-90; *Rose* 15,292-7.

Care and Treatment—*cont.*

OCCUPATION:

- Claybury, Barham* 7316, 7320-2, 7353-9, 7525-8, 7636-40.
- Divergent practice *re*, *Parker* ... 11,752
- Extra stimulus advocated, *Parker* ... 11,743-5
- Heavy outdoor work, benefit experienced, *Mr. P.* 14,285-7, 14,296-9
- Importance of, *Dixon* 3828; *Devine* 4346-7; *Barham* 7316, 7320-1.
- Nature of, *Connell* 4145-8, 4191-2; *Lobjoit* 5174; *Wiese* 12,362-6.
- Objection to do own work on trade union principles, *Mr. P.* ... 14,285, 14,299
- Patients employed as workers, payment advocated, *Lomax* ... 12,555, 12,776-7
- Payment for, by credit voucher, suggestion, *Gibson* ... 12,251-2
- Provision of, possible methods, *Parker* 11,752-9
- Retardation of discharge if patient useful, *Lomax* 12,778-800; *Miss H.* 19,698; *Mr. O.* 20,213-7.
- Denial, *Blood* 12,210-11.
- Scotland, Marr* ... 15,665-6
- Work on farm, non-payment for, *Mr. P.* 14,296-7
- Open-door system, as far as possible, *Scotland, and success of, Robertson* ... 16,116-20

PADDED ROOMS:

- Absence of, *Scotland, Robertson* 16,121-26, 16,197
- may have Advantages in special cases, *Robertson* 16,165
- Personal experience *Miss B.* 14,759, 14,761, 14,780-2, 14,824-6, 14,869, 14,871-80, 14,895
- Rats in, *Mrs. M.* ... 14,143-6
- Removal of patient to, without doctor's order, *Mrs. M.* ... 13,915-22
- Seclusion in, case, *Parker* 11,488, 11,489, 11,494-9, 11,501

Parole, *see that title.*

- Patients capable of managing own money matters should be allowed to do so, *Miss C.* 14,568-73
- Personal belongings, parcels, etc., put in store room, and not always obtained by patients, *Mrs. M.* ... 14,003-7
- Pocket handkerchiefs, non-provision of, *Mrs. M.* 13,999-4002
- Previous history gone into, *Bond* ... 8460
- Private accommodation for private belongings desirable, *Dixon* ... 3951

PUNISHMENT:

- Acute ward, *Hill* 18,315-43; *Glanvill* 18,333.
- Cases of, *Hill* 18,297, 18,313-43; *Glanvill* 18,305.
- "Curative treatment" guise, should be prevented, *Parker* ... 11,801(26)
- Drugs as: *Mrs. M.* ... 13,963-9
- Use of, doubted, *Yellowlees* ... 5685-9
- Forms of, *Parker* ... 11,601
- Locked seclusion, *Mr. Y.* ... 20,680-5
- Month in bed, *Mr. E.* ... 14,383-6
- Refractory ward, case of, *Parker* 11,488, 11,489, 11,503, 11,514-8, 11,522
- Relegation to lower ward, complaint of, *Parker* 11,601-8
- Retardation of discharge, *Lomax* ... 12,801-9
- Seclusion, complaint *re* method of administering, and question of remedy, *Parker* 11,609-25, 11,631-8

RECREATION:

- Books and periodicals, supply, *Parker* 11,748-50, 11,760, 11,762-73; *Gibson* 12,366; *Wiese* 12,367.
- Caged birds desirable, *Parker* 11,746-7, 11,761
- Facilities inadequate, *Mr. L.* ... 20,339-47
- additional Facilities needed, *Parker* 11,654-9; *Gibson* 12,247-50, 12,366.
- Gardening should be allowed, *Mr. L.* ... 20,344-8
- Indoor, improvement needed, *Gibson* ... 12,366
- Men and women together, *Robertson* 16,069-71
- Nature of, *Wiese* ... 12,362-3
- Reading and writing room, *Scotland, Marr* 15,379
- Sub-Committee of Visiting Committee should be appointed to deal with, *Mr. L.* ... 20,370

Care and Treatment—cont.

REFRACTORY WARD:

- Patients locked in at night with no nurse in charge, *Mrs. M.* ... 14,131-5
 Personal experience of, *Mrs. M.* 14,103-7,
 14,128-57, 14,162-76
 as Punishment, *Parker* 11,488, 11,489, 11,503,
 11,514-8, 11,522.
 Sending to, for making criticism in letter,
Mrs. M. ... 14,056-8, 14,082
 Sanitary towels, non-provision, *Mrs. M.* 14,027-9;
Miss H. 19,689-92.
 Shaving, provision of safety razors desirable,
Parker ... 11,733-8
 Solicitor, position re access to, *Willis* ... 781-6

SPECIAL FORMS OF TREATMENT:

- Glandular therapy, York, The Retreat, *Yellowlees* ... 5673-4
 Psycho-analysis:
 Care needed in selecting cases, *Yellowlees* 5806
 Claybury, *Barham* ... 7421-2, 7689-90
 of little Use by time patient in mental hospital, *Dixon* ... 3840
 Psychological, York, The Retreat, *Yellowlees* 5673, 5803-7
 Toilet accessories, non-provision of, *Mrs. M.* 13,996
 Toothbrush provided when asked for, *Mrs. M.* 13,986-7
 Treatment better if patients quiet and asked for nothing, *Mrs. M.* ... 13,996-8

VISIT BY OUTSIDE DOCTOR:

- Valueless, *Mr. H.* ... 8548-52
 Possibility of, *Bond*, *Macleod*, *Willis* 418-26;
Lobjoit 5193-6.
 VISITS BY PATIENT'S PERSONAL DOCTOR:
 Advocated, *Parker* 11,104; *Worth* 17,342-3,
 17,353-63.
 Position re, *Willis* ... 787-8
 Provision for, Scotland, *Marr*, *Rose* ... 15,383-4
 Visitation, see that title.
 Wards should be decorated differently, *Hill* 18,269
 Wedding ring, taking away of, *Mrs. M.* 13,730-3, 13,777-81

Wrongful detention, see Detention.

Central Administration, see Administration.

Central Association for Mental Welfare, evidence on behalf of, see Tredgold, Alfred Frank, M.D., F.R.S. (Edin.), etc... 21,099-259
 Certifiable Cases, non-certification, procedure re, *Willis* ... 670-84

Certificates:

GENERAL:

- Criticism, *Schuster* ... 1011-9
 Deficiencies and errors, *Macleod*, *Bond* 168-74,
 180-201, 858; *Dixon* 3780; *Devine* 4540-1A;
Yellowlees 5586-7, 5642, 5832-5; *Robertson* 15,750, 15,757-66.
 Desire of patients to see, after discharge, *Parker* 10,364-75
 Form of opinion re, *Yellowlees* ... 5837-9
 Friends should be allowed to see, *Lomax* 12,832
 Hearsay evidence, steps taken to verify, personally, but should be made obligatory, *Broome Giles* ... 3699-707
 Medical Superintendent of Institution should only sign, in certain cases of emergency, *Lomax* 12,822

One:

- Advocated with preliminary detention order, *Lomax* ... 12,822, 12,857
 and Calling in of second opinion would be satisfactory, *Propert* ... 6049-50
 with Power to justice to call for second, approved, *Devine* 4276; *Lobjoit* 5182-3; *Lovsey* 5235-9; *Parker* 10,939-46.
 Statement of facts, difficulty in some cases, *Stoddart* ... 9659-61

Two:

- Advantages of, to medical men, *Yellowlees* 5641, 5644-6
 Advocated in every case and joint certificate should be allowed, *Cole* ... 16,964-5

Certificates—cont.

GENERAL—cont.

- in All cases, question of, *Sidney* 19,202-10
 no great Importance attached to, *Barr* 7104-12
 One, by specialist, question of, *Yellowlees* 5664-8; *Leach* 6254-8; *Robertson* 15,767-70.
 Option of, advocated, *Lomax* ... 12,822, 12,828
 a Protection to medical men, *Hawthorne* 13,686, 13,703
 a Safeguard, *Cole* ... 16,625

PAUPER:

- Cost*, *Baly* ... 2841-2
 Hearsay evidence, mainly, case of, *Lord* 2214-8
 by usual Medical attendant advocated, *Phillips* 5896-8
 One: *Macleod* ... 243-4
 found Satisfactory, but second desirable, *Lord* 2221-31
 generally Sufficient, *Baly* ... 2843-5

Two:

- Advocated, *Langdon-Down* 7963-79; *Menzies*, *Lord*, *Cole* 17,004-15.
 Advocated, one by patient's usual attendant, *Chubb* ... 6672-80, 6817-8
 Advocated, although not found necessary in practice, *Devine* ... 4272-6
 Advocated, one doctor being an expert, *Leach* 6111-6, 6254-8
 Advocated as means of assimilating procedure, *Yellowlees* ... 5636-46, 5757
 Advocated if necessary in private cases, *Lobjoit* ... 5108-15, 5120-1, 5219-39
 Desirable, but power to call for, in border line cases might be sufficient, *Lord* 2221-31, 2277-8
 Desirable, but financial question, *Barnsley* 1807-12, 1942-50
 Independent examination by doctors should not be obligatory, *Langdon-Down* 7978-86, 7989-92
 and Justice seeing patient the best method, *Lidbetter* ... 1570-7
 by own Medical man, and by person specially qualified or appointed, suggestion, *Dixon* 4006
 One, by specialist, difficulty, *Chubb* ... 6818-20
 Scotland, second may be filled in by medical officer of asylum and objection to, *Marr*, *Rose* 15,216-30
 Second, by medical officer of mental hospital, would be approved, *Devine* ... 4534-5
 Preliminary detention certificate and order, scheme, *Lomax* 12,816, -28, 12,857-8, 12,951-4

PRIVATE:

- Difficulties experienced by doctors in connection with framing, *Bond* ... 213-4
 Disagreement between doctors:
 Order should not be made, *Lidbetter* 1564-5, 1574-8, 1585, 1594.
 Procedure on, *Lidbetter* 1563-5, 1581-4, 1586-93; *Barnsley* 1965, 1979.
 Form 8:
 Difficulty of dealing with, and method adopted, *Baly* 2597-640, 2681-2, 2702-20, 2790-803, 2818-9, 2846-8, 2894-909.
 Successful but certain suggestions to be made, *Bond* ... 212-3
 Forms prescribed, *Bond* ... 202-3
 Independent examination, interpretation put on by Board, *Bond* 829-33; *Macleod* 833; *Willis* 833.
 by Mental expert:
 Question of, *Bond* 857-8; *Phillips* 5978-9.
 would be Desirable, *Devine* ... 4530-3
 Nature of, *Bond* ... 203
 One, by doctor well acquainted with patient desirable, *Bond* ... 856-7
 One medical certificate plus justice as satisfactory, *Lidbetter* ... 1562
 One, with power to doctor or justice of the peace to call in second opinion, second opinion would always be called in, *Yellowlees*... 5641, 5662-3
 Persons qualified to give, *Macleod* 142, 144-52

Certificates—cont.**PRIVATE—cont.**

- Question whether justice bound by, as conclusive factor, *Lidbetter* ... 1752-5
 not by Regular medical attendant, notification of reason, papers returned in case of failure, *Yellowlees* ... 5845-6
 Requirements of Act *re*, *Macleod* ... 143-52
 Safeguard, usual medical attendant, *Macleod* 161
 Scrutiny by Board of Control, *Bond* 204-6; *Willis* 210-11.
 Second medical man the patient's usual attendant (Sec. 31):
 Advocated whenever possible, *Langdon-Down* 7994
 Approved, *Phillips* ... 5896-7
 Desirable but difficulties in connection with, *Yellowlees* ... 5647-59
 Two:
 Desirable from point of view of public, *Yellowlees* ... 5636, 5660-2, 5756
 Required, *Willis* ... 141
 should be Shown to patient, *Mrs. C.* 14,538-45, 14,553-6, 14,578-80

Certification:

see also Lunacy Act and Reception Orders.

- Abolition of judicial procedure and substitution of notification advocated, *Robertson* 15,822-52, 15,879-82
 temporary Abolition advocated, except in certain cases, *Craig* ... 20,697, 20,836
 Action by patient, legal position, *Hawthorne* 13,687
 Appeal to Quarter Sessions, suggestion, *Parker* 11,027-35, 11,801
 Avoidance of, by every possible means, Scotland, *Robertson* ... 15,888-9

CERTIFYING DOCTORS:

- Collusion between, risk negligible, *Marr* 15,183
 Consultation between:
 Approved, *Lomax* 12,821-2; *Robertson* 15,771-84.
 Objection to, *Miss C.* ... 14,546-52
 Independent examination by, should not be obligatory, *Langdon-Down* 7978-86, 7989-92
 Position of, distinction between lunacy certificates and infectious disease certificates, *Langdon-Down* ... 13,679
 Protection of:
 Difficulties of, *Craig* ... 20,934-51
 same Immunity as in Court of Law:
 not Advocated, *Parker* 10,741-3; *Craig* 20,933.
 Proposal, *Langdon-Down* 8014-64; *Hawthorne*, *Murrell*, *Langdon-Down*, *Verrall* 13,679-702.
 Increase of responsibility of judicial authority, suggestion, *Verrall* 13,697-700; *Murrell* 13,701.
 Judge with two assessors to decide whether action should take place, suggestion, *Craig* 20,933
 Nature of, desired by profession, *Craig* 20,930-51
 Necessity for, *Baly* 2912-9; *Devine* 4528-9; *Craig* 20,755-70, 20,934-6, 20,941, 20,949-51.
 Necessity for, and suggestion, *Barr* 7143-4, 7154-63
 Onus on plaintiff to establish want of care would be improvement on present position, *Langdon-Down* ... 8050-7
 Question of method, *Lomax* ... 12,950-62
 Sanctioning of prosecutions by Attorney-General desirable, *Langdon-Down* ... 8057-9
 Two certificates in every case would assist, *Hawthorne* ... 13,686, 13,703
 Qualifications of second doctor, wide general experience approved, *Lord*... 2277-8

Certification—cont.**CERTIFYING DOCTORS—cont.**

- Reluctance to certify, *Baly* 2912-9; *Dixon* 3867, 4029-32; *Devine* 4528, 4544; *Chubb* 6762-7, 6770, 6850-2, 6864-78; *Barr* 7143, 7160-2; *Langdon-Down* 8011-12, 8024-6, 8048-9; *Phillips* 10,306; *Lomax* 12,950; *Hawthorne* 13,685; *Verrall* 13,698; *Sandhurst* 17,820-1; *Craig* 20,697, 20,761, 20,930, 20,940-1.
 Reluctance to certify not met with, *Broome Giles* 3708
 Remuneration not dependent on certification, *Craig* ... 9303-6
 Special medical officers for:
 Advocated, *Lidbetter* ... 1748, 1749
 Glasgow, *Marr* 15,186-7; *Carswell* 16,479, 16,482-3, 16,499-520, 16,539-42.
 Necessary under scheme for provisional treatment in hospitals, *Carswell* ... 16,484-98
 Proposal approved, *Craig* 20,841-4, 20,981-4
 Suggestion, *Lobjoit* 5114-9; *Sidney*, *Gardner* 19,202, 19,212-32.
 Visit to patients in own homes desirable, *Carswell* ... 16,542
 Special qualification:
 not Advocated, *Langdon-Down* 7990, 7994-8002, 8010-2; *Edwards* 8002-9.
 not Prescribed in Act, *Willis* ... 925-8
 Question of, *Marr* ... 15,183-204
 Specialist:
 Advocated, *Lovsey* ... 5364
 Districts for, suggestion, *Leach* ... 6115-6
 in Clinics, *see under Clinics.*
 Code, difficulty of working, *Leach* ... 6079-88
 of Criminal in prison, medical man unprotected, *Craig* ... 20,755-6, 20,762-70
 Danger to themselves and others and incapability to manage own affairs should be only reason for, *Lomax* ... 12,553-6
 Deterrent to early treatment, *Devine* 4384-8;; *Craig* 20,697, 20,771-4.
 Effect on children, *Devine* ... 4388
 Failure to certify, cases of, *Bond* ... 858
 Forensic element, undesirable, *Propert*... 6038-46
 increased Formality not advocated, *Langdon-Down* 7924-60
 GROUNDS OF, INFORMATION *re*:
 to Patient or representative, advocated, *Parker* 10,903-35, 11,018-21, 11,801; *Lomax* 12,829-56.
 to Patients:
 Advocated, *Miss C.* 14,538-45, 14,553-6, 14,578-80.
 Dangerous in many cases, *Marr* ... 15,282-5
 Extent to which desirable, *Connell* ... 4238-44
 to Relatives or friends, position *re*, *Willis* 563-4, 567-75.
 IMPROPER: *Parker* 10,988-1001; *Lomax* 13,002-4.
 no Case known, *Brock* 1174; *Edwards* 6440.
 Complaint of, *Mr. H.* 8262-363, 8817-922, 9039-79; *Mr. W.* 20,245-77; *Miss G.* 20,512-38, 20,557-9; *Mr. P.* 20,653-8.
 Doctor should be liable in damages, clause in Lunacy Act advocated, *Mr. L.* ... 20,420-4
 One case only known, and that one of malingering, *Devine* ... 4265-71
 Cases known of, *Lord* ... 6293-4
 Cases of refusing to receive patient, *Chubb* 6707-15, 6719-21
 Safeguards against, *Lidbetter* ... 1532-5
 Inception of, *Edwards* 6316-8, 6320; *Craig* 9391-6.
 INFORMATION TO PATIENT OF MEANING OF PROCEEDINGS:
 Advocated, *Mrs. G.* ... 20,564-7, 20,576
 Desirable in many cases, *Parker* 10,831-9, 10,847-58, 10,870-95
 Initiation, sworn information advocated, *Parker* 10,766-93
 Judicial authority, *see that title.*
 Judicial enquiry into alleged delusions advocated, *Miss C.* ... 14,524-6
 JUDICIAL PROCEEDINGS:
 Advocated, *Mr. H.* ... 8412-21

Certification—cont.**JUDICIAL PROCEEDINGS—cont.**

- with Representation of patient:
 - not Possible, *Smith* ... 10,065, 10,124-8
 - Question of, *Phillips* ... 10,249-55, 10,266-305, 10,312-6
- Scheme, *Parker* ... 10,738-1036, 11,801
- Justice of the Peace, *see that title.*
- Medical Certificates, *see Certificates.*
- Medical and legal procedure, scheme, *Lomax* ... 12,818-28, 12,857-8
- Methods, diversity of, *Parker* ... 10,727-30
- Papers *re*, and particulars should be given to patient, *Mr. L.* ... 20,417

PAUPER:

- Doubtful cases, power to justice to call in second opinion would be satisfactory, *Devine* 4276; *Lobjoit* 5182-3; *Lovsey* 5235-9; *Parker* 10,939-46.
- Petition advocated, *Cole* ... 16,966
- Procedure, *Macleod* ... 236-51
- proposed Procedure, *Usher* 3364-75; *Senior* 3375-8.
- Relatives, &c., communication with:
 - Importance of, *Baly* 2661-6, 2849-50, 2853
 - Lambeth, *Baly* 2570-9, 2650-77, 2849-54, 2864
 - by Workhouse doctor only, not approved, *Lobjoit* 5109-11, 5115, 5122-3

PAUPER AND PRIVATE PATIENTS, DISTINCTION IN PROCEDURE:

- Abolition advocated, *Lidbetter* 1545, 1552-3, 1558-61, 1596-7, 1726; *Connell* 4052-9, 4134, 4155-7; *Lobjoit* 5108-15, 5120-1; *Lovsey* 5218-39; *Probert* 6031-5; *Parker* 10,608-10, 10,721-6, 11,801; *Cole* 16,633, 16,963; *Sidney* 19,203-27; *Gardner* 19,218-24.
- Nature of, *Willis* 61-3; *Macleod* 244-8; *Lidbetter* 1545.
- in Scotland, none, *Marr* 15,174-6; *Robertson*, 15,736-7.

- Pauper stage, increase in number of cases passing through, and question of avoiding stigma, *Dixon* ... 3867-74
- Personal experience, *Mr. H.* 8262-363, 8817-922, 9039-79; *Mrs. M.* 13,796-821; *Mr. P.* 14,210-19; *Miss C.* 14,457-61; *Mr. B.* 14,614-23; *Mr. O.* 20,063-76; *Mr. W.* 20,253-77; *Mrs. G.* 20,565-7.
- Petition, Scottish system, *Marr* ... 15,175-82

PRIVATE:

- Inquisition, *see that title.*
- Judicial authority, *see that title.*
- Petition:
 - might be Abolished, *Beard* ... 19,559-61
 - Adjournment by judicial authority for further consideration, *Macleod* ... 130, 155
 - Dismissal by judicial authority, procedure on, *Macleod* ... 130-2
 - Petitioner, not always satisfactory, and question of official petitioner, *Yellowlees* 5812-5
 - Procedure by, *Macleod* ... 93, 96, 111
 - by Receivers in some cases, *Sandhurst* 17,835-9
 - Suspicion as to motives, power of judicial authority to adjourn consideration, *Whitemore* ... 3570-7
 - Procedure, *Macleod* 93; *Whitemore* 3590-5.
 - Reception Orders, *see that title.*
 - Urgency Orders, *see that title.*
- proposed Procedure, *Usher* 3364-75; *Senior* 3375-8; *Parker* 10-738-1036, 11,801; *Lomax* 12,818-58.
- Provisional, *see Provisional Orders.*

PUBLICITY:

- Advocated, if desired by patient, *Parker* ... 10,938, 11,003-17
- Increase advocated, *Lomax* ... 12,818
- Register covering name of doctor and magistrate, suggestion, *Lobjoit* ... 5170
- Relieving officer might deal with all cases, *Lidbetter* ... 1558-61

REPRESENTATION OF PATIENT:

- by Authorised agent, question of, *Craig* 9402-11

Certification—cont.**REPRESENTATION OF PATIENT—cont.**

Patient should be given chance of, *Mr. H.*

8282-9

- Representative, selected from panel, scheme, *Parker* ... 10,826-902, 11,801
- a Safeguard, *Lobjoit* ... 5128-9
- Safeguards, comparison between private and pauper cases, *Macleod* ... 249-50
- Scottish system, *Marr*, *Rose* 15,154-82, 15,205, 15,221-2, 15,226-7, 15,230-1, 15,270-80.
- Stigma, question of, and of means for removing, *Baly* 2858; *Dixon* 3909-22, 4017-22; *Connell* 4093-6; *Devine* 4388; *Faudel-Phillips* 5959; *Craig* 20,816-25.

Treatment without, *see that title.*

of Voluntary Boarders, *see that title.*

Voluntary, curable and temporary cases should not be certified, *Lewis* ... 4632-3

Chancery Visitors, *see Visitors under Lord Chancellor.*

Chaplains:**APPOINTMENT:**

- for Five years at least, renewable at end of each period, suggestion, *Chelmsford* 17,523-7, 17,530-1, 17,535
- Terms of, *Barns* ... 17,590-4
- Bishop's power of licensing and right to refuse licence if stipend, &c., not satisfactory desired, *Chelmsford* ... 17,505-22
- Complaints through, possibility of making, *Lobjoit* 5100
- Full time officer advocated where patients number 1,000, *Chelmsford* ... 17,450-1, 17,502-4, 17,544
- Length of service desirable as, *Chelmsford* 17,536-8, 17,542-3, 17,545-6
- Medical missionaries as, question of, *Chelmsford* 17,539-40
- Nature of work and value of, *Chelmsford* 17,452-60, 17,532-4; *Barns* 17,565-85, 17,596-628.
- Newly ordained man not suitable as, and consequent need for more adequate remuneration, *Chelmsford* ... 17,547
- Part time appointments undesirable, *Chelmsford* 17,450-1, 17,471, 17,474; *Barns* 17,589, 17,607.
- Percentage of patients registered under different denominations, *Chelmsford* 17,439-46; *Barns* 17,583.
- Position of, and need for clearer recognition of status, *Chelmsford* ... 17,436-8, 17,485
- Position as regards asylum staff, *Chelmsford* 17,491-4, 17,497-502
- Remuneration, increase desired, without superannuation, *Chelmsford* ... 17,552
- Special training for work desirable, *Chelmsford* 17,528-9, 17,535
- Superannuation system, *Chelmsford* 17,530, 17,538, 17,551; *Barns* 17,530.
- Type of service taken, *Barns* ... 17,629
- Type of service taken by, greater elasticity desirable, *Chelmsford* ... 17,460-70
- Work not distinctively denominational, *Chelmsford* 17,447-9
- Work not very popular, *Chelmsford* ... 17,472-3

Chargeability:

see also Maintenance.

Elimination of poor law, means of, *Francis*

21,448-68, 21,519-24

System, *Willis* 269, 280-2; *Keene* 4853-7, 4862-4; *Francis* 21,448-57.

Charitable Institutions, patients in, reports sent to Lord Chancellor, and power of discharge, *Schuster* 977-80

Chartham Mental Hospital, medical staff and patients, numbers, *Collins* ... 17,196-7

Lady Chichester Hospital, *see under Hove.*

Children, *see Juveniles.*

Chronic Cases:

Harmless cases happier in small rural Poor Law Institutions than in Asylums, *Usher* 3295-301

Chronic Cases—cont.

separate Institution for reception and observation of cases under Sections 20 and 21 and for detention of harmless, chronic cases, proposal, *Usher, Senior* 3281-310, 3314-5, 3481-5, 3509, 3510, 3517-22, 3537-9.

Provision for chronic and harmless cases by Metropolitan Asylums Board, *Keene* ... 4920-9

Removal from mental hospitals to Poor Law Institutions desirable, *Dixon* ... 3905-7

Treatment at home, difficulties, *Devine* ... 4466

Classification:

Benefit to mental cases of association with ordinary patients, *Comrie* ... 16,351, 16,361-6

IN DIFFERENT INSTITUTIONS:

not Advocated, *Sidney* ... 19,408-10
Desirable, *Glanvill* 18,294-5; *Mapother* 18,886-7, 18,889-96.

Facilities at present, *Dixon* 3832-7; *Connell* 4117-28; *Chubb* 6776-81; *Barham* 7409-18, 7687-8.

Grading of patients, popular fallacies *re, Yellow-lees* ... 5739-41

Importance of, and need for improvement, *Dixon* 3833-8; *Barham* 7409-17; *Parker* 11,660, 11,790-7, 11,801; *Mr. P.* 14,220-4, 14,237; *Robertson* 16,206-12; *Comrie* 16,345-9, 16,351, 16,385; *Sandhurst* 17,858-60; *Hildyard* 18,205-17; *Hill* 18,268-78, 18,386-9; *Mapother* 18,781, 18,783-6, 18,887-900, 18,913-7; *Sidney* 19,407; *Mr. L.* 20,344; *Mrs. G.* 20,587-90; *Craig* 20,780-2.

Legal, *Willis* ... 58

ACCORDING TO MENTALITY:

Advocated, *Walden* ... 2066

Impossible, *Gibson* ... 12,137-42

Segregation of acute and possibly recoverable cases from chronic incurables advocated, *Mott, Lord* 16,948-53

Claybury Hall:

Accommodation, *Barham* ... 7175

Ex-service men in, *Keene* ... 4848-9

Fees, *Barham* ... 7361-5

Claybury Mental Hospital:**ADMISSION:**

Classification on, extent of, *Barham* 7409-18, 7687-8

Procedure on, *Barham* ... 7380-93, 7511-4

Admission wards, *Barham* ... 7382-6

Area lay-out, etc., *Barham* ... 7172-80

Artificial feeding, *Barham* ... 7549-50

Bathing arrangements, *Barham* ... 7551-2

Chaplains, salaries, etc., *Chelmsford* 17,474-83; *Barns* 17,624-5.

Clothing, *Barham* ... 7369-76

Complaints by patients, facilities, *Barham* 7252-4

Daily life of patients, *Barham* ... 7561-80

Dental treatment, facilities, *Barham* ... 7680-1

Detention, wrongful, question, *Barham*... 7524

Dietary, *Barham* ... 7631-5

DISCHARGE:

Procedure, *Barham* ... 7522-4

Statistics, *Barham* ... 7472-4

Tests applied, etc., *Barham* 7587-607, 7621-2

Employment of patients, *Barham* 7316, 7320-2, 7353-9, 7525-8, 7636-40

Ex-service patients, *Barham* ... 7377-9, 7626

Gardener nurses, *Barham* ... 7636-40

Hours of rising and going to bed and of meals, *Barham* ... 7331-53, 7641, 7671-9, 7686-7

Labourers, gardeners and tradesmen, number, *Barham* ... 7313-9

Leave on trial, allowances during, *Barham* 7480-1

Maintenance rate, *Barham* ... 7323-4

Medical officer, daily visit to wards, *Barham* 7517-21

Medical staff and increase desired, *Barham* 7198-201, 7508-10, 7661-2, 7666-7

MEDICAL SUPERINTENDENT:

Convalescent patients, touch with, *Barham* 7694

Functions, *Barham* ... 7433-56, 7647-52, 7663-5

Letters from patients, *Barham* ... 7581-5

Claybury Mental Hospital—cont.**NURSING STAFF:**

Accommodation, *Barham* ... 7295-300

Complaints against, procedure on, *Barham* 7240-51

Day's work, *Barham* ... 7301-6

Female:

Age of entrance, *Barham* ... 7642-4

Recruiting method and difficulty, *Barham* 7223-7

Hours, *Barham* 7204, 7325-30; *Wiese* 12,068-9.

Male, satisfactory on the whole, *Barham* 7231-2

Numbers, *Barham* ... 7201-4, 7208-9

Probationary period, *Barham* ... 7264-6

Proportion to patients, *Barham* ... 7204-7

Qualifications, *Barham* ... 7217

Recreation, *Barham* ... 7307-9

Steps taken to attract right type, *Barham* 7276-8

Supervision of, *Barham* ... 7691-3

Training, *Barham* ... 7213-22, 7234-9, 7294

Opened 1893, *Barham* ... 7169

Patients, statistics, *Barham* 7179-97, 7534-48

Patients' provisions, cost per head per week, *Barham* ... 7681-5

Private patients, *Barham* ... 7366-8

Recreation, *Barham* ... 7353, 7360, 7567-80

Sub-Committee, *Barham* ... 7210-2

Treatment of patients, facilities, *Barham* 7419-29, 7689-90

Voluntary hospital visitor, work of, and value, *Barham* ... 7391-408, 7601-3

Clinics:

See also Treatment without certification.

Administration should be dealt with by lunacy committee, *Sidney* 19,121-4, 19,137-8, 19,148

ADMISSION TO:

Means of, question of, *Craig* ... 20,835-44

through Relieving officer, question of, *Craig* 20,836-9, 20,843

Advocated, *Barnsley* 1834-5; *Lomax* 12,974; *Langdon-Down* 13,626-33; *Menzies* 16,766.

ATTACHMENT TO GENERAL HOSPITAL:

Advantages, *Gilmour* 18,394-8, 18,411, 18,470-5, 18,486

Advocated and scheme for, *Devine* 4550; *Goodall* 16,645-7; *Boyle* 18,556-8, 18,630-6; *Chichester* 18,645-6.

Advocated if independent clinic impossible, *Mapother* ... 18,943-4

Desirable, but must be run by arrangement with mental hospital, *Gilmour* 18,437-40, 18,470

Preferred where possible, *Langdon-Down* 13,631-2, 13,656-9; *Masterman* 13,648-50; *Cole, Lord* 16,955-7.

Attachment to both general and mental hospitals

advocated, *Gibson* ... 12,324-8, 12,415

should be Associated with General Hospitals or be separate institutions, but not attached to mental

hospitals, *Lewis* ... 4579-82

Attachment to infirmaries not advocated, *Goodall* 16,655

if Certification necessary, question of place of, *Goodall* ... 16,708-14

CERTIFICATION OF PATIENTS IN:

Question of, *Craig* ... 20,854-63

Undesirable, *Lewis* 4566-71; *Mapother* 18,799-805, 18,810-3; *Sidney* 19,097-8; *Gardner* 19,108.

Certified cases in, not approved, *Gilmour* 18,459

Class of cases to be sent to, and to mental hospitals, *Lewis* 4574, 4585, 4677; *Menzies, Worth, Goodall* 16,715-23; 16,722-8, 17,381-96; *Gilmour* 18,412-31;

Boyle 18,569-70, 18,604-6, 18,611-7, 18,622-9, 18,650, 18,671-4; *Chichester* 18,646-8; *Mapother* 18,789-98, 18,806-7, 18,814; *Gardner, Sidney* 18,139-47; *Craig* 20,968-70.

as Clearing houses, *Devine* ... 4550

CONNECTION WITH MENTAL HOSPITALS:

Advocated, *Gibson* ... 12,324-8, 12,415

Objected to, *Lewis* 4579-82; *Worth* 17,372; *Boyle* 18,559, 18,640-2.

Clinics—cont.

DETENTION:

- in Emergency, position of medical man, *Craig* 20,826-8
- Length of notice, question of (24 hours too short), *Sidney* ... 19,062-9
- 48 hours' notice, few patients would desire to leave, *Craig* ... 20,971-2
- Obligation on patient to remain for certain period not advocated, *Mapother* ... 18,806-9
- Power of:
- not Advocated, *Lewis* ... 4590-9
 - not Advocated beyond 72 hours, *Cole* 16,757; *Lord* 16,760.
- some Power of, necessary, and suggestions, *Langdon-Down* 13,634-45; *Craig* 20,829-35, 20,884, 20,966-7.
- Question of, *Lord*, *Goodall* 16,691, 16,738-45, 16,724; *Buzzard* 17,296-8.
- Question of, and need for enabling power for odd cases, *Taggart* 13,131-49, 13,175-7, 13,251-64; *Hodgson* 13,319-24.
- 72 hours' notice advocated, *Goodall* 16,725-8; *Lord* 16,746-53; *Collins* 16,753-5; *Cole* 16,757-8.
- Effect on mental hospitals, question of, *Cole* 16,802; *Lord* 16,802-5.
- Establishment in all large centres of population advocated, *Mapother* 18,860, 18,919-22, 18,945-8, 18,959-60
- Establishment of, should be obligatory, not merely permissive on Local Authority, *Cole* 16,849; *Lord* 16,849-50
- Financial question, *Mott*, *Lord* ... 16,813
- Government assistance advocated, *Boyle*... 18,637-9
- near Homes of the patients, desirable, *Lewis* 4586
- In-patient, separate from hospital proper advocated, *Worth* ... 17,397-9
- In-patients' and out-patients' department advocated, *Lewis* ... 4673
- Independent institutions desirable, *Mapother* 18,943
- Local clinics with a few beds desirable, *Worth* 17,373-80
- as Mental hospitals of improved type for non-certified cases, *Mott* ... 16,803-12
- NON-VOLITIONAL CASES:
- should be Admitted, *Mapother* ... 18,814-8
 - Detention, question of, *Lord*, *Goodall* 16,738-45.
 - Notification of, to central authority advocated, *Lord* 16,758-9; *Menzies* 16,779.
 - some form of Notification desirable, *Craig* 20,847-52
- Operation cases from mental hospitals might be sent to, and then taken back, *Menzies* ... 16,760-2
- OUT-PATIENT:
- Attached to asylums:
- Preferable where possible, *Barr* ... 7145-8
 - Proposal, *Dixon* 4012-6; *Connell* 4205.
- Attached to general hospital:
- at all Hospitals, advocated, *Craig* ... 20,697
 - Success of, in certain cases, *Phillips* 5894, 5899
 - would be useful, *Gilmour* ... 18,444-7
 - should be Attached to reception houses rather than to general hospitals, *Barnsley* ... 1966
 - Desirable, *Lidbetter* 1751; *Walden* 2082; *Connell* 4104-7; *Lewis* 4573-8; *Barr* 7079; *Gibson* 12,324; *Taggart* 13,127-30, 13,250; *Boyle* 18,554-5.
 - on lines of Guy's Hospital Neurological Department advocated, *Craig* ... 20,697, 20,727-34
 - Home visiting in connection with, desirable, *Phillips* ... 5976-7
 - Social setting at home, difficulty caused by, *Phillips* ... 5899
 - not Sufficient, *Goodall* ... 16,650-1
- Poor Law buildings might be used as, *Cole* 16,958-9
- Provision by Local Authorities, proposals, *Lewis* 4579, 4589, 4637-40, 4685-96; *Taggart* 13,070-130, 13,173-80, 13,250; *Hodgson* 13,312-8; *Mapother* 18,969-70; *Craig* 20,960-1.

Clinics—cont.

- Psychiatric training in, value of, *Goodall* 17,164-7; *Buzzard* 17,293-5.
- Scheme, *Craig* 20,697, 20,727-34, 20,796-7, 20,829-63, 20,884, 20,960-1, 20,966-72.
- Scheme applicable to rate-aided patients only, *Menzies* ... 16,801
- SELECTION OF CASES:
- Proposal, *Goodall* ... 16,703-8
 - Specially appointed officer for, scheme, *Menzies* 16,767-71
- Separate building or ward in general hospital, question of, *Gilmour* ... 18,476-84
- Separate institutions advocated, *Craig* 20,697, 20,796-7
- Size question, *Lewis* 4587; *Mapother* 18,861, 18,865-6.
- Small dormitories important, *Gilmour* 18,485, 18,487
- Special ward of general hospital advocated, *Miller* 17,414; *Buzzard* 17,400-2.
- Uniform scheme all over country not possible at present, *Lord* ... 16,814-5
- Voluntary patients, question of correctness of description "voluntary," *Goodall*, *Cole*, *Lord* 16,729-37
- Young people might be sent to, in connection with cases from the courts, *Langdon-Down* 13,631, 13,704-5
- Clothing, *see under* Care and Treatment.
- Committees of Visitors, *see* Visiting Committees.
- Complaints by patients, *see under* Care and Treatment.
- Constable, functions *re* lunatic not a pauper and not wandering at large, *Macleod* ... 254-60
- Consultants, resort to, advocated, *Worth* 17,344-52
- Continuation Reports and Certificates, *see under* Detention.
- CONVALESCENCE:
- Difficulty in connection with, *Parker* 10,659-79, 11,813-34
 - "Half-way house" system advocated, *Lomax* 12,870-2
 - Patient might be made a voluntary boarder, *Parker* 10,672, 10,676-9, 11,813-9, 11,826, 11,830
- Convalescent Homes, advocated, *Mapother* 18,946, 18,953
- Co-operative and Provident Societies, cessation of benefits during mental incapacity, *Hildyard* 18,101-9
- Coroners, more legal responsibility on medical superintendent to make absolutely accurate statement advocated, *Lomax* ... 12,732-47
- Correspondence, *see under* Care and Treatment.
- COUNTY COUNCILS' ASSOCIATION:
- Constitution, functions, etc., *Hodgson* ... 13,293-8
 - Evidence on behalf of, *see* Hodgson, Alderman Sir William ... 13,005-13,499
- Criminal lunatics, under Home Office jurisdiction, *Brock* ... 1095
- CRIMINAL LUNATICS ACT, 1884:
- Order under, personal experience, *Mr. L.* 20,323-34, 20,405-9
 - Patients certified under, equivalent of petitioner should be appointed, *Mr. L.* ... 20,415
- Croton Oil, *see under* Drugs under Care and Treatment.
- Cruelty, *see* Ill-treatment or Cruelty, under Care and Treatment.
- DELIRIUM:
- as result of Physical condition, certain restraint necessary and difficulties *re*, *Craig* 20,697, 20,702-14
 - Procedure *re* delirious cases, *Baly* 2723-45, 2785-9; *Giles* 3155-6.
 - Treatment under Lunacy Act, and other method desirable, *Senior* ... 3464, 3511-4
- Dementia præcox cases, *Yellowlees* ... 5729-30
- Dental Treatment, *see under* Care and Treatment.
- Derby Borough Mental Hospital, *see* Rowditch.

Detention:

Appeal to Board of Control, right of, Scotland,
Marr 15,272, 15,275-80, 15,286, 15,293-4, 15,302
 Approval of Act as instrument of, *Devine* 4258
 Average period, question of, *Parker* ... 11,694-7
 many Cases willing to submit to treatment, *Devine*
 4431-4
 in Clinics, *see that title.*

CONTINUATION REPORTS AND CERTIFICATES:

Difficulty in connection with, *Dixon* 3740-9,
 3754-6; *Yellowlees* 5612-7; *Robertson* 15,799-811.
 no Difficulty experienced and method of inter-
 preting, *Devine* ... 4333-40, 4485-92
 Judicial sanction or sanction of two members of
 visiting committee advocated, *Cole* ... 17,091-2
 a Legal matter and responsibility should be re-
 moved from Medical Superintendent, scheme
 for, *Lewis* ... 4605-35, 4649-56
 Modified form, proposal, *Dixon* 3757-70, 3934-6,
 4000-3; *Yellowlees* 5618-9; *Robertson* 15,799-811.
 Scottish form, and criticism of, *Robertson*
 15,799-811
 Signing of, by two members of Visiting Com-
 mittee, suggestion, *Lobjoit* ... 5180-1
 Medical statement sent to Board of Control after
 reception, *Willis*, *Macleod*, *Bond* 215-25, 252

MONTH-END REPORTS:

should Apply also to pauper patients, *Parker*
 11,058-9
 System, *Macleod*, *Willis*, *Bond*
 290-5, 319-25, 828-30

Value attached to, extent of, *Willis* ... 326-7
 Pauper, further reports system, *Bond* ... 329-30
 Periodical reports by medical superintendent or
 medical attendant, *Macleod* ... 303-12
 Power of, needed without recourse to Lunacy Acts,
Baly ... 2739, 2744-5
 in Reception houses, *see that title.*

Report to Lord Chancellor with view to inquisi-
 tion, alteration of Sec. 39 desirable, *Schuster*
 984-6

periodic Revision by justices, would relieve
 medical superintendent of responsibility, but not
 advocated, *Devine* ... 4458-60
 Sec. 315, *see under* Lunacy Act.

during Treatment without certification, *see that*
title.

Unnecessary, but legal, owing to difficulty of
 accommodation, *Lomax* ... 12,769-76
 of Voluntary boarders, *see that title.*

Week-end reports, *Bond* 845; *Dixon* 3785, 3800,
 3971-3, 3988.

WRONGFUL:

no Case known or found, *Willis* 932-3; *Brock*
 1139-40, 1174; *Devine* 4343; *Sandhurst* 17,948.
 Case of, *Mr. M.* ... 19,988-20,007, 20,010-28
 a few Cases known of, *Vickers* ... 7781-2
 many Cases of, *Parker* ... 11,209
 Complaint of, *Mr. E.* 14,354-92; *Miss B.* 14,775-9,
 14,796-823, 14,864-70; *Mr. O.* 20,182, 20,186-219.
 few Complaints received by Ministry of Health,
Francis ... 1283-4, 1288-94
 Doubted, *Lovsey* ... 5313-33
 no Evidence of, received, *Langdon-Down* 7819-22
 in Licensed Houses, *see that title.*
 every Possible care taken, *Walden* ... 2130
 little or no Risk, *Sanders* 2390, 2394-5; *Devine*
 4457; *Lobjoit* 5084; *Yellowlees* 5793-4, 5808-11;
Langdon-Down 7924.
 Safeguards against, *Bond* 382-3; *Willis* 382-3,
 403, 497-9, 507-8; *Macleod* 384, 385, 403, 486-96,
 545-6; *Walden* 2107; *Dixon* 3827-9, 3983-7;
Devine 4344-9; *Chubb* 6740-7.
 Steps that can be taken by patient, *Willis*,
Macleod ... 779-92
 of Wealthy man in asylum as pauper patient,
 safeguard against, *Willis* ... 645-9
 owing to Work being valuable, *Lomax*
 12,778-800; *Miss H.* 19,608; *Mr. O.* 20,213-7.
 owing to Work being valuable, denial, *Blood*
 12,210-11

Detention Order, Scotland, made by Sheriff, system,
Robertson ... 15,738-66, 15,797-9, 15,822-31
 Diet, *see Food under* Care and Treatment.

Dillwyn Committee (Select Committee of the House
 of Commons), 1877, *Willis* ... 20-2

Discharge:

Appeal to Asylum Board, suggestion, *Lomax*
 12,812-3

TO CARE OF RELATIVE OR FRIEND (Sec. 79):

Precaution that patient should be properly
 looked after, advocated, *Whitemore* ... 3587-9
 Right of, might be strengthened, *Parker*
 11,228-34

System, *Willis* 527-30; *Keene* 4745-6

Committee, suggestion, *Lomax* ... 12,814

NOT CURED:

Difficulties, *Brock* ... 1163-71
 by Parish Council or petitioner, Scotland, *Marr*
 15,385, 15,391, 15,402-3
 Questions considered, *Taggart* ... 13,281-4

DIFFICULTIES:

After care, *Willis* 511-2, 514-7; *Walden* 2107;
Barr 7140-2; *Worth* 17,249; *Sandhurst* 17,921-7,
 17,934-40.

Employment, *Connell* ... 4142-4
 Home surroundings, etc., *Connell* 4085; *Barham*
 7457-71, 7475-9

Relatives' reluctance in some cases, *Connell*
 4082-4; *Yellowlees* 5629-35; *Sandhurst* 17,925-8.

Difficulty of obtaining, *Mr. H.*, *Mr. L.* 20,352-4,
 20,374-9, 20,410; *Mr. W.* 20,304-15.

Distinction between private and pauper patients,
Willis ... 748-67

by Escape, Scotland, *Marr* ... 15,410

Financial provision after, where receiver
 appointed, *Parker* ... 11,175-80

Fitness for, difficulty of determining, *Brock* 1174-9
 by General Board of Control, Scotland, powers, on
 report from two independent medical men, *Marr*,
Rose ... 15,404-9

BY GUARDIANS:

against Advice of medical officer, no case known,
Leach ... 6283-6
 Power of, *Willis* 717; *Leach* 6283-5.

under Sec. 81, unnecessary delay sometimes
 caused, *Senior* ... 3438

Half-way houses out, desirable, *Langdon-Down*
 13,602

INDEPENDENT INQUIRY:

Advantage of, doubted, *Yellowlees* ... 5779-802
 by Board with medical expert, medical super-
 intendent and magistrate, proposal for, in
 certain cases, *Walden* ... 2121-8, 2137-40
 Judicial enquiry not desirable, *Walden* 2118-20
 Objection to proposal, *Schuster* 1051-3, 1062-5;
Dixon 3807-11, 3814.

Power to call in expert desirable, *Walden* 2116-7

Inquiry made on, re treatment, *Lobjoit* 5158-67;
Hodgson 13,345-51.

"not Insane," *Willis* 929-31; *Keene* 4971-4, 5012-5.
 certifying Judicial Authority should be connected
 with, *Parker* ... 10,658-701, 11,801

**BY JUDICIAL ORDER AND MEDICAL BOARD INSTEAD OF
BY VISITING COMMITTEE:**

Scheme, *Lewis* 4605-35, 4649-56, 4674, 4679-84.
 Suggestion objected to, *Lomax* ... 12,518-20
 Judicial procedure, suggestion, *Mr. L.* 20,356-61,
 20,377, 20,427

at end of or during Leave of absence on trial,
Macleod, *Bond*, *Willis*, 475-80; *Chubb* 6568-73.

BY MEDICAL SUPERINTENDENT:

not Advocated, *Taggart* ... 13,268-9
 Dependence entirely on and objection to, *Mr. L.*
 20,374-7, 20,427

Individual attention question, *Robertson* 16,232-5
 the Only method known in practice, *Broome*
Giles ... 3692-7

Onus of detention should not be on medical super-
 intendent, *Parker* ... 10,662

Opinion should be predominant element, *Dixon*
 3799, 3803-6, 3901-3

Power to, difficulty, *Cole* 17,094; *Collins* 17,094-5;
Lord 17,095.

Discharge—cont.**BY MEDICAL SUPERINTENDENT—cont.**

Responsibility of, question of possible reluctance to advise, *Lovsey* ... 5313-33
must be Responsible, *Lomax* ... 12,517-20

NOTICE OF RECOVERY:

Extent to which used, question of, *Parker* ... 11,134-5, 11,139, 11,160

Question of giving, to pauper patient himself, or relatives, *Barham* ... 7613-20

Obligation on person in charge to discharge case on recovery, *Willis* ... 499-502

PAUPER PATIENTS:

Board of Control's power in connection with, *Macleod*, *Bond*, *Willis* ... 397, 544, 548-60

Examination by two doctors on order of Board of Control, *Willis* 549, 551, 556, 560, 579-85; *Bond* 586-94; *Chubb* 6740-3.

by Operation of law, *Willis* ... 606

Rights of relations and friends, *Willis* 552-9, 576-8, 790-5, 798-801; *Macleod* 796-8.

Personal experiences, *Mr. H.* 8723-36, 8754-9; *Mrs. M.* 14,113-27, 14,178-87; *Mr. P.* 14,306, 14,318-25.

FROM POOR LAW INFIRMARIES:

Procedure, variation in, *Usher* ... 3441

without Order being made, *Baly* 2625-30, 2698-701

Temporary cases, medical officer should have power of, *Usher*, *Senior* ... 3371-8, 3440-6

Power to Ministry of Health, not advocated, *Brock* ... 1180

Prevention of, by nurses or attendants, denial, *Blood* 12,202-5; *Gibson* 12,206-9.

PRIVATE PATIENTS:

Judicial procedure, by way of appeal, suggestion, *Parker* ... 11,147-51, 11,161-5, 11,181-227, 11,235, 11,801

Methods of discharge by Board of Control, *Willis* 481; *Keene* 4744-5.

Methods of discharge, general Operation of the law (statutory), *Willis* ... 531-2

by Petitioner:

Prevention by Procurator-Fiscal, Scotland, *Marr*, *Rose* ... 15,411-20

Provision not entirely satisfactory, and proposed alternative, *Sandhurst* 17,929-33, 17,945-55

Right of, subject to barring certificate, *Willis* 482-5; *Devine* 4373-9; *Keene* 4744-5.

Risk of petitioner not acting and question of safeguards, *Parker* 11,131-73, 11,181-227

without Petitioner's consent, unofficial instructions against, *Mr. H.* ... 8727-30

Powers under Sec. 75 should be enlarged, *Mr. L.* ... 20,417

Receiver to have right of, instead of petitioner, suggestion, *Sandhurst* ... 17,945-55

Unofficial instructions against, to superintendents of private establishments, *Mr. H.* ... 8727-34

where Urgency order or reception order lapses, *Willis* ... 541-2

by Visitors or Commissioner against advice of Medical Superintendent, extent of functioning, question of, *Parker* ... 11,183-95, 11,224

as Recovered, by Superintendent, Scotland, *Marr*, *Rose* ... 15,385-7, 15,391, 15,394-5, 15,401

in Recurrent mania cases, question of, *Parker* ... 10,687-8

Registered hospitals, duty of superintendent, *Willis* ... 506-7

by Relative, *Cole* ... 16,869-70

Retardation of, as punishment, *Lomax* ... 12,801-9

ordinary Routine practice, *Dixon* ... 3802

Scottish system, *Rose*, *Marr* ... 15,385-7, 15,391, 15,394-5, 15,401-20, 15,410-20

STANDARD REQUIRED FOR:

should be Same as that required for reception, *Parker* ... 10,658-720, 11,801, 11,826-34

Variation of, in different institutions, *Parker* ... 10,688

on Trial first, *Devine* ... 4498-9

BY VISITING COMMITTEE:

against Advice of medical superintendent, *Lovsey* ... 5296-310

Discharge—cont.**BY VISITING COMMITTEE—cont.**

Applications to Committee by patients and friends, *Taggart* ... 13,229-31

without Approval of Medical Superintendent and subsequent suicide of patient, case of, *Lovsey* ... 5260-7

Extent of reliance on opinion of Medical Superintendent, *Taggart* ... 13,182-204

Functions, *Willis* ... 509-12, 767-71, 798-800

Functions nominal only, *Parker* 10,681-3, 10,698

on Initiative of Committee, *Beard* 19,484-94

Medical Superintendent's position, *Devine* ... 4555-60

on Order of three visitors, no case known, *Broome Giles* ... 3692

Origination, *Lobjoit* ... 5184-90

on Own responsibility, *Lobjoit* ... 5186-9

Power to three members, criticism, *Dixon* 3799, 3803-6, 3941-6; *Beard* 19,475-7, 19,480.

Practice re, *Lobjoit* ... 5157-67

Request for complaints during consideration of, and in future request to be made after discharge, *Birmingham*, *Lovsey* ... 5351-9

System, *Willis* 509-12, 543-4, 767-71, 798-800; *Keene* 4743-5.

by Three members without advice of Medical Superintendent, cases of, *Keene* ... 4960-70

by Three members in opposition to Medical Superintendent, cases of, and objection to, *Taggart* ... 13,182-8, 13,208

by Whole Committee, advocated, *Taggart* 13,182-208; *Beard* 19,475-80.

Disposal of cases between different types of institution:

Private practitioner should have voice in, *Cole* ... 16,801

Specially appointed officer for, scheme, *Menzies* ... 16,767-71

District Asylums, Scotland:

Number, etc., *Rose* ... 14,944-5, 15,058-64

Powers of General Board of Control re, *Rose* ... 15,098-106

Private patients in, *Rose*, *Marr* 15,105-8, 15,111-2

Sites, plans, etc., control by General Board of Control, *Rose* ... 15,098-102

Domestic trouble, cases resulting from, *Baly* ... 2607-14, 2869-70

Dorchester, Herrison Asylum, accommodation for private patients, *Sandhurst* ... 17,989

Drugs, see under Care and Treatment.

Edinburgh Royal Infirmary:

Character of, *Comrie* ... 16,265-8

Mental cases, treatment, history and development of, *Comrie* ... 16,269-81

Social service, *Comrie* ... 16,326-8

SPECIAL WARD FOR MENTAL CASES: *Devine* ... 4413, 4545-6

Accident cases taken in, *Comrie* ... 16,366-76

Accommodation, and improvements needed, *Comrie* ... 16,331-2, 16,342-8, 16,381-6

Advantages of facilities, *Comrie* ... 16,303-10, 16,378-80, 16,437-8

Cases admitted, 1852-3, 1883, 1913, 1923-4, and results, statistics, *Comrie* ... 16,402-19, 16,428, 16,436, 16,443-8, 16,450-7

Certifiable cases, procedure re, *Comrie* 16,420-7

Class of cases taken and time for which kept, *Comrie* ... 16,282, 16,390-8

Classification, more facilities desirable, *Comrie* ... 16,345-9, 16,351, 16,376

Cost, question of, compared with ordinary wards, *Comrie* ... 16,387-9

Female nurses, and male orderlies, *Comrie* ... 16,333-5, 16,352-4

Medical staff, *Comrie* ... 16,356-60

Obstreperous cases, methods of dealing with, *Comrie* ... 16,333-9

Outdoor clinic, *Comrie* ... 16,318-25

Publicity, advantage of, *Comrie* ... 16,438

Re-admissions, *Comrie* ... 16,433-4

Recovery rate, *Comrie* ... 16,378

Restraint, practice re, *Comrie* ... 16,288-302

Edinburgh Royal Infirmary—cont.**SPECIAL WARD FOR MENTAL CASES—cont.**

- Sending of cases to, and to Royal Asylum,
decision as to *Comrie* ... 16,311-7
no Suicides after admission, *Comrie* ... 16,350
Transfer of cases from ordinary wards in dis-
cretion of physician, *Comrie* ... 16,429-32
Unofficial inspection by Board of Control,
Comrie ... 16,340-1
Visiting by friends, etc., *Comrie* ... 16,329-30
Edinburgh University psychiatry course and diploma,
Robertson ... 15,724-38
Emergency Orders, *see* Urgency.
Encephalitis, serious effects of, *Tredgold* ... 21,236-7
English Lunacy Legislation Committee, recommend-
ations approved generally, *Lewis* ... 4,697-8
Epileptics, number increasing going North to South
of Great Britain, *Robertson* ... 16,105-7

Escape:**14 DAYS' PERIOD:**

- Extension desirable, *Chubb* ... 6,598-607
no Reason known for provision, *Yellowlees*
... 5,847-51
Lapse of reception Order if patient escapes without
recapture within 14 days, *Willis* 533-6, 537-9;
Bond 536-7.
Everett case, *Parker* ... 10746-57
Exercise, *see* under Care and Treatment.

- Farms, at London County Council Mental hospitals,
Keene ... 4,756-8
Feeble-minded cases, segregation desirable, *Robert-
son* ... 16,189
Food, *see* under Care and Treatment.
France, lay head of asylums, and objection to,
Robertson ... 16,226
Friends, *see* Relatives and Friends.

General Board of Control, Scotland:

- Appeal to, against detention, right of, *Marr*
15,272, 15,275-80, 15,286, 15,293-4, 15,302
Commissioners, appointment method, *Rose* 14,929
Composition, *Rose, Marr* ... 14,911-28, 14,930
Daily working of, *Rose* ... 14,974-5
District Boards, system, *Rose, Marr*
... 14,940-63, 15,388-93
Evidence on behalf of, *see* *Rose, Sir H. Arthur,*
D.S.O., and Marr, Dr. Hamilton C.
... 14,901-15,683.
Licensing and inspection, &c., of lunatic wards
in poor houses by, *Marr, Rose*
... 15,422, 15,432-4, 15,439.
Medical Commissioner, vacancy, *Rose, Marr*
... 14,918, 14,922-3, 14,926, 14,928
Medical Deputy Commissioners, *Rose* ... 14,931-9
Meetings, Conferences, etc., *Rose* ... 14,970-1
Powers and functions, *Rose*
... 14,968, 14,972-3, 15,093-6, 15,404-9, 15,650-2
Powers of, *re* different institutions, *Rose* 15,093
Re-establishment of General Board of Commis-
sioners in Lunacy as, *Rose* ... 14,908-9
Relationship with local authorities, *Rose*
... 15,655, 15,674-6

VISITATION:

- Complaints of ill-treatment, procedure on, *Marr*
Rose ... 15,009-39
Interviews with patients, *Marr* ... 14,984-94
System, *Rose, Marr* ... 14,976-5,008

General Nursing Council:

- Registration by, *Wiese, Gibson* ... 12,175-80
Relationship with Medico-Psychological Associa-
tion, *Collins, Cole* ... 16,613-9

General Paralysis of the Insane:

- wrong Diagnosis of, *Mr. P.* ... 14,328-37
Malaria treatment, *Hodgson* 13,328; *Golla* 21,076-8,
21,087.
Remissions, *Craig* ... 9,506-12

Glasgow:

- Hospitals and accommodation for mental cases,
Carswell ... 16,523-34

Glasgow—cont.

- Mentally defective children, provision for, *Cars-
well* ... 16,594
Observation wards, *Carswell*
16,474-83, 16,515-23, 16,535, 16,545-59, 16,574-91
Special certifying medical officer, *Carswell* 16,479,
16,482-3, 16,499-520, 16,539-42
Göttingen, Clinic under Professor Cramer, *Boyle*
... 18,666

Grants in Aid:

- Board of Control should administer, *Gibson*
12,264-78; *Menzies* 17,040-3; *Lord* 17,041.
Board of Control has no functions *re, Willis* 873
not Desired if increased State control involved,
Hodgson ... 13,409, 13,446-8
Increase desired, *Mapother* ... 18,989-90
if Increased, proposed condition of, *Francis*
... 21,459, 21,466-8
should be Increased, or abolished if Governmental
control involved, *Taggart* 13,112, 13,232-40;
Hodgson 13,459.
Proposal *re, to* Mental hospitals, *Gibson* ... 12,285-8
in Scotland, *Marr* 15,149-53; *Rose* 15,673.
Treatment and care of patients might be im-
proved, *Francis* ... 21,558-61
Greenock Parochial Asylum, *Rose, Marr* 15,070-6,
15,110

Guardians, Boards of:

- Discharge by, *see* under Discharge.
Elimination of, suggested, *Gibson* ... 12,271-2
Financial conflict with local authorities, *Gibson*
... 12,407-11
Position of, in receivership cases, *Hildyard*
... 18,070-3
should be Notified of inquests, *Leach* ... 6174-3
further Powers of, investigation advocated, *Hill*
... 18,297-310, 18,344-6
Responsibility for accommodation should rest on
Visiting Committee, not with, *Willis* ... 21,386
Visitation by, *see* that title.

Guy's Hospital:

- Neurological Department, *Craig* 20,697, 20,727-34
Special ward for temporary cases, *Craig* 20,719-24

Hanwell Mental Hospital:

- Chaplain, work of, &c., *Barns* ... 17,554-629
Clothing, case of inadequacy, *Hill* 18,363-4, 18,375;
Glanvill 18,370, 18,374.
Punishment of patient by putting in acute ward,
Hill ... 18,315-43

Hartlepool Poor Law Infirmary, Mental Cases:

- Accommodation, class of, &c., *Usher* ... 3231
Diet, *Usher* ... 3249-54
Inmates, number, *Usher* ... 3231
Maintenance cost of inmate, and comparison with
Asylum, *Usher* ... 3255-8
Nursing staff, number, pay, &c., *Usher*
... 3239-43, 3246-8
Observation arrangements, etc. *Usher* 3235-6, 3244-6
Health Leave of Absence, *see* under Leave of Absence.

Health, Ministry of:

- Appointment of Medical Superintendents by, de-
sirability, *Lomax* ... 12,492-501
Chief Medical officer, questions relating to medical
treatment, bringing of, within purview of, de-
sirable, *Brock* ... 1210, 1219-21
Complaints, method of dealing with, *Brock*
1195-208; *Francis* 1300-50, 1466-70.
Control of licensed houses by, no objection to,
Edwards ... 6478-9
should be Court of Appeal from Board of Control,
Mr. L. ... 20,417
Discharge, power *re, not* advocated, *Brock* 1180
Evidence on behalf of, *see* *Brock, L. G., C.B.,*
1066-1222, and *Francis, H. W. S., O.B.E.,*
1223-1473, 21,401-569.
Inspectors, method of dealing with reports,
Francis ... 1351-66
Jurisdiction over buildings, and certain duplica-
tion with Board of Control, *Willis* ... 36, 37-8

Health, Ministry of—cont.

Letters from patients and relations, &c., character and method of dealing with, *Brock* 1116-41, 1195-208

Licensing of licensed houses by, advocated, *Edwards* ... 6395

Medical officers of, investigation of medical treatment by, *Brock* 1128-9, 1142-62.

POOR LAW DIVISION:

Letters from patients in workhouses, method of dealing with, *Francis* ... 1286-97

Powers and duties:

Poor Law administration in connection with lunatics, *Francis* ... 1224-1473

Workhouses, transfer to, from asylums, *Francis* 1236-45

Women inspectors, *Francis* ... 1440-1

Position *re* workhouse accommodation, *Francis* 21,525-9, 21,565-8

Powers *re* local authorities, *Brock* 1098-101, 1111-5, 1191-2

POWERS *re* LUNACY ADMINISTRATION:

Nature of, *Brock* ... 1078-9, 1096-115, 1213-7

Transfer from Local Government Board and Home Office, *Brock* ... 1070-80

Value of, *Brock* ... 1173, 1181-2

Relations with Board of Control, *Willis* 723-9; *Schuster* 1026; *Brock* 1082-9, 1106-8, 1189-90, 1193-4.

STAFF:

no Expert alienists on, *Brock* ... 1104-5, 1207

Specialists and alienists on, would be desirable, *Brock* ... 1218

Herrison Asylum, *see* *Dorchester*.

Hertfordshire County Asylum, cost of food, *Parker* 11,715-26

Home Secretary:

Jurisdiction over criminal lunatics, *Willis* 36

Powers *re* lunacy administration, *Brock* 1076, 1090-5

Transfer to Ministry of Health, *Brock* 1070, 1075-8

Horton Mental Hospital:

Probationer nurses, difficulty of obtaining, *Keene* 4951-2

Training of hospital visitors, *Barham* ... 7402

Hospital Visitors, Voluntary:

Extension desirable, *Parker*... 10,590-5

Work done by, and value of, and need for increase, *Barham* ... 7391-408, 7601-3, 7611-12, 7627-8

Hospitals:**GENERAL:**

Attachment of clinics to, *see* *under* *Clinics*.

Insane cases in, *Langdon-Down* ... 13,653-4

Provisional treatment in, specially selected certifying doctor (for rate-aided patients) an indispensable feature of, and scheme for, *Carswell* ... 16,484-98

Reception of urgent cases in, question of, *Langdon-Down* 8178-85, 8190-204; *Edwards* 8186-9, 8199-200.

Special wards in:

Advantages of, *Comrie* ... 16,449, 16,458-65

Class of cases suited for, *Comrie* 16,439-49

Grant towards, desirable, *Craig* 20,798-9, 20,898

as Part of general hospital advocated, *Comrie* 16,385, 16,399-401

for Temporarily insane cases desirable, *Craig* 20,716-24, 20,792-3, 20,807

Treatment of mental cases in, proposal, *Baly* 2930-46; *Craig* 20,807-10.

Wards attached to, for observation, *see* *under* *Observation period*.

Mental, *see* *that* title.

Registered, *see* *that* title.

Hove, Lady Chichester Hospital, particulars *re*, *Chichester*, *Boyle* 18,501-610, 18,651, 18,659, 18,755-6; *Langdon-Down* 13,646-8.

Hull, City of, Mental Hospital, report on conditions by lady visitor, *Parker* ... 11,738-41

Humberstone City Mental Hospital:

Accommodation, source of patients, etc., *Dixon* 3720-34, 3979-82

Bathing arrangements, *Dixon* ... 3956-63

Humberstone City Mental Hospital—cont.

Bedridden patients, *Dixon* ... 3947-50

Bed-time, freedom *re*, *Dixon* ... 4045-50

Cases, statistics *re*, *Dixon* ... 3927, 4021-2, 4038-42

Classification of patients, *Dixon* ... 3839

Cupboards in wards, notices, etc., *Dixon* 3951-5

Dental treatment, *Dixon* ... 3989

Exercise, *Dixon*... 3990

Magazine produced by patients, *Dixon* 3778, 3875-9

Maintenance charge per head, *Dixon* ... 3992-6

Medical treatment, *Dixon* ... 3831, 3839-45

Nursing staff, *Dixon* ... 3859-61, 3923-33

Hypnotic suggestion, inducing of crime by, not considered possible, *Yellowlees* ... 5807

Ill-treatment or cruelty, *see* *under* *Care and Treatment*.

Illegal Detention, *see* *Wrongful under Detention*.

Infirmaries, *see* *Poor Law Institutions*.

Infirmity ward of Mental Hospital, bad conditions in, *Mr. O.* 20,084-170; *Mr. W.* 20,279-99, 20,302

Injury to pauper patient, Guardians should be notified and be represented at inquiry, *Hill* 18,297-310; *Glanvill* 18,305.

Inquests, Guardians should be notified, *Leach* 6174-5

Inquisition:

Application to Lord Chancellor for, *Willis* 614

CASES:

Number of, to 1st January, 1924, *Willis* 287A-8

Number held in year, *Schuster* ... 1027-9

Number at present, *Sandhurst* ... 17,793

IN PRIVATE CARE:

Commissioners' power to visit, question of, *Sandhurst* ... 17,879-82

Visitation four times a year for at least two years, *Sandhurst* ... 17,803-5

Number small and decreasing, *Willis* ... 42, 45-9

Chancery Visitors, *see* *that* title.

Lunatic so found unable to contract marriage, *Hildyard* ... 18,051-3

Procedure, *Willis* ... 51-6

Procedure dying out, *Hildyard* ... 18,033, 18,040, 18,049-50

Report to Lord Chancellor with view to alteration of Sec. 39 desirable, *Schuster* ... 984-6

Retention of procedure probably desirable, *Hildyard* ... 18,041-53

Visitation, *Macleod* 342-53; *Sandhurst* 17,801-3.

Insanity:

Alternation between sane and insane periods, *Craig* 20,740-54

Definition question, *Parker* 10,645-720, 11,801; *Craig* 20,740-54.

Types of, *Connell* ... 4096

Inspection, Compulsory, by Central Authority, necessary, *Edwards* ... 6399

Inspector of the Poor, Scotland, *Rose* 15,677-83

Judge in Lunacy, jurisdiction, *Sandhurst* ... 17,853-7

Judicial Authority:

should be Competent man, *Chubb* 6690-700, 6716-8

should be Connected with discharge proceedings, *Parker* ... 10,658-71, 11,801

Distinction from ordinary justice dealing with pauper patients, *Macleod* ... 112-4

Evidence by doctor before, in place of giving certificate, question of, *Barr* ... 7163

Explanation of term, *Macleod* ... 112-3

Functions of, and proceedings before, *Macleod* 122-60

Functions and position of, *Langdon-Down* 7936-60

Jurisdiction, *Macleod* ... 112-5

Medical certificates must be relied on, *Broome* 3625-8, 3690-1

Papers seen by, *Lord* ... 2193-5, 2290-1

Persons appointed to act as, *Macleod*, *Willis* 115-21

PROCEEDINGS BEFORE:

Information to patients of meaning of proceedings, question of, *Barr* 7127-31; *Langdon-Down* 7949-52.

Judicial Authority—cont.**PROCEEDINGS BEFORE—cont.**

Interview with certifying doctor, suggestion,
Chubb 6845, 6861

Interview with patient:

Advocated, *Lidbetter* 1563, 1569-73; *Barnsley* 1827; *Walden* 2021-7; *Whitemore* 3545-52; *Broome Giles* 3606-9; *Devine* 4272; *Lovsey* 5213-4; *Chubb* 6680-90, 6694, 6701, 6716, 6720-2, 6860; *Barr* 7098-103; *Langdon-Down* 8013; *Parker* 10,936-7; *Cole*, *Collins*, *Menzies* 16,998-7004; *Beard* 19,503-5, 19,514, 19,522.

Legal representation of patient, proposal not agreed with, *Lomax* 12,828

Medical man who gave certificate not present, *Lord* 2196

Method of carrying out, *Broome Giles* 3611-5, 3679-85

not considered Necessary, *Yellowlees*... 3758-71

not obligatory, *Lidbetter* 1523-4

not Obligatory, and disadvantage, *Bond* 263, 275-6

Patient seen before seeing doctor, to prevent being influenced, owing to personal qualifications, *Broome Giles* 3621-6

Persons present, *Lord* 2197-8

Presence of friend or relative:
Advocated, *Broome Giles* ...3610-6, 3669-70

Cases of, rare, *Broome Giles*... 3613-6, 3674-8

Relative or friend not present, *Lord* ... 2198

the Usual practice, *Barr* 7125-6

Medical practitioner should appear before, *Parker* 10,946-72

Power to call for doctor's attendance advocated, *Beard* 19,516-8, 19,521

Presence of patient at, question of, and discretion necessary, *Parker* ... 10,972-85

Presence of relatives or friends:
Desirability dependent on circumstances, *Whitemore* 3553-63

Opportunity of attending, advocated, *Senior* 3471-5

Power to call for, advocated, *Beard* ... 19,519

Safeguards, *Macleod* 128-9, 137-8; *Willis* 573.

Secrecy of, *Willis* 568

Taken in private, *Macleod* 127-8

Two justices advocated and clerk to justices should be present, *Beard* 19,497-544, 19,561, 19,564

Justices of the Peace:

Cardiff, appointment, annually, of all justices to act under Lunacy Acts, *Sanders* ... 2309

Difficulty in getting hold of, *Lidbetter* ... 1721-6

Duties of, re lunacy administration, certification and removal to institution, *Barnsley*...1782-817

Examination of alleged lunatic by (Sec. 16), criticism of wording "examination," *Langdon-Down* 13,660-78

Experience desirable, *Walden*... ..2159-60, 2179

Functions and position of, *Langdon-Down* 7936-60

should be more or less Guided by medical opinion, *Connell* 4211

Local doctor as, question of, *Connell* ... 4193-4

Old justices certifying as matter of routine, objection to, *Parker* 10,734-7

Panel, proposal, *Walden* 2058

Position of, should be more clearly defined, *Baly* 2855-7

PROCEEDINGS BEFORE:

Macleod 239-43

Assistance of patient by neutral person, suggestion not approved, *Lobjoit* ... 5203-5

little or no Difficulty experienced, *Walden* 2168-9; *Lord* 2211-8, 2284; *Sanders* 2368-70; *Lovsey*, 5239-46.

Difficulty in some cases, and further observation necessary, *Walden* ... 2029-30, 2043-4

Disagreement between justice and medical man, proposed procedure, *Walden* ... 2043-9

Doubt, power to make 14-day order for detention in workhouse, *Barnsley* 1796-803; *Lord*, 2242-7.

Justices of the Peace—cont.**PROCEEDINGS BEFORE—cont.**

Information to patient of meaning of, question of, *Langdon-Down* 7949-52

Information to patient of grounds of certificate not desirable, but given to relative or representative, *Barnsley* 2005-15

Information would be given to relation or representative, *Walden* 2060-1

Interview with patient:
Cab full of patients, *Barr* 7149

little Importance attached to, *Yellowlees* 5758-71

Importance of, *Barnsley* 1827-31; *Lord* 2191-2; *Langdon-Down*, 8013.

Lunatic believed to be brought to, in rural areas, *Lidbetter* 1758-62

Magistrate should go to patient rather than patient to be taken before magistrate, *Dixon* 3862-6

Medical practitioner consulted previously, but practice not in accordance with Sec. 16, *Lord* 2256-8

Medical certificate not always seen before, *Cardiff*, *Sanders* 2332-3

Place of:
in Motor car outside private house, *Lord* 2199-213

at Patient's own home or brought to justices, *Barnsley* 1786-9

at Police Court, *Bond*... .. 696

at Police Court, undesirable, *Walden* 2090; *Broome Giles* 3636-8; *Lovsey*, 5294; *Langdon-Down*, 7987.

at Private house, place of business or private room at Police Courts, *Barnsley* 1915-7, 1921-2, 1926-9

at Private residence, undesirable, *Walden* 2081, 2089

at Workhouse, *Lidbetter* 1543-4; *Sanders* 2323-35, 2406, 2418; *Baly* 2494-515.

at Workhouse, objected to, *Walden* 2080

Presence of friend or relative:
Advocated, *Lord* 2233-9, 2252-5, 2268-76, 2290-3

not considered Necessary, *Baly* ... 2849-57

Relatives could attend, *Cardiff*, *Sanders* 2415-6

must be Private with no judicial element, *Lord* 2240-1

Procedure at, *Barnsley* 1790-6, 1993-2015; *Walden* 2031-64; *Sanders* 2359-68, 2396-402, 2417; *Baly* 2641-56, 2678-97.

proposed Reception house would be useful for, *Barnsley* 1918-24; *Walden* 2080, 2087-9.

Relatives seen in some cases, *Lambeth Infirmary*, *Baly* 2650-6

Value, question of, *Robertson* 15,740-56, 15,785-93

Medical certificate always seen, *Barnsley* 1973-4, 1991-2

Medical certificate must be relied on, *Sanders* 2355-68, 2396-402

a Medical man present, *Walden* 2031-2, 2037-42

Medical man not generally present, *Barnsley* 1804-6

Nature of, approved, but should be before person other than magistrate, *Robertson* 16,169-73

Previous medical history considered, *Walden* 2150-3

Power to call for doctor's attendance advocated, *Beard*19,516-8, 19,521

Presence of patient at, question of, discretion necessary, *Parker* 10,972-85

Reception order, given without enquiry into patient's financial position, *Lord* ... 2259-63

Relative's or guardian's attendance, power to call for, advocated, *Beard* 19,519

Relative of patient generally present, and approval of, *Barnsley* 1993-2003

Relatives should be informed that proceedings being taken, *Sanders* 2407-11; *Senior* 3436-7

Justices of the Peace—cont.**PROCEEDINGS BEFORE—cont.**

- Representation of patient by solicitor not advocated, *Barnsley* ... 2001
- Two justices advocated and clerk to justices should be present, *Beard* ... 19,497-544, 19,561, 19,564
- Value attached to, *Barr* ... 7151
- Value of, doubted, *Taggart* ... 13,149-72
- Written statement by relative seen in majority of cases, *Sanders* ... 2334-5, 2407-8
- Refusal to accept medical evidence, case of, *Taggart* ... 13,278-80
- Refusal to certify, *Devine* ... 4502-3
- Refusal to certify in spite of doctor's certificate, case of murder of wife and children after, *Barnsley* ... 1850-7
- Refusal to make order, and discharge on, *Lidbetter* ... 1546-8
- SPECIALLY APPOINTED JUSTICE:**
- Advocated, *Dixon* 4004-5; *Lobjoit* 5170-1; *Menzies, Cole* 16,992-7.
- not Advocated, *Langdon-Down* ... 7959
- Proposal, *Lidbetter* ... 1748, 1751
- Question of, *Lewis* ... 4657-63
- Training of, suggestion, *Langdon-Down* ... 7960
- Use of stipendiary magistrate in Birmingham for certain cases, *Barnsley* ... 1912-14
- Visitation by, *see under Visitation.*

Juveniles:

- Admission to public mental hospitals, objection to, *Devine* ... 4472
- in Asylums, Scotland, *Robertson* ... 16,224-5
- Certifiable as lunatics, not mental defectives, special provision advocated for, *Flint* 6244-8, 6275-8
- should be Dealt with under Mental Deficiency Act rather than Lunacy Acts, *Lidbetter* ... 1726-9
- Early treatment, importance of, *Boyle* 18,574-83, 18,653, 18,657-60, 18,665
- Provision for, in Glasgow, *Carswell* ... 16,594
- Separate accommodation for, in workhouses, advocated, *Senior, Usher* ... 3422-35
- in Same institution as adults, objection to, *Yellowlees* 5727-8; *Flint* 6242-8, 6275-7.

Kent County Mental Hospitals, *see* Chartham and Maidstone.

Lady Chichester Hospital, Hove, particulars *re, Chichester, Boyle* 18,501-610, 18,651, 18,659, 18,755-6

Lady Visitors, *Lord* ... 17,266-76

Lambeth Guardians, persons chargeable to, on account of illness or sickness, and number suffering from mental disorder, *Baly* ... 2886

Lambeth Infirmary:

- Justices, regular attendance, *Baly* ... 2494
- Legal position, *Baly* ... 2830
- Nature of accommodation, etc., *Baly* ... 2452-72

MENTAL CASES:

- Admission, methods, *Baly* ... 2473-7
- 14 days' detention, *Baly* 2530, 2681-2, 2702-28, 2792-803, 2820-5, 2894-911, 2947-53
- Increase in number partly owing to more rigid carrying out of Act, *Baly* ... 2536-45
- where Insanity due to physical condition, kept in infirmary if possible and not sent to mental hospital, *Baly* ... 2893
- Male ward, accommodation inadequate, *Baly* 2471-2, 2859-60
- Nature of, *Baly* ... 2490-3
- Numbers and classes, 1923-24, *Baly* ... 2516-35
- Patients not always detained 3 days, *Baly* 2881
- Procedure after admission, *Baly* 2478-515, 2570-83, 2616-866
- Straight jacket, case of using, *Baly* 2814, 2887-8
- Mental department, staff, *Baly* 2584-93, 2867-8

NURSING STAFF:

- Conditions of life, and service, *Baly* ... 2980-7
- Efficiency, *Baly* ... 2988-96
- Inadequate, *Baly* ... 2888, 2958-71

Lambeth Infirmary—cont.**NURSING STAFF—cont.**

- Men, source of, *Baly* ... 2976
- Qualifications obtainable after service, *Baly* 2977-9
- Remuneration, *Baly* ... 2972-8A
- Relative, friend or representative, attendance of, *Baly* ... 2570-9, 2650-6, 2871
- Specialist, cases of calling in, *Baly* 2826-8, 2844-5

Lancashire:

- Lunatics and mental deficient, accommodation for, *Taggart* ... 13,212-23

LUNATIC PATIENTS:

- Clinic for incipient cases, suggestion, *Taggart* 13,070-130; *Hodgson* 13,313.
- Discharges, statistics *re, Taggart* 13,114-25

MENTAL HOSPITALS:

- Medical Superintendent, appointment system, *Taggart* ... 13,243-9
- Number and accommodation, *Taggart* 13,212, 13,218
- Private patients, accommodation for, *Taggart* 13,058-61, 13,270-7
- Research work, *Beard* ... 19,556-7
- Poor law mental cases, statistics, etc., *Leach* 6147-50, 6158-61, 6183-93
- Visitation of Asylums by Guardians, procedure, *Leach* ... 6131-8
- Lancaster Mental Hospital, Morecambe Bay, private patients, *Sandhurst* ... 17,993-4
- Lavatory accommodation, *see under* Care and Treatment.

Leave of Absence:

- 48 hours, *Dixon* ... 3750-3, 4033, 4494-5
- Health, system, *Macleod* ... 467-9

ON TRIAL:

- Allowances during, *Macleod* 455, 466; *Willis* 523-4; *Connell* 4236-7; *Devine* 4555; *Lovsey* 5368-9; *Barham* 7480-1.
- Divergent practice *re, Parker* ... 11,106, 11,109
- Case remains under certificate, *Willis* 527-30; *Chubb* 6562-3.
- De-certification by, would restrict leave, *Chubb* 6829-30
- Discharge during, *Chubb* ... 6568-73
- Discharge at end of procedure, *Macleod, Bond, Willis* ... 475-80
- Divergence in application of section, *Parker* 11,106-11
- Encouragement by Board of Control, *Bond* 470; *Willis* 520, 524, 525.
- Extended use of, advocated, *Parker* 11,106, 11,109-23; *Mr. L.* 20,415.
- Extension, *Chubb* ... 6574-6
- Home conditions in connection with, *Barr* 7061-4

Non-return:

- some Amendment of practice desirable, *Chubb* 6603-11
- automatic Discharge, *Chubb* ... 6576-97
- Procedure, *Willis* 540; *Devine* 4452-6.
- Number of cases, 1922-23, from mental hospitals, *Willis* ... 519-20
- largely Resorted to, *Macleod* 454; *Bond* 460.
- Responsibility for patient during, *Chubb* 6586-90, 6596-7, 6612-25
- Return to hospital during, *Chubb* 6565-7, 6591-2
- Return to institution if necessary, before expiry of, *Macleod, Willis* ... 471-4
- Superintendent's fear of reputation suffering, question of, *Bond, Willis* ... 470
- System, and value of, *Macleod, Bond, Willis* 385-6, 452-9, 468-70, 472-5; *Dixon* 4033-6; *Keene* 4782-9; *Chubb* 6552-60; *Barr* 7065-6.
- Visiting of patients during, *Lovsey* 5366-7; *Worth* 17,255-6; *Goodall* 17,265.

Leeds Infirmary:

- Distinction felt by people between workhouse and, *Ford* ... 6213-7
- Mental blocks, *Ford* ... 6197, 6198
- Private cases in, *Ford* ... 6213-5
- Leicester City Mental Hospital, *see* Humberstone.

Letters, *see* Correspondence, under Care and Treatment.

Licensed Houses:

- Abolition advocated, *Gibson* 12,289-323, 12,367-88, 12,392-400
- Access to outside world, *Fawcett* 6988-9, 7016-23
- Accounts, audit of, would not be objected to, *Craig* 20,987-92
- Adequacy of accommodation, question of, *Cole* 17,046-7
- Admission to, through poor law, *Chubb* ... 6675-7
- Admissions, 1923, *Edwards* 6330
- Advantages of, *Craig* 20,993
- Advantages of public institution over, *Miss C.* 14,466-501
- Approval of system, *Craig* 20,924-8
- Balance sheet and list of shareholders, publication proposed, *Lomax* 12,928-34
- Bathing, etc., arrangements, complaint of, *Miss B.* 14,855-6
- alleged Bonus to doctor on each patient, *Miss C.* 14,584-6
- Charges, supervision question, *Craig* 20,985-92
- Complaints of detention not made at first interview, but by persons under detention for some period, *Fawcett* 6979-85
- COMPLAINTS:
- Deterrance from, owing to fear, no risk known, *Fawcett* 7037-9
- Investigation of, *Fawcett* 6917-27
- Continuance of, advocated, and want met by, *Langdon-Down* ... 13,500-12, 13,519-39
- should be under Control if certified cases taken, *Boyle* 18,707-8, 18,710-8, 18,723-6, 18,736-9, 18,741
- Convalescent and seaside homes, *Edwards* 6400-5
- Convalescent ward, personal experience and complaint, *Miss C.* ... 14,419-22, 14,425-34
- CONTROL:
- Board of Control, extent, *Edwards* ... 6475-6
- by Ministry of Health, no objection to, *Edwards* 6478-9
- Correspondence, *Edwards* 6365-6; *Fawcett* 7016-24.
- Criticism of, and increase objected to, *Parker* 11,288-329, 11,801
- public Demand for, *Lomax* 12,904-5; *Verrall* 13,516; *Cole* 17,044-5; *Sandhurst* 17,967-9, 17,987; *Hildyard* 18,231-40.
- Demand could not be met by registered hospitals, *Langdon-Down* 13,531
- DETENTION, IMPROPER:
- no Case known, *Fawcett* 6942-54; *Barr* 7054-61, 7113-6; *Hildyard* 18,234.
- certain Conflict of interest and duty, *Sandhurst* 17,997-8
- Safeguards against, *Willis* 497-9, 507-8; *Edwards* 6352-83, 6463-5; *Fawcett* 6988-9, 6993-5; *Barr* 7049, 7132-6; *Langdon-Down* 13,504, 13,543-4, 13,547-57; *Cole* 17,051, 17,060; *Sandhurst* 17,983, 17,995-7.
- Safeguard against, increase could be considered, *Langdon-Down* 13,558-9
- Tendency to keep people in, owing to profit made, *Miss C.* 14,411-7, 14,595-600
- Detention, unnecessary, denied, *Cole* 17,052-62
- Distinction from registered hospitals, *Yellowlees* 5818-20; *Edwards* 6333-9.
- unsatisfactory Distribution of, *Cole* ... 17,048
- Escape from, *Miss C.* 14,462-3
- Exploitation of patients, no risk of, *Cole* 17,052
- Extension, Board of Control should have power of, if necessary, *Cole* 17,281, 17,282
- Food, complaint of, *Miss B.* 14,857-9, 14,885, 14,887, 14,896
- History of, *Edwards* 6315-21
- Increase desirable, *Sandhurst* 18,005
- Interest on part of relatives to keep patients in, possibility of, admitted, *Langdon-Down* 13,708-9
- Lavatory accommodation, *Mr. B.* ... 14,721-2
- Letter writing and receiving not allowed, *Miss B.* 14,735-44, 14,750-5, 14,774, 14,895

LICENCES:

- Lapsed during last 15 years, *Sandhurst* 18,005-11
- Revocation, Lord Chancellor's power, *Willis* 619; *Schuster* 982-3.

Licensed Houses—cont

LICENSING:

- by Ministry of Health advocated, *Edwards* 6395
- System and procedure, *Edwards* ... 6394-5
- Limited liability corporations, *Edwards* 6472-4
- Medical supervision in, not always adequate, *Sandhurst* 17,897-915

MEDICAL SUPERINTENDENT:

- no Financial interest in many cases, *Edwards* 6463
- Mental qualifications desirable, *Sandhurst* 18,018-20
- inadequate Supervision by, *Mr. B.* 14,637-8, 14,652-4, 14,674-7
- Medical Visitor, duties, *Fawcett* 6899-904

METROPOLITAN:

- Licensed by Board of Control, *Willis* ... 616
- Number of cases in, 1st January, 1924, *Willis* 67
- Metropolitan and Provincial, numbers, *Edwards* 6343-6
- no New houses allowed under 1890 Act, *Willis* 82-8, 627-8, 923-4
- Notices, posting up of, *Bond* 802; *Fawcett* 7024-8.
- Number of, and of patients, decrease, *Edwards* 6321-8, 6340-2, 6351, 6421-4

NURSING STAFF:

- Advantages of public institution as regards, *Miss C.* 14,500-1
- Constant change, *Gibson* 12,319-22, 12,396-400
- Hours, *Miss C.* 14,581-3
- Period of service, *Lomax* 12,940-2
- Remuneration from patients' friends, objection to, *Gibson* 12,323
- Objection to, *Miss C.* 14,404
- Occupation, lack of, *Miss C.* 14,474-7; *Mr. B.* 14,678-82, 14,685.
- for Pauper patients formerly, but private only now, *Edwards* 6321, 6325-7
- Personal experience, *Miss C.* 14,557-77; *Mr. B.* 14,605-729; *Miss B.* 14,734-900.
- lack of Personal interest in patients, *Mr. B.* 14,605, 14,673, 14,682
- Private accommodation, provision in Lancashire by Local Authorities, *Taggart* 13,058-61, 13,270-7
- Private ownership of, objected to, and proposal re State or local running of, *Lomax* 12,901-20
- Profits, enquiry into, advocated, owing to temptation as result of, *Parker* 11,287-314, 11,317, 11,322-6, 11,801

PROVINCIAL:

- Licensed by justices, *Willis* 616
- Number of cases in, 1st January, 1924, *Willis* 67
- Visitation, *Willis* 294, 299-300; *Macleod* 299-302, 334-5, 341; *Barnsley* 1818-24; *Langdon-Down* 13,715-9.
- Receipt by patients of comforts for which payment made, question of safeguard, *Sandhurst* 17,999-18,004
- Recovery rates, *Langdon-Down* 13,504
- Recovery rate lowered by early discharge of patients by friends, *Cole* 17,053-4
- REMOVAL TO OTHER LOCALITIES:
- should be Allowable, *Cole* 17,048-9
- Difficulty, *Sandhurst* 17,970-9
- Removal of patients from one home to another, difficulty of, and procedure should be facilitated, *Boyle* 18,694-705, 18,729-31, 18,757-9
- Reports etc., scrutiny by Board of Control, *Fawcett* 6967-9
- RESTRICTIONS:
- a Mistake, *Cole* 17,044, 17,286-7; *Sandhurst* 17,967.
- Reason for, *Sandhurst* 17,980-2
- Repeal advocated, *Langdon-Down* 13,527-30; *Boyle* 18,682-93, 18,706, 18,719, 18,740-50.
- no Saleable value attached to, *Edwards* 6421-5
- Scottish system, *Marr* 15,478, 15,495-502, 15,533
- System, *Willis* 915-24
- Tenure, insecurity of, and suggestion, *Chubb* 6796-800
- Theoretical objection to, basis of, *Langdon-Down* 13,501
- Transference of licences, facilitation advocated, *Edwards* 6400-5
- Treatment in, complaint of, *Miss C.* 14,418-55

Licensed Houses—cont

very Useful and limitation might be reconsidered,
Willis ... 660-1
 Useful part played by, *Edwards* 6339, 6349-50

VISITATION:

by Commissioners, and interviews with patients,
Macleod 296-8, 301, 332-5, 341; *Edwards*
 6353-60, 6371-3; *Chubb* 6506-21, 6524-5, 6545-55,
 6825-8, 6880-7.

by Justices and medical visitor, procedure and
 interviews with patients, *Willis* 294, 299-300;
Macleod 299, 302, 334-5, 341; *Barnsley* 1818-24;
Chubb, 6504-5, 6520, 6536-48, 6801-16, 6881,
 6883; *Faussett* 6905-87, 6990-2, 6996-7014;
Barr 7052-61.

by Magistrates, continuation necessary, *Edwards*
 6396
 by Relatives, *Chubb* ... 6791-5

VOLUNTARY BOARDERS:

Admission on written request only, advocated,
Craig ... 20,697, 20,912

Encouragement of system advocated, *Langdon-Down*
 ... 13,520-3

Increase in number, *Lord* ... 17,048

becoming Insane, Amendment of Sec. 315
 desirable, *Edwards* ... 6427-39

Well conducted, *Lomax* ... 12,901, 12,903

L.R.C.P. and M.R.C.S., Curriculum for, *Baly*
 3000-9

Liverpool, Lunatic Patients:

Maintenance charges, *Taggart* ... 13,053-61

Pauperisation of, even when friends pay contribution,
Taggart ... 13,036-68

Transfer to private side, system re, *Taggart*
 13,040-8

Local Authorities:

Financial conflict with Guardians, *Gibson* 12,407-11

Position re research and suggestions, *Mott* 17,138-40;
Goodall 17,163-4; *Cole* 17,287; *Golla* 21,075.

Power of Ministry of Health re, *Brock* 1098-101
 1111-5, 1191-2

Powers and duties of, *Keene* 4702-19, 4729, 4734

Provision of Clinics by, see under Clinics.

Subscription to after care work, *Cole* 17,279;
Sidney 1921-3, 19,280.

Local Government Board, transfer of powers to
 Ministry of Health, *Brock* ... 1070-80

London County Council:

Lunacy administration by, *Keene* ... 4703, 4715-8

MENTAL HOSPITALS:

Accommodation possessed by, *Keene* ... 4852

Admission, discharge and readmission statistics,
Keene ... 4792-801, 5018-33

Admissions, sources of, statistics, *Keene* 4909-19

Clothing, *Sidney* 19,317, 19,325-7; *Gardner*
 19,317-24, 19,328.

Committee, *Keene* ... 4709-13, 4773-6, 4840-4, 4975

Negotiations with National Asylum Workers'
 Union, *Keene* ... 4773-6

Sub-Committees, *Keene* ... 4865-9

Domestic staff, wages, *Keene* ... 5040-5

Farms at, *Keene* ... 4756-8

Food, *Keene* 4747-53, 4955; *Sidney* 19,297-8,
 19,304, 19,306-7, 19,309-16; *Gardner* 19,299-303,
 19,305-6, 19,308-16.

Increase not anticipated, *Gardner* 19,380; *Sidney*
 19,380-2.

Laboratories, *Sidney* 19,352; *Gardner* 19,353.

Maintenance charge, *Keene* 4813, 4830, 4836-7.

Matrons, general hospital training desired,
Keene ... 4948-51

Medical Staff:

no Difficulty in obtaining, and method of,
Keene ... 4933-41, 5017

Facilities for qualifying in psychological
 medicine, *Sidney* 19,334-42; *Gardner* 19,339,
 19,342-6.

Increase, *Sidney* ... 19,332-3

Qualifications required, *Mott* 17,106, 17,109;
Sidney 19,347-50.

Salaries, *Keene* ... 4759-63

Study leave, *Mott* ... 17,110

London County Council—cont.**MENTAL HOSPITALS—cont.****Medical Superintendents:**

Knowledge of individual cases, *Sidney* 19,386,
 19,400-1, 19,403-4; *Gardner* 19,402-3.

Position, *Sidney* ... 19,390-9

Nursing Staff:

Conditions of service improved, *Sidney*
 19,369

Female:

Difficulty of obtaining suitable nurses,
Keene 4942, 4951; *Gardner* 19,355,
 19,359-62; *Sidney* 19,367.

Employment in male wards under considera-
 tion, *Sidney* ... 19,354

Hours, *Keene* 4994-6; *Sidney* 19,368.

Promotion, *Keene* 4770-2, 4781; *Gardner* 19,372.

Remuneration, *Keene* 4764-81, 4944-6, 4990-3,
 4997-5001.

Private patients in: *Baly* ... 2861

Admission as pauper patients and subsequent
 re-classification, *Keene* 4802-4, 4816-22,
 4953-4, 4956-9, 5035-9, 5065-8.

Charge the same as for pauper patients,
Keene ... 4809, 4811-3

Ex-service men, etc. as, if maintenance paid
 by the State, *Keene* ... 4848-51

Maximum sum charged, *Keene* ... 5069-71

Reports on, by Visiting Committee, *Keene*
 4790-3

Treatment the same as that of pauper
 patients, *Keene* ... 4805-10

Villa system, extension of, *Sidney* ... 19,405-7

no Overlapping with Middlesex County Council,
Keene ... 4858-61

Research under, *Golla* 21,008-46, 21,051, 21,062-74

Statistics of patients under, *Keene* ... 4848

Lord Chancellor:

Appeal from, to House of Lords, *Schuster* 966

Inquisitions, see that title.

JURISDICTION: *Willis* 32-35, 36; *Schuster* 1020.

Charitable institutions, patients in, *Schuster*
 977-80

Departments, *Schuster* 951.

Retention, question of need for, *Schuster*
 1002-II, 1030-7, 1042-4

Legal position, *Schuster* ... 964-6

LETTERS FROM PATIENTS:

Method of dealing with, *Schuster* 995-1001

Nature of, *Schuster* ... 998

MASTER IN LUNACY:

Appeal from, to Lords Justices, *Schuster* 961-3

Appointment, *Schuster* ... 951

Department:

Functions, *Hildyard*
 18,025-9, 18,032-5, 18,039, 18,091-6

Notification to, in certain cases, suggestion,
Hildyard ... 18,057, 18,170-95

Organisation, *Hildyard* ... 18,030-1

Jurisdiction, *Schuster* 952-60; *Sandhurst*,
 17,833-6, 17,853-7.

One only, now, *Sandhurst* ... 17,774-5

Relation to Board of Control, *Willis* 729-30;
Schuster 973-81.

Revocation of licences, power, *Willis* 619; *Schuster*
 982-3.

Visitation by order of, *Macleod*, *Willis* 342-8,
 353; *Schuster* 975-6.

Visitation, overlapping with Board of Control,
 no difficulty caused, *Willis* ... 39-42

VISITORS IN LUNACY:

Amalgamation with Board of Control visitors,
 question of, *Schuster* ... 1053-6

Appointment and duties, *Schuster* ... 967

Functions, distinction from those of Board of
 Control, *Schuster* ... 1032-5

Number, *Sandhurst* ... 17,767-73

Overlapping with Board of Control's visitors.
Schuster ... 1054-8

Reports, method of dealing with, *Schuster*
 989-94

Section 183, interpretation question, *Sandhurst*
 17,779-84

Lord Chancellor—cont.**VISITORS—cont.**

- Special reports by, to Lord Chancellor, *Sandhurst* ... 17,785-6
 Visitation by, *see* Chancery Visitors under Visitation.
 Work of, could be done by Board of Control, *Willis* ... 43
 Lords Justices, jurisdiction of, *Schuster* ... 961-4

Lunacy Act:

See also Certification and Reception Order.

- Sections 11 and 20, unnecessary duplication, *Whitemore* ... 3542-3

SECTION 13:

- Classes of cases coming under, *Lidbetter* ... 1488

- Conversion of non-pauper into pauper by, *Lidbetter* ... 1489, 1492-4

- Demarcation between pauper cases and cases under, *Macleod* ... 277-8

- Functions of relieving officer under, *Lidbetter* 1485-8, 1526, 1537-8

- Misunderstanding in connection with, *Lidbetter* 1488-90

- Persons sent to Poor Law Institutions under, *Bond* ... 262, 272, 278-9, 286-7

- Procedure under, *Macleod*, *Bond* 254-66, 286-7; *Willis*, *Macleod* 737-44.

- Procedure under Section 14 or, difficulty, *Leach* 6081-8, 6249-53

- Section 14 more used than, in Sheffield, *Flint* 6232-7

- Use, extent of, *Lidbetter* ... 1495-6

- Working of, in Cardiff, *Bond* 261-6, 286-7; *Sanders* 2336-42.

Section 15, *see* Lunatic wandering at large.

SECTION 20:

- Extension to borough asylums, suggestion, *Leach* 6099

- Large number of cases dealt with under, *Leach* 6090-2

Sections 24, 25, 26, *see* under Poor Law Institutions.

Section 49, proposed elimination of certain words, *Mr. L.* ... 20,418-9

PART XI:

- Anomalies in, *Bodkin* ... 17,630-763

- Classification of offences in, question of justification for, *Bodkin* ... 17,708-12

- Orders under, acceptance without further proof should be provided for, *Bodkin* 17,633-41

- Summary proceedings, alternative by indictment in certain cases, suggestion, *Bodkin* 17,650-9, 17,723-31

SECTION 315:

- Amendment desirable, *Edwards* 6407-13, 6427-39

- Cases dealt with under, nature of, *Bodkin* 17,637-91

- Date of committing offence, *Bodkin* ... 17,661-5

- Difficulty in connection with, and possible remedy, *Langdon-Down* 7854-60, 7869-79

- Initiation of proceedings under, *Bodkin* 17,692-3

- Safeguard against wrongful incarceration, *Bodkin* ... 17,669-75

- Splitting up of, desirable and suggestion *re*, *Bodkin* ... 17,642-50

- Terminology, etc., difficulties in connection with, *Bodkin* ... 17,680-6, 17,732-35

- Variation in terminology in, and suggestion *re*, *Bodkin* ... 17,660-5

- Voluntary system, safeguarding of, *Bodkin* 17,666-8

Section 317, insertion in, of "Director of Public Prosecutions," question of reason, and need for, *Bodkin* ... 17,694-707, 17,713-5

Section 320, "Sued," criticism of wording, *Bodkin* ... 17,722

Section 321, criticisms, *Bodkin* ... 17,736-8

Section 322, criticism, *Bodkin* ... 17,756-61

Section 326, criticism, *Bodkin* ... 17,763

Lunacy Act—cont.

- Section 327, criticisms of wording, *Bodkin* 17,739-49

- Section 328, criticism, *Bodkin* ... 17,750-4

- Intention not carried out, *Parker* ... 10,430-2

- Synopsis of, should be made available in pamphlet form for information of the public, *Parker* 11,046-50

Lunacy Administration, *see* Administration.

Lunacy Commissioners, *see* Board of Control.

Lunacy Law:

- Administration difficulty, *Parker* ... 10,611-4

- Code, *Willis* ... 15-13

- previous Inquiries, *Willis* ... 19-26

- Legal aspect emphasised instead of medical, *Craig* ... 20,697

- Legal element, re-assertion of, *Parker* 10,415-27

- Machinery very good on the whole, *Langdon-Down* 7920-1

- Principles of, *Willis* ... 13-14

- Simplification desirable with necessary safeguards, *Giles* 3095-9, 3114-6; *Cole* 16,624-8; *Collins* 16,624-32, 16,634-5.

- Special Acts, *Keene* ... 4714

Lunatic "Wandering at Large" (Sec. 15):

- Interpretation, *Lidbetter* ... 1763-4

- Procedure *re*, *Macleod* 243; *Lidbetter* 1554-6.

Maidstone, Kent County Mental Hospital:

- Open door wards, numbers in, *Lewis* ... 4618

- Reception ward, *Lewis* ... 4646-7

- Staff, proportion to patients, *Lewis* 4648, 4675-6

Maintenance:

See also Chargeability and under Mental Hospitals.

- Discretionary trusts, and position of Master in Lunacy, *Hildyard* ... 18,085, 18,091-6

PAYMENT:

- by Guardians, *Glanvill*, *Hill* ... 18,365-70

- Methods, *Hildyard* ... 18,082-8

Master in Lunacy, *see* under Lord Chancellor.

Maudsley Hospital:

- Langdon-Down* ... 13,647-50, 13,655

- Admission of patients and selection, *Mapother* 15,793-8

- After care, *Gardner* ... 19,294

- Approval of system, *Miss G.* 20,435-8, 20,458-9

- Cases sent by Guardians, *Gardner*, *Sidney*, 19,037, 19,074-85, 19,089

- no Certification of patients at, *Mapother* 18,799-805, 18,811-3

- Class of cases taken, *Mapother* 18,839-40; *Sidney*, *Gardner* 19,012-9, 19,124-36.

- Cost of running, *Mapother* 18,853-9; *Sidney* 19,050-9.

- Detention in, extent of, *Mapother* 18,787-8; *Sidney* 19,062-9, 19,090-4.

- Dietary cost, *Mapother* ... 18,992

- Discharge not recovered, *Mapother* ... 18,955-8

- Features of, *Keene* ... 4935-7

- Free treatment in certain cases, *Sidney*, *Gardner* 19,028-42, 19,044-53

- Functions of, *Mapother* ... 18,777

- a Legal anomaly, *Miller* ... 17,417

- Non-provision for non-volitional patients, a disadvantage, *Cole* ... 16,799

NURSING STAFF:

- Female, employment in male wards, *Goodall* 17,072; *Mapother* 18,905-9.

- Interest in research work, *Golla* ... 21,092

- Training, *Mapother* ... 18,910, 18,918

- Objects of, *Sidney* ... 19,020-7

- Out-patient department, *Keene* ... 4932-4

- Particulars *re*, *Mott* ... 16,809-10

- Patient desiring to leave, procedure *re*, *Sidney* 19,062-74

- Pathological laboratory, *Gardner* 19,346, 19,353; *Sidney* 19,351.

- Paying patients, charge to, *Sidney* ... 19,043

- Psychiatric training at, *Mott*, 17,106, 17,110, 17,118, 17,127-32; *Sidney*, *Gardner* 19,337-46.

- Research, *Mott* 17,173-4, 17,195; *Mapother* 18,976-7, 18,984; *Golla* 21,009-46, 21,062-74.

- Source of patients, *Gardner*, *Sidney* ... 19,086-9

Maudsley Hospital—cont.

- Statutory provisions *re*, Sidney ... 19,008-88
 Success of, *Mott* ... 16,807
 Voluntary boarders, statutory provision for, *Keene* 4930-2
 Voluntary patient becoming non-volitional, question of procedure and certification at Maudsley objected to, *Sidney* ... 19,094-121
 Mechanical Restraint, *see under* Care and Treatment.

Medical Certificates, *see* Certificates.

Medical Education in Psychiatry:

- Bethlem, *Phillips* ... 5974-5

CLINICAL TEACHING:

- Advocated, *Mott* ... 17,101
 at Cambridge University, not obtainable, *Mott* 17,116; *Goodall* 17,164.
 at Oxford University, difficulty, *Goodall* 17,164-5
 in Clinics, importance of, *Goodall* ... 17,164-7
 Clinics would be of value for, *Buzzard* 17,293-5
 Diploma, Edinburgh University, *Robertson* 15,732-5

- Edinburgh University course, *Robertson* 15,724-35
 Importance of, *Mott* ... 17,099-100
 Improvement desirable and lines of, *Connell* 4212-3; *Craig* 20,994-1000.

- Improvement necessary, *Buzzard* ... 17,291-5

- Inadequacy of, *Goodall* ... 17,164

- Lectures on general psychology at end of physiological course advocated, *Mott* 17,112-3, 17,126

- London M.D. in Psychological Medicine, *Mott* 17,132-6; *Cole* 17,136-7.

- at Maudsley Hospital, *Mott* 17,106, 17,110, 17,118, 17,127-32; *Sidney*, *Gardner* 19,337-46.

- Position *re*, *Edwards* ... 8002-9

- Provision in Mental Treatment Bill approved, *Mapother* ... 18,979

- Post-graduate courses, scheme, *Mott* ... 17,101

PSYCHOLOGICAL MEDICINE DIPLOMA:

- Good results from institution of, *Mott* ... 17,099
 Number of, and limitation to a few recognised universities desirable, *Mott* 17,110, 17,114-6, 17,119-22

- Obligatory for senior medical officers in London

- County Council asylums, *Mott* 17,106, 17,109

- Proportion of medical officers of asylums holding, question of, *Mott* ... 17,107-8

- Scotland, *Sandhurst* ... 18,024

- Teaching by general physician in ward desirable, *Craig* ... 20,995

Medical Staff of Institutions:

- Allocation of cases to, suggestion, *Lomax* 12,590, 12,592-4, 12,598-609

- Clerical work, *Lomax* ... 12,594-8

- greater Facilities for study and passing examinations desirable, *Hodgson* ... 13,326, 13,339

- Fluctuations and questions of preventing, *Golla* 21,083-5

- General medical experience desirable and position improving, *Collins* 17,230-3; *Mott* 17,230, 17,233.

- Inadequacy of, in many hospitals, *Lomax* 12,588-91

- Increase needed, *Parker* 11,801; *Mr. L.* 20,366.

- Interchange between asylums desirable, *Hodgson* 13,326-8, 13,339

- Proportion to number of patients, opinion *re*, *Collins* 17,196-200; *Craig* 20,977-80.

- Psychiatric training, *see* Medical education.

- Qualifications, *Mott* ... 17,107-8

- Retirement age, *Keene* ... 5001

- Salaries, scales, London County Council Mental hospitals, *Keene* ... 4759-63

- Special training, question of, *Bond* ... 859-65

- STUDY LEAVE:

- Difficulties in connection with, *Collins* 17,158-62.

- System under London County Council, *Mott* 17,110

Medical Superintendents:**ADMINISTRATIVE DUTIES:****Delegation:**

- Desirable and possible, *Yellowlees* 5401-11; *Langdon-Down* 13,560-81; *Marr* 15,658-60, 15,664; *Collins*, *Cole* 17,220-9, 17,233-41.

Medical Superintendents—cont.**ADMINISTRATIVE DUTIES—cont.****Delegation—cont.**

- in Practice, *Robertson* 16,228, 16,246-51; *Collins* 17,209-16, 17,226-9.
 Demarcation question, *Lomax* 12,471-6, 12,480-91, 12,507-15; *Hodgson* 13,333; *Masterman*, 13,582-93.
 Departmental heads advocated, *Robertson* 16,227-9

Relief from:

- Advocated, *Lomax* 12,465-91, 12,502-17, 12,562, 12,583-5; *Hodgson*, 13,329-38; *Sandhurst* 17,885-94; *Mr. L.* 20,366, 20,370.

- not Advocated, Superintendent must be supreme head, *Langdon-Down* 13,560-81; *Robertson* 16,226; *Worth* 17,333-41; *Sidney* 19,390-9.

- Difference of opinion *re*, *Sandhurst* ... 17,886-7

- Difficulty and possible solutions, *Parker* 11,362-426

- in Military hospitals, etc., *Sandhurst* 17,889-90

- not Possible, *Marr* ... 15,663, 15,667

- Question of possibility of certain relief, *Barham* ... 7433-49

- Transfer to clerk and steward advocated and no need for friction, *Goodall* 17,201-9, 17,219

APPOINTMENT:

- Assistance of Board of Control, case of, *Willis* 926-8

- Improvement in method advocated, *Parker* 11,348-54, 11,358-9

- by Ministry of Health, desirability, *Lomax* 12,492-501

- Period of, question, *Parker* ... 11,355-7

- Provisional, would be approved, *Parker* 11,360-1

- System, Lancashire, *Taggart* ... 13,243-9

- by Visiting Committees, objection to, *Lomax* 12,492-501, 12,577-80

- Dependence on Chief Attendant and suggested remedy, *Mr. Y.* ... 20,629-33

- Discharge by, *see that title.*

- Dismissal of nursing staff should be in power of Committee, not of, *Gibson* ... 12,328-44

- Duties, confining of, to medical affairs advocated, but remaining disciplinary authority with power of suspension only, *Gibson* ... 12,328-41

- should Go round wards with officers, *Lomax* 12,517, 12,569

- alleged Inattention on part of, complaints heard, *Sandhurst* 17,883-4, 17,895-6, 17,902-5, 17,913-5

- Individual attention to patients, extent of, *Robertson* ... 16,229-35, 16,240-61

- Interchange between asylums advocated, *Hodgson* 13,327-8

- Knowledge of cases, extent of, *Devine* ... 4559-60

- shorter Period of service for pension advocated, *Hodgson* ... 13,328

- Personal interest in patients, importance of, *Lomax* 12,568-9, 12,571-2, 12,576

- as Petitioner, should not be allowed, *Miss G.* 20,553-6

- POSITION OF:

- should be more Independent of Visiting Committee, *Lomax* ... 12,492-501, 12,563, 12,577-82

- as regards Medical treatment, *Parker* 11,335-47

- QUALIFICATIONS: *Parker* 11,352-4; *Sandhurst* 18,021-4.

- not always Adequate, *Parker* ... 11,640

- Medico-psychological technical, advocated, *Hodgson* ... 13,325

- Psychological medicine diploma, advocated, *Mott* 17,124

- Special, desirable, *Walden* ... 2131-3, 2161

- Reliance on subordinates to some extent essential in large institutions, *Sidney* 19,384, 19,386-9; *Gardner* 19,385.

- Research work, advantage to, *Hodgson* ... 13,328

- Retirement, age, *Dixon* 4007-11; *Keene* 5001.

- Senior medical officer for medical duties, suggestion, *Parker* ... 11,374-82, 11,385-95, 11,411-26, 11,801

Medical Superintendents—cont.

- subsequent Service under Board of Control, should count for pension, *Hodgson* ... 13,477
 Signing of certificates by, opinions *re*, *Devine* 4534-5; *Lomax* 12,822.
 Specialist advocated as, *Lomax* ... 12,573, 12,581
 Strain of work, *Hodgson* ... 13,328
 Surprise visits by, impossibility, *Mr. Y.* ... 20,678
 Visits to more advanced institutions or to research body, suggestion, *Parker* ... 11,355, 11,357

Medical Treatment, see under Care and Treatment.**Medico-Psychological Association of Great Britain and Ireland:**

- Evidence on behalf of, *see* *Cole*, Dr. R. H., M.D., F.R.C.P., etc. ... 16,599-17,287
 Certificate, *see under* Nursing Staff.
 Formation, objects, etc., *Cole* ... 16,602-5
 Relationship with General Nursing Council, *Collins*, *Cole* ... 16,613-9
 M.R.C.S., curriculum for, *Baly* ... 3000-9

Mental After-Care Association, see After-Care Association.**Mental Board of Health:**

- Approval of, *Carswell* ... 16,592
 Suggestion, *Gibson* ... 12,425-7
 Suggestion, *Menzies* ... 17,031

Mental Defectives:

- Accommodation difficulty, *Devine* ... 4515
 Increase question, *Devine* ... 4516-7
 Transfer from Lunacy Act to Mental Deficiency Act, difficult, *Devine* ... 4514

Mental Deficiency Act:

- Amendment of, to include cases of adolescent mental disorder, question of, *Fox*, *Tredgold* 21,241-3, 21,246-9
 Certification under, of patient who could not be certified under Lunacy Acts, *Baly* ... 2928-9
 Class of persons dealt with, and distinction from class under lunacy law, *Willis* ... 8-12
 Juveniles should be dealt with under, rather than under Lunacy Acts, *Lidbetter* ... 1726-9
 Semi-charitable institutions under, *Langdon-Down* 13,524-6
 Visitation by justices under, *Barnsley* 1881-911, 1936-41

Mental Disease, new attitude towards, required, Langdon-Down ... 7811**Mental Excitement, decrease of, and causes, Robertson** ... 16,144-68**Mental Hospitals:**

- Acute block, separation from mental hospitals, suggestion, *Mott*, *Lord*, *Cole* ... 16,948-53, 16,962
 Admission, *see that title*.
 Admissions, 1923, *Edwards* ... 6330
 might be Allocated for special types of cases, if suggestions *re* treatment in general hospitals, etc., carried out, *Craig* ... 20,800-3
 Atmosphere of, *Blood* 12,181-4; *Gibson* 12,185-6.
 Care and treatment, *see that title*.
 Cases from workhouses, proportion, *Macleod* 875
 Chronic cases only in, arguments against, not agreed with, *Craig* ... 20,811-2
 Class of cases that should and should not be dealt with in, *Lomax* 12,528-56; *Boyle* 18,611-7, 18,622, 18,649; *Mapother* 18,843-5. 18,961-2 (*see also under* Clinics).
 Closer association with teaching institutions and universities advocated, *Worth* ... 17,344
 Comfort of patients, jurisdiction of Board of Control, *Willis* ... 667
 Consultative alienist, desirable if possible, *Parker* 11,383-4

Detention in, see that title.**Discharge from, see that title.****80 per cent. of cases are in, Willis** ... 60**Executive officer, medical man as desirable, Lomax** 12,570-5**Government grant, proposal, Gibson** ... 12,285-8**HOSPITAL CASES:**

- Larger section of hospitals should be devoted to, *Lomax* ... 12,534, 12,999-3000
 Practice *re*, and medical officer should continue to attend to own cases, *Lomax*... 12,609-10

Mental Hospitals—cont.

- Hospitalisation of, progress in Scotland, and importance of, *Robertson* ... 16,095-143, 16,197-205

INTERNAL ADMINISTRATION:

- Committees of inquiry, *Willis* ... 669-70
 no Statutory powers to Board, and not needed, *Willis* ... 841, 842-3

MAINTENANCE CHARGE AND CHARGEABILITY:

- in Excess of 14s., approval of County Council required, *Keene* ... 4831-5
 per Head, *Willis* ... 524
 Medical arrangements, jurisdiction of Board of Control, *Willis* ... 668

Medical Staff, see that title.**Medical Superintendent, see that title.**

- Number, *Willis* ... 89

- Number of cases in, 1st January, 1924, *Willis* 67

Nursing Staff, see that title.

- Nursing and treatment satisfactory on the whole, *Devine* ... 4504-6

Private patients, see that title.**PUBLIC INTEREST IN, INCREASE:**

- Desirable, *Dixon* ... 3811-24
 Doubtful, *Parker* ... 10,575-87

PUBLICITY:

- Increase desirable, *Dixon* 3811-24; *Barham* 7608-10.

- Value of, *Devine* ... 4354-5

Reception, see that title.

- Rules and regulations, statutory requirement, *Willis* ... 666

SIZE:

- 1,000 patients, sufficient, *Lomax* ... 12,515-7
 2,000 patients not excessive, *Sidney* 19,383-4, 19,400

- Large, not objected to where only chronic cases, *Mapother* ... 18,862-4

- Limitation desirable, *Parker* 11,366-8, 11,801

- Question, *Barham* 7505-6, 7531-3, 7668-9; *Craig* 20,974-7.

- Staff, duties of Visiting Committee *re*, *Keene* 4735-9

- Stigma should be removed from, *Yellowlees* 5719

- Structural alterations, procedure, *Keene* ... 4723-7

- attached to Towns and part of communal life preferable to large isolated institutions, *Devine* 4351-64, 4468

- Transfer of cases to Poor Law Institutions, *see under* Poor Law Institutions.

- Transfer of senile cases to workhouses, suggestion, *Beard* ... 19,418-52

Visitation, see that title.**Voluntary Boarders, see that title.****Mental Hospitals Association:**

- Faudel-Phillips* ... 5926-9

- Constitution, functions, etc., *Taggart* 13,005-19

- Evidence on behalf of, *see* *Taggart*, Alderman J. G., J.P., and *Hodgson*, Alderman Sir William 13,005-13,499

- Objects of, *Hodgson* ... 13,443

- Mental Medical Officer of Health, regional local authorities should have power to appoint, *Carswell* ... 16,593

Mental Treatment Bill:

- After-care expenditure by Local Authorities, provision approved, *Sidney* ... 19,280, 19,291-3

- Approved, *Phillips* ... 5872-3

- Approved in the main, *Langdon-Down* 8164; *Sidney* 19,006-7.

- Board of Control staff, proposed reduction, *Parker* 10,449-54.

- Clause 2, permissive power only, not sufficient, *Cole*, *Lord* ... 16,849-50

- Inspectors, criticism of clause, *Hodgson* ... 13,449, 13,451-64

- Medical training provisions approved, *Mapother* 18,979

- Principle approved by Association of Municipal Corporations, *Beard* ... 19,453, 19,554-6

- Principle approved but not certain details, *Hodgson* ... 13,358-61, 13,471

- Provisions approved, *Barnsley* ... 1951-60

Mental Treatment Bill—cont.

- Research, provisions *re*, *see under* Psychiatric research.
 Selection of medical practitioners for certification of voluntary patients, criticism, *Hodgson* 13,465-71
 Single care cases, omission from, *Cole* 16,857-62
 Visiting Committees, provisions *re*, *see under* Visiting Committees.
 Voluntary boarder and voluntary patient, distinction objected to, and "voluntary patient" advocated, *Cole*, *etc.* ... 16,851-6, 16,862-73

Metropolitan Asylums Board:

- Number of cases under, *Willis* 67; *Francis* 1410, 1414-7.
 Senile dementia cases now received by, without certificates, *Lidbetter* ... 1737-9

Middlesex Hospital:

- St. Luke's Clinic, particulars *re*, *Gilmour* 18,391-500
 Special ward for temporary cases, *Craig* ... 20,719

Moorcroft:

- Contact with outside world, *Mr. H.* 8645-60, 8952-60
Fees, *Stilwell* ... 9784-5, 9789-93
 Life at, *Mr. H.* 8393-549, 8561, 8771-92, 8801-6, 8935-51, 8992-9002, 9075-6; *Craig* 9251-62, 9279-300, 9473-6; *Steele* 9560-616; *Stilwell* 9716-69, 9793-926, 9931-40; *Smith* 9973-40.
 Death certificates, complaint *re*, *Mr. H.* ... 8691
 Medical treatment prescribed by patient, *Mr. H.* 8617-21
 Patients, sources of, *Stilwell* ... 9775-82
 Position of witness *re*, *Craig* 9476-86, 9540-3

Morningside Royal Hospital:

- Admission to, methods, *Robertson* ... 15,812-20
 Exercise, *Robertson* ... 16,111-3
 Medical staff, *Robertson* ... 16,081-5, 16,231
 Nursing staff, *Robertson* ... 16,042, 16,080
 Particulars *re*, *Robertson* 15,687-723, 16,069-71, 16,228-61

Munro, Dr.:

- Opinion *re*, *Mr. H.* ... 9950
 Surrender of licence, *Mr. H.* 8553-60, 8727-34; *Sandhurst* 18,009.

Napsbury Mental Hospital, weights on going in and coming out recorded, *Lohjoit* ... 5168-9**National Association of Masters and Matrons of Poor Law Institutions:**

- Evidence on behalf of, *see Senior*, *Harold*, and *Usher*, *George* ... 3174-3539
 Membership, *Usher* ... 3259-65
 Representative character of, *Usher* ... 3479-80
 National Association of Relieving Officers, evidence on behalf of, *see Lidbetter*, *Ernest James* 1474-1775

National Asylum Workers' Union:

- Administration, *Gibson* ... 11,869
 Branches, *Gibson* ... 11,864-8
 Conferences, *etc.*, *Gibson* ... 11,863
 Evidence on behalf of, *see Blood*, *Walter*; *Gibson*, *George*; and *Wiese*, *Maud* ... 11,835-12,451
 Magazine, *Gibson* ... 11,871-6
 Membership, and proportion of workers represented by, *Gibson* ... 11,852-5
 Negotiations with London County Council Mental Hospitals Committee, *Keene* ... 4773-6
 Objects of, *Gibson* ... 11,861-2
 Officers' section, *Gibson* ... 11,856-8

National Council for Mental Hygiene: *Fox* 21,244

- Evidence on behalf of, *see Buzzard*, *Dr. E. Farquhar*, *M.A.*, *F.R.C.P.*, *etc.* 17,288-17,433
 Formation, objects, *etc.*, *Buzzard*... 17,288-90

National Society for Lunacy Reform:

- Evidence on behalf of, *see Parker*, *Robert Montgomery Birch* ... 10,346-11,834
 Formation, membership and objects, *etc.*, *Parker* 10,346-64, 10,376
 Statement on behalf of, 23rd day.

Naval and Military hospitals, number of cases in, 1st January, 1924, *Willis* ... 64, 67

- Neurasthenic cases, voluntary treatment, *Salford Union Infirmary*, *Giles* ... 3157-8
 Non-certification of certifiable patient, case of, *Barr* 7117-23

Non-Volitional cases:

see also under Clinics.

- should be Admissible to clinics, *Mapother* 18,814-8
 Admission on application by relative, friend or public official, with two medical recommendations, proposal, *Willis* ... 21,355-60, 21,377
 Admission for six months' period, with power of extension, proposal, *Willis* ... 21,368-70
 Certification not advocated necessarily, *Boyle* 18,727-8
 Detention question, *Lord*, *Goodall* 16,738-45; *Cole* 16,914-7
 Discharge from passive class, proposed power to Board of Control, *Willis* ... 21,362
 Institutions, inspection by Board of Control, proposal, *Willis* ... 21,361
 Institutions proposed for, *Willis* ... 21,350-4
 Medical report to Board of Control within seven days, proposal, *Willis* ... 21,361
 Method of dealing with, *Sidney*, *Gardner* 19,152-68
 Notification, proposal, *Lord* 16,758-9; *Menzies* 16,779; *Worth* 17,323; *Willis* 21,361.
 Position, *Willis* ... 21,263-7
 proposed Procedure, *Barr* 7091-7; *Robertson* 15,892-3.
 Recovery of volition, proposed procedure, *Willis* 21,371-5
 Removal by petitioner, proposal, *Willis*, *Macleod* 21,363-7
 becoming Resistant, proposed procedure, *Willis* 21,376
 Voluntary boarders becoming, *see under* Voluntary boarders.

Norfolk County Mental Hospital:

- Cases, statistics, *Connell* ... 4220-30
 Children in, *Connell* ... 4181-4
 Classification of cases, *Connell* ... 4117-28
 Conditions in, *Connell* ... 4081-2, 4090
 Correspondence, method of dealing with, *Connell* 4065-8
 Diet, *Connell* ... 4140-1
 Employment of patients, *Connell* ... 4045-8, 4191-2
 Maintenance rate, *Connell* ... 4138-9
 Number of cases, *Connell* ... 4080

NURSING STAFF:

- Age of, *Connell* ... 4195-8
 Hours of work, *Connell* ... 4199
 Number of, to number of patients, *Connell* 4175-7
 Two cases of dismissal for ill-treatment of patients, *Connell* ... 4165-7
 Source of patients, *Connell* ... 4152-3
 Visits by medical officers, *Connell* ... 4170-4

Notices, *see under* Care and Treatment.

Notification of Patients:

see also under Non-volitional Cases and Nursing Homes.

- to Board of Control, advocated, in place of certification, with increased inspection and visitation, *Robertson* ... 15,832-52, 15,879-82, 15,899
 some Form of, necessary in certain cases, *Craig* 20,818
 Frivolous and needless, greater safeguards against, desirable, *Whitemore* ... 3584-5

Nursing Homes:

see also Private Houses and Single Care.

- Control not advocated unless certified cases taken, *Mapother* ... 18,819-33
 Registration and supervision, suggestions, *Buzzard* 17,299-321, 17,430; *Mapother* 18,824-6; *Craig* 20,637, 20,909.

TREATMENT OF MENTAL CASES IN:

- Advocated, *Mapother*, *Craig* 18,868; 20,697, 20,912-4
 should be Allowed subject to inspection, *Edwards* 6410-3

Nursing Homes—cont.**TREATMENT OF MENTAL CASES IN—cont.**

Certified cases should be received in homes approved by Board of Control, *Willis* 21,386
 Desired, difficulty and question of solution, *Buzzard* 17,299-322, 17,429-30; *Worth* 17,327-32; *Miller* 17,428.
 Inspection of home by Board of Control, proposal, *Willis* ... 21,318-27
 Notification to Board of Control, proposal for, in certain cases, *Willis, Macleod, Bond* 21,274-84, 21,295, 21,303-7
 Suggestion, *Willis*, etc. ... 21,268-307
 not Suitable, *Barr* ... 7163-5

Nursing Staff:**ACCOMMODATION:**

Claybury, Barham ... 7295-300
 Living out, desirable, *Gibson* 12,357, 12,359-61
 York, The Retreat, *Yellowlees* ... 5497
 Age, *Connell* ... 4195-8
 Better class advocated, *Miss C.* ... 14,528-37
 Career favourable compared with general nursing, *Phillips* ... 5916
 subsequent Careers, *Yellowlees* ... 5502-4
 Certificates, other qualifications more important, *Lomax* ... 12,668-9

CHARGE NURSE:

Duties, *Gibson* ... 11,911-22, 12,087
 Transfer to another institution, difficulty, *Gibson* 12,044-6
 no Complaint of, *Miss C.* ... 14,498-9
 Conditions of service, improvement desirable, *Dixon* 3848-55; *Lomax* 12,674.
 no Difficulty experienced, *Giles* ... 3134
 Difficulty of obtaining, *Keene* ... 4951-2

DISABLEMENT FROM DISEASE:

present Procedure, *Gibson* 12,153-4, 12,163-74
 Special diseases should be scheduled as industrial diseases under Workmen's Compensation Act, *Gibson* ... 12,153-74
 Dismissal, should be in power of Committee and not of Medical Superintendent, *Gibson* 12,328-44
 EXAMINATIONS: *Gibson* 11,942-67, 12,442-6, 12,450-1; *Wiese* 11,965.

Desirable type of women excluded by, *Gardner*

19,359-66

Failure to pass final examination, procedure on, *Gibson* ... 11,903-9

Medico-Psychological: *Gibson* 11,951, 11,965-6
 too Difficult, *Mott* ... 17,168-71, 17,184

Drawing up of scheme, *Hodgson* 13,479-80

Interest of nurses in lectures, *Cole* ... 17,188

Syllabus, not too difficult, *Hodgson* ... 13,481-2

same Syllabus adopted by General Nursing Council, *Collins* ... 17,190

Working of, in practice, *Collins* 17,184-92

Method of holding, criticism, *Lomax* 12,678-80; *Gibson* 12,681-2.

Standard too difficult, *Lomax* ... 12,668, 12,675

FEMALE:

Accommodation, *Miss H.* ... 19,581-3

Accommodation and suggested improvement, *Gibson, Wiese* ... 12,357-8

16 too young, *Mr. P.* ... 14,339-40

Bad class of, and use of bad language, *Miss H.*

19,577, 19,592, 19,600-12, 19,649

Complaint of, *Mrs. G.* ... 20,585

Difficulty of getting, *Baly* 2958-71; *Devine* 4471;

Keene 4942, 4951; *Gardner* 19,355, 19,359-62;

Sidney 19,367.

Employment in male wards:

Abroad, *Goodall* ... 17,072

Advantages of, *Hodgson, Taggart* 13,484-91;

Robertson 16,047, 16,060, 16,089-94.

Advocated, *Parker* 11,455-6; *Marr* 15,688;

Robertson 16,061-4; *Goodall, Menzies* 17,063-

87; *Mapother* 18,904-9.

All cases not suitable for, *Menzies* ... 17,085

Approved, *Lomax*... 12,993-5

Approved with certain limitations, *Barham*

7267-71, 7624-5

Camberwell House, *Edwards* 6414-20, 6457-62;

Gibson 12,135-7.

Nursing Staff—cont.**FEMALE—cont.**

Employment in male wards—cont.

Discretion to medical superintendent advocated, *Lord* ... 17,087-9

in London County Council hospitals, under consideration, *Sidney* ... 19,354

Male nurses will lose training necessary for registration, *Wiese* ... 12,175

Memorial from asylum medical officers to Board of Control, *Robertson*... 16,072

Objections to, *Gibson, Wiese* ... 12,100-52

Objections to, reply to, *Robertson* ... 16,056-9

in Practice, *Comrie*, 16,333-5, 16,352-4; *Hodgson, Taggart* 13,484-8; *Goodall* 17,072; *Gilmour* 18,490-3; *Mapother* 18,905-9.

Resignations awaited, no men displaced by, *Robertson* ... 16,086-8

Results not satisfactory, *Gibson* 12,143-52

in Scotland, *Marr, Rose* 15,669-72; *Robertson*

16,036-68, 16,075-9, 16,086-90.

Spreading of phthisical cases throughout institution owing to, *Gibson* ... 12,137, 12,152

Success of, *Goodall* ... 17,067-71, 17,082-4

Trade Union attitude, *Robertson* 16,073-7;

Goodall 17,073-9.

Fluctuations, *Dixon* 3930-3; *Barham* 7218, 7272-

5; *Gibson, Wiese* 11,975-81, 12,080-3;

Mapother 18,903.

Hospital training, lack of, and need for, *Miss H.* ... 19,612, 19,666

Illiteracy of, *Miss C.* ... 14,528-32

Personal experience as nurse, *Miss H.* 19,567-810

Recruiting method and difficulty, *Barham* 7223-7

Thefts by, *Miss H.* ... 19,682-3

Unsatisfactory prospects, *Gibson, Wiese* 11,990-3

large Floating population, *Lomax* ... 12,670-2

FOOD:

Badness of, *Miss H.* ... 19,701

Charge for meals even if not had, *Miss H.*

19,704-15

and Comparison with that of patients, *Gibson*

12,035-7

Good type, difficulty of obtaining, *Gibson* 12,406

HOURS OF WORK: *Connell* 4199; *Devine* 4470;

Keene 4994-6; *Crosland, Yellowless* 5482-9, 5501;

Chubb 6821-2; *Barham* 7204, 7325-30; *Sidney*

19,368.

Long hours in some cases, *Gibson* ... 12,092-5

Three-shift system and desirability of, *Gibson,*

Wiese 11,888, 11,891-4, 12,055, 12,068-9, 12,075-

97, 12,348-50, 12,434-9.

Ill-treatment by, see under Care and Treatment.

Increase needed, *Parker* 11,801; *Mr. L.* 20,366.

Inefficiency, *Mrs. M.* 13,870-1, 13,876-8.

in Infirmarys and Asylums, comparison, *Leach*

6101-10

INTERCHANGEABILITY WITH GENERAL HOSPITALS:

not Likely to be successful, *Edwards* ... 6441-5

Question of, *Dixon* 3856-8; *Yellowlees* 5428-32,

5445, 5449-57, 5467-8; *Barham* 7286-93, 7553.

Interest in patients, *Blood, Gibson, Wiese* 12,194-6

Key chains, abolition advocated, *Gibson* 12,253-4,

12,259; *Wiese* 12,254-8.

Leave, *Gibson, Wiese* 12,092-9.

should be Made a Vocation, *Barham* ... 7529

MALE:

Conditions more satisfactory than on female

side, *Gibson* 11,984-90.

14 hours day, *Mr. W.* ... 20,303

Inexperienced, *Mr. O.* ... 20,222

Dr. *Lomax's* testimony to, quoted, *Gibson*

12,226

Personal experience as attendant, *Mr. M.*

19,812-20,038

more Satisfactory when in charge of sister,

Lambeth Infirmary, Baly ... 2988-96

Special:

Extra pay should be received by, *Mr. M.*

19,827, 19,835-44

Unable always to give whole attention to

patient, *Mr. M.* ... 19,844

Thefts of patients' food by, *Mr. M.* 19,853-84

Nursing Staff—cont.**MALE—cont.**

20-30 patients in charge of one attendant while other attendants in playing fields, *Mr. M.* 19,931-47

Type of, complaint *re, Mr. P.* ... 14,340-8

Understaffing, *Mr. O.* ... 20,150-2

Matrons, general hospital training, desirable, *Keene* 4948-51.

MEDICO-PSYCHOLOGICAL CERTIFICATE:

Incentive to obtain, *Hodgson* ... 13,482-3

Number of awards, *Gibson* 11,968-9; *Cole* 16,606.

Requirements and system of certification and comparison with those of General Nursing Council, and question of fusion, *Collins* 16,608-18; *Cole* 16,619-20.

National Asylum Workers' Union, negotiations between London County Council Mental Hospitals Committee and, *Keene* ... 4773-6

Night, inadequacy of, and assistance by witness, *Mrs. M.* ... 13,943-5

One nurse in charge of four wards for 9-10 duty, *Miss H.* ... 19,715-52, 19,800-6

Patience of, under provocation, *Lovsey* ... 5273-4

Periods of service of male and female, *Gibson* 11,971-2, 11,980

POOR LAW INFIRMARIES:

Daily worker, *Mrs. M.* ... 13,729, 13,789-93

Extra work paid for, Southampton, *Senior* 3500-1

25 should be minimum age, *Senior* ... 3499

Training, proposal, *Senior* ... 3466

Prevention of discharge by, denial, *Blood, Gibson* 12,202-9

Private nursing, prospects, *Gibson* 12,008-19, 12,021-2, 12,023-6; *Wiese* 12,019-21, 12,023.

PROBATIONERS:

Charge of suicide cases at 18, *Gibson* ... 12,413-4

Contract to stay for certain period advocated, *Lomax* ... 12,672

Duties, pay, &c., *Senior* 3488-501; *Gibson* 11,884-92

Duties and training after first three months, *Gibson* ... 11,895-903

Good class of, important, and question of inducements, *Gibson* ... 11,923-9

Hours, *Gibson* ... 11,887-94

Monthly contracts generally, *Gibson* ... 11,880-3

Previous experience very rare, *Gibson* ... 11,877-9

Qualifications required, criticism, *Miss H.* 19,575-7

Promotion prospects, London County Council mental hospitals, *Keene* ... 4770-2 4781

Proportion to patients, *Connell* 4175-7; *Yellowlees* 5720-1; *Barham* 7204-7.

Qualifications desirable, *Barham* ... 7255-64

Receiving ward, number of nurses and patients, *Mrs. M.* ... 13,949-50

Recruitment, more supervision over character of nurses engaged needed, *Lomax* ... 12,672

Registration by General Nursing Council, *Wiese, Gibson* ... 12,175-80

REMUNERATION: *Baly* 2972-6; *Senior* 3222-4, 3490-1, 3498; *Usher* 3246-8; *Dixon* 3929; *Keene* 4764-81, 4944-6, 4990-3, 4997-5001; *Edwards* 6469; *Chubb* 6653-6.

no Emoluments generally nowadays, *Gibson* 12,404-5

Excessive for probationers and insufficient for seniors, *Dixon* ... 3849-50

Fixed salary with deduction for services given by authorities advocated, *Gibson* 12,028-39

no General standard, *Gibson* ... 12,001

Increase desirable for obtaining certificate, *Gibson* ... 11,930

of Male charge nurse, recommendation of Departmental Committee inadequate, *Gibson* 12,039-44

Recommendations, *Gibson* ... 12,047-53

by Salary and emoluments, objection to system, *Gibson* ... 12,027-39

of Uncertified staff, opinion *re, Gibson* 11,930-1, 12,351-2

Nursing Staff—cont.**RETIREMENT:**

Age of, *Keene* ... 5002-7

at 55, many female nurses break down before, *Gibson* ... 12,345-7

Status, improvement advocated, *Parker* 11,433, 11,451, 11,710

Subsequent experience in general hospitals, difficulty, *Barham* ... 7279-93

TRAINING:

Bethlem, *Phillips* ... 5915, 5918

Claybury, *Barham* ... 7213-22, 7234-9, 7294

Examinations, *see that title above.*

General hospital experience:

Desirable, *Phillips* 5917-8; *Chubb* 6659-63.

Desirable for certain number, *Yellowlees* 5442-4, 5454-6, 5470

not Desirable, *Edwards* ... 6441

Importance of, *Leach* ... 6101-6, 6280

Importance of, *Gibson* ... 11,932

Improvement, *Gibson* ... 11,924

Inefficient in some institutions, *Gibson* 11,907, 11,937-41

Lectures to, *Dixon* ... 3859

Maudsley Hospital, *Mapother* ... 18,910, 18,918

at the Retreat, York, *Yellowlees* 5424-70, 5491-500

Standards should not necessarily be enforced on existing staff, *Lewis* ... 4667-72

Subsequent training in general hospital, difficulty of obtaining, *Wiese* 11,994-7; *Gibson* 11,994-12,000

Tribute to, *Leach* ... 6104

Uncertificated, no new entries of, should be allowed, *Gibson* ... 12,353-4

Understaffing, *Blood* ... 12,198-9, 12,201

Unsympathetic, *Mrs. M.* ... 13,864-78

Untrained, *Miss B.* ... 14,896

Well qualified and well selected, importance of, *Dixon* ... 3846-55

Observation Hospitals, *see* Reception Houses.

Observation Period:

Cure during, possibility of, *Walden* 2071, 2076

Detention order would be necessary, *Barnsley* 1870-1

power of Detention during, would be necessary, *Baly* 2813-8; *Giles* 3090, 3100-9, 3160.

Discharge during, at any time, on Justices' order, advocated, *Barnsley* ... 1872-5

Legal restraint necessary during, *Lomax* ... 12,866

Longer than 14 days, Board of Control sanction should be required, as safeguard, *Whitemore* 3581-4, 3598

Need for, *Lidbetter* 1670-2, 1707-8; *Walden* 2065-6;

Lord 2248-51, 2283, 2289; *Baly* 2605, 2804-8;

Giles 3088-92, 3099, 3110-1, 3117; *Whitemore* 3578-84;

Broome *Giles* 3632-4; *Faudel-Phillips* 5957-8;

Probert 5993-5, 5997; *Flint* 6224-9;

Chubb 6731-9, 6753-68; *Barr* 7080; *Langdon-Down* 7839-44;

Phillips 10,308-11; *Parker* 10,479-82;

Mapother 18,926-32, 18,936-7.

PRIVATE CASES:

Desirable, and proposal *re, Whitemore* 3578-84; *Broome* *Giles* 3632-4.

Place of, question of, *Broome* *Giles* ... 3637-47

Securing of, by use of Section 24 in addition to Section 20, *Lidbetter* ... 1613-7, 1655-6, 1662-3

Temporary observation order, suggestion, *Phillips* 5880-95, 5909-12

WARDS ATTACHED TO GENERAL HOSPITALS:

Advantages of, *Carswell* 16,538, 16,574-6, 16,579-83

Advocated, *Devine* 4292-6; *Phillips* 5889-91.

Application to England, question of possibility, *Carswell* ... 16,596-7

Detention:

Compulsory power not advocated, *Carswell* 16,558-72

Position *re, Carswell* ... 16,545-59

Observation Period—cont.**WARDS ATTACHED TO GENERAL HOSPITALS—cont.**

Scotland, system, *Marr*, *Rose* 15,251-62, 15,269, 15,611-2; *Carswell* 16,474-83, 16,515-23, 16,535, 16,545-59, 16,574-91.

Treatment during, desirable, *Lidbetter* 1675-6, 1680; *Giles* 3170.

would be Useful for deciding whether case to be dealt with under Mental Deficiency or Lunacy Acts, *Lidbetter* ... 1732-4

Occupation, *see under* Care and Treatment.

Old Age Pensions:

Cessation during residence in asylum and objection to, *Hildyard* ... 18,109-18

of Patients in institutions, practice *re*, and anomaly in connection with, *Francis* 21,530-52

Overcrowding, Mental disorders a result, *Baly* 2879

Oxford University, clinical training difficulty, *Goodall* ... 17,164-5

Padded rooms, *see under* Care and Treatment.

Paranoiac patients:

Case of, *Dixon* ... 3879-904, 3923, 3937-40

Difficulty in connection with, *Sandhurst* 17,917-20

Parliament, questions in, *Brock* ... 1182-6

Parochial Asylum, Greenock, *Rose* 15,070-2, 17,076, 15,110; *Marr* 15,073-5.

Parole:

Approval of system, *Mr. P.* ... 14,264-72

Divergent practice *re*, *Parker* ... 11,774-7

Increased use of, advocated, *Mr. L.* 20,348-51, 20,414

Scotland, *Robertson* ... 16,118

Undertaking required not to post letters, *Mr. L.* 20,401A-3

Pass system, Scotland, *Marr* ... 15,396-9

Pauper:

Definition, and stigma question, *Macleod* 269-72; *Willis* 272-3.

Statutory definition, *Lidbetter* ... 1490

Stigma attaching to term, and question of remedy, *Willis* 58; *Francis* 1419-39; *Usher* 3458; *Connell* 4090; *Langdon-Down* 7905-8; *Masterman* 8205-7.

Temporary treatment of self-supporting person as, *Macleod etc.* 734-47; *Francis* 1419-39; *Propert* 5998-6025; *Leach* 6081-3, 6183-7, 6193.

Pauper Lunatics, number, 1st January, 1924, and distribution among different classes of institution, etc., *Francis* ... 1376-417

Pauperisation element, elimination advocated as far as possible and suggestions *re*, *Lomax* 12,944-6; *Taggart* 13,028-130; *Hodgson* 13,302-3; *Cole*, *Lord*, *Menzies* 16,967-87, 16,990-1.

Peckham House, After care, *Sandhurst* ... 18,017

Penshurst, Cassel Hospital, *Craig* 20,735-8, 20,974-6

Peritane House, *see* Winchelsea.

Persons incapable of looking after themselves, dealt with under Lunacy Act for want of other machinery, Lambeth, but procedure under Public Health Act preferable, *Baly* 2542-69, 2834-40.

Petition, *see under* Private under Certification.

Phipps Institute, Baltimore, *Mott* 17,149; *Boyle*, 18,567-70.

Plans of Buildings, *see under* Buildings.

Pneumonia, delirious, legal position, *re* restraint, *Comrie* ... 16,288-94

Police Stations:

See also under Interview with patient under Justice of the Peace.

Taking of mental cases to, not desirable, *Baly* 2922-4

Poor Law:

Mental health should be dissociated from, *Devine* 4439; *Lewis* 4579, 4636.

OUT-DOOR RELIEF FOR NON-CERTIFIED INSANE:

Number of patients in receipt of, 1st January, 1924, *Willis* ... 67, 809-11

System, *Willis*, *Macleod*, *Bond* ... 626, 809-17

Persons in receipt of relief, number, 1st January, 1924, and number insane or mentally defective, *Francis* ... 1374-9

Poor Law—cont.

Prejudice against, decreasing, and poor law relief becoming popular, *Propert* ... 6002-5, 6023-4

Stigma not agreed with, *Ford* ... 6212

Stigma attaching to, *Cole*, *Mott* ... 16,960-2

Stigma of, and elimination desired, *Lobjoit* 5128, 5142-9

Stigma less than if patients taken direct to Asylum, *Propert* ... 5998

Transfer of lunacy administration from, means of, etc., *Francis* ... 21,403-29, 21,562

Poor Law Institutions:**ACCOMMODATION, ETC.:**

Improvement, means of, *Francis*... 21,553-69

Relation of Board of Control to, *Francis* 21,510-2, 21,525-9, 21,565

Removal of chronic cases to workhouses would assist, *Lidbetter* ... 1710-1

Satisfactory on the whole, but certain improvements desirable, and position *re*, *Francis* 21,553-69

Admission of cases to, procedure, *Macleod*, *Bond* 876-82; *Lidbetter* 1485-520.

Buildings, power of Ministry of Health *re*, *Francis* 1249-52

CASES IN:

Acute cases, advantages of retention in workhouse, and provision for, *Francis* ... 1449-52

Board of Control's powers and duties *re*, *Macleod*, *Willis* ... 708, 711, 713-6, 891-2

Board of Control not always aware of, *Willis* 874; *Macleod* 874.

Classes of, *Francis* ... 1275-9, 21,403-19

two Classes, separate accommodation in some cases, *Francis* ... 1442-6

Classification in, *Hill* ... 18,386-9

no Continuation report or certificate, *Macleod* 711

Correspondence, position *re*, *Willis* 718; *Francis* 1286-97

Number of, 1st January, 1924, *Willis* ... 67

Separate accommodation and special staff in some institutions only, *Francis* ... 1266-82

Clinics attached to, not advocated, *Goodall* 16,055

Detention, wrongful, *see that title*.

Discharge from, *see that title*.

Experience in, *Mrs. M.* 13,765-824; *Mr. P.* 14,210.

Ill-treatment, *see that title*.

Indefinite detention in, after reception order, illegal, *Lidbetter* ... 1712-6

Insane persons in, cases of failure to certify, *Bond* 858

Mental wards, separate from Infirmary in some cases, *Senior*, *Usher* ... 3524-8

Mixing up of patients, *Mrs. M.* 13,729-30, 13,777-82, 13,807-8, 13,814-7

Nursing Staff, *see that title*.

Objection to detention in, *Lomax* ... 12,946

OBSERVATION WARDS:

Fulham, *Propert* ... 5998, 6010-3, 6036

Southampton, and more classification desirable, *Senior* ... 3193-7, 3206-15

OFFICERS:

Dismissal, power of Minister of Health, *Francis* 1253-5

Ministry of Health jurisdiction, extent of, *Francis* ... 1458-65

Premature superannuation if not up to work, power of, *Francis* ... 1453-7

Qualifications, *Francis* ... 1471

PERMANENT DETENTION IN:

Class of patients, Southampton, *Senior* 3185-91

Justices' power to order, under Section 24, *Barnsley* ... 1813-7

Justices' order and two medical certificates required, *Willis* 693-5, 696-8, 700; *Macleod* 698-700.

Periodical revision of cases by rota of justices, proposal, *Senior*, *Usher* 3382-421, 3486-7, 3536, 3539

Provision *re*, *Willis* ... 693-5

Poor Law Institutions—cont.

- "Poor Law Institution," wording should be used instead of Workhouse, *Usher* ... 3458
- Private patients passing through, to mental hospital, Cardiff, *Sanders* ... 2443-7
- Private patients taken to, in emergency, *Willis*, 633-4
- Reconstitution for reception of non-certified patients would be approved, *Ford* ... 6292-3
- Regulations, *Francis* ... 1256-61
- Sending of patients to asylum or, largely accidental and need for discrimination, *Willis* 701-8, 709-10, 719-21

Senile dementia cases in, *see that title*.

- Separate buildings desirable, *Lomax* ... 12,946
- Stage not passed through in Scotland, admission direct to asylum, *Rose* ... 15,247-50, 15,262-9

TEMPORARY DETENTION IN:**3 days:**

- Cases rarely disposed of during, *Senior* 3325, 3331-4
- Date on which order made should not count, *Senior* ... 3379-81
- Difficulties in connection with Section 20, and procedure under Section 24 in addition, but need for amendment, *Lidbetter* ... 1608-25
- Discharge during:
- on Justices' order, *Lidbetter* 1690, 1701-3
 - without Magistrates' order, *Giles* 3046-9
 - by Master, question of, *Lidbetter* 1696-701
 - Possibility and extent, *Lidbetter* ... 1685-91
- in Many cases people should not be sent to workhouse, *Broome Giles* ... 3709-10
- Patient not seen by doctor before removal to workhouse, *Lidbetter* ... 1766-71
- Refusal of accommodation, power under Section 20, and consequent difficulties, *Lidbetter* 1626-43
- Remand, no power of, and need for, *Proper* 5992-5, 5997
- Results of cases, Salford Union Infirmary, *Giles* 3038-65, 3079-85, 3112-3, 3119-26, 3151-3
- 14 days' detention: *Barnsley* 1796-803; *Lord* 2242-7.

Adjournment, power of, needed, *Whitemore*

3589

- Discharge during, large number of cases, *Senior* ... 3199-202
- little Experience of, in Birmingham, *Barnsley* 1799, 1925, 1929

Increase to 28 days, suggestions, *Giles* 3139-44, 3171-2; *Senior*, *Usher* 3202-5, 3234-7, 3311-5, 3319, 3364-71, 3504-5.

Difficulties in connection with, *Baly* 2704-17; *Senior*, *Usher* 3319-34, 3336-72.

Lapse of order during, or at end of, if patient recovered, *Baly* ... 2792-803, 2894-6

Magistrate should visit institution and see patient before making order, *Senior* 3319

Methods of securing, *Baly*, 2530, 2631-2, 2702-20, 2846-8, 2947-53; *Senior* 3319-30, 3336-63; *Usher* 3359-61.

Power to detain cases for longer period desirable, *Baly* ... 2880

Recertification under Section 24, *Baly* 2792-803

not Sufficient in all cases, but if lengthened means of treatment would be necessary, *Baly* 2820-5, 2883

Suspension not resorted to, Salford Union Infirmary, but permanent order made, *Giles* 3031-7

Suspension not resorted to at Southampton, *Senior* ... 3328

Treatment during, no facilities, Southampton, *Senior* ... 3208-11

Accommodation should be separate from that for permanent detention cases, *Giles* ... 3144-9

Admission to asylums direct from homes, preferable, *Lewis* ... 4645

Advantage of, *Leach* ... 6096-101

Certification prevented by, in some cases, *Devine* 4281

Poor Law Institutions—cont.**TEMPORARY DETENTION IN—cont.**

must Continue for certain class, *Parker* 10,616-41

Disadvantageous to prospects of recovery, *Devine* 4281-91, 4296

Discharges during, *Lidbetter* 1669-71, 1677-84

50 per cent. of cases cured during, Hartlepool

Poor Law Institution, *Usher* ... 3235-6

Need for system, question of, *Bond* ... 883-5

Objection to, *Sidney* 19,249-50, 19,252; *Gardner* 19,250-2.

without Order, desirable in some cases, *Senior* 3464

Order for extended observation in, question of, *Sidney* ... 19,268-9, 19,275-7

certain Poor Law Institutions unsuited for, and proposed remedy, *Usher* 3281-310, 3481-3, 3509, 3520; *Senior* 3510.

one Poor Law Institution should be specially selected and equipped for, in each district, *Usher*, *Senior* 3281-310, 3314-5, 3481-5, 3509-10, 3517-22, 3537-9

Portsmouth system, *Devine* ... 4277-91

no Provision for, in Act, and method of securing, *Lidbetter* ... 1655-84

proper Reception houses advocated instead, *Lidbetter*, 1742-51, 1772; *Walden*, 2066-73.

Relieving officer should have power to effect, at any time, without waiting for justices' order, *Lidbetter* ... 1650-4

Removal to asylum by relieving officer, *Lidbetter* 1549-51

Separate ward desirable, *Devine* ... 4283

Sections of Act dealing with, *Willis*, *Macleod* 685-92

Tying down in bed, *Mr. O.* ... 20,055-9

Transfer of cases from Asylums: *Willis* 700; *Francis* 1236-45.

Desire of patients for, in some cases, *Leach* 6143, 6166-71; *Ford* 6198.

Increase advocated, *Flint* ... 6239-41

Lancashire, position *re*, *Leach* 6147-50, 6158-61

Sections 25 and 26 might be made greater use of, *Leach* ... 6143-71

Senile cases, suggestion, *Beard* ... 19,418-52

Transfer of cases to mental hospitals from, power of, *Macleod* ... 708

Transfer of premises to asylum accommodation, possible means of, etc., *Francis* 21,420-47, 21,513-29, 21,562

Use of buildings as clinics, suggestion, *Cole* 16,958-9

might be Used as clearing houses if chronic cases removed to mental hospitals, *Craig* 20,809-10

Visitation, *see that title*.

Poorhouses, Lunatic Wards, Scotland:

Admission system, *Rose* 15,426; *Marr* 15,427-31, 15,441-2, 15,451-65.

DETENTION IN:

Authority of Board of Control required, *Marr* 15,432; *Rose* 15,432-4.

Legal power, question of, *Marr* 15,445-8, 15,458

Discharge system, *Marr* ... 15,466

Inspection by Board of Control, *Marr* ... 15,439

Licensing by Board of Control annually, *Marr* 15,422

Relationship of Board of Control with Poor Law authorities, *Rose* ... 15,674-6

Satisfactory for certain type of patient, *Marr* 15,467-8

Sending of cases to asylum or, decision as to, *Marr*, *Rose* ... 15,436-40

Statistics, *Rose* ... 15,076-80

Transfer of cases to, from asylums, *Marr*... 15,435, 15,465, 15,470-1

Portsmouth Borough Mental Hospital:

Accommodation and number of patients, *Devine* 4249-56, 4526-7

all Cases taken first to Infirmary, *Devine* 4277-91

Children in, *Devine* ... 4472

Maintenance rate, *Devine* ... 4289, 4518-9

Medical staff, *Devine* ... 4520-1

Portsmouth Borough Mental Hospital—cont.

Nursing staff, <i>Devine</i> ...	4468-71
Overcrowded, <i>Devine</i> ...	4365-6
Private cases, <i>Devine</i> ...	4522-5, 4536-9
Readmissions, <i>Devine</i> ...	4553-4
Reception of new cases, classification and accommodation, <i>Devine</i> ...	4297-332
Recovery rate, <i>Devine</i> ...	4551-2
Type of cases, and few could be removed to Poor Law Institution, <i>Devine</i> ...	4367-72
Visiting days, <i>Devine</i> ...	4496-7

Prestwich Asylum, use of croton oil, <i>Parker</i> ...	11539-50
Prisons, mental cases in, <i>Boyle</i> ...	18,652-6, 18,661-5
Private Asylums, <i>see</i> Licensed Houses.	
Private Asylums, Scotland, <i>Rose, Marr</i> ...	15,066-9, 15,109, 15,114-5, 15,118

Private Houses:

See also Nursing Homes and Single Care.

Freedom to take in patients without supervision advocated, except in case of certified patients, <i>Boyle</i> ...	18,682-93, 18,706, 18,719, 18,740-50, 18,753-4
Scotland, system, <i>Devine</i> ...	4389, 4546-7; <i>Marr, Rose</i> 15,083, 15,118, 15,605-10, 15,614-7, 15,619-22, 15,624; <i>Robertson</i> 15,936-16,035.

Private Patients:

Accommodation, *see that title*.

Privileges for which payments made, not received, case of, <i>Mr. M.</i> ...	18,845-52
number of, 1st January, 1924, and number of paupers, <i>Bond</i> ...	849
Privileges, leaflet explaining, for relatives and patients, worth consideration, <i>Rose</i> ...	15,291; <i>Marr</i> 15,301-2.

Probation:

Interview by whole Visiting Committee before, objection to, <i>Broome Giles</i> ...	3649-50
Scotland, <i>Marr</i> ...	15,396
Propaganda work, for education of public re mental disease, suggestion, <i>Beard</i> ...	19,459-66

Property:**ADMINISTRATION OF:**

County Court jurisdiction over small estates, suggestion, <i>Hildyard</i> ...	18,128, 18,150, 18,168, 18,196-8
various Methods of, <i>Hildyard</i> ...	18,143-66
Patients under Section 116 (1) (d):	
Difficulties in connection with, where receiver appointed, <i>Sandhurst</i> ...	17,816-9
Increase in number owing to Harnett case, <i>Sandhurst</i> ...	17,820-1
Post office jurisdiction, drawbacks of, and question of alternative, <i>Hildyard</i> ...	18,154-66
in Provisional Order cases, <i>Craig</i> ...	20,889-95
System, <i>Willis, Macleod</i> ...	611-5
many Cases not in Chancery which should be, <i>Schuster</i> ...	1056-61
Control of, without finding person to be a lunatic, <i>Willis</i> ...	777-8
Notification to Master in Lunacy Department, suggestion <i>re</i> , <i>Hildyard</i> ...	18,057, 18,170-95

RECEIVERSHIPS:

Administration of estate, procedure, <i>Hildyard</i> ...	18,063-81
Appointment of receivers in all cases, question of, <i>Hildyard</i> ...	18,057-62, 18,119
Costs, <i>Hildyard</i> ...	18,119-42
Persons appointed, <i>Hildyard</i> ...	18,097-100
Termination, procedure, <i>Hildyard</i> ...	18,218-30
Relieving officers' powers <i>re</i> , <i>Lidbetter</i> ...	1601, 1604-6
of Voluntary patients, administration question, <i>Hildyard</i> ...	18,189-94, 18,199-204
Prosecutions for misdemeanour under Act, power of Minister of Health to direct, <i>Brock</i> ...	1109-10

Provisional Orders:

Advantage of, from public point of view, doubted, <i>Boyle</i> ...	18,618, 18,627-8, 18,675-7, 18,726
Certification after expiry, proposed procedure before Justice of the Peace, <i>Cole, Lord, Menzies</i> ...	16,888-94, 16,907-13, 16,925
Period, question of, <i>Cole, Lord</i> ...	16,927-30
Proposal approved, <i>Parker</i> ...	10,861-3
Stigma, question of, <i>Cole</i> ...	16931-2; <i>Craig</i> 20,896.

Provisional Orders—cont.

Suggestions for, <i>Lewis</i> ...	4584-5; <i>Chubb</i> 6724-30; <i>Langdon-Down</i> 7943; <i>Parker</i> 10,483-5; <i>Robertson</i> 15,936; <i>Menzies, Lord, Goodall, Cole</i> 16,780-99, 16,877-87, 16,895-906, 16,919-24, 17,009; <i>Worth</i> 17,390-3; <i>Mapother</i> 18,926-32, 18,936-7; <i>Sidney</i> 19,168; <i>Craig</i> 20,697, 20,861-4, 20,876, 20,885, 20,888-96; <i>Willis, Macleod</i> 21,378-85, 21,387-400.
Psychological medicine, reluctance of doctors to take up owing to legal difficulties, <i>Craig</i> ...	20,697, 20,698-700

Psychiatric Research:

Backwardness of, compared with other research, <i>Golla</i> ...	21,035, 21,407
Birmingham, <i>Mott</i> ...	17,146, 17,152, 17,176-7
Central laboratory in association with University psychiatric clinic advocated, <i>Goodall</i> ...	17,164
Central laboratory in connection with University for group of asylums, scheme, <i>Mott</i> ...	17,146, 17,152-4, 17,172-7, 17,183, 17,194-5
Comparison with foreign countries, <i>Golla</i> ...	21,086-91
Control of, by Board of Control, not desirable, <i>Mott</i> ...	17,182
Differentiation of functions between asylum laboratory and, <i>Mott</i> ...	17,153-4
Facilities for pathological research at individual mental hospitals and central laboratories advocated, <i>Golla</i> ...	21,004-8, 21,050-9, 21,095
Financial assistance, need for, <i>Mott</i> ...	17,146-9
Grants by Local Authorities would be approved if under some Central Authority, <i>Golla</i> ...	21,075
Importance of, <i>Mapother</i> ...	18,979-88; <i>Golla</i> 21,035-40, 21,076-7, 21,093-4
Investigation of cases by ordinary medical officer, importance of, <i>Golla</i> ...	21,033-4
in Laboratories associated with central school and university desirable, <i>Mapother</i> ...	18,986
Laboratories, expense of fitting up, <i>Golla</i> ...	21,061
Lines on which desirable, <i>Mapother</i> ...	18,981-2
Local authorities' position <i>re</i> , and suggestion, <i>Mott</i> ...	17,138-40; <i>Goodall</i> 17,163-4; <i>Cole</i> 17,287.
under London County Council, <i>Golla</i> ...	21,008-46, 21,051, 21,062-74
Maudsley Hospital, <i>Mott</i> ...	17,173-4, 17,195;
<i>Mapother</i> ...	18,976-7, 18,984; <i>Golla</i> 21,009-46, 21,062-74.
in Provinces, <i>Golla</i> ...	21060, 21,079-82
present Provision for, <i>Mott, Collins</i> ...	17,146, 17,155-8
Provisions in Mental Treatment Bill:	
Approved, <i>Mapother</i> ...	18,979
Reply to criticisms, <i>Mott</i> ...	17,179-83
Scheme for, <i>Mott</i> ...	17,138-54, 17,172-7, 17,183, 17,194-5
Three months' seconding of men from mental hospitals to Maudsley Hospital, <i>Golla</i> ...	21,015, 21,041-6, 21,062-4
Public Education of, important, <i>Devine</i> ...	4423-30
Public Health Authority, substitution for Poor Law Authority, desirable, <i>Carswell</i> ...	16,592-3
Public Prosecutions, Director of, powers and functions, <i>Bodkin</i> ...	17,716-21
Puerperal Cases:	
Accommodation in after-care homes not in asylums advocated, <i>Hill</i> ...	18,272, 18,291-4
should not be Certified, <i>Mrs. G.</i> ...	20,576
Punishment, <i>see under</i> Care and Treatment.	
Queen Adelaide Fund, <i>Keene</i> ...	5008; <i>Lobjoit</i> 5150; <i>Worth</i> 17,243-3.
Readmissions, percentages, <i>Keene</i> ...	4800-1, 5018-30
Receiving Rooms, Scotland, <i>Robertson</i> ...	16,206
Reception:	
OF NEW CASES:	
Classification and accommodation, <i>Connell</i> ...	4117-28; <i>Devine</i> 4297-332.
Examination:	
Complaint <i>re</i> , <i>Mrs. M.</i> ...	13,925-38, 14,030; <i>Miss H.</i> , 19,584-9, 19,594-6.
System, <i>Bond</i> ...	845-8; <i>Baly</i> 2479-82, 2488-93, 2570-83, 2594-7, 2616-7, 2864-6, 2889-90, <i>Dixon</i> 3785-9.

Reception—cont.**OF NEW CASES—cont.**

- Frightening effect of official atmosphere, *Mrs. M.* 13,857-63
- Procedure on, *Bond* ... 845-8
- Symptoms described on certificate not present, cases of, *Dixon* ... 3790-9, 4023-5
- Pauper, without certificates prior to 1811, *Edwards* 6318
- Personal experience, *Mrs. M.* 13,832-43; *Mr. O.* 20,082-97.
- WARDS:** *Connell* 4117; *Devine* 4297-326.
- Desirability of, *Dixon* ... 3837-8
- Difficulty, *Yellowlees* ... 5739
- Injurious effect of association with violent cases, *Mrs. M.* ... 13,844-56, 13,939-47
- more Single rooms desirable, *Craig* ... 20,952-9

Reception Houses (Observation Hospitals):

- Advocated in co-operation with clinics in place of present observation wards, and scheme, *Mapother* 18,846-52, 18,923-42, 18,945-8, 18,959-60, 18,963, 18,991

- Attachment to asylums advocated, *Lomax* 12,861-5
- Attached to general hospitals, advantages and disadvantages, *Lomax* ... 12,861
- Attached to general hospitals or mental hospitals, question of, *Barham* ... 7490-8
- should be under Board of Control, *Walden* 2093
- Desirable in some cases, but not needed at Cardiff, *Sanders* ... 2424-5

DETENTION, POWERS OF:

- for Certain period advocated, *Mapother* 18,926-37
- would be Necessary, *Gardner* ... 19,272
- Local Authorities should be responsible, with central supervision by Board of Control, *Mapother* ... 18,969-70
- London County Council scheme, *Sidney* 19,248, 19,254-67
- Need for, and proposals, *Lidbetter* 1742-51, 1772; *Barnsley* 1834-80; *Walden* 2066-81; *Lobjoit* 5125-7; *Langdon-Down*, *Edwards* 8178-89; *Sidney*, *Gardner* 19,248-56.
- Number required, question of, *Walden* ... 2173-7
- Poor Law institutions not the most suitable for, *Giles* ... 3161-70
- good Proportion of cases would go to, *Walden* 2170-1

- would Relieve pressure on asylums, *Walden* 2083
- Sending of patient to, should be at discretion of justice, *Barnsley* ... 1850
- Special institutions for acute recoverable cases, suggestion, *Mapother* ... 18,949-52
- Value of, *Barnsley* 1951-60; *Walden* 2172.
- Visitation by justices, proposal, *Walden*... 2078-9
- Voluntary resort to, should be possible, *Barnsley* 1839, 1876-80

Reception Orders:

see also Certification and Lunacy Act.

- Change of wording from "certified lunatic," question of, *Dixon* ... 3968-70
- Deterrent effect, *Langdon-Down* ... 7910
- Duration, *Macleod* ... 303
- Given without enquiry into patients' financial position, *Lord* ... 2259-63
- Granted too freely, and suggestions, *Chubb* 6845, 6853-63

SUMMARY:

- under Section 13, system and procedure, *Macleod*, *Bond* ... 254-66, 286-7
- under Section 13 or under Section 14, difficulty, *Leach* ... 6081-8, 6249-53
- Section 14 used more than Section 13 in Sheffield, *Flint* ... 6232-7
- proposed Procedure, *Lomax* ... 12,822
- System and procedure, *Macleod* ... 237-53
- Temporary 3 days order on one medical certificate and subsequent 28-31 days order by justice if necessary, suggestion, *Langdon-Down* 8068-139
- Term "pauper" should be removed, *Connell* 4090
- Records, improved system, proposal, *Lidbetter* 1748-9, 1751

Recovery:

Discharge, see that title.

RATE:

- Dixon* 3927, 4021-2, 4040-1; *Connell* 4096, 4221-30; *Devine* 4551-2; *Keene* 5010-1.
- Calculation method, criticism, *Parker* 11,694-702
- Competition among Medical Officers to secure good rate, *Willis* ... 325
- great Improvement not anticipated with present medical knowledge, *Barham* 7658-60
- in Licensed houses, *Chubb* 6748-51, 6887-90; *Cole* 17,053-4; *Langdon-Down* 13,504.
- in Private institutions, comparison with public institutions desirable, *Parker* ... 11,703
- within Three months and six months, *Leach* 6068, 6139-40
- Voluntary boarders, Bethlehem, *Phillips* 5874
- Recreation, see under Care and Treatment.
- Recurrent Cases might be treated at clinics, *Lewis* 4574
- Refractory ward, see under Care and Treatment.

Registered Hospitals:

- Admissions, 1923, *Edwards* ... 6330
- Charitable work, *Yellowlees* ... 5725
- Discharge, duty of superintendent, *Willis* 506-7
- Distinction from private asylum and licensed house, *Yellowlees* 5818-20; *Edwards* 6333-9.
- Extension desirable, *Mapother* ... 18,881-5
- Funds, *Yellowlees* ... 5396-8
- no Limitation on number, *Willis* ... 84-5
- Management, *Yellowlees* ... 5385-6
- Management Committees, representative of local authority on, would be approved, *Gibson* 12,373-9, 12,392-4
- Medical staff, women on, advocated, *Yellowlees* 5412, 5415-8, 5825-31
- Medical superintendent, administrative work must be under, with suitable delegation, *Yellowlees* ... 5401-11
- Nature of, *Willis* ... 64
- Notices, posting up of, *Bond* ... 802
- Number, *Willis* ... 90
- Number of cases in, 1st January, 1924, *Willis* 67
- Personal experience in, *Miss G.* ... 20,428-559
- Profits, no inducement to make, *Yellowlees* 5724-5
- VISITATION:**
- by Commissioners, account of, by ex-attendant, *Parker* ... 11,245-9
- by Managing Committees, *Macleod* ... 353
- Wrongful detention, safeguard against, *Willis* 497-9, 507-8
- Regulations and rules, danger of over-elaboration, *Parker* ... 11,640-8

Relatives and Friends:

- Access to Board of Control, *Willis* ... 607-10
- Attitude of, *Baly* 2871; *Giles* 3103, 3121-6.
- Charge of lunatic by, *Willis*, *Bond*, *Macleod* 283-5, 818-24; *Parker* 11,045-6, 11,051-6.
- Power to discharge, see under Discharge.
- Visitation by, see under Visitation.

Relieving Officers:

- Admission to clinics through, question of, *Craig* 20,836-9, 20,843
- All cases might be dealt with by, followed by two medical certificates, *Lidbetter* ... 1558-61
- possible Alternative to, if entire administration taken over by lunacy authority, *Francis* 21,469-509

APPOINTMENT:

- Method, *Lidbetter* ... 1480-3
- Qualifications, *Lidbetter* ... 1482
- Functions, *Francis* ... 1368-9, 1599-600
- Functions re lunatic not a pauper and not wandering at large, *Macleod* ... 254-60
- Methods by which cases come to notice of, *Lidbetter* ... 1497-507
- Ministry of Health position re, *Francis* 1367, 1370-3
- Notice to justice of alleged lunatics, *Macleod* 239-40, 254

Relieving Officers—cont.

should have Power to effect temporary removal to Poor Law Institution without Justice's order, *Lidbetter* ... 1650-4

POWERS AND DUTIES:

under Acts of 1890 and 1891, *Lidbetter* ... 1485-551
 Conveyance to and from and between institutions, *Lidbetter* ... 1600-3, 1607
 Lunatic wandering at large ... 1554-6
 Property, *Lidbetter* ... 1601, 1604-6
 Procedure by, after receipt of information, *Lidbetter* ... 1508-44
 Protection by Section 330, *Lidbetter* ... 1693
 Removal of patients, assistance, provision for, *Lidbetter* ... 1765
 Responsibility of, *Lidbetter* ... 1693-4, 1704-6
 Special designation of, to perform duties under Lunacy Act, by Section 2 (2) of Act of 1891, *Lidbetter* 1598; *Baly* 2497-503.
 Work well done, *Lewis* ... 4641-3
 Research, *see* Psychiatric research.
 Rochdale, Infirmary nursing staff, *Leach* ... 6107-10
 Routine employment, bad mental results, *Boyle* 18,584-6, 18,667-70

Rowditch Mental Hospital, Derby:

Dietary, *Blood* ... 12,232, 12,238-9
 Patients, hours of bedtime, *Blood* ... 12,065-7

Royal or Chartered Asylums, Scotland:

Admission, system, *Marr, Rose* 15,154-82, 15,205-39
 Numbers, etc., *Rose* ... 15,048-57
 Patients from England and Ireland, *Marr, Rose* 15,127-45
 Paupers in, payment for, *Rose, Marr* 15,146-53
 Powers of General Board of Control *re, Rose* 15,093-6
 Private patients, *Rose, Marr* 15,056, 15,090-2, 15,113-7
 System, *Marr* ... 15,120-6

Royal Commission of 1904-8 (under Lord Radnor), *Willis* ... 23-6
 Recommendations, *Parker* ... 10,434-8, 10,445
 Rules in Lunacy, codification desirable, *Sandhurst* 17,813-4

Safeguards:

see also under Certification, Improper; Detention Wrongful, and Voluntary Boarders.
 Existing machinery adequate, *Willis* ... 934
 against Ill-treatment, *Connell* ... 4072-9
 no Overlapping of jurisdiction, *Willis* ... 38
 any Practicable suggestions would be welcomed, *Willis* ... 935-7
 St. Bartholomew's Hospital, Out-patient mental department, *Phillips* ... 5902-8
 St. George's Retreat, *Fawcett* ... 6903-4
 St. Luke's Hospital Clinic, particulars *re, Gilmour* 18,391-500

Salford Union Infirmary:

Accommodation for mental cases, procedure, etc., *Giles* ... 3016-20, 3030-169
 Medical staff, *Giles* ... 3136
 Nursing staff, *Giles* ... 3134-5
 as Observation place, would not be satisfactory unless improvements made, *Giles* ... 3161-3
 Permanent cases, *Giles* ... 3069-79

Salisbury, Old Manor:

Accommodation, nature of, *Chubb* ... 6483
 Admission to, through poor law, *Chubb* ... 6675-7
 Cases, statistics, *Chubb* ... 6482-4
 Children in, formerly, *Chubb* ... 6847-9
 Classification of patients, *Chubb* ... 6776-81
 Clothing, *Chubb* ... 6526-9
 Consulting surgeon and operations, *Chubb* 6664-7, 6669-70
 Dental treatment, *Chubb* ... 6667-8
 Ex-service patients, *Chubb* 6483, 6526, 6841-4

Salisbury, Old Manor—cont.

Farms and dairy in connection with, *Chubb* 6636-43
 Fees, *Chubb* ... 6632-5
 History, *Chubb* ... 6482-97
 Leave of absence on trial, *Chubb* ... 6552-97
 Licensing by Subsidiary Justices, *Chubb* ... 6503
 no Mechanical restraint, *Chubb* ... 6815-6
 Medical staff, *Chubb* ... 6644-5, 6831-3
 Medical Superintendent, position, *Chubb* 6497-502
 Nursing staff, *Chubb* 6646, 6650-6, 6821-2, 6887-8
 Occupation, *Chubb* ... 6788-9
 Ownership, etc., *Chubb* ... 6485-97
PATIENTS:
 Daily life, *Chubb* ... 6530-5
 Some taken on special terms or gratuitously, *Chubb* ... 6629-31
 Walks into town and country unattended, *Chubb* 6522-3, 6782-7, 6838-40
 Recovery rate, *Chubb* ... 6748-51, 6887-90
 Recreation, *Chubb* ... 6790
 Sharp tools, use of, by patients, *Chubb* ... 6647-9
VISITATION:
 by Commissioners and interviews with patients, *Chubb* 6506-21, 6524-5, 6545-55, 6825-8, 6880-7
 by Justices, *Chubb* 6504-5, 6520, 6536-48, 6801-16, 6883
 by Medical visitor, *Chubb* ... 6537-44
 by Relatives, *Chubb* ... 6791-5
 Voluntary boarders, *Chubb* 6753-73, 6834-7, 6863-78

Scotland:

Accommodation, types and numbers, *Rose* 15,048-85
 Administration, *see that title.*
 After-care, *Rose* ... 15,653-4
 Boarding-out system, *Marr, Rose* 15,472-604; *Robertson* 16,032-5.
CARE AND TREATMENT:
 Bathing privacy, arrangements, *Marr* ... 14,994-5
 Communication with outside world, *Marr, Rose* 15,376-84
 Exercise, *Robertson* ... 16,095-115
 Food, *Rose, Marr* ... 15,655-8
 Ill-treatment, prosecutions, *Marr* 15,010-26, 15,030-2, 15,034
 Institution shops and refreshment room, *Marr* 15,379
 no Locked seclusion, *Robertson* ... 16,121-9, 16,202-5
 Mechanical restraint, abolition of, *Robertson* 16,129
 Occupation, *Marr* ... 15,665-6
 Open-door system as far as possible, and success of, *Robertson* ... 16,116-20
 no Padded rooms, *Robertson* 16,121-26, 16,197
 Parole system, *Robertson* ... 16,118
 Pass system, *Marr* ... 15,396-9
 Post boxes in wards, *Marr* ... 15,298-9
 Reading and writing room, *Marr* ... 15,379
 Visit by own medical man, provision for, *Marr, Rose* ... 15,383-4
 no Written notices, *Marr* 15,286-90; *Rose* 15,292-7.
 Certificates, nature of errors in, *Robertson* 15750, 15,757-66

CERTIFICATION:

Avoidance of, by every possible means, *Robertson* 15,888-9
 System, *Marr, Rose* 15,154-82, 15,205, 15,216-31, 15,270-80; *Robertson* 15,736-7.
 procedure *re* Dangerous lunatics, *Rose* ... 15,240-6
 Detention, appeal to Board of Control, right of, *Marr* 15,272, 15,275-80, 15,286, 15,293-4, 15,302.
DISCHARGE:
 by Escape, *Marr* ... 15,410
 by General Board of Control, *Marr, Rose* 15,404-9
 by Petitioner, *Marr, Rose* ... 15,411-20
 as Recovered, *Marr, Rose* 15,385-7, 15,391, 15,394-5, 15,401
 not Recovered, *Marr* 15,385, 15,391, 15,402-3

Scotland—cont.**DISCHARGE—cont.**

System, *Rose, Marr* 15,385-7, 15,391, 15,394-5,
15,401-20

District Asylums, *see that title.*

Emergency certificates, *Marr* 15,219, 15,232-5;
Robertson 15,812-9.

General Board of Control, *see that title.*

Grant, *Marr* 15,149-53; *Rose* ... 15,673

Inspector of the Poor, *Rose, Marr* 15,677-83

Juveniles in Asylums, *Robertson* ... 16,224-5

Licensed houses, *Marr* 15,478, 15,495-502, 15,533

Lunatics, statistics, *Ross, Marr* 15,042-7, 15,086-8,
15,127-36

Medical training in mental science, *Sandhurst*
18,024

Mental hospitals, hospitalisation of, *Robertson*
16,095-143, 16,197-205

Observation wards attached to general hospitals,
system, *Marr, Rose* 15,251-62, 15,269, 15,611-2;
Carswell 16,474-83, 16,515-23, 16,535, 16,545-59,
16,574-91.

Pauper lunatics, transfer to England and Ireland,
procedure, *Marr* ... 15,422-5

Poorhouses, *see that title.*

Private Asylum, *Rose, Marr* 15,066-9, 15,109,
15,114-5, 15,118

Private houses, system, *Devine* 4389, 4546-7; *Rose,*
Marr 15,083, 15,118, 15,605-10, 15,614-7, 15,619-
22, 15,624; *Robertson* 15,936-6035.

Private patients, provision for, *Rose, Marr* 15,056,
15,090-2, 15,105-17, 15,392; *Cole* 17,050.

Probation, *Marr* ... 15,396

Receiving rooms, *Robertson* ... 16,206

Royal, or Chartered Asylums, *see that title.*

Sheriff detention order by, system, *Marr* 15,207-9;
Robertson 15,738-66, 15,792-3, 15,797-9, 15,822-31.

Single care, *Marr, Rose* ... 15,472-604

Verandahs, *Robertson* ... 16,101, 16,104

Visitation, *see that title.*

Voluntary Boarders, *see that title.*

Seclusion, *see under Care and Treatment.*

Senile Dementia Cases:**IN POOR LAW INSTITUTIONS:**

Difficulty re, *Usher, Senior* ... 3459-63

Transfer to asylum, objection to, *Lovsey*
5247-9, 5286-8, 5370-4

Treatment in, desirable, *Dixon* ... 3905-7, 3925-6

Certification of, not advocated except in very rare

cases, *Lidbetter* ... 1726, 1737-9

now Received by Metropolitan Asylums Board with-

out certificates, *Lidbetter* ... 1737-9

Special certificate for, proposal, *Usher, Senior*
3459-63

Transfer to workhouses, advocated, *Taggart*
13,203-25

Sheffield:

Cases dealt with, statistics, *Flint* ... 6225-36

Cases discharged without certification, *Flint*
6227-8, 6267-74, 6303-8

Pauper, or non-pauper, reasons for classification
as, *Flint* ... 6259-66

Single Care:

see also Nursing Homes and Private Houses.

Admissions, 1923, *Edwards* ... 6330

Approval of, and wide powers advocated, *Craig*
20,697, 20,910-3, 20,920-3

Approved, *Parker* ... 11,315-6

Economy, tendency, *Sandhurst* ... 18,015

other Insane persons in home, cases of failure to
certify, *Bond* ... 858

More than two patients should be allowed, *Cole*
17,282-5

Number in, 1st January, 1924, *Willis* ... 67

Objection to, *Gibson* ... 12,312

Provision for, in Mental Treatment Bill needed,
Cole ... 16,857-62

Removal suggested in some cases, *Sandhurst*
18,012-4

Removal of patient, power of Board of Control if
not satisfied with house, *Willis* ... 661-2

Scottish system, *Marr, Rose* ... 15,472-604

Single Care—cont.

System, *Willis, Bond, Macleod* 639-41, 643, 644

Transfer of cases to, from institutions, *Willis* 519

Visitation, *Macleod, Willis* 353-5, 356; *Sandhurst*
17,830-2.

Voluntary boarders should be allowed, subject to
supervision and control, *Mapother* 18,868-80

Wrongful detention, safeguard against, *Willis*
497, 507-8

Social service, development would be useful,

Langdon-Down 13,615-7; *Boyle* 18,643-4.

South-West Lancashire Association for Mental Wel-
fare, work of, *Andrew* ... 21,213-29

Southampton Poor Law Institution:

Accommodation, class, etc., *Senior* 3189-215, 3328,
3503, 3524-6, 3528

Aliens admitted under deportation law, *Senior*
3470

Character of, *Senior* ... 3180

Diet, *Senior* ... 3225-8

14 days' detention, procedure, *Senior* ... 3341-59

Maintenance cost of patient and comparison with
asylum, *Senior* ... 3229-30

Mental wards, staff, number, remuneration, etc.,
Senior ... 3216-24

NURSING STAFF:

Diet, and cost of, compared with inmates, *Senior*
3494-7

Probationer nurses, duties of, pay, etc., *Senior*
3488-501

Qualifications, *Senior* ... 3465, 3476-8

Permanent cases, number, *Senior* ... 3529

Springfield Mental Hospital, children in, *Lobjoit*
5175

Statistics, lines on which further statistics desirable,
Leach ... 6064-78

Sterilization of Lunatics:

Cases known of, *Robertson* ... 16,188

Objection to, *Robertson* ... 16,180-95

Stigma:

see also under Certification; Pauper; Poor Law and
Provisional Orders.

Dislike of, *Giles* ... 3103, 3127-9, 3150, 3159

Nature of, *Cole, Menzies, etc.* ... 16,931-48

Removal of, by treatment of mental cases in general
hospital, proposal, *Baly* ... 2930-46

Study Leave, *see under Medical Staff.*

Suicide:**ATTEMPTED:**

Cases brought to Poor Law Institutions, diffi-
culty in connection with, and proposals, *Senior,*
Usher ... 3447-57, 3502, 3506-8

Cases brought in under Section 20, dealt with
under Lunacy Act, Lambeth Infirmary, *Baly*
2773-85

Examination of all cases by mental expert:

Advocated, *Senior* ... 3447-52, 3516-6

not Advocated, *Usher* ... 3454

Methods of dealing with, *Baly* ... 2773-85

Difficulties in connection with, *Miller* 17,403-16

Summary Reception Orders, *see under Reception*
Orders.

Terminology:

Assimilation as far as possible to that of ordinary
hospital desirable, *Phillips* ... 5913-4

ASYLUM:

Objection to use of word, and deterrent effect of,
Hodgson ... 13,304-11

possible Use of "mental hospital" instead,
Langdon-Down ... 7845-52

Change advocated as concession to public feeling,
Langdon-Down ... 7824-5

Change desired by public, *ProPERT* ... 6021

suggested Classification, *Langdon-Down* ... 7887-92,
7897-905

"Hospital" advocated in lieu of "asylum" or
"mental hospital," *Leach* ... 6176-9

Terminology—cont.

- "Insanity," definition question, *Parker* 10,645-720, 11,801
- "Mental abnormality," suggestion, *Langdon-Down* 7887, 7902-5
- "Mental ailment" and "mentally ailing," suggestion, *Langdon-Down* ... 7865-8, 7898-902
- "Mental disability," suggestion, *Langdon-Down* 7880-6
- "Mental disorder," suggestion, *Langdon-Down* 7862-3
- "Pauper," elimination desirable, *Langdon-Down* 7905-8; *Masterman* 8205-7.
- "Person of unsound mind," suggested use of, and definition, *Langdon-Down*... 7826-30, 7858, 7861-8
- Suggestion, *Phillips* ... 5913-4
- OF UNSOUND MIND:
- Definition question, *Parker* ... 10,703-19
- Definition by Royal Commission in 1908, *Parker* 10,437
- Ticehurst House, *Fawcett* 6903-4, 7028-37; *Mr. H.* 8688-748.

Treatment:

- Assimilation to treatment of other forms of illness desirable as far as possible, *Propert* 6026-30; *Ford* 6288-91; *Craig* 20,794-5.
- Certified nurses should be sent to homes in some cases, *Gibson* ... 12,324-6
- Close association with treatment of physical disease desirable, *Craig* ... 20,697, 20,725, 20,908
- in Specialised mental institutions undesirable, general institution preferable, *Baly* ... 2858

Treatment without Certification:

- Administration by lunacy or public health authorities, question of, *Beard* ... 19,465-70
- Advantages, *Comrie* ... 16,303-10
- initial Certification process and continued suspensions, suggestion approved, *Devine* ... 4473-80
- Clinics, *see that title.*

DETENTION:

- Patient could be certified if treatment objected to, *Devine* ... 4394, 4396-7
- Possibility of, needed, *Miller*, *Buzzard* 17,417.
- certain Power of, necessary, and suggestions, *Connell* 4158-64; *Leach*, *Ford* 6120-7, 6202-4, 6281-2; *Gibson* 12,417-24.
- Question of, *Rose*, *Marr* ... 15,614-7, 15,626-49
- in Foreign countries, *Boyle* ... 18,560-71

IN GENERAL HOSPITALS:

- would Alleviate fear of stigma, but not advocated, *Giles* ... 3130
- Opposed as regards certain cases, *Devine* 4410-3, 4421
- Desirable, *Ford* 6205-12, 6278-9; *Parker* 10,596-606, 11,801.
- Desirable in many cases, *Baly* ... 2884-5, 2930-46
- Undesirable, *Giles* ... 3130-3
- in General hospitals, or special hospitals, or clinics separate from mental hospitals, *Craig* ... 20,697, 20,726

- General hospitals and clinics as clearing houses advocated, *Craig* ... 20,807-10
- Institutions taking cases should be under control and supervision, *Devine* ... 4404, 4447
- Need for, *Sanders* 2411-3; *Dixon* 3908; *Devine* 4389; *Lewis* 4573-8, 4664-6; *Propert* 6042; *Leach* 6117-9, 6281; *Ford* 6196-200, 6204; *Barham* 7485-9; *Miss C.* 14,522-3; *Robertson* 15,853-9; *Cole* 16,636-9; *Worth* 17,364-71; *Buzzard* 17,431-3; *Boyle* 18,560-6, 18,653-66, 18,677-81; *Mapother* 18,834-7; *Beard* 19,453; *Craig* 20,697, 20,784-91.
- Notification system would be approved, and suggestion, *Devine* ... 4389-4422, 4435-50
- Number of cases that could be treated voluntarily, *Devine* ... 4542-4
- Nursing homes, *see that title.*
- Postponement of certification for three months advocated when possible, *Gibson* 12,417, 12,440-1
- Problem of, *Yellowlees* ... 5694-718
- Psychosis cases, proposal *re*, *Devine* ... 4389-422

Treatment without Certification—cont.

- in Public mental hospitals advocated, *Devine* 4407-9
- Reception Houses, *see that title.*
- Reluctance of people to send incipient cases to asylums, *Ford* ... 6308-9
- Scheme, *Langdon-Down* 8065-139; *Craig* 20,864-6.
- IN SCOTLAND: *Devine* 4389, 4546-7; *Rose*, *Marr* 15,605-10, 15,614-22, 15,624.
- Detention question and power not advocated, *Marr*, *Rose* ... 15,614-7, 15,626-49
- Notification desired, *Rose* 15,615, 15,621-2; *Marr* 15,627.
- Statistics suggested to strengthen case for, *Leach* ... 6064-78
- Supervision, by Board of Control advocated, *Craig* ... 20,697, 20,899-903
- Voluntary Boarders, *see that title.*
- Trial Leave of Absence, *see under* Leave of Absence.
- Tuebrook Asylum:**
- Visitation of, *Barr* 7052-61.
- Voluntary boarders, *Barr* 7067-9.

- Unemployment, a cause of mental disorder, *Baly* 2869, 2879

Urgency Orders:

- Application to pauper cases, suggestion, *Lobjoit*, 5142-9
- Clerk to justices should be notified and record kept, *Beard* ... 19,545
- must Continue in certain cases, *Parker* 10,616-41, 10,818-25
- Extended use of, suggested, in connection with proposed appointment of specially selected certifying doctor, *Carswell* ... 16,485-98
- Objection to, *Parker* ... 10,614A, 11,471
- Procedure, *Parker* ... 10,616-41
- proposed Procedure, *Lomax*... 12,822
- Provisional, suggestion, *Willis*, etc. 21,382-3, 21,395-8
- Scotland, *Marr* 15,219, 15,232-5; *Robertson*, 15,512-9.
- for Short period only, advocated, *Beard* 19,509-10, 19,540-1
- Sworn statement should be required, *Parker* 10,821-4
- System, *Macleod* ... 94-5, 105-9
- Used too frequently and provisional order suggested in place of, *Chubb*... 6724-30
- Urgent cases, question of procedure, *Langdon-Down* 8082-92, 8177-85, 8190-203; *Edwards* 8186-9; *Masterman* 8204-14.
- Utrecht Neuro-psychiatric Clinic, *Langdon-Down* 13,638-45; *Goodall* 17,072, 17,164; *Boyle* 18,569, 18,617, 18,666.

Verandahs, *see under* Buildings.

Villa system, *see under* Buildings.

Violent cases might be dealt with in special portions of mental hospitals without certification, *Craig* 20,813-5

Visitation:

- by Board of Control, *Macleod* 337-8, 353, 874; *Willis* 726-7; *Connell* 4069-71.
- Account of, by ex-attendant, *Parker* ... 11,245-9
- Adequacy of, *Bond* ... 361-7
- of All cases, desirable, *Willis* ... 42-3
- Complaints to, difficulty of making, and suggested remedies, *Parker* ... 11,264-70
- Farcical nature of, *Mr. P.* ... 14,311-7
- no Help from, rather harm, personally, *Miss C.* 14,587-92
- Ineffectiveness of, *Parker* ... 11,239-80
- Information always received beforehand, *Parker* 11,249-51; *Mr. P.* 14,312-4.
- Interviews with patients, insufficient time for, *Mr. M.* ... 19,971

Visitation—cont.

by Board of Control—cont.

Licensed houses, *see that title*.Notification of, and preparation for, *Gibson* 12,190-1; *Mr. M.* 19,966-8; *Mr. O.* 20,167.Ordering of, by Lord Chancellor, power of, *Macleod, Willis* 342-8, 353; *Schuster* 975-6.Patient's account of, *Parker* ... 11,264Patients actually seen and talked to, *Willis* 29 of Poor Law Institutions, *Macleod* 708; *Willis* 713-6; *Senior* 3396-8.Preparation for, no time for, generally, *Blood* 12,192-3Private interviews with patients, *Willis, Macleod, Bond*

29, 357-60, 366-8, 381, 384, 387-90

Difficulty of obtaining, *Parker* ... 11,264Pauper patients, no right of, but given if asked for, *Macleod* 358; *Bond* 368-9, 372-4.Right of, to pauper patients, no objection to, but no more interviews would result, *Willis* ... 375Record of, extent, *Bond* 370, 371, 379-81, 392-3; *Willis* 371, 375-8.Value of, *Bond* ... 394-6, 403Procedure, *Macleod* ... 357-60as Safeguard against wrongful detention, *Bond, Willis, Macleod* ... 382-5, 403Single patients, *Macleod* 353-5, 356; *Willis* 355.Statutory, *Macleod* ... 451Value of, *Macleod* ... 401-3

BY CHANCERY VISITORS:

Complaints received on, nature of, *Sandhurst, 17,840-4, 17,858-75, 17,883-4, 17,895-6, 17,902-17.*Division of cases between visitors, *Sandhurst, 17,807, 17,878.*Duties of, *Sandhurst* ... 17,776-92, 17,803-6Nature of, etc., *Schuster* 967-73, 1038-40Number of cases on books and classes of, *Sandhurst* ... 17,794-800to Persons discharged relieved, *Sandhurst* 17,822-9Private houses, *Sandhurst* ... 17,830-2Procedure, etc., *Sandhurst* 17,815, 17,845-52, 17,863-7where Receiver appointed, *Sandhurst* 17,808-14Special reports to Lord Chancellor (Sec. 185), *Sandhurst* ... 17,785-6Special visits by request, *Sandhurst* ... 17,806Suggestions, no difficulties experienced *re* getting suggestions carried out, *Sandhurst* 17,846-52.

BY GUARDIANS:

right of Access at all times to proper representatives advocated, *Hill* 18,281-90, 18,379-81; *Glanvill* 18,381.Announced beforehand, uselessness of, *Hill* 18,249-63, 18,280Complaints, procedure on, *Hill* ... 18,261-8Farical nature of, *Mr. P.* ... 14,309-10Ineffectiveness of, *Parker* ... 11,281Nature of, *Senior* ... 3384-90Nature of, and comparison with, visitation by Visiting Committee, *Sanders* ... 2373-81Powers *re*, ignorance of, *Hill* ... 18,255Procedure, *Leach* 6131-8; *Glanvill* 18,382-3.every Six months advocated, *Leach* ... 6137Special visiting committees, advantage of, *Hill* 18,249, 18,279, 18,287, 18,312; *Glanvill* 18,331.Surprise visits instituted, *Wandsworth, Hill* 18,249, 18,255, 18,258, 18,267Value of, *Leach* ... 6123-30on Home Secretary's order, *Brock* ... 1091-4of Inquisition cases, *Macleod* 342-52; *Sandhurst* 17,801-3, 17,879-82.

BY JUSTICES:

of Licensed houses, *see that title*.no Objection to proposal, *Dixon* ... 3964-5of Reception houses, proposal, *Walden* 2078-9as Safeguard against wrongful detention, proposal, *Barnsley* ... 1894-905, 1930-5

Visitation—cont.

BY JUSTICES—cont.

Scheme under Mental Deficiency Act advocated, *Barnsley* ... 1881-911, 1936-41careful Selection of visitors necessary, *Barnsley* 1906-9Licensed houses, *see that title*.by Lord Chancellor, *see that title*.by Medical practitioner appointed by Guardians, *Parker* ... 11,282-5

BY PETITIONER:

Obligatory once in six months, *Willis* 353; *Bond* 404.Provision not entirely satisfactory and suggested improvement, *Sandhurst* 17,956-63

OF POOR LAW INSTITUTIONS:

by Ministry of Health, *Francis* 1262-5, 1351-66by Visiting Committee of Asylum, proposal not agreed with, *Usher* ... 3414-21of Registered hospitals, by Managing Committees, *Macleod* ... 353BY RELATIVES AND FRIENDS: *Bond, etc.* 405-8, 412-7; *Chubb* 6791-5; *Parker* 11,087-95.Complaints to, uselessness of, *Miss H.* 19,680-2.Effect, *Dixon* ... 3974more Frequent in case of poor patients than wealthy, *Sandhurst* ... 17,964-6Nurses not allowed to talk to, *Miss H.* 19,677-9Personal experiences, *Mrs. M.* 14,051-4, 14,109-15, 14,171-2, 14,176; *Miss B.* 14,794-801.Scotland, *Marr, Rose* ... 15,381-4

SCOTLAND:

by Justices of the Peace, *Rose* ... 15,377by Parish Councillors, *Rose* ... 15,378by Sheriff, *Marr* ... 15,376System, *Marr* 15,376; *Rose* 15,377-8.of Single care patients, *Macleod, Willis* 353-5, 356Surprise visits, difficulty of securing, *Parker* 11,259; *Gibson* 12,189-91.by Unpaid visitors, *Keene* ... 4892-4

BY VISITING COMMITTEES:

Comparison with visitation by Guardians, *Sanders* ... 2373-81

Complaints to, by patients:

Action on, *Keene* 4877-80, 4886-91, 4895, 4897, 4978-81, 5045-65Committee should sit for certain time at intervals to hear, *Lomax* 12,626-35, 12,659Freely made, *Hodgson* ... 13,343-4Freedom of, and action on, *Lovsey* 5257-9, 5268-72, 5275-9, 5339-50Prevention of, through fear, doubted, *Lobjoit* 5095-6, 5100Dinner should be abolished as a function, *Lomax* 12,636-42Farical nature of, *Lomax* 12,615-21, 12,626, 12,649; *Mr. P.* 14,300-8; *Mr. L.* 20,370.Free access to, *Blood* 12,217-20; *Wiese* 12,221-2.Ineffectiveness of, *Parker* ... 11,239-80Interviews with patients: *Walden* 2099-106, 2111-5; *Sanders* 2382-7; *Broome Giles* 3655-60, 3665-7, 3672-3; *Connell* 4060; *Keene* 4976-80.no Difficulty experienced by patients in obtaining, *Lobjoit* ... 5090-4, 5100no Facilities for, *Mr. P.* ... 14,308Records of, extent of, *Walden* 2154-8; *Keene* 4871-6.Right of private patient to demand, and no reason against pauper patients having, *Keene* ... 4898-9any Member should have access to institution at any time, *Lomax* ... 12,662-7of Poor Law Institutions, proposal not agreed with, *Usher* ... 3414-21Procedure, *Connell* 4060-1; *Lobjoit* 5088-105, 5200.System, *Macleod, Willis* 335-8, 353; *Walden* 2098; *Keene* 4740-2.Visitors independent of lunacy administration, suggestion, *Parker* ... 11,801 (22)by Voluntary visitors, desirability doubted, *Lovsey* 5337-8

Visiting Committees:

Appointment of, by central department desirable,
Lomax 12,645
 Continuation reports and certificates might be
 counter-signed by two members of, *Lobjoit*
 5180-1

CO-OPTION OF MEMBERS:

Approved, *Cole* 16,850-1
 Criticism, *Hodgson* 13,362-93
 Possibility of, through use of Mental Deficiency
 Act, *Keene* 4706-13, 4975
 outside the Local Authority would be useful,
Lomax 12,660-2
 Doctors on, would be approved, *Lovsey* ... 5335-6
 Examination of letters by, *Lobjoit* ... 5103-5
 Interview of patient before probation, by whole
 Committee, objection to, *Broome Giles* 3649-50
 Medical Superintendent should be more indepen-
 dent of, *Lomax* 12,492-501, 12,563, 12,577-82
 Name, alteration desirable, *Beard* 19,471-5
 One for number of Asylums, *Keene* ... 4703

POWERS AND DUTIES OF:

Keene 4719
 Accommodation and upkeep, *Keene* 4719,
 4723-33, 4926
 Admissions, consideration of new cases, *Lobjoit*
 5154-6
 Dietary, *Keene* 4829
 re Discharge, *Willis* 509-12, 767-71, 798-800;
Keene 4743-5.
 Dismissal of nursing staff, proposal, *Gibson*
 12,328-44
 Research, subject to approval of Board of Con-
 trol, criticism of Mental Treatment Bill,
Hodgson ... 13,394-409, 13,412-29, 13,495-9
 to make Rules and regulations, *Keene* 4823-6
 to Spend Money, *Keene* 4723; *Hodgson* 13,366-9,
 13,371-6
 Staffing of asylums, *Keene* 4734-9
 Visitation, *see that title*.
 Representatives of County Councils on, expenses
 should be paid, *Taggart* 13,492-4
 Responsibility for accommodation should rest on,
Willis 21,386
 Strengthening advocated, *Parker* 11,801
 Sub-Committees, suggestion, *Mr. L.* 20,370, 20,372
WOMEN ON:
 Importance of, *Lomax* 12,667
 no Objection to, *Beard* 19,562-4
 Visitors, Chancery, *see under* Lord Chancellor.

Voluntary Boarders:**ADMISSION:**

on Application and immediate notification, desir-
 able, *Barr* 7071-5
 of Attempted suicide as, objection to, *Miss G.*
 20,539-44
 Delay objected to, and power to admit cases
 with subsequent notification to Board of Con-
 trol, &c., advocated, *Edwards* ... 6389-92
 less Formality advocated, *Barr* 7071-5; *Langdon-*
Down 8147.

to Mental Hospitals:

Advocated, *Lewis* 4585, 4600-4; *Edwards* 6393;
Barham 7499-501; *Parker* 10,487-90, 10,501;
Goodall 16,718-20; *Sidney, Gardner* 19,141-3,
 19,149-51, 19,172, 19,191, 19,197-201; *Craig*
 20,697, 20,867-8.
 Advocated at discretion of medical superinten-
 dent, *Boyle* 18,751-2
 becoming Certifiable, question of procedure,
Sidney 19,117-8
 Procedure, question of, *Gardner* 19,173,
 19,177-8, 19,180, 19,183, 19,187-90; *Sidney*
 19,174-86, 19,192-5.
 Question of, *Barr* 7081-4
 to Public institution, recommendation might be
 made by medical superintendent, *Willis*
 21,309-12

Voluntary Boarders—cont.**ADMISSION—cont.**

on own Written application or if under 18 on
 written application of parent or guardian, with
 one medical recommendation, suggestion,
Willis 21,262, 21,287, 21,300, 21,307-12
 Advantage of system, *Dixon* ... 3771-6, 3975-8
 Approval of system, *Lovsey* 5250-3
 Approval of system as carried out at Maudsley
 Hospital, *Miss G.* 20,435-8, 20,458-9
 Attitude of Board of Control, *Yellowlees*
 5745-6, 5749-50
 Bedding, complaint of, *Miss G.* 20,484-9
 Bethlem Royal Hospital, *Phillips*
 5861-75, 5931-3, 5953-6
 Camberwell House, *Edwards* 6383-90, 6470-2, 6476

SUBSEQUENT CERTIFICATION:

Bethlem practice *re, Phillips* 5863-70
 Objection to, and question of alternative,
Robertson 15,896-904
 Personal experience and objection to, *Mrs. G.*
 20,566-72
 Possibility of, would act as deterrent, *Chubb*
 6753-4
 Procedure, *Phillips* 10,326-45
 in Same Institution:
 Advocated, *Edwards* 8155-63
 Objection to, *Miss G.* 20,515
 Objection to, but less objectionable in case of
 existing institutions, *Parker* 10,529-52
 Personal experience and complaint, *Miss G.*
 20,511-38, 20,557-9

Correctness of description "voluntary," ques-
 tion of, *Goodall, Cole, Lord* ... 16,729-37

DETENTION:

24 hours approved, *Parker* 10,502-28
 72 hours:
 Approved, *Langdon-Down* 8148-54
 Approved, but should be maximum time,
Lobjoit 5130-41, 5176-9
 too Long, *Parker* 10,503-9, 10,519
 Proposal, *Connell*, 4111-6, 4161-4, 4214-9;
Willis, Macleod, ... 21,291-4, 21,337-49.
 Proposal not agreed with, *Lomax* ... 12,866
 Bethlem, *Phillips* 5864, 5866-7
 some Control necessary, *Connell* 4100-2, 4108,
 4111-6
 Undertaking to give right to authorities of de-
 tention and control for 28 days if required,
 advocated, *Lomax* 12,866, 12,976
 Voluntary agreement for, for certain period,
 system would be useful, *Phillips* 5968-73; *Leach*
 6281

Documents signed by patient on admission, misre-
 presentations and suggestion *re, Miss G.*
 20,443-57

Encouragement of system desirable, *Connell* 4098-9,
 4109-16, 4136-7; *Phillips* 5861, 5876; *Faudel-*
Phillips 5953-8; *Barr* 7069-71, 7077-8.
 Extension of facilities desired, *Lobjoit*... 5129
 present Facilities for, *Sidney, Gardner* 19,197-201
 Increase in number owing to reluctance of doctors
 to certify, *Chubb* 6762-7, 6770, 6850-2, 6864-78
 Inspection by Board of Control proposal, *Willis*,
Bond 21,318-27, 21,337
 Institutions proposed for, *Willis* ... 21,262, 21,289
 Institutions should be under Local Authorities, not
 Board of Control, unless Board reorganised with
 District Commissioners, *Parker* 10,554-74A, 11,801
 Maudsley Hospital, *Keene* 4930-2; *Sidney* 19,094-121
 Medical report within seven days, proposal, *Willis*
 21,313-7
 Melancholic cases, difficulty, *Yellowlees* ... 5705
 Mental Treatment Bill, would be approved, *Phillips*
 5872-3
 New class of institution for, desirable, *Parker*
 10,500, 10,553

BECOMING NON-VOLITIONAL:

Evanesence, case of, *Macleod* 21,331-6
 Maudsley Hospital, *Sidney* 19,094-121
 proposed Procedure, *Craig* 20,869-85; *Macleod*,
Bond, Willis 21,328-37.
 Provision *re, Macleod, Bond* ... 21,330-37

Voluntary Boarders—cont.

- Notification not advocated unless restraint necessary, *Worth* ... 17,323-32
 Observation period under provisional certificate preferable, *Chubb* ... 6753-68
 Patients persuaded to come in as, by friends, when certifiable, *Barr* ... 7071, 7076, 7085-90

PAUPER:

- Encouragement of system advocated, *Phillips* 5877-8
 Facilities would be availed of, *Carswell* 16,589
 Personal experience, *Miss G.* ... 20,429-559
 Refusal at mental hospitals, *Menzies* ... 16,766
 Removal, proposed powers to Board of Control, *Willis* ... 21,322-3

SAFEGUARDS:

- Certificate from usual medical attendant, *Robertson* ... 15,890-1
 Necessary, *Langdon-Down* ... 8140-6
 Necessary, in connection with Section 315, *Bodkin* ... 17,666-8
 Question of need for, *Parker* ... 10,491-6
 Seeing of, by Commissioners, and making of return, *Robertson* ... 15,885-6
 Statement of willingness to remain, daily signing or initialling of, suggestion, *Miss G.* 20,508
 Scheme, *Langdon-Down* ... 8163-75

SCOTLAND:

- Admission on written application to superintendent, *Rose, Marr* 15,307, 15,340-9; *Robertson* 15,861-2, 15,864-78, 15,917.
 Certifiable persons as, and difficulty in connection with, *Marr, Rose* 15,324-6, 15,328-35, 15,336-8, 15,340-52.
 becoming Certifiable, procedure, *Marr* 15,353-70
 subsequent Certification on ground of giving notice to go, *Robertson* ... 15,894-6, 15,903
 Development of system, *Robertson* ... 15,922-9
 Notification to Board of Control and sanction, *Rose* 15,308-9, 15,371-5; *Robertson* 15,862-3.
 Paupers sent as, in some cases, but Government grant not applicable to, *Marr* 15,366-8; *Robertson* 16,007-9, 16,217-21; *Comrie* 16,435.
 Percentage of, *Marr* 15,320; *Robertson* 15,908.
 sufficient Protection provided in, *Rose* 15,372-5
 no Regulations re, *Marr* ... 15,312
 72 hours' detention, *Rose, Marr* 15,310-20, 15,356-60; *Robertson* 15,909-15.
 Signing of form under persuasion in some cases, *Robertson* ... 15,918-9
 Statutory provisions re, *Marr, Rose* 15,313-28
 Statutory recognition, *Robertson* ... 15,912-3
 System, *Robertson* ... 15,860-78, 15,884, 15,888
 Value of system, *Rose* ... 15,336-9
 in Single care should be allowed, subject to supervision and control, *Mapother* ... 18,868-80
 Six-monthly reports, proposal, *Willis* ... 21,314-8
 System, *Willis* ... 80-1
 System approved for certain class of cases, *Chubb* ... 6769, 6772-5
 should be Treated apart from ordinary inmates on, *Chubb* ... 6879-80
 Treatment as certified lunatic, complaint of, *Miss G.* ... 20,465-83
 Tuebrook Asylum, *Barr* ... 7067-9
 York, The Retreat, *Yellowlees* ... 5742-50

Voluntary treatment:

see also Voluntary Boarders.

- Certain cases suitable for, and compulsory detention not desirable, *Langdon-Down* ... 7800-5
 Desire for, *Mrs. M.* 13,729, 13,734-7, 13,809-12, 13,813; *Mr. P.* 14,208.

- Will, power of making in asylum, *Craig* ... 20,916-7
 Winchelsea, Periteau House, *Fawssett* ... 6903-4
 Work by patients for payment, see under Occupation under Care and Treatment.
 Workhouses, see Poor Law Institutions.

York, The Retreat:

- Access to outside world, *Yellowlees, Crosland* 5531-44, 5548-76.
 Accommodation and number of patients, *Yellowlees* ... 5395
 Admission of cases, and subsequent procedure, *Yellowlees* ... 5577-611
 Buildings, *Yellowlees* ... 5388-9
 one Child in, *Yellowlees* ... 5727
 Continuous bath, *Yellowlees* ... 5674, 5840
 Correspondence, procedure re, *Yellowlees* 5561-7
 Detention, attitude of patients towards, *Yellowlees* 5620-5, 5669
 Dietary, *Yellowlees* ... 5734
 Discharge, methods and procedure, *Yellowlees* 5627-35
 Domestic staff, *Yellowlees* ... 5490
 Drugs, control over, *Yellowlees* ... 5681-9, 5797-8
 Favourable position of, *Yellowlees* ... 5772-8
 Fees, *Yellowlees* ... 5722-6
 Foundation and management, *Yellowlees* 5385-6, 5412-3
 Funds, *Yellowlees* ... 5396-7
 Holiday home, *Yellowlees* ... 5841-3
 Lady doctor, *Yellowlees* ... 5828-30
 Maintenance cost, *Crosland, Yellowlees* ... 5731-3
 Managing Committee, *Crosland, Yellowlees* 5419-23
 Managing Committee, contact with patients, *Yellowlees, Crosland* ... 5530, 5532-7
 Medical staff, *Yellowlees* ... 5415-8
 Medical superintendent, contact with patients, *Yellowlees* ... 5511-29
 Medical treatment, *Yellowlees* 5670-89, 5839-40, 5844
NURSING STAFF:
 Accommodation, *Yellowlees* ... 5497
 subsequent Careers, *Yellowlees* ... 5502-4
 Dismissals, *Yellowlees* ... 5507-9
 Hours, *Crosland, Yellowlees* ... 5482-9, 5501
 Proportion to number of patients, *Yellowlees* 5720-1
 Recruitment and training, *Yellowlees* 5424-70, 5491-500
 Remuneration, *Crosland, Yellowlees* 5472-9, 5484
 Tribute to, *Yellowlees* ... 5501
 Organisation, *Yellowlees* ... 5400-11
 Selection of cases, *Yellowlees* ... 5735-8
 Special position of, *Gibson* ... 11,995
 Staff, *Yellowlees* ... 5399-401
 Visitation by Commissioners, *Yellowlees* 5548-54
 Visits by friends and relatives, *Yellowlees* 5556-60
 Visits to town on parole, *Yellowlees* ... 5568-76
 Voluntary boarders, *Yellowlees* ... 5742-50

INDEX TO WITNESSES.

- AFTER CARE ASSOCIATION, evidence on behalf of, *see* Vickers Miss ... 7695-795
- ANDREW, Miss FLORENCE, *see* Tredgold, Alfred Frank, M.D., F.R.S. (Edin.), &c. 21,099-259
- ASSOCIATION OF MUNICIPAL CORPORATIONS, evidence on behalf of, *see* Beard, Sir Lewis 19,412-565
- ASSOCIATION OF POOR LAW UNIONS, evidence on behalf of, *see* Probert, Rev. P. S. G., *etc.* 5982-6309.
- B., Mr.: ... 14,601-14,732
 Licensed houses, experiences of ... 14,605-729
- B., Miss: ... 14,733-14,900
 Licensed house, experiences of ... 14,734,900
- BALY, Dr. A. L., M.R.C.S., L.R.C.P., Medical Superintendent, Lambeth Infirmary: 2449-3009
 Accommodation ... 2688-97
 Alcoholism ... 2746-73, 2874-7
 Certification ... 2841-5, 2858, 2912-9, 2930-46
 Delirious cases ... 2723-45, 2785-9
 Detention, power of ... 2739, 2744-5
 Domestic trouble ... 2607-14, 2869-70
 Form 8, doubtful cases 2597-640, 2681-2, 2702-20, 2790-803, 2818-9, 2846-8, 2894-909
 14 days' detention system 2530, 2681-2, 2702-303, 2820-5, 2846-8, 2880, 2883, 2894-911, 2947-53.
 Justice, position of ... 2855-7
 Lambeth Infirmary 2452-545, 2570-97, 2616-868, 2888-90, 2956-38A
 L.R.C.P. and M.R.C.S. curriculum ... 3000-9
 Mental Deficiency Act ... 2928-9
 Observation period ... 2605, 2804-8, 2813-8
 Persons incapable of looking after themselves, method of dealing with ... 2542-69, 2834-40
 Police stations, taking of mental cases to, not desirable ... 2922-4
 Relatives and friends of patient 2570-9, 2650-77, 2849-57, 2864, 2871
 Relieving officer ... 2497-503
 Suicide, attempted ... 2773-85
 Treatment of mental cases in general hospital, proposal ... 2858, 2884-5, 2930-46
 Unemployment and overcrowding ... 2869, 2879
 Workhouse, discharge without order being made 2625-30, 2698-701
- BARHAM, Dr. G. F., M.D., Medical Superintendent of London County Mental Hospital at Claybury: 7166-7694
 After care ... 7457-60, 7481
 Care and treatment, improvement ... 7653-60
 Claybury Hall ... 7175-7, 7361-5
 Claybury Mental Hospital ... 7169-694
 Clothing ... 7369-76
 Discharge 7457-79, 7522-4, 7587-607, 7613-22
 Employment of patients 7316, 7320-2, 7353-9, 7636-40
 Hospital visitors, voluntary 7391-408, 7611-12, 7627-8
 Meals and bed time, hours of ... 7332-53
 Medical staff ... 7508-10, 7661-2, 7666-7
 Medical superintendents 7433-56, 7647-52, 7663-5, 7694
- MENTAL HOSPITALS:
 Publicity ... 7608-10
 Size ... 7505-6, 7531-3, 7668-9
 Nursing staff 7201-9, 7213-27, 7231-2, 7234-51, 7255-309, 7325-30, 7553, 7624-5 7642-6
 Psycho-analysis ... 7421-2, 7689-90
 Reception houses ... 7490-8
 Treatment without certification ... 7485-9
 Voluntary boarders ... 7499-501
- BARNES, Rev. W. E. C., M.A., Chaplain at Harrow and Cane Hill Mental Hospitals: 17,530, 17,554-629
 Chaplains, nature of work, &c. 17,530, 17,554-629
- BARNSELEY, Brig.-Gen. Sir JOHN, D.L., V.D., J.P.: ... 1776-2015
 Asylums, visitation by justices, proposal 1881-911, 1930-41
 Birmingham, number of lunatics, accommodation, &c. ... 1969-72, 1975, 1980-90
 Certification of private patients 1827, 1965, 1979
 Certificates, pauper ... 1807-12, 1942-50
 Clinics for outpatients ... 1834-5, 1966
 Justices of the Peace, duties of, and proceedings before ... 1782-824, 1926-9, 1973-4, 1991-2015
 Licensed houses ... 1818-24
 Mental Treatment Bill ... 1951-60
 Poor Law infirmaries 1796-803, 1813-7, 1925, 1929
 Reception houses ... 1834-80, 1951-60
- BARR, Sir JAMES, C.B.E., D.L., M.D., F.R.C.P.: 7040-7165
 Certificates ... 7104-12
 Certification, protection of medical men 7143-4, 7154-63
 Clinics ... 7079, 7145-8
 Contact with outside community ... 7152-3
 Detention, improper 7049, 7054-61, 7113-6, 7132-6
 Discharge ... 7140-2
 Judicial authority, proceedings before 7098-103, 7125-31
 Justice of the Peace, proceedings before ... 7149-51
 Leave of absence on trial ... 7061-6
 Licensed houses, visitation ... 7052-61
 Non-certification of certifiable patient ... 7117-23
 Nursing homes ... 7163-5
 Observation period ... 7080
 Tuebrook Asylum ... 7052-61, 7067-9
 Voluntary boarders ... 7067-78, 7081-90
- BEARD, Sir LEWIS, on behalf of the Association of Municipal Corporations: 19,412-565
 Board of Control ... 19,547-52
 Discharge ... 19,475-80, 19,484-94
 Justices of the Peace, procedure before 19,497-544, 19,561, 19,564
 Lunacy administration ... 19,547-9
 Mental hospitals, transfer of senile cases to work-houses ... 19,415-52
 Mental Treatment Bill ... 19,453, 19,554-6
 Petition ... 19,559-61
 Propaganda work ... 19,459-66
 Treatment without certification 19,453, 19,465-70
 Urgency orders ... 19,509-10, 19,540-1, 19,545
 Visiting Committees ... 19,562-4, 19,471-5
- BLOOD, WALTER; GIBSON, GEORGE; and WIESE, Miss MAUD, National Asylum Workers' Union: ... 11,835-12,451
- CARE AND TREATMENT:
 Bathing ... 12,389-91
 Bed time ... 12,055-74
 Clothing ... 12,244-6
 Diet ... 12,037, 12,229-40, 12,407-11
 Drugs ... 12,212-6, 12,355-6, 12,428-33
 Ill-treatment ... 12,187-8, 12,201
 Recreation and employment 12,247-52, 12,362-6
 Remedial treatment... 12,197-9, 12,201
 Classification ... 12,137-42
 Control ... 12,241-3, 12,261-84
 Discharge ... 12,202-11
 Government grant ... 12,285-8
 Licensed houses... 12,289-323, 12,367-88, 12,392-400
 Medical superintendent ... 12,328-41
 Mental Health Authority ... 12,425-7
 National Asylum Workers' Union ... 11,852-76
- NURSING STAFF:
 Accommodation ... 12,357-61
 Charge nurses ... 11,911-22, 12,044-6, 12,087
 Disablement ... 12,153-74
 Dismissal, power of ... 12,328-44

BLOOD, WALTER, etc.—cont.

NURSING STAFF—cont.

Female:

Employment in male wards	12,110-52, 12,175
Prospects	11,990-3
Hours and leave	11,887-94, 12,055, 12,068-9, 11,932, 11,937-69, 11,994-2000, 12,442-6, 12,450-1, 12,681-2.
Key chains	12,253-9
Periods of service	11,971-2, 11,975, 11,980, 12,080-3, 12,401-3
Private nursing	12,008-26
Probationers	11,877-92, 11,895-903, 11,923-9, 12,413-4
Registration	12,175-80
Remuneration	11,930-1, 12,001, 12,027-53, 12,404-5
Superannuation	12,345-7
Training and examinations	11,895-909, 11,924, 11,932, 11,937-69, 11,994-2000, 12,442-6, 12,450-1, 12,681-2
Understaffing	12,198-9, 12,201
Registered hospitals	12,373-9, 12,392-4
Single care	12,312
Treatment without certification	12,324-8, 12,415-24, 12,440-1.
Visitation	12,189-93, 12,217-22

BOARD OF CONTROL, evidence on behalf of, *see* Willis, Sir Frederick J., K.B.E., C.B., Macleod, S. J. Fraser, K.C., and Bond, Dr. C. H., C.B.E., D.Sc., M.D., F.R.C.P. 1-944, 21,260-400

BODKIN, Sir ARCHIBALD, K.C.B.: 17,630-17,763
Lunacy Act, Part XI, anomalies in 17,630-763

BOND, Dr. C. H., C.B.E., D.Sc., M.D., F.R.C.P., *see* Willis, Sir Frederick J., &c. 1-944, 21,260-400

BONE, Dr. J. W., M.B., C.M., on behalf of British Medical Association, *see* Langdon-Down, Dr. R., &c. 7796-8215, 13,500-719

BOYLE, Dr. HELEN, *see* Chichester, Countess of, and Boyle, Dr. Helen 18,501-18,759

BRITISH MEDICAL ASSOCIATION, evidence on behalf of, *see* Langdon-Down, Dr. R. &c. 7796-8215, 13,500-13,719

BROCK, L. G., C.B., Assistant Secretary, Ministry of Health: 1066-1222
Board of Control, relations of Ministry of Health with 1127-34, 1136-41, 1082-9, 1106-8, 1189-90, 1193-5
Buildings 1087-9, 1098-103, 1213
Certification 1174
Detention, wrongful 1139-40, 1174
Discharge 1163-71, 1174-80
Health, Ministry of, powers *re* lunacy administration, &c. 1070-82, 1096-141, 1181-2, 1191-2, 1195-208, 1215-3
Home Office, powers *re* lunacy administration 1076, 1090-5
Ill-treatment, complaints of 1195-208
Medical treatment 1128-9, 1142-62, 1209-10, 1215-6, 1219-21

BROOME GILES, Colonel P., C.B., F.R.C.S., J.P.: 3599-3711
After care 3664
Alcoholism 3709-10
Certificates 3699-708
Discharge 3692-7
Ill-treatment 3660-4
Judicial authority, proceedings before, and interview with patient 3606-16, 3621-8, 3669-70, 3674-85, 3690-1
Justices, interview with patient 3686-8
Observation period 3632-4, 3637-47
Visitation, interview with patients 3655-60, 3665-7, 3672-3

BUZZARD, Dr. E. FARQUHAR, M.D., F.R.C.P., MILLER Dr. H. CRICHTON, M.D., and WORTH, Dr. R., O.B.E., M.B., on behalf of the National Council for Mental Hygiene: 17,288-17,433

Board of Control 17,403, 17,419-26

BUZZARD, Dr. E. FARQUHAR, M.D., F.R.C.P., etc.—cont.

Clinics	17,293-8, 17,372-402, 17,414
Consultants	17,344-52
Incipient cases	17,364-71, 17,431-3
Medical superintendent	17,333-41
National Council for Mental Hygiene	17,288-90
Non-volitional cases	17,323
Nursing homes	17,299-332, 17,428-30
Provisional Orders	17,390-3
Psychiatry, education in	17,291-5
Suicides, potential	17,403-16
Treatment without certification	17,417
Voluntary patients	17,323-32

C, Miss: 14,394-14,600
After care 14,510-21, 14,593
Care and treatment 14,482-97, 14,502, 14,568-73
Certification 14,457-61, 14,466-501, 14,524-6, 14,538-56, 14,578-80
Discharge 14,593
Escape 14,462-3
Licensed house, experience of, and objections to 14,404, 14,411-55, 14,474-7, 14,557-77, 14,584-6, 14,595-600
Mental hospitals, grounds 14,502-7
Nursing staff 14,498-9, 14,500-1, 14,528-37, 14,581-3
Private patients, accommodation for 14,405-10
Treatment without certification 14,522-3
Visitation by Commissioners 14,587-92

CARSWELL, Dr. JOHN, F.R.F.P.S. (Glasgow), L.R.C.P. (Edinburgh): 16,470-16,598
GLASGOW:

Hospitals and accommodation for mental cases 16,523-34

Observation wards 16,474-83, 16,515-23, 16,535, 16,545-59, 16,574-91

Mental Board of Health 16,592

Mental Medical Officer of Health 16,593

Mentally defective children 16,594

Observation wards attached to general hospitals 16,538, 16,558-72, 16,574-6, 16,579-83, 16,596-7

Public Health Authority substitution for Poor Law authority 16,592-3

Specialty appointed certifying doctor 16,479, 16,482-520, 16,539-42

Treatment without certification 17,417

Voluntary patients, pauper 16,589

CENTRAL ASSOCIATION FOR MENTAL WELFARE, evidence on behalf of, *see* Tredgold, Alfred Frank, M.D., F.R.S. (Edin.), &c. 21,099-259

CHELMSFORD, the Rt. Rev. the Lord Bishop of, Chaplains, position of, and suggestions, *re* 17,434-17,553

CHICHESTER, the Countess of, and **BOYLE**, Dr. HELEN: 18,501-18,759
Boarding out 18,666
Lady Chichester Hospital 18,501-610, 18,651, 18,659, 18,755-6

Clinics 18,554-9, 18,569-70, 18,604-6, 18,611-7, 18,622-9, 18,630-42, 18,645-8, 18,650, 18,671-4

Licensed houses 18,682-93, 18,706-8, 18,710-9, 18,723-6, 18,736-50

Mental hospitals, admission direct 18,733-4

Non-volitional cases 18,727-8

Private houses, freedom to take in patients 18,682-93, 18,706, 18,719, 18,740-50, 18,753-4

Provisional certificates 18,618, 18,627-8, 18,675-7, 18,726

Removal of patients from one home to another 18,694-705, 18,729-31, 18,757-9

Routine employment 18,584-6, 18,667-70

Social service 18,643-4

Treatment without certification 18,560-71, 18,653-66, 18,677-81

Voluntary boarders 18,751-2

- CHUBB, Sir CECIL, Bart., LL.B., proprietor of the
Old Manor, Salisbury ... 6480-6891
Certificates ... 6672-80, 6707-15, 6719-21, 6817-20
Certification ... 6762-7, 6770, 6850-2, 6864-72
Detention, improper ... 6740-7
Discharge ... 6740-3
Escape ... 6598-607
Judicial authority, proceedings before
6680-701, 6716-22, 6845, 6860-1
Leave of absence on trial 6552-97, 6608-25, 6829-30
Licensed Houses, tenure ... 6796-800
Nursing staff 6646, 6650-6, 6659-63, 6821-2, 6887-8
Observation period ... 6731-9, 6753-68
Reception orders ... 6845, 6853-63
Salisbury, Old Manor ... 6482-6891
Urgency orders ... 6724-30
Visitation 6504-21, 6524-5, 6536-55, 6791-5, 6801-16,
6825-8, 6880-7
Voluntary boarders
6753-75, 6834-7, 6863-78, 6850-2, 6864-80
- COLE, Dr. R. H., M.D., F.R.C.P.; COLLINS,
Dr. M. A., O.B.E., M.D.; GOODALL, Dr. E.,
C.B.E., M.D., F.R.C.P.; LORD, Dr. J. R.,
C.B.E., M.B.; MENZIES, Dr. W. F., B.Sc.,
M.D., F.R.C.P.; MOTT, Sir FREDERICK W.,
K.B.E., LL.D., M.D., F.R.C.P., F.R.S., and
WORTH, Dr. R., O.B.E., M.B., on behalf of
the Medico-Psychological Association ... 16,599-
17,287
After care ... 17,242-71, 17,277-9
Board of Control ... 17,016-43
Cardiff, Clinic and hospital ...
16,650-1, 16,653, 16,816-48, 17,163
Certification 16,625, 16,633, 16,888-97, 16,907-11,
16,913, 16,963-5, 16,993-7015
Classification ... 16,948-53
Clinics 16,645-7, 16,650-1, 16,655, 16,691, 16,703-62,
16,766-79, 16,801-5, 16,808-15, 16,849-50,
16,914-7, 16,955-9, 17,287
Continuation reports and certificates ... 17,091-2
Discharge ... 16,872, 17,094-5
Disposal of cases between different types of
institution ... 16,767-71, 16,801
Lady visitors ... 17,266-76
Licensed houses 17,044-62, 17,281-2, 17,286-7
Lunacy law ... 16,624-32, 16,634-5
Maudsley Hospital 16,799, 16,807-10, 17,106, 17,110,
17,118, 17,127, 17,173-4, 17,195
Medical education
17,099-116, 17,119-23, 17,126, 17,132-6, 17,164-7
Medical staff 17,110, 17,158-62, 17,196-200, 17,230-3
Medical Superintendents
17,124, 17,201-16, 17,219, 17,220-9, 17,233-41
Medico-Psychological Association 16,602-5, 16,613-9
Mental Treatment Bill ... 16,849-73, 17,179-83
NURSING STAFF:
Examination and training
16,606, 16,608-20, 17,168-71, 17,184-94
Female employment in male wards 17,063-89
Pauperisation ... 16,967-87, 16,990-1
Petition ... 16,966
Private patients ... 17,050
Provisional Orders
16,780-99, 16,877-913, 16,919-24, 16,928-32, 17,009
Psychiatric research
17,138-58, 17,163-4, 17,172-83, 17,194-5, 17,287
Psychology, London M.D. in ... 17,136-7
Single care ... 16,857-62, 17,282-5
Stigma ... 16,931-2, 16,934-48, 16,960-2
Treatment without certification ... 16,636-9
Voluntary boarders ... 16,718-20, 16,766
- COLLINS, Dr. M. A., O.B.E., M.D., on behalf of
the Medico-Psychological Association, *see* Cole,
Dr. R. H., &c. ... 16,599-17,287
- COMRIE, Dr. JOHN D., M.A., B.Sc., M.D.,
F.R.C.P.: ... 16,262-16,469
Alcoholic cases ... 16,450-7
Classification ... 16,345-9, 16,351, 16,361-6, 16,385
Edinburgh Royal Infirmary, special ward for
mental cases ... 16,264-469
Mechanical restraint ... 16,337-8
- COMRIE, Dr. JOHN D., M.A., B.Sc., M.D.,
F.R.C.P.—*cont.*
Special wards of general hospitals, advantages, &c.
16,385, 16,399-401, 16,439-49, 16,458-65
Treatment without certification ... 16,303-10
Voluntary patients, pauper ... 16,435
- CONNELL, Dr. O. G., M.C., L.R.C.P., Medical
Superintendent, Norfolk County Mental
Hospital: ... 4051-4244
After care ... 4143, 4190
Certification 4052-9, 4093-6, 4134, 4155-7, 4238-44
Discharge ... 4082-5, 4142-4
Employment of patients ... 4145-8, 4191-2
Ill-treatment ... 4072-9
Insanity, types of ... 4096
Justices ... 4211
Leave on trial ... 4236-7
Medical men, training ... 4212-3
Reception order ... 4090
Norfolk County Mental Hospital 4117-28, 4045-8,
4065-8, 4080-2, 4090, 4138-41, 4152-3, 4165-7,
4170-7, 4181-4, 4191-2, 4195-9, 4220-30
Recovery rate ... 4096
Treatment without certification 4098-9, 4100-2,
4108-16, 4136-7, 4158-64, 4205, 4214-9
Visitation ... 4060-4, 4069-71
- COUNTY COUNCILS' ASSOCIATION, evidence on
behalf of, *see* Hodgson, Alderman Sir William
13,005-13,499
- COURTENAY LORD, Dr. C., M.R.C.S., L.R.C.P.,
on behalf of British Medical Association, *see*
Langdon-Down, Dr. R., &c. ... 7796-8215
- CRAIG, Sir MAURICE, C.B.E., M.D., F.R.C.P.:
9123-9543, 20,689-21,000
Attorney, power of ... 20,913-9
Board of Control ... 20,697, 20,899-906, 20,929
Cassell Hospital ... 20,735-8, 20,974-6
CERTIFICATION: 9303-6, 9391-6, 9402-11, 20,697,
20,761, 20,771-4, 20,816-25, 20,841-4, 20,886,
20,930, 20,940-1, 20,981-4
Protection of medical men 20,755-70, 20,933-51
Charge against, Mr. H. ... 8832-57, 8870-85
Classification ... 20,780-4
Clinics 20,697, 20,727-34, 20,796-7, 20,826-63,
20,884, 20,960-1, 20,966-72
Delirious cases ... 20,697, 20,702-14
Guy's Hospital ... 20,697, 20,719-24, 20,727-34
Mr. H. case ... 9123-543
Insanity, definition difficulty ... 20,740-54
Licensed houses 20,697, 20,912, 20,924-8, 20,985-93
Lunacy Acts ... 20,697
Mental Hospitals ... 20,800-3, 20,811-2, 20,974-7
Medical staff ... 20,977-80
Nursing Homes ... 20,697, 20,909, 20,912-4
Poor Law Infirmary ... 20,809-10
Position of, as acting for Mr. H. and his brother
9357-70
Property ... 20,889-95
Provisional certification or notification
20,697, 20,861-4, 20,876, 20,888-96, 20,907
Psychiatric medicine training ... 20,994-1000
Reception wards ... 20,952-9
Single care ... 20,697, 20,910-3, 20,920-3
Treatment without certification ... 20,697, 20,726,
20,784-91, 20,807-10, 20,864-6, 20,899-903
Treatment of mental disease ... 20,697, 20,725,
20,794-5, 20,908
Violent cases ... 20,813-5
Voluntary boarders ... 20,697, 20,867-85
Wards in general hospitals ... 20,716-24, 20,792-3,
20,798-9, 20,807, 20,898
- CROSLAND, Mrs. CONSTANCE, M. R., member of
the Managing Committee of The Retreat, York,
see Yellowlees, Dr. Henry, O.B.E., M.D., and
Crosland, Mrs. Constance, M. R. 5381-5851
- DEVINE, Dr. H., O.B.E., M.D., F.R.C.P., Medical
Superintendent of Portsmouth Borough Mental
Hospital: ... 4245-4560
After care ... 4383
Care ... 4346-7, 4350-1

DEVINE, Dr. H., O.B.E., M.D., F.R.C.P.—*cont.*

Certification

4265-76, 4384-8, 4502-3, 4528-35, 4540-1A, 4544

Children ... 4472

Chronic cases ... 4466

Continuation reports and certificates

4333-40, 4485-92

Detention ... 4288, 4343-9, 4431-4, 4457-60

Discharge ... 4373-9, 4498-9, 4555-60

Leave of absence, on trial ... 4452-6, 4555

Mental defectives ... 4514-7

Nursing staff ... 4468-71

Observation ... 4292-6

Poor Law Institutions, temporary detention in

4277-91, 4296

Portsmouth Borough Mental Hospital

4249-56, 4277-91, 4297-332, 4365-72, 4468-72,

4494-7, 4518-27, 4536-9, 4551-4

Public, education of ... 4423-30

Public Mental Hospitals, attachment to towns
rather than large isolated institutions

4351-64, 4468

Reception of new cases ... 4297-332

Recovery rate ... 4551-2

Treatment without certification

4389-422, 4435-50, 4473-80, 4542-7, 4550

DIXON, Lt.-Col. J. FRANCIS, M.A., M.D., Medical

Superintendent of the City Mental Hospital,

Humberstone, Leicester: ... 3712-4050

After care ... 4036-7

Bathing arrangements ... 3956-63

Care of patients ... 3951, 3955-63, 3990-1

Certification

3780, 3867-74, 3909-22, 4006, 4017-20, 4029-32

Chronic cases ... 3905-7

Classification ... 3833-8

Correspondence ... 3955

DETENTION: ... 3975-9, 3983-7

Orders ... 3740-9, 3754-70, 3934-6, 4000-3

Safeguards ... 3827-9

Discharge ... 3799-811, 3814, 3901-3, 3941-6

Justices ... 3802-6, 3964-5, 4004-5

Leave, 48 hours ... 3750-3

Leave, on trial ... 4033-6

Leicester City Mental Hospital, Humberstone

3720-34, 3778, 3831-7, 3839-45, 3859-61, 3875-9,

3927-33, 3947-63, 3979-82, 3989-96, 4021-2,

4038-42, 4045-50

Medical superintendents ... 4007-11

Nursing staff ... 3846-59, 3929-33

Paranoiac patients, care of 3879-904, 3923, 3937-40

Publicity and public interest ... 3811-24

Reception of new patients 3788-99, 3837-8, 4023-5

Reception order ... 3968-70

Senile cases ... 3905-7, 3925-6

Treatment without certification ... 3908, 4012-6

Visitation by friends and relatives ... 3974

Voluntary boarders ... 3771-6

Week-end reports ... 3785, 3800, 3971-3

E., Mr.: ... 14,350-393

Ill-treatment ... 14,379-86

Wrongful detention ... 14,354-92

EDWARDS, Dr. F. H., Medical Superintendent,

Camberwell House: ... 6310-6479

Accommodation for private patients ... 6329-32

Camberwell House

6365-6, 6383-90, 6395, 6414-20, 6427-72, 6476

Certification, improper ... 6440

Convalescent and seaside homes ... 6400-5

Inspection ... 6399

Licensed houses

6315-28, 6333-46, 6349-83, 6394-8, 6400-5, 6421-5,

6472-6, 6478-9

Lunacy Act, Section 315 ... 6407-13, 6427-39

Nursing staff ... 6441-5

Voluntary boarders 6389-90, 6427-39, 6470-2, 6476

EDWARDS, Dr. F. H., M.D., M.R.C.P., on behalf

of British Medical Association, *see* Langdon-

Down, Dr. R., &c. ... 7796-8215

FAUDEL-PHILLIPS, LIONEL L., governor of

Bethlem Royal Hospital, *see* Phillips, Dr. J. G.

Porter, M.D., F.R.C.P., and Faudel-Phillips,

Lionel L. ... 5852-5981

FAWSSETT, Dr. FRANK, M.B., Medical Visitor to

Licensed Houses: ... 6892-7039

Licensed houses, visitation of, and safeguards

against improper detention, &c.... 6894-7039

FLINT, J. W., J.P., Member of the Sheffield Board

of Guardians and representing the Association

of Poor Law Unions, *see* Probert, Rev. P. S. G.,

&c. ... 5982-6309

FORD, JAMES H., Clerk to the Leeds Union and

representing the Association of Poor Law Unions,

see Probert, Rev. P. S. G., &c. ... 5982-6309FOX, Miss EVELYN, *see* Tredgold, Alfred Frank,

M.D., F.R.S. (Edin.), &c. ... 21,099-259

FRANCIS, H. W. S., O.B.E., Assistant Secretary of

the Ministry of Health: ... 1223-1473, 21,401-569

Health, Ministry of, Poor Law Division, powers

and duties ... 1224-473

Old Age Pensions ... 21,530-52

"Pauper," stigma, attaching to term ... 1419-39

Pauper lunatics, statistics and distribution 1376-417

Poor law administration, question of transfer to

lunacy authority ... 21,401-569

POOR LAW INFIRMARIES:

Insane patients 1266-82, 1286-97, 1442-6, 1449-52

Medical officers ... 1458-65, 1471

Officers, premature superannuation ... 1453-7

Regulations ... 1256-61

Treatment, complaints *re*

1285, 1295, 1300-50, 1466-70

Wrongful detention, complaints 1283-4, 1288-94

Relieving officers ... 1367-73

G., Mrs., Personal experiences ... 20,560-621

G., Miss, Personal experiences ... 20,428-20,559

GARDNER, Mrs. ROSE DUNN, J.P., L.C.C., *see*

Sidney, Hon. William, J.P., L.C.C., and

Gardner, Mrs. Rose Dunn, J.P., L.C.C.

19,002-19,411

GENERAL BOARD OF CONTROL, SCOTLAND,

evidence on behalf of, *see* Rose, Sir H. Arthur,

D.S.O., and Marr, Dr. Hamilton C.

14,901-15,683

GIBSON, GEORGE, General Secretary National

Asylum Workers' Union, *see* Blood, Walter, &c.

11,835-12,451

GILES, Dr. J. DUDGEON, M.D. Edin., and Medical

Superintendent of Salford Union Infirmary:

3010-3173

Code, simplification desirable ... 3095-9, 3114-6

Neurasthenic cases ... 3157-8

Observation period

3088-92, 3100-11, 3117, 3160, 3167-9

Poor Law institutions in provinces, temporary

detention in ... 3031-7, 3066-7, 3139-49, 3171-2

Reception houses ... 3161-70

Relatives ... 3103, 3121-6

Salford Union Infirmary, mental cases, accommo-

dation, procedure, &c. ... 3030-169

Stigma ... 3103, 3127-9, 3150, 3159

Treatment of mental cases in general hospital

3130-3

GILMOUR, Dr. RICHARD WITHERS, M.B.,

B.Sc. (Durham), M.R.C.S., L.R.C.P.:

18,390-500

Clinics attached to general hospitals 18,394-8,

18,411-31, 18,437-40, 18,444-7, 18,459, 18,470-867

St. Luke's Hospital Clinic ... 18,391-500

GLANVILL, Mrs. F. M., and HILL, GEORGE,

Wandsworth Board of Guardians: 18,248-18,389

Cane Hill, padded room ... 18,347-62

Classification ... 18,268-78, 18,294-5, 18,386-9

Clothing ... 18,363-4, 18,370-6

GLANVILL, Mrs. F. M., etc.—*cont.*

Guardians, further powers of investigation advocated	18,297-310, 18,344-6
Ill-treatment	18,297, 18,308, 18,312, 18,315
Maintenance, payment by Guardians	18,365-70
Puerperal cases	18,272, 18,291-4
Punishment	18,297, 18,305, 18,313-43
Visitation by Guardians	18,249-68, 18,280-90, 18,312, 18,379-81
GOODALL, Dr. E., C.B.E., M.D., F.R.C.P., on behalf of the Medico-Psychological Association. See Cole, Dr. R. H., &c	16,599-17,287
GOLLA, Dr. FREDERICK LUCIEN, Research work	21,001-98
GRAVES, Dr. T. C., B.Sc., F.R.C.S., Superintendent Rubery Hill and Hollymoor Asylums. See Lovey, William Edward, and Graves, Dr. T. C.	5206-380

H., Mr.:	8216-9122
Account of illness	8217
Action against Dr. Stilwell	8935-46

CERTIFICATION:

Dr. Dempster not a certifying doctor as a personal friend, <i>Craig</i>	9442-51
Negligence, complaint of	8262-363, 8817-922, 9039-79

Certification, neglect, reply to charges <i>re, Craig</i>	9207-50, 9267-78, 9307, 9396-401, 9490-505, 9514-9; <i>Stoddart</i> 9631-704; <i>Smith</i> 9950-68, 9983, 10,016-23, 10,129-32.
---	---

Charges at Moorcroft, <i>Stilwell</i>	9757-67
Conveyance to Moorcroft, 8368-94, 8923-30; <i>Phillips</i>	10,163-70, 10,173-5, 10,217-24.

Cheques paid by, 9084-91; <i>Craig</i>	9370-7, 9384-90.
Correspondence, complaint <i>re</i> treatment of, at Moorcroft	8595-6

Escape, telegram to Board of Control after	9020-30
--	---------

EXAMINATION OF:

by Elrich Adler, 8243-53, 8272, 8877; <i>Craig</i>	9155-68, 9312-26, 9338-53.
--	----------------------------

by Dr. McNaughton, 8517-24, 8526-47, 8782-90; <i>Craig</i>	9257-9, 9262.
--	---------------

by Dr. Porter Phillips, 8290-311, 8686-7, 8815-21, 8919-26; <i>Craig</i>	9243-7, 9354-7, 9421-7; <i>Phillips</i> 10,136-62, 10,176-248.
--	--

by Dr. R. P. Smith, 8262-71, 8312-62, 8815-21, 8886-918, 9039-74; <i>Craig</i>	9233-42, 9354-7, 9449; <i>Smith</i> 9950-70, 10,016-23, 10,129-32.
--	--

by Dr. Butter Stoddart, 8271-4, 8361, 8878-85; <i>Craig</i>	9207-15, 9371-7, 9514-9; <i>Stoddart</i> 9620-704.
---	--

Experiences at Teignmouth	9054-63
---------------------------	---------

General Paralysis of the Insane:

Diagnosis, <i>Stoddart</i> ...	9631, 9692-6
--------------------------------	--------------

Diagnosis and treatment, <i>Craig</i>	9166-204, 9262, 9264-78, 9312-53
---------------------------------------	----------------------------------

Diagnosis, probable wrong, <i>Craig</i>	9488-9
---	--------

Information not given to patient, <i>Craig</i>	9429-41
--	---------

Wrong diagnosis of	8247-59, 8361, 8438-46, 8526, 8536-45, 8660-87, 8701-2, 8738-53, 8853-8, 8870
--------------------	---

Interview with solicitor, Mr. Steele	8625-46, 8978-90
--------------------------------------	------------------

Life at Moorcroft and escape, 8393-549, 8771-92, 8801-16; <i>Craig</i>	9251-62; <i>Stilwell</i> 9852-926.
--	------------------------------------

Life at Moorcroft after recapture, 8561, 8935-51, 8992-9002, 9075-6; <i>Craig</i>	9279-300, 9473-6; <i>Stilwell</i> 9716-69, 9793-851, 9931-40; <i>Smith</i> 9973-8.
---	--

Life at Ticehurst and escape	8688-748
------------------------------	----------

Medical history, <i>Craig</i> ...	9124-78
-----------------------------------	---------

Medical treatment at Moorcroft, <i>Stilwell</i> ...	9874-95
---	---------

Position in relation to and interviews with, at Moorcroft, <i>Steele</i>	9546-616
--	----------

Removal from Moorcroft, steps taken by Mr. Steele, 8630; <i>Steele</i>	9592-610.
--	-----------

Removal to Ticehurst	8628
----------------------	------

Residence at Dr. Dempster's house, Croydon, and subsequent action against	8226-368, 9004-12, 9031-8, 9041-4
---	-----------------------------------

Residence with Dr. Dempster, <i>Craig</i>	9148-250
---	----------

Sitting room at Moorcroft, <i>Steele</i>	9611-5; <i>Stilwell</i> 9769-74, 9793-7.
--	--

Urgency order, reason for, <i>Craig</i>	9490-505, 9528-39; <i>Stoddart</i> 9636-9; <i>Smith</i> 9962-8, 10,002.
---	---

H., Mr.—*cont.*

Visits to, at Moorcroft, <i>Craig</i>	9452-72
Wife's attitude on, 8859-69, 9105-11; <i>Craig</i>	9145, 9146-8, 9148-52.

Will, proceedings <i>re, Steele</i>	9559-60, 9578-81, 9585, 9616
-------------------------------------	------------------------------

H., Miss: Personal experiences as nurse	19,566-19,811
---	---------------

HAWTHORNE, Dr. C. O., F.R.C.P., M.D., on behalf of British Medical Association, see Langdon-Down, Dr. R., &c.	7796-8215, 13,500-13,719
---	--------------------------

HEALTH, MINISTRY OF, evidence on behalf of, see Brock, L. G., C.B., 1066-1222, and Francis, H. W. S., O.B.E.	1223-1473, 21401-569
--	----------------------

HILDYARD, G. M., K.C., Master in Lunacy	18,025-18,247
---	---------------

Classification	18,205-17
----------------	-----------

Co-operative and Provident Societies	18,101-9
--------------------------------------	----------

Guardians	18,070-3
-----------	----------

Inquisition	18,033, 18,041-53
-------------	-------------------

Licensed houses	18,231-40
-----------------	-----------

Maintenance, payment for, methods	18,082-8
-----------------------------------	----------

Master in Lunacy, functions, &c.	18,025-35, 18,039, 18,085, 18091-6
----------------------------------	------------------------------------

Old Age Pensions	18,109-18
------------------	-----------

Private patients, accommodation	18,231-47
---------------------------------	-----------

Property and estates, administration	18,057-81, 18,085, 18,091-100, 18,119-66, 18,170-204, 18,218-30
--------------------------------------	---

HILL, GEORGE, see Glanvill, Mrs. F. M., and Hill, George, Wandsworth Board of Guardians	18,248-18,389
---	---------------

HODGSON, Alderman Sir WILLIAM, on behalf of the Mental Hospitals Association, see Taggart, Alderman J. G., J.P., and Hodgson, Alderman Sir William	13,005-13,499
--	---------------

KEENE, HENRY FURSE, O.B.E., Chief Officer of the Mental Hospitals Department of the London County Council:	4699-5071
--	-----------

Accommodation and buildings	4727-9
-----------------------------	--------

After care	5008-9
------------	--------

Complaints by patients	4870-908, 4978-89, 5045-65
------------------------	----------------------------

Chargeability	4853-7, 4862-4
---------------	----------------

Chronic and harmless cases	4920-9
----------------------------	--------

Correspondence	4900-5, 4984-9
----------------	----------------

Dietary	4747-58, 4955
---------	---------------

Discharge	4744-5, 4960-74, 5012-5
-----------	-------------------------

Leave of absence on trial	4782-9
---------------------------	--------

Local Authority, powers and duties	4702-19, 4729, 4734
------------------------------------	---------------------

London County Council, lunacy administration	4703, 4715-8, 4848, 4852, 4858-61
--	-----------------------------------

LONDON MENTAL HOSPITALS:	
--------------------------	--

Admissions, &c.	4792-801, 4909-19, 5018-33
-----------------	----------------------------

Committee and Sub-Committees	4709-13, 4840-4, 4865-9, 4975
------------------------------	-------------------------------

Domestic staff	5040-5
----------------	--------

Maintenance charge	4813, 4830-7
--------------------	--------------

Medical staff	4759-63, 4938-41, 5001, 5017
---------------	------------------------------

Nursing staff	4764-81, 4942, 4944-51, 4990-5007
---------------	-----------------------------------

Private patients in	4790-3, 4802-13, 4816-22, 4848-54, 4956-9, 5035-9, 5065-71
---------------------	--

Structural alterations	4723-7
------------------------	--------

Maudsley Hospital	4930-7
-------------------	--------

Special Acts	4714
--------------	------

Visitation, unpaid visitors	4892-4
-----------------------------	--------

Visiting Committees	4706-13, 4719, 4723-45, 4823-6, 4829, 4926, 4975
---------------------	--

L., Mr.:	20,316-427
-----------------	------------

Certification	20,417, 20,420
---------------	----------------

Classification	20,344
----------------	--------

Complaints by patients	20,420
------------------------	--------

Correspondence	20,389, 20,394-404
----------------	--------------------

Criminal Lunatics Act, patients under	20,415
---------------------------------------	--------

Discharge	20,352-4, 20,356-61, 20,374-7, 20,410, 20,417-9, 20,427
-----------	---

Food	20,366-70, 20,372, 20,386, 20,390-2
------	-------------------------------------

Ill-treatment	20,380-6, 20,417
---------------	------------------

Leave of absence on trial	20,415
---------------------------	--------

L., Mr.—*cont.*

- Medical staff ... 20,366
 Medical Superintendent ... 20,366, 20,370
 Nursing staff ... 20,366
 Parole ... 20,348-51, 20,401A-3, 20,414
 Recreation and exercise ... 20,339-48, 20,370
 Visitation by Visiting Committee ... 20,370
- LANGDON-DOWN, Dr. R., M.B., M.R.C.P.**
 (London); **BONE, Dr. J. W., M.B., C.M.**
 (Luton); **EDWARDS, Dr. F. H., M.D.,**
M.R.C.P. (London); HAWTHORNE, Dr. C. O.,
F.R.C.P., M.D. (London); MASTERMAN, Dr.
E. W. G., M.D., F.R.C.S. (London);
MURRELL, Dr. CHRISTINE, M.D. (London);
VERRALL, Sir JENNER, LL.D., L.R.C.P.,
M.R.C.S. (Leatherhead); and LORD, Dr. C.
COURTENAY, M.R.C.S., L.R.C.P., British
Medical Association 7796-8215, 13,500-13,719
 After-care ... 13,594-614, 13,617-25, 13,710-4
 Approved homes ... 7893-6
 Board of Control ... 13,706-7
 Certificates ... 7963-86, 7989-8012
 Certification: ... 7924-60
 Protection of medical practitioners
 8014-64, 13,679-703
 Reluctance of doctors 8011-12, 8024-6, 8048-9
 Clinics ... 13,626-45, 13,648-50, 13,656-9, 13,704-5
 Clothing ... 7910-9
 Detention, wrongful ... 7819-22, 7924
 Judicial authority and justices
 7936-60, 7987, 8013, 13,660-78
 Licensed houses 13,500-12,
 13,516, 13,519-39, 13,543-59, 13,708-9, 13,715-9
 Lunacy Act, Section 315 ... 7854-60, 7869-79
 Medical Superintendent ... 13,560-93
 Mental Treatment Bill ... 8164
 Observation period ... 7839-44
 Reception and clearing houses 8068-139, 8178-90
 Reception Order ... 7910
 Temporary Orders ... 7942
 Terminology 7824-30,
 7845-52, 7858, 7861-8, 7880-92, 7897-908, 8205-7
 Urgent cases 8080-92, 8177-85, 8186-9, 8190-214
 Voluntary boarders ... 8140-75
 Voluntary treatment ... 7800-8
- LEACH, R. A., Clerk to the Rochdale Union and**
representing Association of Poor Law Unions.
see **Propert, Rev. P. S. G., &c.** 5982-6309
- LEWIS, Dr. HERBERT WOLSELEY, M.D.,**
F.R.C.S., Medical Superintendent, Kent County
Mental Hospital, Maidstone: ... 4561-4698
 Certification ... 4584-5, 4632-3
 Clinics 4566-782, 4585-7, 4590-9, 4664-6, 4677
 Conveyance to asylum ... 4645
 Detention and discharge
 4605-35, 4649-56, 4674, 4679-84
 English Lunacy Legislation Committee ... 4697-8
 Justices of the Peace ... 4657-63
 Maidstone, Kent County mental hospital
 4618, 4646-8, 4675-6
 Nursing staff ... 4648, 4667-72, 4675-6
 Poor Law ... 4579, 4636, 4641-3
 Voluntary boarders ... 4585, 4600-4
- LIDBETTER, ERNEST JAMES, President of the**
National Association of Relieving Officers:
 1474-1775
 After-care ... 1751
 Asylum accommodation ... 1709-20
 Certification 1523-4, 1532-5, 1540-8, 1552-3, 1558-65,
 1570-8, 1596-7, 1581-94, 1726, 1748-55,
 1758-62
 Clinics, for out-patients ... 1751
 Judicial authority, interview with patient im-
 portant ... 1563, 1569-73
 Justices, difficulty in getting hold of ... 1721-6
 Juveniles ... 1726-9
 Lunatic wandering at large ... 1554-6, 1763-4
 Lunatic not wandering at large, &c.
 1485-96, 1526, 1537-8
 Observation period 1613-7, 1655-84, 1707-8, 1732-4
 Pauper, statutory definition ... 1490
 Poor Law Infirmaries 1485-520, 1549-51, 1608-43,
 1650-4, 1685-91, 1696-703, 1712-6, 1766-71

LIDBETTER, ERNEST JAMES—*cont.*

- Property ... 1601, 1604-6
 Reception houses ... 1742-51, 1772
 Records ... 1748-9, 1751
 Relieving officers, appointment, powers, &c.
 1480-3, 1485-551, 1554-61, 1598-607, 1693-4,
 1704-6, 1767
 Senile dementia ... 1726, 1737-9
- LOBOIT, WILLIAM GEORGE, O.B.E., J.P.,**
 Chairman of Visiting Committee of Middlesex
 Mental Hospitals and of Mental Hospitals Com-
 mittee for Middlesex: ... 5072-5205
 After-care ... 5150-1
- CARE:**
 Access to independent person ... 5091-105
 Complaints by patients ... 5095-6, 5100, 5197-202
 Correspondence ... 5103-5
 Outside doctor ... 5193-6
 Employment ... 5172-3
 Certification 5108-23, 5128-9, 5142-9, 5170, 5182-3
 5203-5
 Continuation orders ... 5180-1
 Detention, improper ... 5084
 Discharge ... 5157-67, 5184-90
 Justices, Special ... 5170-1
 Reception houses ... 5125-7
 Urgency orders ... 5142-9
 Visiting Committees ... 5088-105, 5154-6, 5200
 Voluntary boarders ... 5129-41, 5176-9
- LOMAX, Dr. MONTAGU, M.R.C.S.: 12,452-13,004**
 Admission of person no longer insane ... 12,977-87
 Board of Control ... 12,873-94
 Boarding out system ... 12,775-6
- CARE AND TREATMENT:**
 Bedtime ... 12,991
 Croton oil ... 12,996-8
 Food ... 12,988-92
 Ill-treatment ... 12,692, 12,704-31, 12,754-68
 Certification 12,553-6, 12,818-53, 12,956-62, 13,002-4
 Clinics ... 12,974
 Convalescence ... 12,870-2
 Coroners ... 12,732-47
 Detention ... 12,769-80
 Discharge ... 12,517-20, 12,812-4
 Infirmary wards ... 12,946
 Licensed houses ... 12,901-34, 12,940-2
 Nursing staff 12,668-72, 12,674-5, 12,678-80, 12,993-5
 Observation period ... 12,866
 Medical staff ... 12,588-609
 Medical Superintendent
 12,465-520, 12,562, 12,568-9, 12,571-3, 12,576-85
- MENTAL HOSPITALS:**
 Classes of patients that should and should not be
 dealt with in ... 12,528-56
 Executive officer ... 12,570-5
 Hospital cases 12,534, 12,609-10, 12,999-3000
 Size ... 12,515-7
 "Pauperisation" ... 12,944-6
 Reception houses ... 12,861-5
 Visiting Committees
 12,615-21, 12,626-42, 12,645, 12,649, 12,659-67
 Voluntary boarders ... 12,866, 12,976
 Workers, patients employed as 12,555, 12,776-80
- LONDON COUNTY COUNCIL, representatives, *see***
Sidney, Hon. William, J.P., and Gardner, Mrs.
Rose Dunn, J.P. ... 19,002-19,411
- LORD, Dr. J. R., C.B.E., M.B., on behalf of the**
Medico-Psychological Association, *see* Cole, Dr.
R. H., &c. ... 16,599-17,287
- LORD, WILLIAM HENRY, Justice of the Peace:**
 2181-2304
 Certification ... 2190-293
 Lunacy Acts, working of, in Birmingham 2181-304
 Observation period ... 2248-51, 2283, 2289
- LORD CHANCELLOR'S DEPARTMENT, evidence**
on behalf of, *see* Schuster, Sir Claud, K.C.B.,
C.V.O., K.C. ... 945-1065
- LOVSEY, WILLIAM EDWARD, Chairman of the**
Birmingham Asylums Committee, &c., and
GRAVES, Dr. F. C., B.Sc., F.R.C.S.: 5206-380
 Birmingham asylums, admission method ... 5290-2
 Certification ... 5213-4, 5218-46, 5294, 5364

LOVSEY, WILLIAM EDWARD, *etc.*—*cont.*

Complaints by patients	5257-9, 5268-72, 5275-9, 5339-59
Detention, wrongful	5313-33
Discharge	5260-7, 5296-310, 5313-33
Ill-treatment	5275-8
Leave of absence on trial	5366-9
Lunacy administration	5280-5
Nursing staff	5273-4
Re-admissions	5375-80
Senile cases	5247-9, 5286-8, 5370-4
Visitation by Voluntary visitors	5337-8
Visiting Committees	5335-6
Voluntary boarders	5250-3

M., Mr., Personal experience as attendant

19,812-20,038

M., Mrs.:	13,720-14,192
Admission and reception	13,832-63, 13,925-38
Bathing and washing arrangements	13,952-73, 14,013-26

Care and treatment	13,730-3, 13,777-81, 13,939-49, 13,977-14,012, 14,027-9, 14,032-43
--------------------	--

Certification	13,796-821
Clothing	13,974-6, 13,988-95
Conveyance to hospital	13,825-31
Correspondence	14,055-96
Diet	14,095
Discharge	14,113-27, 14,178-89
Illness of	13,738-64
Infirmaries	13,729-30, 13,765-824
Lavatory accommodation	13,880-8, 13,910-4
Medicines	13,880, 13,889-910, 13,968-9
Nursing staff	13,729, 13,789-93, 13,864-78, 13,943-5, 13,949-50
Padded cells	13,915-22, 14,143-6
Receiving ward	13,949-50
Refractory wards	14,056-8, 14,082, 14,103-7, 14,128-57, 14,162-76
Visitation by relatives and friends	14,051-4
Voluntary treatment	14,109-15, 14,171-2, 14,176

MACLEOD, S. J. FRASER, K.C., *see* Willis, Sir Frederick J., &c.

1-944, 21,260-400

MAPOTHER, Dr. EDWARD, M.R.C.P., F.R.C.S.:

18,760-19,001

Qualifications, <i>etc.</i>	18,761-76
Classification	18,781, 18,783-6, 18,886-900, 18,913-7
Clinics	18,789-814, 18,860-1, 18,865-6, 18,919-22, 18,943-8, 18,959-60, 18,969-70
Convalescent homes	18,946, 18,953
Food	18,992
Grant	18,989-90
Maudsley Hospital	18,777, 18,787-8, 18,793-805, 18,811-3, 18,839-40, 18,853-9, 18,905-10, 18,918, 18,955-8, 18,976-7, 18,984, 18,992

MENTAL HOSPITALS:

Class of cases suitable for	18,843-5, 18,961-2
Size	18,862-4
Nursing homes	18,819-33, 18,868
Nursing staff	18,903-7
Observation hospitals	18,846-52, 18,923-42, 18,945-53, 18,959-60, 18,963, 18,969-70, 18,991
Private patients, accommodation	18,868
Registered hospitals	18,881-5
Research	18,976-7, 18,979-88
Single care	18,868-80
Treatment without certification	18,834-7
Villa system	18,993-19,001

MARR, Dr. HAMILTON C., Senior Commissioner, General Board of Control for Scotland, *see* Rose, Sir H. Arthur, D.S.O., and Marr, Dr. Hamilton C.

14,901-15,683

MASTER IN LUNACY, *see* Hildyard, G.M., K.C.,

18,025-18,247

MASTERMAN, Dr. E. W. G., M.D., F.R.C.S., on behalf of British Medical Association, *see* Langdon-Down, Dr. R., *etc.*

7796-8215, 13,500-13,719

MEDICO-PSYCHOLOGICAL ASSOCIATION OF GREAT BRITAIN AND IRELAND, evidence on behalf of, *see* Cole, Dr. R. H., *etc.*

16,599-17,287

MENTAL AFTER CARE ASSOCIATION, evidence on behalf of, *see* Vickers, Miss

7695-795

MENTAL HOSPITALS ASSOCIATION, evidence on behalf of, *see* Taggart, Alderman J. G., J.P., and Hodgson, Alderman Sir William

13,005-13,499

MENZIES, Dr. W. F., B.Sc., M.D., F.R.C.P., on behalf of the Medico-Psychological Association, *see* Cole, Dr. R. H., *etc.*

16,599-17,287

MILLER, Dr. H. CRICHTON, M.D., on behalf of the National Council for Mental Hygiene, *see* Buzzard, Dr. E., Farquhar, *etc.*

17,288-17,433

MOTT, Sir FREDERICK W., K.B.E., LL.D., M.D., F.R.C.P., F.R.S., on behalf of the Medico-Psychological Association, *see* Cole, Dr. R. H., *etc.*

16,599-17,287

MURRELL, Dr. CHRISTINE, M.D., on behalf of British Medical Association, *see* Langdon-Down, Dr. R., *etc.*

7796-8215, 13,500-13,719

NATIONAL ASSOCIATION OF MASTERS AND MATRONS OF POOR LAW INSTITUTIONS, evidence on behalf of, *see* Senior, Harold, and Usher, George

3174-3539

NATIONAL ASSOCIATION OF RELIEVING OFFICERS, evidence on behalf of, *see* Lidbetter, Ernest James

1474-1775

NATIONAL ASYLUM WORKERS' UNION, evidence on behalf of, *see* Blood, Walter, *etc.*

11,835-12,451

NATIONAL COUNCIL FOR MENTAL HYGIENE, evidence on behalf of, *see* Buzzard, Dr. E. Farquhar, *etc.*

17,288-17,433

NATIONAL SOCIETY FOR LUNACY REFORM, evidence on behalf of, *see* Parker, Robert Montgomery Birch

10,346-11,834

O., Mr., personal experiences

20,039-237

P., Mr.:

14,193-349

Attendants

14,339-48

CARE AND TREATMENT:

Bed time	14,277-9
Closet accommodation	14,241-52
Curative treatment	14,289-95
Employment	14,285-7, 14,296-9
Food	14,275-6
Ill-treatment	14,340-8
Medicine	14,242, 14,295
Washing and bathing arrangements	14,239-41, 14,253-63

Certification

14,210-19

Classification

14,220-4, 14,237

Conveyance to asylum

14,210

Discharge

14,306, 14,318-25

General Paralysis of the Insane, wrong diagnosis

14,328-37

Illness of

14,201-7

Infirmaries

14,210

Parole system

14,264-72

Visitation

14,300-17

Voluntary treatment

14,208

PARKER, ROBERT MONTGOMERY BIRCH,

Chairman of the National Society for Lunacy Reform:

10,346-11,834

After-care

11,801

Board of Control

10,396-406, 10,438-40, 10,449-54, 10,456, 10,469-73, 10,476, 11,111-6, 11,801

Boarding out

11,124, 11,127-8

Buildings

11,677, 11,783-6

CARE AND TREATMENT:

Bathing

11,730-1

Books and periodicals

11,748-50, 11,760, 11,762-73

Case books

11,331-4, 11,627-30

Contact with outside world

10,594-5

Correspondence

11,060-86, 11,801

Curative treatment

11,661-75, 11,801

Diet

11,714-28, 11,820-5

PARKER, ROBERT MONTGOMERY BIRCH, etc.—*cont.*

- Drugs ... 11,464-8, 11,472-578, 11,801
 Employment ... 11,654-9, 11,743-5, 11,752-9
 Environment 11,649-54, 11,746-7, 11,761, 11,801
 Examination of lunatic ... 11,103-4, 11,801
 Hours of rising and going to bed 11,777-82
 Ill-treatment ... 11,432-54, 11,459-64
 Information as to rights 11,097-102, 11,801
 Latrines ... 11,579-92
 Medical treatment facilities 11,678-93
 Parole ... 11,774-7
 Punishment
 11,488-9, 11,494-9, 11,501, 11,503, 11,514-8,
 11,522, 11,601-25, 11,631-3
 Recreation ... 11,654-9
 Shaving ... 11,733-8
 Visits by personal doctor ... 11,104
 Central administration and certain localisation
 10,441-8, 10,458-74A, 11,801
 Certification ... 10,608-10, 10,721-1036, 11,801
 Classification ... 11,660, 11,790-7, 11,801
 Convalescence ... 10,659-79
 Detention, improper ... 11,209
 Discharge 10,658-720, 11,131-235, 11,801, 11,826-34
 Hospital visitors ... 10,590-5
 Hulk Mental Hospital ... 11,738-41
 "Insanity," definition question 10,645-720, 11,798
 Internal administration ... 11,640-3
 Leave of absence ... 11,106-23
 Licensed houses ... 11,287-329, 11,801
LUNACY ACT:
 Section 22 ... 11,045-6, 11,051-6
 Synopsis for public ... 11,046-50
 Lunacy law ... 10,415-27, 10,430-2
 Medical staff ... 11,801
 Medical superintendents 11,335-426, 11,640, 11,801
 Mental hospitals, size ... 11,366-8, 11,801
 Month-end reports ... 11,058-9
 National Society for Lunacy Reform
 10,346-64, 10,376

- Nursing staff
 11,433, 11,451, 11,455-6, 11,706, 11,710, 11,801
 Observation period ... 10,479-82
 Provisional order ... 10,483-5
 Recovery rates ... 11,694-703
 Royal Commission ... 10,434-8, 10,445
 Single care ... 11,315-6
 Treatment without certification 10,596-606, 11,801
 "Unsound mind" ... 10,437
 Urgency orders 10,614A, 10,616-41, 10,818-25, 11,471
 Visitation ... 11,087-95, 11,239-85, 11,801
 Voluntary boarders 10,487-96, 10,500-74A, 11,801

PHILLIPS, Dr. JOHN GEORGE PORTER, M.D.,

- F.R.C.P.: ... 10,133-10,345
 Certification 10,249-55, 10,266-306, 10,312-6
 Charges against, *Mr. H.* ... 8815-57
 Examination by, *Mr. H.*
 8290-311, 8686-7, 8815-21, 8919-26
 Mr. H. case ... 10,136-62, 10,176-248
 Observation period ... 10,308-11
 Voluntary boarders 10,307, 10,321, 10,326-45

PHILLIPS, Dr. JOHN GEORGE PORTER, M.D.,

- F.R.C.P., and FAUDEL-PHILLIPS, LIONEL
 L., Bethlem Royal Hospital, &c.: 5852-981
 Accommodation for private patients ... 5980-1
 Bethlem Royal Hospital
 5861-75, 5915, 5918-21, 5931-56, 5959-67, 5974-5
 Certificates ... 5978-9, 5896-8
 Clinics, out-patient ... 5894, 5899-901, 5976-7
 Mental Hospitals Association ... 5926-9
 Nursing staff ... 5915-8
 Observation period ... 5880-95, 5909-12, 5957-8
 St. Bartholomew's Hospital, out-patient mental
 department ... 5902-8
 Stigma ... 5959-60
 Terminology ... 5913-4
 Voluntary boarders ... 5861-78, 5953-8, 5968-73

PROPERT, Rev. P. S. G.; LEACH, R. A.; FORD, JAMES H., and FLINT, J. W., J.P., on behalf of the Association of Poor Law Unions:

5982-6309

PROPERT, Rev. P. S. G., etc.—*cont.*

- Admission to asylum direct ... 6089-101
 Admission of new cases ... 6139-42
 Certification and reception
 6031-5, 6038-46, 6079-88, 6293-4
 Certificates ... 6049-50, 6111-6, 6254-8
 Clothing ... 6172-3
 Discharge by Guardians ... 6283-6
 Fulham, observation wards 5998, 6010-3, 6036
 Inquests ... 6174-5
 Juveniles ... 6242-8, 6275-8
 Lancashire cases ... 6183-93
 Leeds infirmary ... 6197, 6198, 6213-7
LUNACY ACT:
 Sections 13 and 14 ... 6081-8, 6232-7, 6249-53
 Section 20 ... 6090-2, 6099
 Lunacy administration ... 5986-90
 Nursing staff ... 6101-10, 6280
 Observation period ... 5993-5, 5997, 6224-9
 Paupers, temporary treatment of self-supporting
 person as ... 5998-6025, 6081-3, 6183-7, 6193
 Poor Law, stigma question 5998, 6002-5, 6023-4
POOR LAW INSTITUTIONS:
 Temporary detention in ... 6096-101
 Transfer to, from asylums 6143-71, 6198, 6239-41
 Poor Law Unions, Association of ... 6053-61
 Sheffield, cases ... 6225-8, 6259-74, 6303-8
 Statistics ... 6064-78
 Stigma ... 6212
 Terminology ... 6021, 6176-9
 Treatment ... 6026-30
 Treatment without certification
 6042, 6064-78, 6117-27, 6196-212, 6278-9,
 6281-2, 6308-9
 Visitation by Guardians ... 6128-38
 Voluntary boarders ... 6281

ROBERTSON, Professor GEORGE M., M.D.,

- F.R.C.P. (Edin.): ... 15,684-16,261
 Boarding out ... 16,032-5
 Certification
 15,736-7, 15,750, 15,757-84, 15,822-52, 15,879-82,
 15,888-9
 Classification ... 16,206-12
 Continuation reports and certificates 15,799-811
 Detention orders 15,738-66, 15,797-9, 15,822-31
 Drugs and sedatives 16,130-6, 16,174-9, 16,222-3
 Emergency certificates ... 15,812-9
 Epileptics ... 16,105-7
 Exercise ... 16,095-115
 Feeble-minded cases ... 16,189
 Ill-treatment ... 16,237-9
 Judicial procedure 15,740-56, 15,785-93, 16,169-73
 Juveniles ... 16,224-5
 Locked seclusion ... 16,121-9, 16,202-5
 Lunacy laws, administration in Scotland 15,928-33
 Mechanical restraint ... 16,129, 16,165
 Medical Superintendent ... 16,226-35, 16,240-61
 Mental excitement ... 16,144-68
 Mental hospitals, hospitalisation of
 16,095-143, 16,197-205.

Morningside Royal Asylum

- 15,687-723, 15,812-20, 16,042, 16,069-71, 16,080-5,
 16,111-3, 16,228-61
 Noisy patients ... 16,213-7
 Non-volitional cases ... 15,892-3
 Notification ... 15,832-52, 15,879-82, 15,899
 Nursing staff, female employment in male wards
 16,036-94
 Open door system ... 16,116-20
 Padded rooms ... 16,121-6, 16,165, 16,197
 Parole ... 16,118
 Private dwellings system ... 15,936-6035
 Provisional Order ... 15,936
 Psychiatric education ... 15,724-35
 Recreation ... 16,069-71
 Sterilization ... 16,180-95
 Treatment without certification ... 15,853-9
 Voluntary patients
 15,860-78, 15,884-6, 15,888, 15,890-929, 16,007-9,
 16,217-21.

- ROSE, Sir H. ARTHUR, D.S.O., Chairman of the General Board of Control for Scotland; and MARR, Dr. HAMILTON C., Senior Commissioner: ... 14,901-15,683
- Accommodation ... 15,048-85
- Administration ... 14,940-67
- After care ... 15,653-4
- Boarding out ... 15,472-604
- CARE: ... 14,994-5, 15,286-306, 15,379
- Communication with outside world, ... 15,376-84
- Employment ... 15,665-6
- Food ... 15,655-8
- Certification ... 15,154-205, 15,216-31, 15,270-85
- Dangerous lunatics ... 15,240-6
- Detention 15,272, 15,275-80, 15,286, 15,293-4, 15,302
- Discharge 15,385-7, 15,391, 15,394-5, 15,401-20
- District Asylums 14,944-5, 15,058-64, 15,098-108, 15,111-2
- District Boards ... 15,388-93
- Emergency Orders ... 15,219, 15,232-5
- General Board of Control 14,908-9, 14,911-63, 14,970-5039, 15,093-6, 15,650-2, 15,655
- Grant ... 15,149-33, 15,673
- Ill-treatment ... 15,010-26, 15,030-2, 15,034
- Inspector of the Poor ... 15,677-83
- Licensed houses ... 15,478, 15,495-502, 15,533
- Lunatics, statistics 15,042-7, 15,086-8, 15,127-36
- Medical Superintendent ... 15,658-67
- Nursing staff, female, employment for male cases 15,668-72
- Observation wards ... 15,251-62, 15,269, 15,611-2
- Parochial Asylum ... 15,070-6, 15,110
- Pass system ... 15,396-9
- Petition ... 15,175-82
- Poorhouses, lunatic wards 15,076-80, 15,422, 15,426-42, 15,445-8, 15,451-68, 15,670-1, 15,674-6
- Private Asylums, 15,066-9, 15,109, 15,114-5, 15,118
- Private dwellings ... 15,083
- Private patients ... 15,056, 15,090-2, 15,105-17
- Probation system ... 15,396
- Royal and Chartered Asylums 15,048-57, 15,090-6, 15,113-7, 15,120-82, 15,205-39
- Treatment without certification 15,605-10, 15,614-7, 15,619-22, 15,626-49
- Visitation ... 15,376-8, 15,381-4
- Voluntary boarders ... 15,307-375
- SANDERS, Councillor C. F., J.P., Cardiff: 2305-2448
- Cardiff, working of Lunacy Acts ... 2305-47
- Justices, proceedings before 2323-35, 2396-402, 2406-18, 2554-70
- Reception houses ... 2424-5
- Section 13 ... 2336-42
- Treatment without certification ... 2411-3
- Visitation ... 2373-87
- SANDHURST, The Lord: ... 17,764-18,024
- After care ... 17,921-7, 17,934-40, 18,016-7
- Certification ... 17,820-1, 17,835-9
- Chancery Visitors, duties, &c. ... 17,767-17,917
- Classification ... 17,858-60
- Detention, wrongful ... 17,948
- Discharge ... 17,921-40, 17,945-55
- Ill-treatment ... 17,827-9, 17,863-75
- Inquisition cases ... 17,793, 17,801-5, 17,879-82
- Judge in Lunacy ... 17,853-7
- Licensed houses 17,897-915, 17,967-83, 17,987-18,020
- Master in Lunacy ... 17,774-5, 17,833-6, 17,853-7
- Medical Superintendents 17,883-96, 17,902-5, 17,913-5, 18,021-4
- Paranoiacs ... 17,917-20
- Rules in Lunacy ... 17,813-4
- Single care ... 18,012-5
- Visitation: by Friends and relatives ... 17,964-6 by Petitioner... 17,956-63
- SCHUSTER, Sir CLAUD, K.C.B., C.V.O., K.C., Permanent Secretary to the Lord Chancellor: 945-1065
- Aliens ... 1045-7
- Board of Control, Members, appointment 1025-6
- Certificates ... 1011-9
- Controlling body ... 1006-12, 1037
- Inquisitions ... 1027-9
- LORD CHANCELLOR: Jurisdiction of, and question of retention 951-1061
- Letters from patients ... 995-1001
- Public inquiry to determine sanity or insanity of inmate of institution ... 1051-3, 1062-5
- Visitors in Lunacy 967-73, 989-94, 1032-5, 1053-6
- SENIOR, HAROLD, and USHER, GEORGE, National Association of Masters and Matrons of Poor Law Institutions: ... 3174-3539
- Certification of paupers ... 3364-79
- Children ... 3422-35
- Chronic harmless cases ... 3295-301
- Delirious cases ... 3464, 3511-4
- Discharge, power of ... 3371-8, 3438, 3440-6
- Hartlepool Poor Law Institution ... 3231-58
- Justices, proceedings before ... 3436-7, 3471-5
- National Association of Masters and Matrons of Poor Law Institutions ... 3259-65, 3479-80
- Nursing staff 3222-4, 3246-8, 3465-6, 3476-8, 3488-501
- "Pauper" ... 3458
- Poor Law Institutions 3199-205, 3208-11, 3234-7, 3281-310, 3311-5, 3319-72, 3379-421, 3464, 3481-7, 3504, 3509-10, 3517-22, 3526-7, 3536-9
- Senile dementia cases ... 3459-63
- Southampton Poor Law Institution 3180-230, 3341-59, 3465, 3470, 3476-8, 3488-501, 3524-6, 3528-9
- Suicide, attempted 3348-9, 3447-57, 3502, 3506-8, 3515-6
- Visitation ... 3384-90, 3396-8, 3414-21
- "Workhouse" ... 3458
- SIDNEY, Hon. WILLIAM, J.P., L.C.C., and GARDNER, Mrs. ROSE DUNN, J.P., L.C.C.: 19,002-19,411
- After care ... 19,280-95
- Board of Control ... 19,373-5
- Boarding out ... 19,233-47
- Certification ... 19,168, 19,202-32
- Classification ... 19,407-10
- Clinics 19,062-9, 19,097-8, 19,108, 19,121-4, 19,137-48
- Clothing ... 19,317-28
- Food ... 19,297-315
- London County Council Mental Hospitals 19,317-28, 19,332-54, 19,359-72, 19,380-2, 19,386, 19,390-407
- Maudsley Hospital 19,008-136, 19,294, 19,297-315, 19,337-46, 19,351, 19,352
- Medical Superintendents ... 19,384-99
- Mental Hospitals, size ... 19,383-4, 19,400
- Mental Treatment Bill ... 19,006-7
- Non-volitional cases ... 19,152-68
- Nursing staff ... 19,354-5, 19,359-72
- Poor Law Institutions, temporary detention in 19,249-52, 19,268-9, 19,275-7
- Reception houses ... 19,248-67, 19,272
- Voluntary boarders 19,117-8, 19,141-3, 19,149-51, 19,172-201
- SMITH, Dr. ROBERT PERCY, M.D., F.R.C.P., &c.: ... 9941-10,132
- Certification ... 10,065, 10,124-3
- Examination by, and charges against, Mr. H. 8262-71, 8312-62, 8815-57, 8886-918, 9039-74
- no Financial interest in any mental institution 9947-9
- Mr. H. case ... 9941-10,132
- STEELE, CHARLES RICHARD: ... 9544-616
- Conversation with, Stilwell ... 9916-24
- Mr. H. case ... 9544-616

- STILWELL, Dr. REGINALD JOHN, M.R.C.S.,
M.R.C.P.: 9705-9940
Charge against, *Mr. H.* 8842, 8962-4
Mr. H. case 9705-9940
- STODDART, Dr. WILLIAM HENRY BUTTER
9617-704
Examination by, and charge against, *Mr. H.*
8271-4, 8361, 8839-57, 8878-85, 9078-84
Mr. H. Case 9617-704
- TAGGART, Alderman J. G., J.P., and HODGSON,
Alderman Sir WILLIAM, on behalf of the Mental
Hospitals Association: 13,005-13,499
After care 13,476
"Asylum" 13,304-11
Board of Control 13,236-40, 13,394-475
Clinics 13,070-130, 13,131-49, 13,173-80, 13,250-64,
13,312-24
County Councils Association 13,293-8
Discharge 13,182-208, 13,229-31, 13,265-9, 13,281-4
Grants 13,112, 13,232-40, 13,409, 13,446-8, 13,459
General Paralysis of the Insane 13,328
Ill-treatment 13,340-57
Justice of the Peace 13,149-72, 13,278-80
Lancashire accommodation, charges, etc.
13,040-8, 13,053-61, 13,212-23
Medical Staff 13,326-9
Medical Superintendents 13,243-9, 13,325-38, 13,477
Mental Hospitals Association 13,005-19, 13,443
Mental Treatment Bill
13,358-409, 13,412-29, 13,451-71, 13,495-9
Nursing staff 13,479-91
Out-patients 13,127-30, 13,250
Pauperisation 13,302-3, 13,028-130
Private accommodation in asylums
13,058-61, 13,270-7
Private patients, accommodation for
13,058-61, 13,270-7
Qualifications of 13,020-6, 13,285-92
Senile cases 13,209-25
Visiting Committees 13,492-4
- TREDGOLD, ALFRED FRANK, M.D., F.R.S.
(Edin.), ANDREW, Miss FLORENCE,
and FOX, Miss EVELYN, representing Central
Association for Mental Welfare: 21,099-259
Adolescent Mental Disorder, present facilities for
dealing with, and suggestions ... 21,101-259
- USHER, GEORGE, *see* Senior, Harold, and Usher,
George 3174-3539
- VERRALL, Sir JENNER, LL.D., L.R.C.P.,
M.R.C.S., on behalf of British Medical Associa-
tion, *see* Langdon-Down, Dr. R., &c.
7796-8215, 13,500-13,719
- VICKERS, MISS: 7695-7795
Mental After Care Association ... 7695-7795
W., Mr., Personal experiences ... 20,238-315
- WALDEN, Sir ROBERT, C.B.E., J.P.: 2016-2180
Accommodation 2083, 2085
After care 2162-7
Board of Control 2094-6
Boarding out 2143-9
Certification of paupers, duties of justices and
proceedings before
2021-64, 2080, 2087-90, 2150-3, 2159-60, 2168-9,
2179
Classification of patients 2066
Clinics for out-patients 2082
Ill-treatment 2104-5, 2110-2
Independent enquiry as to sanity or otherwise of
patient 2116-28, 2137-40
Medical superintendents, special qualifications
2131-3, 2161
Observation period 2065-6, 2071, 2076
Reception homes ... 2066-81, 2083, 2093, 2170-7
Wrongful detention 2107, 2130
- WHITEMORE, L., J.P. for County of London:
3540-3598
After care 3586-7
Certification of private patients ... 3570-7, 3590-5
Discharge to care of relatives or friends... 3587-9
Drink cases, private 3569
14 days' detention 3589
F frivolous or needless notifications ... 3584-5
Judicial authority, proceedings before ... 3545-68
Lunacy Act, Sections 11 and 20, duplication
3542-3
Observation period 3578-84, 3598
- WIESE, Miss MAUD, R.M.N., *see* Blood, Walter,
&c. 11,835-12,451
- WILLIS, Sir FREDERICK J., K.B.E., C.B.,
MACLEOD, S. J. FRASER, K.C.; and BOND,
Dr. C. H., C.B.E., D.Sc., M.D., (F.R.C.P.,
Board of Control: 1-944, 21,260-400
Accommodation 21,386
After-care 511-2, 514-7
- BOARD OF CONTROL:
Access to, of friends of private patients 607-10
Clerical staff 317-329, 838-40
Commissioners, attendance at head-quarters
system 207-9
Complaints to 409-11
Composition 5, 7, 724-5
Functions 27-31
History 4-5
Inquiry on oath 427-32
Position *re* administration of Lunacy Acts
870-2
- Powers:
Internal administration 841-3
Treatment 938-43
Records 313-8, 733
Disclosure 562, 567, 570, 732-3
Secrecy 561-75
Relations with Ministry of Health and Lord
Chancellor 728-30
Scrutiny of documents
131-5, 153, 161-201, 204-6, 210-1, 215-34, 251,
252, 306-12, 834-7
- Visitation
29, 337-8, 353-6, 357-85, 387-90, 392-6, 401-3,
451, 708, 713-6, 726-7, 874
- Boarding out 66, 71-8, 624-6
Buildings 36-8, 617-8, 728
Care 329-30, 438-9, 443-6, 802-8, 843
Certification
61-3, 93, 128-9, 137-8, 141-52, 161, 168-74,
180-203, 212-4, 236-51, 533-40, 696, 829-33,
849, 856-8
Classification of patients 58
Correspondence 38, 433-7, 443
Cruelty or ill-treatment 893-914
Detention, wrongful, and safeguards
38, 382-5, 403, 486-99, 507-8, 545-6, 645-9,
779-92, 930-7
Diet 842-3
Discharge
397, 481-502, 509-17, 531-2, 541-4, 576-85, 595-603,
606, 748-71, 790-801, 929-31
Discretion, need for 599-603
Guardians, visitation by 338-40, 353
Health leave of absence 467-9
Health, Minister of 37-8
Home Secretary, jurisdiction 36
Inquisition 42, 45-9, 51-6, 257A-8, 342-53, 614
Institutions, classes of 64-6, 620-6
Judicial authority, functions, proceedings before,
&c. 111-60, 568, 573
Licensed houses 82-8, 294, 296-302, 332-5, 341, 616,
619, 627-8, 660-1, 915-24
- LORD CHANCELLOR:
Jurisdiction &c. 32-6, 39-43, 348
Visitation by order of 342-8, 353
Lunacy Commissioners 5-6
Lunacy grant-in-aid 873
- LUNACY LAW:
Code 15-18
Principles of 13-14
Lunacy law and administration, previous inquiries
19-26

WILLIS, Sir FREDERICK J., K.B.E., C.B., *etc.*—*cont.*

Lunatic not a pauper and not wandering at large, not under proper care and control	254-66, 272, 275-9, 286-7, 740, 742-4
Lunatic wandering at large	243
Mechanical restraint	825-8
Medical practitioner's qualifications	925-8
Medical staff	859-65
Mental Deficiency Act	8-12
MENTAL HOSPITALS:	
89, 338, 420-6, 524, 594, 633-9, 650-5, 666-70	
Admission of outside doctors	418-20, 424
Cases from workhouses, proportion	875
Dental work	806
Private patients in	280-2, 636, 638, 656-7
Visitation	335-8, 353, 408, 416-7
Visits by friends and relations	407, 408, 412-6
Month-end and periodical reports	290, 292, 295, 303-12
Non-certification of certifiable cases	670-84
Non-volitional cases	21,350-76
Notices	440-3, 447-51, 807
Nursing homes	21,268-307
Outdoor relief for insane	67, 626, 809-17
"Pauper"	58, 269-73
Petitioners, visitation by	353, 404
Poor Law infirmaries	239-40, 254, 337-40, 353, 604-5, 633-4, 685-721, 874, 876-85, 891-2
Private patients	629-34, 642, 658-9, 781-8
Property and money, control of	611-5, 777-8
Provisional orders	21,378-83, 21,387-400
Reception, procedure after	215-25, 252, 291, 319-29, 845-8
Reception Orders	122-6, 237, 303
Recovery rate, competition	325
Registered hospitals	64, 84-5, 90, 353, 506-70
Single care	67, 353-6, 497, 507-8, 519, 639-44, 661-2
Statistics of cases, 1st January, 1924	67-72
Treatment in hospitals	938-44
Trial leave of absence	385-6, 452-3, 455-60, 466, 468-80, 519-20, 523-4, 525, 527-30, 540, 772-5

WILLIS, Sir FREDERICK J., K.B.E., C.B., *etc.*—*cont.*

Urgency orders	94-5, 105-9
Visitation	42-3, 338-9, 348, 355, 713-6
Voluntary boarders	80-1, 21,262-349
WORTH, Dr. R., O.B.E., M.B., on behalf of the Medico-Psychological Association, <i>see</i> Cole, Dr. R. H., &c.	16,599-17,287
WORTH, Dr. R., O.B.E., M.B., on behalf of the National Council of Mental Hygiene, <i>see</i> Buzzard, Dr. E. Farquhar, &c.	17,288-17,433
Y., Mr.:	
Personal experience	20,622-88
YELLOWLEES, Dr. HENRY, O.B.E., M.D., and CROSLAND, Mrs. CONSTANCE M. R., The Retreat, York	5381-5851
Certificates	5586-7, 5642, 5664-8, 5832-5, 5837-9, 5845-6
Certification procedure	5636-63, 5751-71
Children	5727-8
Complaints	5691-3
Continuation reports	5612-9
Dementia præcox	5729-30
Detention, wrongful	5793-4, 5808-11
Discharge	5627-35, 5779-802
Escape	5847-51
Grading of patients	5739-41
Lady doctor on staff	5412, 5415-8, 5825-31
Medical superintendent, administrative work	5401-11
Medical treatment and drugs	5670-89, 5797-8, 5803-7, 5839-40, 5844
Mental hospitals, stigma	5719
Nursing staff	5424-70, 5472-9, 5482-9, 5491-504, 5507-9, 5720-1
Petitioners	5812-5
Registered hospitals	5395-8, 5724-5, 5818-20, 5823-4
The Retreat, York, particulars <i>re</i>	5381-851
Treatment without certification	5694-718
Voluntary boarders	5705, 5742-50

